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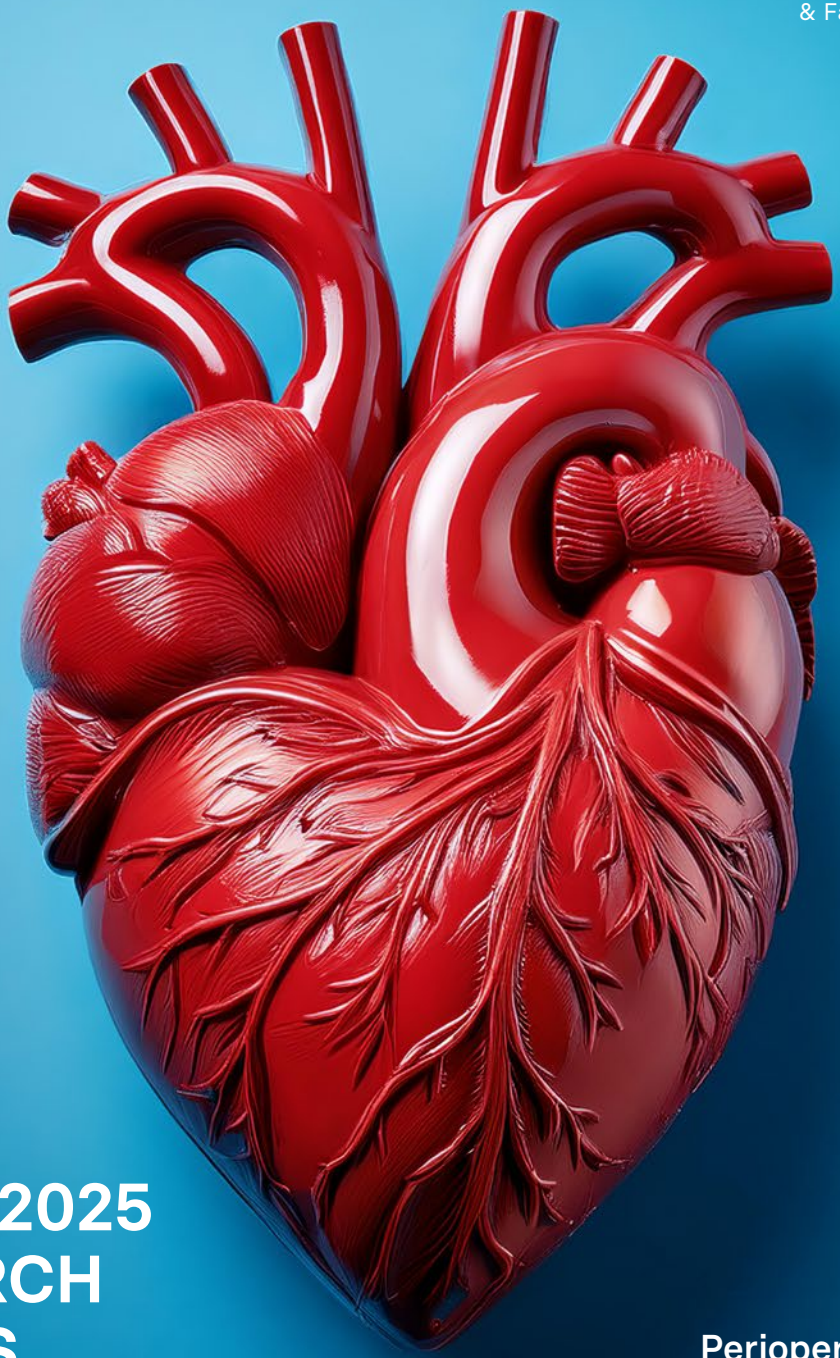
# Bulletin

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

SUMMER 2024



## ANZCA 2025 RESEARCH GRANTS

Funding heart, patient safety and chronic pain projects

### Perioperative Medicine

We've now launched our Chapter of Perioperative Medicine

### Sip Til Send

Latest frontline results: Insights into the experiences and challenges

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# ANZCA
# Benefits of fellowship

*The college is all of us*

- Make a contribution to the ongoing development of our specialty
- Further career development in education, research and leadership
- High quality annual scientific meetings and specialised meetings throughout the year
- Learn how to provide education to others through teaching and examining
- Written information to help communicate with patients
- Eligibility for ANZCA awards
- Only our fellows can use FANZCA
- Access to research librarians and our 24/7 online library
- Access to a new CPD portfolio system
- Professional documents to enhance everyday practice and patient care
- Support towards research, such as grants
- Access to the 24/7 doctor's health support program
- The college advocates on your behalf for workforce wellbeing and quality of care
- Be a part of a college that is a leader in perioperative medicine

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

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

**Exam updates · Events and courses · Committee vacancies**
**Safety alerts · Hospital rotations · Research opportunities**

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**ON THE COVER**

*Stylised, plastic anatomical heart from Adobe Stock AI, generated by ANZCA designer Michelle Nightingale.*


**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 and FPM comprise about 8900 fellows and 1950 trainees. mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

Medical editor: Dr Kate McCrossin
Editor: Clea Hincks
Production editor: Liane Reynolds
Feature writer: Carolyn Jones
Advertising manager: Vivienne Forbes
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**Contact us**
ANZCA, 630 St Kilda Road, Melbourne
Victoria 3004, Australia
+61 3 9510 6299
communications@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine
+61 3 8517 5337
fpm@anzca.edu.au



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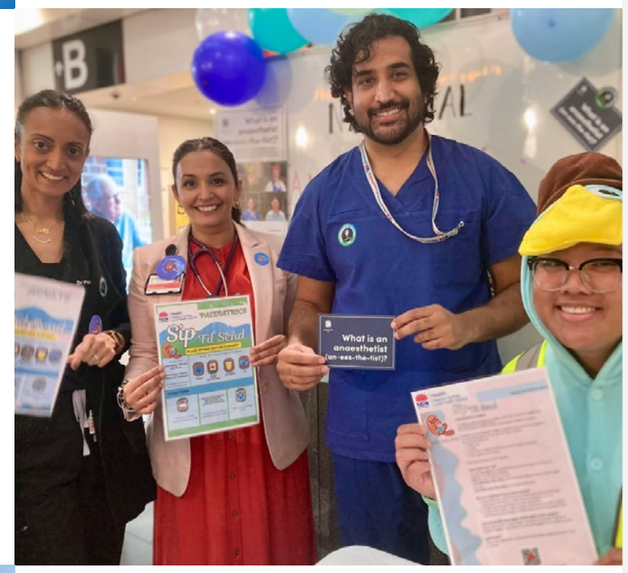
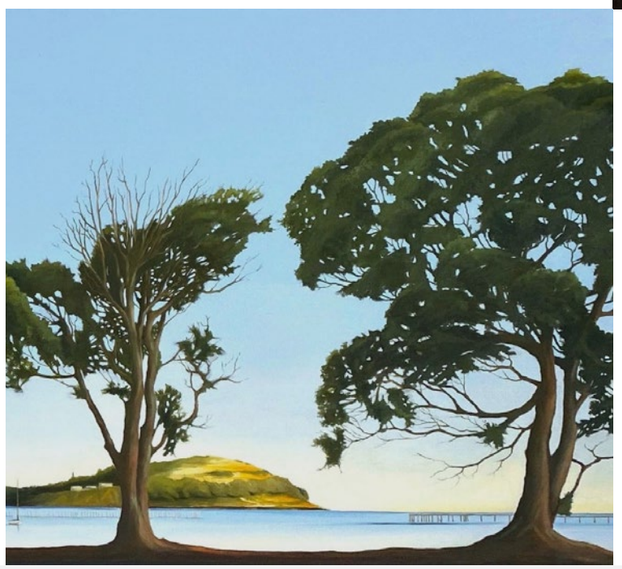
# In this edition









# Advancing perioperative medicine

*You cannot escape the responsibility of tomorrow by evading it today.*
*– Abraham Lincoln*

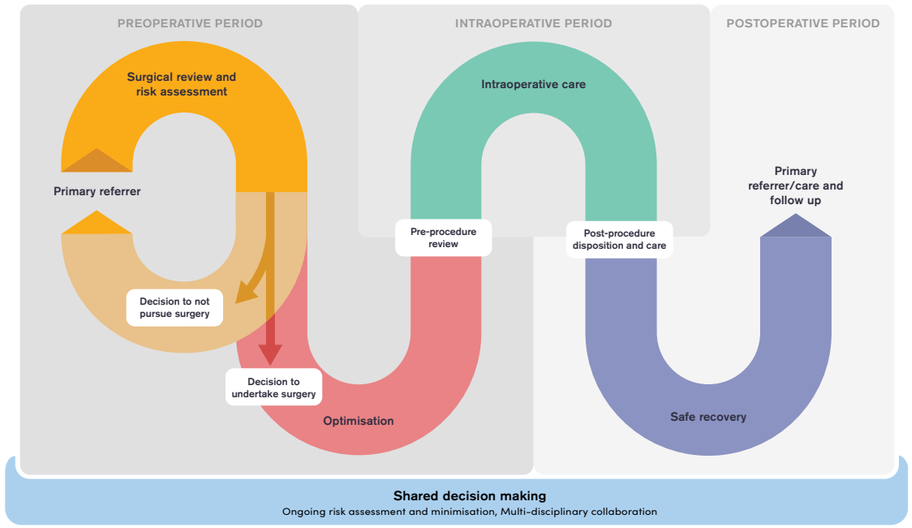
Perioperative medicine (POM) isn't for everyone. Virtually all anaesthetists think being in theatre doing interesting cases with fun surgeons is our work "happy place". But in the ANZCA POM journey, largely pioneered by Dr Vanessa Beavis, we've long known that many anaesthetists would be interested in overseeing up to 24 hours of postoperative care, and a minority, more prolonged care.

The key responsibility and opportunity for tomorrow is to reduce postoperative complications and therefore reduce the burden of new chronic diseases and mortality, and enhance patient postoperative quality of life. What ANZCA is doing today is to continue to develop a world-leading program in perioperative medicine in collaboration with other specialist medical colleges and societies.

One way to think of POM is to envisage the ANZCA perioperative care framework, probably more accurately called the patient journey, but widely known as "the POM nephron".

This is underpinned by shared decision making with the patient (and often family) at the centre. The patient journey starts when (usually) a GP first thinks their patient may need surgery and finishes when the patient has made the best possible recovery. The Bowmans capsule of the nephron (opposite page) is important for avoiding surgery that may be low value or even harmful from the individual patient.

While the visualised journey originated with elective (new buzz phrase "planned") surgery it is applicable to non-elective (unplanned) surgery. The nephron should also be seen as being like a slinky spring toy: in emergency surgery, the first part is compressed but the postoperative period may be prolonged; in day surgery it may all be compressed; in complex cancer surgery with neoadjuvant therapy the first part may be prolonged. I love a good visual analogy.




**LEFT**

*Patient's surgical journey.*

We have recently had a convergence in the "Force for POM". The highly successful POM Special Interest Group (SIG) meeting in November included recognising more than 800 new graduates of the Chapter of Perioperative Medicine (GChPOM): 507 anaesthetists, 173 physicians, 91 intensivists, 17 surgeons, and 34 GPs. The new graduates were grandparented through a points system specific for each specialty. More than 130 received their certificates in person at the SIG meeting and more are still being assessed, applications having now closed.

The first cohort of 36 multidisciplinary participants have recently finished the ANZCA qualification course leading to GChPOM. The course is anchored by the "nephron". One point that makes the course a world leader is clinical immersion which has been provided at 23 hospitals across Australia and New Zealand.

The idea of a chapter was pinched from the college of physicians and is more than a SIG and less than a faculty. It has a governing board which answers to ANZCA Council and is chaired by Dr Chris Cokis, ANZCA Immediate Past-President.

The operational side will be through two committees: Education and Assessment chaired by Associate Professor Joel Symons, and Advocacy and Policy chaired by Dr Jill Van Acker. While led by FANZCAs both these committees will include fellows of the Faculty of Pain Medicine as well as the other colleges and societies.

The work of the chapter adds to FANZCA training, and does not replace or "dumb down" essential learning and training. One example close to my heart is perioperative diabetes (I have type 1) with ANZCA training focusing on providing high-quality care for individual patients with diabetes; an increasingly common and challenging problem. GChPOM builds on this individual care to look at systems approaches to multidisciplinary care.

I have three concrete examples of POM in action from the hospital where I work.

The first is a preoperative pain clinic which provides individualised pain management plans for patients with complex pain conditions and liaises with the Acute Pain Service. This has been a boon for everyday clinical anaesthetists like me.

The second is a geriatrician-led clinic for high-risk patients, particularly those who are frail. This clinic aims to align with patient's goals of care, often avoiding or minimising surgery.

The third is the group of anaesthesia resource nurses who help assess patients under anaesthetist guidance and facilitate preoperative medical optimisation. They are advanced practice nurses rather than independent nurse practitioners.

POM provides FANZCAs with new clinical practice opportunities such as prehabilitation including aerobic, strength, and cognitive training including "surgery school" for patients.

In postoperative care there is also a growing evidence base for advanced recovery room care (ARRC). Patients at intermediate risk of complications receive overnight care similar to a recovery high-dependency unit (HDU) led by anaesthetists. Then depending on how patients have fared overnight anaesthetists then hand over patient care to surgeons, ward POM teams, or ICU This both frees up ICU/HDU beds and reduces postoperative medical emergency team (MET) calls.

However, none of this negates the importance of everyday high-quality anaesthesia care.

The future holds many more complex patients, often older, who need individualised care. The Chapter of Perioperative Medicine is ANZCA taking responsibility for that future today.

**Professor Dave Story**
ANZCA President

# Reflections on 2024

As the year draws to an end it's timely to reflect on how things have changed and the dynamics the college now faces.

The pandemic years were not easy, yet the college continued to deliver on core college activities and deliverables. Post the pandemic we all experienced the hangover of these impacts as the health workforce and health sectors in Australia and New Zealand tried to bounce back.

However, 2024 delivered new challenges for the college, including workforce issues and the impact of climate change. We also witnessed significant socio-political global issues that at times polarised communities, including our own. All of this has occurred in a landscape of generational change and reform across the entire health system with ANZCA at the forefront of having to navigate and respond on behalf of our anaesthesia, pain medicine and perioperative medicine communities.

The number of consultations, submissions, advocacy, and advice sought from a broad range of stakeholders across regulatory, peak bodies, government, and the healthcare sector more broadly to drive reform has been unprecedented this year with ANZCA continuing to play a proactive and leading role.

The introduction of an expedited pathway for specialist international medical graduates (SIMGs) by the Medical Board of Australia and Medical Council of New Zealand and the decision by governments to provide a pathway that bypasses the traditional role of the colleges has been challenging. ANZCA remains committed to supporting and providing a pathway for SIMGs that will lead to fellowship. At the time of writing we are continuing to try to navigate a way through this by focusing on maintaining the safety and quality of patient care and clinical standards of the specialty for the community.

The college has delivered on a number of key strategic priorities and thanks go to the many fellows and trainees that have supported so much of the work in this space and the staff of ANZCA to deliver these outcomes. Of note has been the launch of the Chapter of Perioperative Medicine, and 2025 will witness the second year of this qualification that ANZCA has led with other key specialty colleges. This year was also the second year for graduates from the Advanced Certificate in Rural Generalist Anaesthesia.

The significant investment made by ANZCA Council has seen major progress in the uplift and new development of our suite of IT platforms, including the launch of a continuing professional development (CPD) application, delivery of online exams for the Faculty of Pain Medicine and qualifications for diving and hyperbaric medicine and rural generalist anaesthesia. The development of a new cloud-based training portfolio system is on track for delivery in early 2026. Other ANZCA systems are also on track for delivery of cloud-based secure systems in an environment where cybersecurity has been paramount for the integrity of information and data security.

Next year will see the development of a new ANZCA strategic plan for 2026-2028 and the outcome of the 2024 fellowship survey and the views of our fellowship will be important to feed into this process. In an environment of ongoing significant reform and change and the continued pressure faced by health systems and the workforce in Australia and New Zealand our new strategic plan will be important in focusing the work of the college.

I would like to thank the many fellows, trainees and SIMGs who support the work of the college and the staff of ANZCA after a very tumultuous year.

**Nigel Fidgeon**
ANZCA Chief Executive Officer

# Upcoming elections

## ANZCA COUNCIL ELECTIONS

Fellows are invited to nominate for five vacancies (councillors) on the ANZCA Council. The nomination period opens on Monday 16 December 2024 and must be submitted to the ANZCA Chief Executive Officer by 5pm (AEST) on Friday 31 January 2025. Prior to submission, each nomination form must be signed by two active fellows of the college, as well as by the nominee.

If the number of nominations exceeds the number of positions vacant, a 2025 ANZCA Council election will take place from Monday 10 February – Friday 7 March 2025 via an electronic ballot.

Results of the ballot will be announced at the ANZCA 2025 Annual General Meeting (AGM) which will be held on Monday 5 May 2025 during the ANZCA Annual Scientific Meeting in Cairns.

## FPM BOARD CALL FOR NOMINATIONS AND ELECTION

The call for nominations, for three elected vacancies on the 2025 FPM Board was held between Wednesday 30 October 2024 and Wednesday 13 November 2024, with six nominations received.

Fellows were encouraged to contact the FPM Dean or the Executive Director FPM to gain an understanding of the role and the level of commitment involved, in addition to reviewing the board member attributes document. As the number of nominations exceeds the number of vacancies, the faculty will proceed to an election between Saturday 18 January to Monday 3 February 2025 via an electronic ballot.

Further details on the FPM Board election process can be found on the website. Results of the election will be announced at the FPM Annual Business Meeting which will be held on Sunday 4 May during the 2025 during the ANZCA Annual Scientific Meeting in Cairns.

## ANZCA TRAINEE COMMITTEE ELECTIONS

The 2025 ANZCA Trainee Committee elections will be held in October/November 2024.

The results of the elections will be sent to the Education Executive Management Committee (EEMC) for ratification.

The chairs of the Australian and New Zealand trainee committees make up membership of the ANZCA Trainee Committee.

## VOTING

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

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

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

| Election | Nomination period | Election period | Official announcement date |
|---|---|---|---|
| ANZCA Council | Monday 16 December 2024 to Friday 31 January 2025 | Monday 10 February 2025 to Friday 7 March 2025 | Monday 5 May 2025 at ANZCA Annual General Meeting |
| FPM Board | Wednesday 30 Oct 2024 to Wednesday 13 Nov 2024 | Saturday 18 January 2025 to Monday 3 February 2025 | Sunday 4 May 2025 at the FPM Annual Business Meeting |
| ANZCA trainee committee | Friday 4 October 2024 to Friday 25 October 2024 | Friday 8 November 2024 to Friday 22 November 2024 | Mid December 2024 |

# Letters to the editor

## CONFUSION OVER DRUG APPEARANCE

A very pertinent webAIRS article in the latest Spring *Bulletin* by Dr Lee and Dr Basevi highlights a serious ongoing and unresolved issue in anaesthesia, regarding potential inadvertent administration of the wrong drug, resulting in possible serious complications.

As I open the top drawer on the anaesthetic trolley today, I am confronted with this presentation (below) in the drawer of two drugs used commonly in anaesthesia adjacent to each other, which from above look exactly the same.

One is Dexamethasone 4 mg/ml, the other Metaraminol 10 mg/ml.

I personally know of three instances recently where Metaraminol 10mg/ml has been administered as a bolus in error, due to ampoule confusion.

Fortunately no long term sequelae ensued with any of these mistakes.

An advertorial by a medical defence organisation in the Autumn 2022 *Bulletin* describes a member of the college, and that defence organisation, giving a Metaraminol 10 mg bolus instead of Metoclopramide for a sedation endoscopy. Acute pulmonary oedema ensued; fortunately with full recovery.

The member received a mandatory report to Ahpra by the ICU clinician involved and was given an official reprimand.

I work in a number of different Melbourne hospitals. The image (above right) shows the various presentations of Metaraminol that I find in different facilities, with a sundry assortment of other commonly used drugs in anaesthesia stationed in close proximity in the top drawer of the anaesthetic trolley.


The presentation of Metaraminol 10 mg/ml is a particular problem.

There are four different ampoules above – top right, in this potentially highly dangerous form.

The two ampoules, top left, have 0.5 mg/ml which should be the only presentation of Metaraminol in the anaesthetic setting.

On a wider note as advocated by Dr Lee and Dr Basevi, it is long overdue that standardisation of the presentation of anaesthetic and more widely all medical drugs occurs, despite supply issues and recalcitrant hospital pharmacies reluctant to supply anything other their specific inventory of drugs marketed by their particular sources, and presented according to their manufacturers unquestioned choice.

The tail is continuing to wag the dog – a perilous situation.

Caveat emptor is of course a widely held and valid viewpoint; but anything to reduce human error, which will always occur despite the best intentions must surely be a good choice.

It would be preferable that standardisation of drug presentation was instituted before recommendation by a coronial enquiry.

**Dr Stuart Skyrme-Jones,** FRCA, FANZCA

## DISAPPOINTING CONCLUSION FOR ASPIRATION CASE

I refer to your brief report in your Winter 2024 *ANZCA Bulletin*: "91 year old patient dies from aspiration".

I was disappointed to read the conclusion: "Even when everything is planned and executed perfectly, adverse outcomes can still occur.".

Whilst I agree with the overall sentiments, I strongly disagree with the conclusion reached in this particular case. Aspiration is a dreaded complication which is always on the mind of the anaesthetist. To imply that "everything" was planned and "executed perfectly" with the lack of information provided, is wrong and misses a huge learning opportunity.

There was no mention made of how the patient was beforehand in regard to her aspiration risk apart from "release of abdominal hernia".

Was she vomiting, was there a distended abdomen? What did the AXR show? Did she have an NGT in place? If yes, was the NGT checked that it is working? Was the NGT aspirated before induction. In short was gastric decompression performed?

If no NGT was placed, why not?

Only if every attempt at gastric decompression has been made, could one possibly conclude that despite excellent execution, aspirations can still occur (rarely). In this particular case, it seems there was enough time for decompression.

A decompressed stomach (not fully empty necessarily) in a fully paralysed patient (rocuronium not sux used, as sux increases intragastric pressure) with patient sitting up at 30 degrees, is very unlikely to lead to aspirate, as there is simply no driving pressure to push gastric fluid/content upwards.

The use of gastric ultrasound might well have given us further useful information and serves to highlight the need for anaesthetists to get familiar with this important point of care technology.

To mention less relevant details of INR correction etc but failing to mention crucial efforts at gastric decompression is unacceptable. I hope this can be corrected in your next edition.

**Dr Ingo Weber,** BMBS, FANZCA
Lyell McEwin Hospital, SA

*Editor's note:*

*Our approval to reproduce case studies from the SCIDUA annual reports requires that we do not edit or alter the content in any way. The footnote to the report encourages anaesthetists to read the SCIDUA annual report in its entirety.*

## COMPETENCY BASED MEDICAL EDUCATION IN THE ANZCA TRAINING PROGRAM

I write to highlight the article by Professor Jennifer Weller in the Spring edition of the *Bulletin*, clarifying the purpose and use of workplace-based assessments (WBAs) within the training program.

Her work in this area should not go unnoticed. In particular, the explanation as to how WBAs will form part of the trainee progression decision making process by using "entrustability" (assessed supervision requirements) rather than numerical rating scores. The supervisor roles of support and assessment are now transparently matched.

When WBAs were introduced into the ANZCA curriculum in 2013, there was confusion as to whether they were "formative" (that is, inappropriate for use in assessment to decide progress) or "summative" (that is, able to be used for both learning and assessment processes). There are formative assessments made for our trainees.

As an example, I find it hard to consider that the results of a trial viva could be used to determine whether someone should pass or fail a term. But were the WBAs formative (purely for learning) or summative? In co-writing the 5th module for the ANZCA Educators Program – Assessment in Medical Education (AEME), a decision of ANZCA was required to determine the purpose of WBAs. It was through the work of Jenny Weller (and others) that the way forward became clear, this being that they are low stakes summative assessments with an emphasis on improving learning.

This article may not reach as many supervisors as it should. But it is very important that all of us who interact with trainees understand the use of these learning and assessment tools. Part of the solution is to systematise it within the process (remove the ratings scale). But perhaps more is needed to spread this message across the anaesthesia supervisors (and trainees) in New Zealand and Australia.

**Dr Scott Fortey,** FANZCA
Chair, ANZCA Educators sub-committee

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

# ANZCA and government


## Ongoing concerns around expedited registration pathway

The proposed expedited pathway for specialist international medical graduates (SIMGs) driven by the Australian government began for general practice on 21 October. The Medical Board of Australia (MBA) has provided relevant information on the pathway on their website.

Anaesthesia is one of the next medical specialties due for implementation by the end of 2024.

ANZCA has issued a media release and written to all Australian health ministers calling for an urgent and immediate pause in these plans to fast-track the registration of overseas-trained doctors, without the involvement of medical colleges.

This pathway will bypass existing medical college assessment processes (for agreed qualifications, in anaesthesia's case it will be UK and Irish specialists), with the MBA to conduct paper-based assessment of SIMGs and then approve them for specialist registration in Australia. The college continues to hold considerable concerns about this proposed pathway, in particular the lack of available information to date, ANZCA's limited involvement in developing the proposal and a potential risk to patient safety and quality of care which must remain the central priority.

This expedited pathway will not lead to ANZCA fellowship; therefore, the college is developing a parallel pathway to potential college fellowship to be offered to this expedited cohort. For the college there are some likely non-negotiables, consistent with our current approach. To proceed to FANZCA, we are likely to insist that those on the MBA fast-track must have done an Effective Management of Anaesthetic Crises (EMAC) course, undergone formal ANZCA review of their supporting application and an external workplace-based assessment (the SIMG Performance Appraisal).

ANZCA's concerns about the SIMG pathway detailed in an ANZCA media release attracted strong media coverage across print, broadcast and online media and requests for interviews with president Professor Dave Story. Our widespread concerns are shared by other colleges, including the Royal Australian College of General Practitioners (RACGP), Royal Australasian College of Surgeons (RACS) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) who all published similar media releases.

### MEETING WITH NSW MINISTRY OF HEALTH

ANZCA President Professor Dave Story, NSW regional committee co-chairs Dr Frances Page and Dr Sharon Tivey and college staff met with the NSW Ministry of Health on 9 October. The meeting was initiated following a letter from ANZCA to NSW Health in August 2024 outlining the college's concerns with the NSW anaesthetist workforce profile, workforce shortages and associated perceived lack of government support for our anaesthetists. The meeting touched on the status of NSW Award reform and training requirements to meet workforce demands, both acute and future needs.

ANZCA will continue to work with NSW Health on a range of top priority issues and solutions.

### NSW SPECIAL COMMISSION OF INQUIRY INTO HEALTHCARE FUNDING

Following ANZCA's submission to the inquiry in late 2023, multiple targeted information discovery meetings with the inquiry and the preparation of a detailed witness statement relating to training and accreditation policies and procedures, college representatives attended two hearings:

- Former NSW regional committee chair Dr Michelle Moyle and current committee co-chair Dr Frances Page provided verbal evidence at a hearing session on 24 July which covered workforce and training issues.
- Dr Page also attended a subsequent hearing and intercollege roundtable on workforce and training solutions on 18 October. NSW Health was also present at this session.

The inquiry report is due to be delivered to the NSW government by late March 2025.

### NEW ZEALAND HEALTH REFORM

The Medical Council of New Zealand announced that a fast-track process to obtain registration in the provisional vocational scope of practice in New Zealand was operational on 1 November.

The eligible SIMGs comprise the UK, Ireland and Australia, with anaesthesia being one of the approved areas of medicine.

1 October 2024

**Joint Statement**
**Working together to achieve sustainable high-quality health care in a changing climate**

Climate change and more frequent and intense extreme weather events pose profound and urgent challenges for the physical and mental health of people in Australia.

While Australia has one of the best healthcare systems in the world, it is estimated the health system is responsible, either directly or indirectly, for 5% of Australia's greenhouse gas emissions.[1]

Clinical care contributes more than half of the greenhouse gas emissions produced by health systems. Greening our hospitals' energy and transport is not enough to reduce these emissions. We need to develop low-emission, climate-resilient and culturally safe models of care that deliver on the three principles of sustainable health care:

1. Investing in prevention, to improve health while reducing healthcare demand and associated emissions
2. Minimising potentially harmful and wasteful care, which accounts for around 30% of the emissions footprint of clinical care[2]
3. Minimising emissions associated with the delivery of high-value care.

Recognising that Aboriginal and Torres Strait Islander peoples have been the traditional custodians of the land for thousands of years, we need to embed this knowledge and experience when addressing the health impacts of a changing climate.[3]

Actions to address the health impacts of climate change must also take a health equity approach, because some groups, such as rural and remote communities and Aboriginal and Torres Strait Islander peoples, are at a disproportionately increased risk of adverse health impacts from climate change due to existing inequities.[4]

Australia's first National Health and Climate Strategy, released in December 2023, sets out a whole-of-government plan to address the health impacts of climate change while reducing the health system's significant contribution to the emissions footprint.

The Strategy recognises that Australian medical colleges have important responsibilities in shaping clinical care delivery and in educating and training doctors. Medical colleges play a critical role in preparing the next generation of clinical leaders to practise culturally safe, sustainable medicine in a changing climate.

The Australian Commission on Safety and Quality in Health Care (the Commission), the interim Australian Centre for Disease Control (interim CDC) and Australian medical colleges have agreed to work together to develop a framework for action on climate and health including meaningful and demonstrable actions to:

- Develop low-emissions models of care, including actions to improve care, minimise wasteful health care and involve patients in decisions about appropriate care
- Mobilise and support the health workforce to lead the health system response to climate change.

Joint Statement: Working together to achieve sustainable high-quality health care in a changing climate Page 1

## JOINT STATEMENT ON CLIMATE CHANGE AND HEALTH

The college has signed an historic joint statement to reduce the health system's carbon emissions. This shared commitment is an Australian first with the Australian Commission on Safety and Quality in Health Care (Commission), interim Australian Centre for Disease Control (interim CDC), Council of Presidents of Medical Colleges (CPMC) representing all medical colleges, and the Australian Indigenous Doctors' Association (AIDA).

The Joint Statement: Working together to achieve sustainable high-quality health care in a changing climate recognises that climate change poses profound and urgent challenges to physical and mental health. It outlines how the health system can reduce its own environmental impact by delivering appropriate and sustainable health care.

The commission, the interim CDC, all medical colleges and AIDA have agreed to work together to:

- Develop low-emissions models of care that prioritise prevention, reduce low-value tests and treatments and minimise emissions from high-value care
- Mobilise and support the health workforce to lead the health system response to climate change.

This shared commitment will enable us to work together to achieve a more sustainable health system for the people of Australia.

This joint statement further strengthens ANZCA's commitment, actions and measures to minimising the health impact of climate change, promoting environmental sustainability and reducing its environmental impact. Further information on ANZCA and Environmental Sustainability Network's actions is located on the ANZCA website.

## SUBMISSIONS

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

### Australia

- Australian Commission on Safety and Quality in Health Care: Colonoscopy Clinical Care Standard review.
- Australian Commission on Safety and Quality in Health Care: Updated draft Advisory AS24 Reprocessing of ultrasound transducers used for percutaneous procedures.
- Medical Board of Australia: Health checks for late career doctors.
- Parliament of New South Wales Committee on the Health Care Complaints Committee: Performance of the Health Care Complaints Committee.

### New Zealand

- Medical Sciences Council of New Zealand/Te Kaunihera Pūtaiao Hauora O Aotearoa: Anaesthetic technician scope of practice and competence standards.
- Ministry of Business, Innovation and Employment/ Hīkina Whakatutuki: Work health and safety.
- Ministry of Health/Manatū Hauora: Developing the Hauora Maori Strategy 2025.
- Ministry of Health/Manatū Hauora: Suicide prevention action plan 2025-2029.

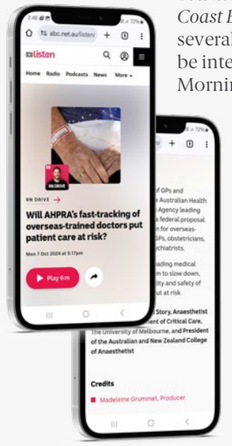




# What we're talking about

## Media

ANZCA President Professor Dave Story was interviewed by Australian media outlets in October about the college's concerns about the fast-tracking proposal for overseas trained doctors by the Australian Health Practitioner Regulation Agency (Ahpra). ANZCA's media release "Patient care at risk under national plan to fast track overseas medical doctors" was reported by the *Herald Sun* and the article by medical editor Robyn Riley was syndicated in print and online to other News Limited publications across Australia (*Daily Telegraph, Adelaide Advertiser, Courier Mail, Hobart Mercury, Cairns Post, Townsville Bulletin, NT News, and Gold Coast Bulletin*). The media release led to several requests for Professor Story to be interviewed on ABC Radio Brisbane Mornings, ABC Radio Perth Drive, ABC Radio Melbourne Drive and ABC Radio National Drive. He was also interviewed by *Australian Doctor* and the *Medical Republic*.




Professor Story also recorded news bulletin audio "grabs" for 2GB and 3AW and these were run in news bulletins on these stations and their syndicated stations. Nearly three million people were reached across these platforms across a diverse demographic of readers and listeners in metropolitan, regional and rural Australia.

## Facebook


The most popular post on Facebook in October (based on impressions) was a snippet from the *ANZCA Bulletin* featuring Auckland City Hospital's Gus the therapy dog. The post received nearly 4000 impressions and had more than 650 post engagements (reactions, shares, comments and clicks). Gus is a two-year-old labrador/golden retriever cross and is owned by consultant anaesthetist Lora Pencheva. Dr Pencheva, who works for the hospital's acute pain service, said the idea of using Gus for pet therapy came to her after she saw other therapy animals in the hospital.

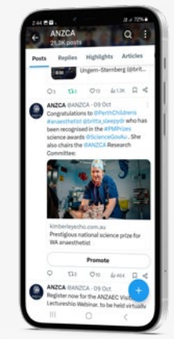
## Instagram

On Instagram, the most popular post was our National Anaesthesia Day compilation video with the theme "You're in safe hands" which featured FANZCAs telling their own stories. The video post attracted 5163 views and 128 interactions and was shared 24 times. The National Anaesthesia Day wrap up post included photos from hospitals across Australia and New Zealand. Nearly 50 hospital champions embraced the day by setting up displays with posters, activity sheets for kids, baking cakes and anaesthesia simulation demonstrations. On YouTube, the NAD videos had more than 1200 views. We also saw a spike in YouTube views for our "What is anaesthesia?" animated video.


## X (formerly Twitter)

ANZCA's Research Committee chair, Professor Britta Regli-von Ungern-Sternberg, received the 2024 Frank Fenner Prize for Life Scientist of the Year. The Perth-based paediatric anaesthetist was presented with her award at the annual Prime Minister's Prizes for Science 2024 awards on 8 October. She was interviewed on the ABC News Breakfast TV program on 9 October about her award and was also a nominee in the 2025 WA Australian of the Year awards.

In addition to her ANZCA role Professor Regli-von Ungern-Sternberg is the first and only chair of paediatric anaesthesia in Australasia and leads the newly founded Institute for Paediatric Perioperative Excellence at the University of Western Australia.



# Farewell to a great leader

**Richard John Willis passed away on 11 October 2024. Known to most as Dick, he lived a full and varied life with activities that spread well beyond his achievements and roles in anaesthesia.**

**ABOVE**

*From top: Dr Dick WIllis was ANZCA president from 2000-2002.*

*Dr Willis at the unveiling of his portrait in the early 2000s.*

## EARLY LIFE

Dick was born in Mt Gambier in south eastern South Australia on 9 April 1944, the child of Jack, a local GP, and Zelma. He had a childhood with all the benefits of growing up in a regional centre. He excelled at the local schools, but moved to Adelaide to attend Adelaide High for his final year of secondary education. The move did not dampen his enthusiasm for academic success and he easily obtained the results needed to study medicine at the University of Adelaide.

During his university years he joined the Royal Australian Navy (RAN), principally to help with his living expenses, but also because he had a strong family connection to the navy. His older brothers were both navy men, both rising to the ranks of Rear Admirals. On completion of his medical degree Dick was required to repay three years to the navy. During this time he saw active service as a doctor on board a hospital ship off the coast of Vietnam.

## FAMILY

Dick had the great good fortune of marrying his childhood sweetheart from Mt Gambier, Greta Partridge. Their loving relationship was apparent to all who were blessed with meeting them. Greta being the great organiser of Dick's diary, and Dick recognising that his achievements would not have been possible without Greta. Greta's death, some seven years ago, was undoubtably the worst experience of Dick's life.

Dick and Greta have four children, Sam (also a FANZCA), Luke, Carl and Gemma. Dick was quietly very proud of his children. Those children have done their parents proud. Between them they have provided 12 grandchildren. There was nothing more important to Dick than family. During his retirement, one of Dick's great passions was to spend time with his grandchildren, often entertaining them with the products of his woodworking skills. His shed was a place of joy, and not lacking in any useful pieces of equipment.

Dick and Greta were avid environmentalists. Their walking holidays through many remote areas of Australia were, in part, the instigation for their involvement in a number of ecological activities. Among these was Plants for Life. There can't have been many plants that received more attention than those that Dick raised.

## ANAESTHESIA

After Dick completed his time with the RAN, he returned to Adelaide where he undertook training in anaesthesia. Upon achieving FFARACS in 1975 (and conferred with FANZCA in 1992) he felt the need for extra clinical experience, so he and Greta and their young family moved to New Zealand for a year, then on to Seattle for another 12 months. He would later reflect upon the importance of this adventure.

Dick returned to Adelaide and took up a position of staff specialist in anaesthesia at the Flinders Medical Centre, with an academic appointment to Flinders University. He rose to the position of deputy director. During this time he was a mentor to many aspiring anaesthetists, and in later years when some of these became FANZCAs his pleasure for them was obvious.

In 1988 Dick was appointed as director of anaesthesia at the Royal Adelaide Hospital. He skilfully, and successfully, managed to cohere a diverse group of anaesthesia consultants and trainees, to work with an even more diverse and demanding troop of surgeons and procedural physicians. His calm and decisive manner was instructive in how to deal with the many conflicts that arise in the day to day management of theatres, and also in the long-term planning for a constantly growing demand for extra anaesthesia services without the necessary increase in funding.

He also maintained an active clinical role, with neuroanaesthesia being a specific area of interest. His presence in theatre was always appreciated, especially by the anaesthesia nurses and junior doctors, who knew that they would have a pleasant shift.

Upon the completion of his term as president of ANZCA in 2004 he was asked to take up the position of director of anaesthesia at the Lyell McEwin Hospital where there had been some management difficulties. He had significant success in this role with an improvement in relationships, and an increase in staff numbers. He retired from this position and clinical anaesthesia in 2009.

## ANZCA

The involvement of Dick in ANZCA, and to a lesser extent the Australian Society of Anaesthetists (ASA), is indicative of his commitment to the advancement of anaesthesia, both locally and nationally.

His roles included:

- Supervisor of training Flinders Medical Centre 1984-1990
- Member ASA SA Committee of Management 1984-1992, Chair 1987-1990, Member, ASA Federal Executive 1987-1990
- Member Panel of Examiners 1985-1997
- South Australian Regional Committee Faculty/ASA Continuing Medical Education Committee Chair 1988-1992
- Member Final Examination Committee (Anaesthesia) 1991-1997
- ANZCA Council Member 1992-2004
- Member, Continuing Education and Quality Assurance Committee 1992-1997, chair, General Scientific Meeting Scientific Program Committee 1992 and 1993
- Annual Scientific Meeting officer and chair ASM Committee 1993-1997
- Joint Consultative Committee on Anaesthesia 1992-1993 and 1997-2000
- Anaesthesia and Industry Liaison Committee 1992-1997
- Chair of Examinations 1993-1997
- Member ANZCA Executive 1995-2004, Chair 2000-2002
- Honorary treasurer 1997-2002
- Computer Committee/Information Technology Committee 1997-1999
- Asia Pacific Committee 1997-1999
- Chair New Zealand Structural Review Working Party of ANZCA 1999
- ANZCA vice president 2000-2002
- ANZCA president 2002-2004
- ANZCA director of professional affairs 2009-2012

To summarise, he was intimately involved in education, examination, planning, professional development and technology along with oversight and management of ANZCA. The great majority of this work was voluntary. The college owe Dick, and Greta, a huge vote of thanks.

## AWARD

In recognition of Dick's commitment to anaesthesia in the public arena, both as a clinician and manager, and his many roles with ANZCA, he was made a member of the Order of Australia for significant service to medicine in the field of anaesthesia in the 2015 Australia Day Honours.

Dick had a private funeral. His family later celebrated him with a memorial service that was extremely well attended by people who had shared the many aspects of his life. He was remembered as a charming man, a true gentleman, a great friend and colleague, and a man who managed to make every individual special. Appropriately he was farewelled with his favourite tipple. A glass of red wine.

Vale Dick.

**Dr Neil Maycock,** FANZCA
Adelaide

*With thanks to Dr Sam Willis, FANZCA, for his contributions*

# Dealing with simultaneous procedures

**ANZCA's Directors of Professional Affairs, Policy, Dr Michelle Mulligan and Professor David A Scott, explore the issue of anaesthetists undertaking a procedure on a patient while another is still under their care.**

*A young fit and healthy ASA 1 patient is receiving a general anaesthetic with you as the sole anaesthetist. They are completely stable, and the case is going to last for quite some time. There is a long list of patients for the day, and it seems the list might run late. The surgeon is keen to "get on with it" and make sure all the cases are done without delay. You are debating whether to perform a simple shoulder block on the slim, fit and well patient who is up next for shoulder surgery. Should you?*

*Your colleague tells you of a case at St Elsewhere's where a similar patient had an "easy" shoulder block in the anaesthetic bay while another was still having surgery. The patient was left unsupervised immediately after the block and when the anaesthetist looked back through the window the patient was having tonic-clonic seizures. It was treated with midazolam 5mg, but the seizures did not cease and required intubation and transferred to the intensive care unit.*

**Is it ok for anaesthetists to undertake procedures on a second patient in an anaesthetic room or bay, while a primary patient is still under their care?**

It is recognised that this is a complex area because there are so many variables to consider and because there are wide variations in what this practice might entail.

The applications of ANZCA standards and guidelines clarify an approach that an individual anaesthetist, and the organisations in which they work, can apply to balance competing demands and resolve issues.

For the procedure on the primary patient, *PS53(A) Handover* states that the anaesthetist should be «continuously present throughout the procedure». For an anaesthetist to be undertaking, for example, major regional anaesthesia or central venous access on another patient, temporary handover of care of the patient having the ongoing procedure should occur according to the protocol outlined in *PS53(G) Handover Section 2*. In this section, handover to an 'anaesthetist' is specified. Provided the primary anaesthetist is immediately available, temporary delegation of observation to a suitably trained and qualified practitioner working within their scope of practice may be possible, depending on clinical judgement relating to the nature of the primary case, the practitioner's ability to give the patient their undivided attention and the type of anaesthesia. (see *PG18BP Monitoring Section 4.7*). This would also apply to other situations for example going to a nearby area such as to post anaesthetic care unit (recovery) to review a patient.

Any major regional anaesthesia should be conducted in accordance with *PG03(A) Major Regional Anaesthesia* including appropriate assistance and monitoring, and in an appropriate environment. After initiating the regional block, it is the responsibility of the proceduralist to remain immediately available until a satisfactory block has been achieved, the patient is stable, and the potential for immediate complications has passed. On this basis, any such procedure must be relatively minor (for example, intravenous cannulation), done in immediate proximity of the ongoing case, and a medical practitioner or nurse be able to remain with the patient if they have received intravenous sedation.

If sedation has been provided, then the requirements of *PG09 Procedural sedation* need to be followed as well. When drugs are prepared in advance, the risk of syringe swap is very possible, for example muscle relaxant instead of midazolam especially when distracted or task overloaded.

*Standards for Anaesthesia* is the ANZCA document which articulates the identified standards of quality care. They are the benchmark against which quality care can be measured. ANZCA guidelines are tools that recommend actions or steps to be followed to achieve or exceed the expected standard of healthcare delivery, the two document types complement each other.

*ANZCA Standard 3* outlines the standards for intraoperative care. Section 3.4 articulates the standards for monitoring and observation:

> "Observation and monitoring are integral functions of interoperative anaesthesia management. They demand the constant presence of an anaesthetist from induction to emergence and documentation of observations as well as monitored physiological variables... Changes in physiological function arise and may occur rapidly and unpredictably, and with varying degrees of risk during the interoperative period. Mitigation of these risks is achieved through the constant presence of anaesthetists and their advanced specific skills aided by maintenance of situational awareness, which is assisted by observation and monitoring."

It is recognised that considerable work pressure can exist that with the need to efficiently use theatre time. This can create a sense that the necessary time to safely conduct an anaesthetic is somehow "wasting time" as the theatre is not visibly occupied with surgery. As professionals, ANZCA, as well as the Australian Health Practitioner Regulation Agency and the Medical Council of New Zealand, requires professionalism in our practice behaviours. In the ANZCA document *Supporting Professionalism and Performance* (under leader and manager), there is an emphasis on the important responsibility for the anaesthetist who "balances safety, effectiveness and efficiency...".


In addition, the standards note that for an anaesthetist to provide best possible patient care there needs to be the existence of policies and protocols that ensure facilities meet the needs of the services being provided at the health services. Facility policies that align with the ANZCA guidelines and standards encourage a shared understanding between the anaesthetist and the remainder of the surgical team around expected behaviours and timelines for task completion.

ANZCA advocates safety and professionalism in anaesthesia provision, which includes compliance with guidelines and good practice.

**Dr Michelle Mulligan**, FANZCA
**Professor David A Scott**, FANZCA, FFPMANZCA
ANZCA Directors of Professional Affairs, Policy

**ABOVE FROM LEFT**

*Professional Documents; PS53(A) Handover, PG18(A) Anaesthesia monitoring, PG01(A) Major regional analgesia, Standards for anaesthesia (Standard 3).*

# How we celebrated #NAD24

More than 50 hospital champions in Australia and New Zealand embraced National Anaesthesia Day (NAD) on 16 October by setting up displays with posters, activity sheets for kids, baking cakes and even anaesthesia simulation demonstrations.

We also decorated our ANZCA offices around Australia and New Zealand and celebrated with cake.

In Perth, anaesthetists at St John of God Midland Public and Private Hospitals organised a department display with simulation models while fellows at Royal Perth Hospital set up a colorful display featuring posters and educational mannikins.

Special NAD24 cakes were the order of the day in Taree, NSW, at Manning Base Hospital, and at Ipswich Hospital in Queensland and in Canberra, the department of anaesthesia at Royal Canberra Hospital used the day to speak to the public about the specialty in their hospital foyer with snacks and fruit on hand for interested onlookers.

Fellows at the Royal Prince Alfred Hospital in Sydney organised a foyer display while a special order of "You're in safe hands" cupcakes were popular with the departmental staff at St George Hospital in Sydney.

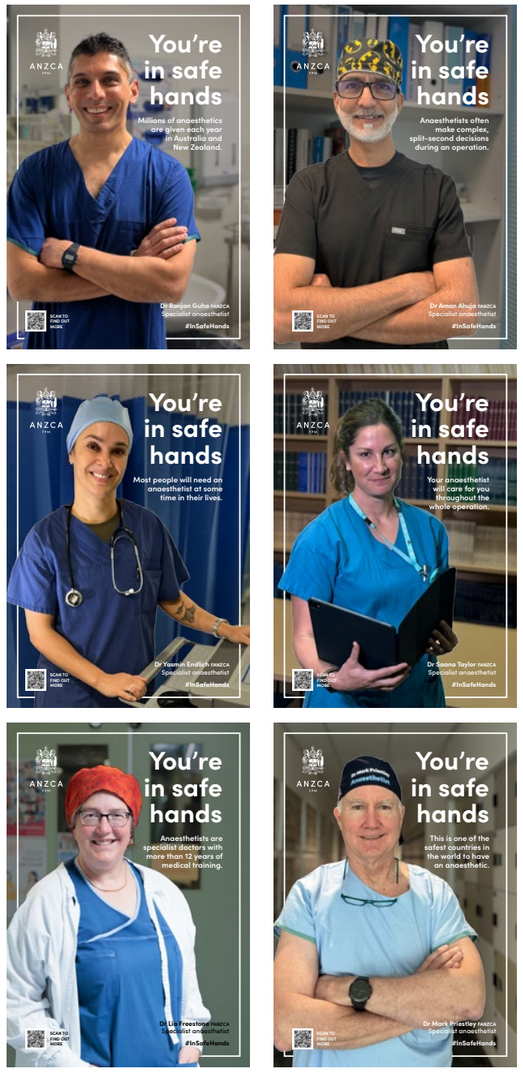
At Sydney's Blacktown Hospital anaesthetists set up a stall to help inform onlookers about their Sip Til Send, patient safety and wellbeing initiatives and Interplast created their own video for NAD.

The Royal Hobart Hospital set up posters and cupcakes and staged their own simulation display in the foyer and you can read more about their support in our breakout article.

National Anaesthesia Day was again strongly supported across New Zealand, with urban and regional hospitals from both islands taking part.

Welington Regional Hospital's display in the main foyer attracted plenty of attention from patients and the public, while Hutt Valley Hospital utilised a large-screen television to help promote the ANZCA pre-recorded interviews with anaesthetists.

In Invercargill, the display included airway equipment and a teaching defibrillator to help attract interest.

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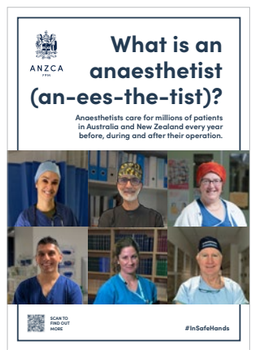
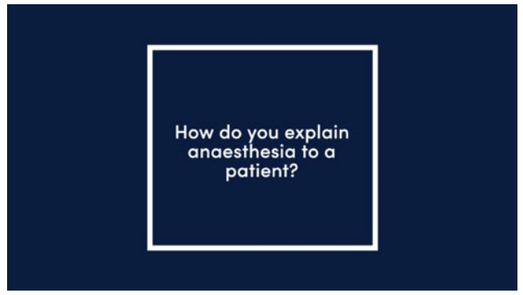
*#NAD24 posters and postcard.*





## NAD COMPILATION VIDEO

The theme for 2024 National Anaesthesia Day was "You're in safe hands" and this year we took a more general approach using real anaesthetists telling real stories.

Our posters featured six fellows across Australia and New Zealand Dr Mark Priestley (NSW), Dr Yasmin Endlich (SA), Dr Saana Taylor (NZ), Dr Ranjan Guha (Vic), Dr Lia Freestone (Tas) and Dr Aman Ahuja (Qld) with the following key messages on each poster:

- Most people will need an anaesthetist at some stage in their lives.
- Anaesthetists often make complex, split-second decisions during an operation.
- Millions of anaesthetics are given each year in Australia and New Zealand.
- This is one of the safest countries in the world to have an anaesthetic.
- Anaesthetists are specialist doctors with more than 12 years of medical training.
- Your anaesthetist will care for you throughout the whole operation.

From the individual interviews with the six anaesthetists, we pulled together a compilation video.

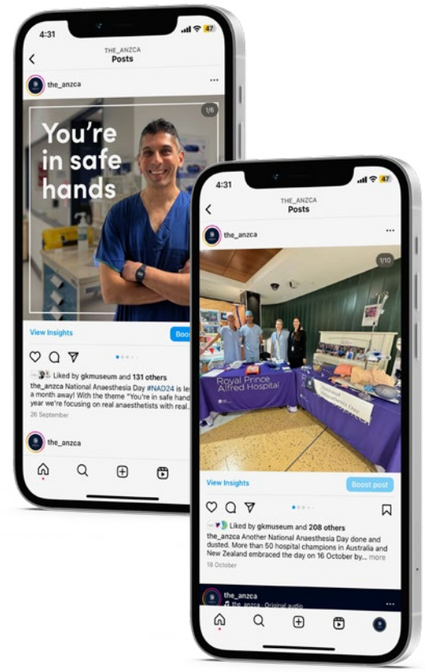
We also created a "What is an anaesthetist? (an-nees-the-tist)" poster. This wording was used for a postcard that included a QR code to the patient information section of our website. All were undated so that they could be used year-round. The whole suite was also translated into te reo Māori.

## DIGITAL AND MAINSTREAM MEDIA

On our website, the NAD page was our third most visited for the day. On social media, our seven videos have so far received nearly 8000 impressions on Facebook, more than 13,000 views on Instagram, and nearly 6400 views on X (Twitter). On YouTube, the videos have more than 1200 views. That's nearly 29,000 views all together. On YouTube, we also saw a spike in views for our "What is anaesthesia" animated video.

We developed six media releases based on the anaesthetists in our posters which were sent to the communications departments of their hospitals, and radio "grabs" pre-recorded with ANZCA President Professor Dave Story were downloaded for news bulletins at stations in NSW and Queensland.

We even had a Spotify playlist "Hey National Anaesthesia Day" developed by staff member Susan Considine's husband Douglas. The 150-plus list included tracks such as "You're in safe hands" (our theme), "Comfortably numb", "Going under", "Fuzzy brain", "Under the knife", "Count to 10", "Fade to grey", "Give me novacaine" and our personal favourite "Wake me up before you go-go".

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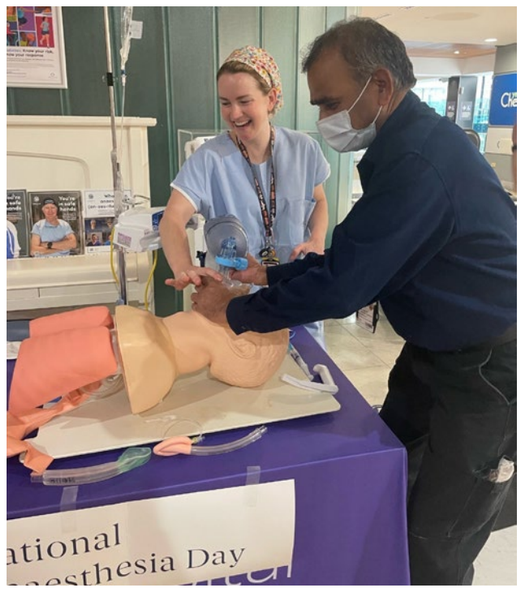
*#NAD24 video stills and socials.*




**CLOCKWISE FROM TOP**

*#NAD24 in Canberra Hospital, Dunedin Hospital, Royal Prince Alfred Hospital in Sydney, Royal Perth Hospital and Ipswitch Hospital.*

# #NAD24 Tasmanian anaesthetists celebrate simulation education

Anaesthetists at Royal Hobart Hospital performed a series of emergency situations for a WIN News crew on 16 October to highlight the specialty in Tasmania on National Anaesthesia Day.

Dr Lia Freestone, specialist anaesthetist at Royal Hobart Hospital, and one of six anaesthetists who featured in the 2024 National Anaesthesia Day poster campaign, was interviewed for the news segment.

The National Anaesthesia Day event in the foyer of the Royal Hobart Hospital celebrated anaesthetists and anaesthetic nurses with a display of the Tasmanian Anaesthetic Simulation Education and Training Network (TASETN) simulation equipment.

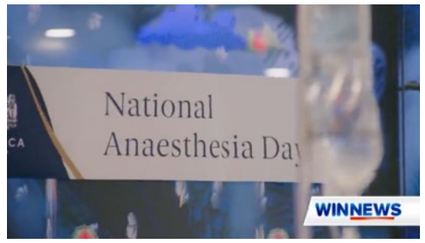
Anaesthetists and anaesthetic nurses who had been trained in the medical simulation approaches also showcased their skills with the new simulation equipment in Launceston and Burnie.

The TASETN is an innovative project that improves patient care through simulation education for anaesthetists and anaesthetic nurses.

Funded through the federal government's Flexible Approach to Training in Expanded Settings (FATES) program which aims to broaden the skills of the specialist workforce, the network is aimed at bringing more specialists to regional areas, and to ensure all Australians can access high-quality care.

Dr Freestone, TASETN Clinical Project Lead, described the network as a game changer for the specialty in Tasmania.

"Simulation is a way of learning without real patients. It improves patient care and patient safety and leads to better clinical performance. This means better outcomes for patients."





The joint medical education simulation project between ANZCA and the Tasmanian Health Service has already involved 21 anaesthetists and anaesthetic nurses across the state at Royal Hobart Hospital, Launceston General Hospital, the North West Regional Hospital in Burnie and the Mersey Community Hospital.

Dr Freestone explained how the first anaesthetic in the southern hemisphere was administered in Launceston in 1847, just one year after the first demonstration on of ether anaestheisa in Boston in the US.

**ABOVE**

*From top: #NAD24 at Royal Hobart Hospital.*

*Stills from WIN News.*

# Perioperative medicine

ANZCA has launched its Chapter of Perioperative Medicine after the first full year of its Course in Perioperative Medicine.

## Our Chapter of Perioperative Medicine launches


Last month we celebrated a very important milestone for ANZCA with the launch of our Chapter of Perioperative Medicine.

The chapter was launched during the Perioperative Medicine Special Interest Group Meeting held in collaboration with Summit III and the PeriOperative Quality Initiative (POQI) from 22-24 November in Melbourne.

We closed the meeting with the presentation of certificates to 133 new graduates of our Chapter of Perioperative Medicine who attended the meeting in person.

These two events were a true celebration in recognition of how far we have come in advancing perioperative medicine in Australia and New Zealand.

The establishment of the Chapter of Perioperative Medicine is a key strategic initiative of the college and underscores ANZCA's commitment to advancing perioperative medicine. It aims to encourage and facilitate research, support standards for professional development, and oversee the quality and delivery of ANZCA's perioperative medicine course.

The chapter also plays a pivotal role in fostering collaboration across specialties and supporting ANZCA's engagement with stakeholders in Australia and New Zealand.

### OUR NEW GRADUATES

We have had 835 applications for the qualification via the recognition pathway and I'd like to thank Dr Vanessa Beavis who has led this process in her role as chair of the Recognition Pathways Working Group. Vanessa and her team have spent countless hours going through the applications.

Vanessa was on the original Perioperative Medicine Taskforce established by then-president Professor Michael Cousins in 2005 to examine perioperative medicine and the role of anaesthetists.

So the launch and presentation ceremony nearly 20 years later was, as she described it, one of the highlights of her career.

Vanessa was recently appointed as our new ANZCA Director of Professional Affairs, Perioperative Medicine.

To the beginning of December, 676 applicants have been assessed and are graduates of the Chapter of Perioperative Medicine (GChPOM). A further 101 have been reviewed with more information required, and 29 have been deemed ineligible.

The cross-specialty collaboration is clearly evident when looking at the figures:

- Fellow of the Australian and New Zealand College of Anaesthetists – 507 applicants (419 granted so far).
- Fellow of the Royal Australasian College of Physicians – 173 (148).
- Fellow of the College of Intensive Care Medicine – 91 (71).
- Fellow of the Royal Australasian College of Surgeons – 17 (16).
- Fellow of Royal Australian College of General Practitioners/RNZCGP Fellow of the Royal New Zealand College of General Practitioners/Fellow of the Australian College of Rural and Remote Medicine – 34 (9)*.
- Other specialty groups such as overseas luminaries: 13 (13)

*Applications for GPs closed on 1 December 2024, a year after the other specialty groups.

**ABOVE**

*Our newest graduates of the chapter.*

## COURSE IN PERIOPERATIVE MEDICINE – OUR INAUGURAL YEAR

We have just completed the first year of our Course in Perioperative Medicine where 36 anaesthetists, surgeons, physicians and GPs have undertaken one or all of the six units of study.

Set at a post-fellowship level, the ANZCA Course in Perioperative Medicine offers a unique opportunity to gain the qualification of Graduate of the Chapter of Perioperative Medicine (GChPOM).

The course enables specialist doctors, including anaesthetists, surgeons, physicians, intensivists, and general practitioners, to deepen their expertise and broaden their skills in perioperative medicine.

The course comprises 40 hours of online learning, 40 hours of clinical immersion at an affiliated hospital and a one-day weekend workshop per unit of study.

Thank you to the eight unit of study leads, 97 supervisors, 27 external assessors and 26 workshop speakers for their invaluable contributions in this inaugural year of the qualification.

Enrolments are now being taken for the first trimester of next year's course and will close on 12 January 2025.

## HOST HOSPITALS

The clinical immersion component of our course is one of the factors that makes it unique in the world.

Earlier this year we welcomed Logan Hospital and Monash Health to the ranks of host hospitals where participants can do the "hands-on" part of the course.

We now have 21 hospitals and are encouraging more to join while we work on processes that will allow clinicians who aren't employed at participating hospitals to enrol in the course.

Thank you to the clinical immersion sites in 2024:

| Australian Capital Territory | New South Wales |
|---|---|
| Canberra Hospital | John Hunter Hospital<br>Prince of Wales Hospital<br>Westmead Hospital<br>Royal North Shore Hospital<br>Royal Prince Alfred Hospital |
| **Queensland** | **South Australia** |
| Ipswich Hospital<br>Logan Hospital | Royal Adelaide Hospital |
| **Tasmania** | **Western Australia** |
| Launceston General Hospital | Fiona Stanley Fremantle Hospitals Group |
| **Victoria** | **New Zealand** |
| Alfred Hospital<br>Austin Hospital<br>Royal Melbourne Hospital<br>Peter MacCallum Cancer Centre<br>University Hospital Geelong<br>Western Health | Te Toka Tumai Auckland City Hospital<br>Christchurch Hospital<br>North Shore Hospital<br>Wellington Regional Hospital |

**ABOVE**

*From left: Dr Chris Cokis at the launch of the Chapter of Perioperative Medicine.*

*ANZCA perioperative medicine luminaries Associate Professor Joel Symons, Dr Vanessa Beavis, Professor Dave Story.*

## GOVERNANCE – OUR NEW COMMITTEES

The inaugural meeting of the Board of the Chapter of Perioperative Medicine will be held on 31 January 2025.

The board has been established as an executive committee that reports to ANZCA Council and will oversee the college's educational offerings in perioperative medicine, and advise on related professional practice, clinical quality and patient safety matters.

Membership of two Chapter of Perioperative Medicine committees that will report to the board – the Education and Assessment Committee and the Advocacy and Policy Committee – will be approved at the inaugural board meeting.

The Education and Assessment Committee, to be chaired by Associate Professor Joel Symons, will bring together a multidisciplinary group of clinicians to develop, guide and report on the college's educational offerings in perioperative medicine.

Dr Jill Van Acker will chair the Advocacy and Policy Committee, which will also have membership reflecting the multidisciplinary nature of perioperative medicine. It will consider professional documents and guidelines, collaborate both locally and internationally, and support advocacy activities to promote the field of perioperative medicine with government and across health sector stakeholders.

Essential to these committees will be the expertise of representatives from the College of Intensivist Care Medicine (CICM), the Royal Australasian College of Physicians (RACP) and its societies focusing on geriatric and internal medicine, the Royal Australasian College of Surgeons (RACS), and the general practitioners' colleges, the Australian College of Rural and Remote Medicine (ACRRM), Royal Australian College of General Practitioners (RACGP) and Royal New Zealand College of General Practitioners (RNZCGP).

## ADVOCACY AND THE VALUE OF PERIOPERATIVE MEDICINE

We truly believe that perioperative medicine can improve the surgical journey for patients and lead to system efficiencies.

Our goal now is to engage with government representatives, peak body groups, private health insurers and other stakeholders including the community to showcase perioperative medicine.

## THANKS TO THE POM SC

Finally, I'd like to thank all members of the Perioperative Medicine Steering Committee, in existence since September 2018, and more recently led by Dr Sean McManus and Dr Vanessa Beavis.

Representing our stakeholder colleges and societies, this group oversaw an enormous amount of work, not least being the establishment of our Perioperative Care Framework and of course our Course in Perioperative Medicine. The committee held its last meeting on 7 October 2024.

**Dr Chris Cokis**
Chair, Board of Perioperative Medicine

More information at anzca.edu.au/pom

## ANZCA COURSE IN PERIOPERATIVE MEDICINE – 2025

| Trimester | Dates | Enrolments open |
|---|---|---|
| Trimester 1 (units of study 1 and 2): | 10 February-27 April | 11 November 2024 |
| Trimester 2 (units of study 3 and 4): | 2 June-17 August | 3 March |
| Trimester 3 (units of study 5 and 6): | 22 September-7 December | 23 June |

# LGH's Multidisciplinary High-Risk Preoperative Clinic

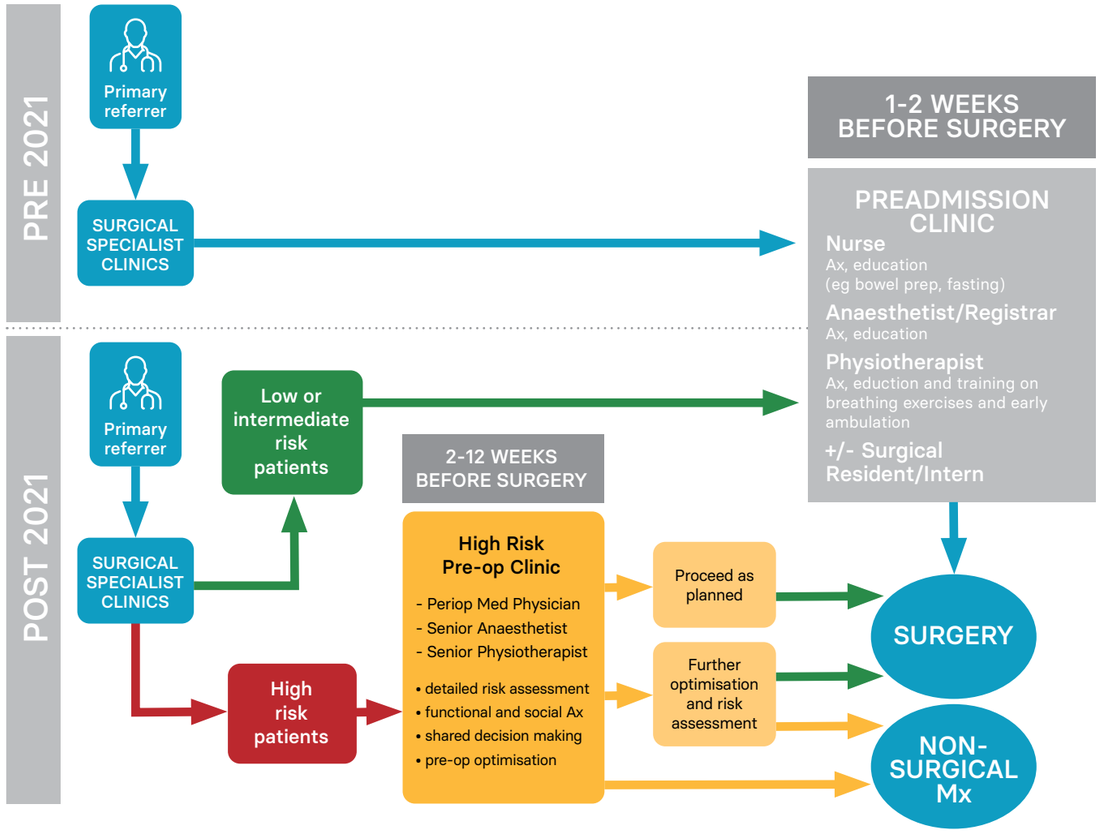
The Launceston General Hospital (LGH) in Tasmania, Australia is a 365-bed regional hospital which supports around 4000 hospital admissions and 3500 emergency department presentations per month.[1]

As the tertiary referral centre for Northern Tasmania, it performs around 17,000 surgical procedures annually across general surgery and surgical subspecialties including: orthopaedics; urology; colorectal; upper gastrointestinal; plastics; ear, nose and throat; as well as interventional radiology and cardiac procedures.[1]

In 2021, a High-Risk Preoperative Clinic commenced at the LGH. The clinic focuses on thorough risk assessment, pre-anaesthetic/surgical optimisation and shared decision-making for patients estimated to have higher risks of adverse perioperative outcomes (see Figure 1).

The multidisciplinary team includes administrative staff, nursing staff, a senior surgical physiotherapist, and a perioperative medicine (POM) team. The POM team has four anaesthesia consultants and a physician who are Graduates of ANZCA Chapter of Perioperative Medicine (GChPOM) and this clinic is a clinical immersion site for current GChPOM candidates.

**Figure 1. Launceston General Hospital Preoperative Pathways**




## WHICH TYPES OF PATIENTS DO WE SEE?

There is no accepted gold standard definition of "high risk" surgical patients, therefore we created a referral form for patients with identified risk factors for adverse perioperative outcomes. This typically includes patient-specific risk factors including complex multimorbidity and frailty, or procedure-specific risk factors such as major upper gastrointestinal surgery, complex head and neck surgery, or prolonged anaesthesia.

Referrals are triaged by the clinical lead anaesthetists, who may also identify appropriate patients from other sources including multidisciplinary meetings, standard clinic referrals, and the Intensive Care Unit bed planning meetings.

## WHAT MODEL OF CARE DO WE USE?

The clinicians meet at the start of the clinic to discuss the upcoming patients and make a plan for the session. Patients are greeted by administrative staff and directed to the waiting room before the initial nursing assessment, which includes routine observations and an ECG. A combined assessment with the physiotherapist and physician occurs next, where a detailed social and functional history is taken, as well as a thorough review of existing comorbidities and identification of any new issues. A plan is made for optimisation and prehabilitation where appropriate, and the patient's values and goals are explored and a shared decision-making process is commenced.

The physiotherapist and physician then discuss the case with the anaesthetist prior to their review, and further risk assessment and shared decision-making conversations occur. Surgical colleagues and intensive care colleagues are consulted real-time when required for discussions around alternative lower risk procedures, and appropriate post operative disposition respectively.

The outcome may include proceeding to surgery as planned, further investigation or consultation prior to a definitive plan, prehabilitation including medical and/or physical optimisation, or a decision to change to a lower risk alternative or non-surgical management.

## WHAT TYPES OF RISK ASSESSMENT TOOLS DO WE USE?

All patients are assessed with a Clinical Frail Scale[2], Duke Activity Status Index (DASI)[3,4], American Society of Anesthesiologists (ASA) score[5], hand grip strength[6], 3-metre timed up and go[7], and sit-to-stand 60 seconds[8,9]. Additional assessments may include American College of Surgeons NSQIP surgical risk assessment[10], Edmonton Frail Scale[11], and Montreal Cognitive Assessment (MOCA)[12].

## HOW DO WE COMMUNICATE OUR DECISIONS?

All clinicians contribute to a combined team assessment which is entered into the Digital Medical Record, and a copy is sent to the patient's referring surgeon, general practitioner, and other relevant members of the treating team. When appropriate, these clinicians may be contacted by phone during the clinic.

## WHAT ARE OUR OUTCOMES SO FAR?

More than 200 appointments have occurred in the first three years. Outcome data from the clinic is being examined at present, however unpublished clinical audits demonstrate that 26 per cent of patients reviewed in the clinic undergo a non-surgical management strategy, and there have been no day-of-surgery cancellations for medical reasons for patients reviewed in the clinic at the time of writing.

**ABOVE**

*High Risk Clinic staff from left: Cindy Chen, nurse; Cecilia Wong, nurse; Ianthe Boden, physiotherapist; Dr Telena Kerkham, physician; Angela Graham, ANUM; Dr Pravin Dahal, anaesthetist.*

**LEFT**

*From left: Angela Graham, ANUM; Dr Lokesh Anand Varadiah, anaesthetist; Ianthe Boden physiotherapist; Dr Telena Kerkham, physician.*

### WHAT ADVICE WOULD WE GIVE TO OTHER CENTRES CONSIDERING A DEDICATED HIGH-RISK PREOPERATIVE CLINIC?

A key consideration is the physical space required for a multidisciplinary assessment. Ideally, this type of clinic requires a room that can fit a patient, support person, physiotherapist, physician, anaesthetist and at times other clinicians such as surgeons and intensive care specialists.

A clear documentation plan is recommended prior to implementation, given the challenges with various information technology platforms.

Choose your staff wisely – our service has thrived due to the enthusiasm of the team members to engage in shared decision making, and the willingness to work collaboratively. A team who are dedicated to patient-centred care and who have the experience and communication skills required to consider alternative management strategies is vital. The team must be willing to consider the longer-term implications of surgery as well as the immediate perioperative outcomes.

Ideally patients are referred prior to surgical consent, and with adequate notice prior to the planned surgical procedure wherever possible.

This type of clinic takes a lot of time. Warn patients in advance that they will be in your clinic for up to two hours to avoid frustration (and parking fines!).

**Dr Telena Kerkham,** FRACP, GChPOM
Launceston General Hospital

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# Sip Til Send: Insights from the Australasian implementation survey

Twelve months ago, the Australasian Sip Til Send Network (previously called Sip Til Send ANZ Network) published an article in the *ANZCA Bulletin* championing the benefits of Sip Til Send and outlining the steps required to fan the flames of enthusiasm for it around Australasia.[1]

This article is a progress update and a call for further collaborative research. We report the results of the Australasian Sip Til Send implementation survey that provides insights into the growth of Sip Til Send and the experiences and challenges faced by those transforming their hospitals into Sip Til Send centres. It is hoped that these insights may be helpful to those in the contemplative or planning stages.

The past year has witnessed pivotal updates to the ANZCA fasting guideline that have incrementally acknowledged the efficacy, popularity and relative safety of Sip Til Send.[2] This has eased the medico-legal angst of many who initially hesitated to develop Sip Til Send due to its lack of broad recognition amongst the anaesthetic community. Amid a coincidental worldwide shortage of intravenous fluids and increased awareness of the risks of prolonged liquid fasting, the update of the *PG07* fasting guideline to recognise Sip Til Send catalysed a paradigm shift in preoperative fasting.[3]

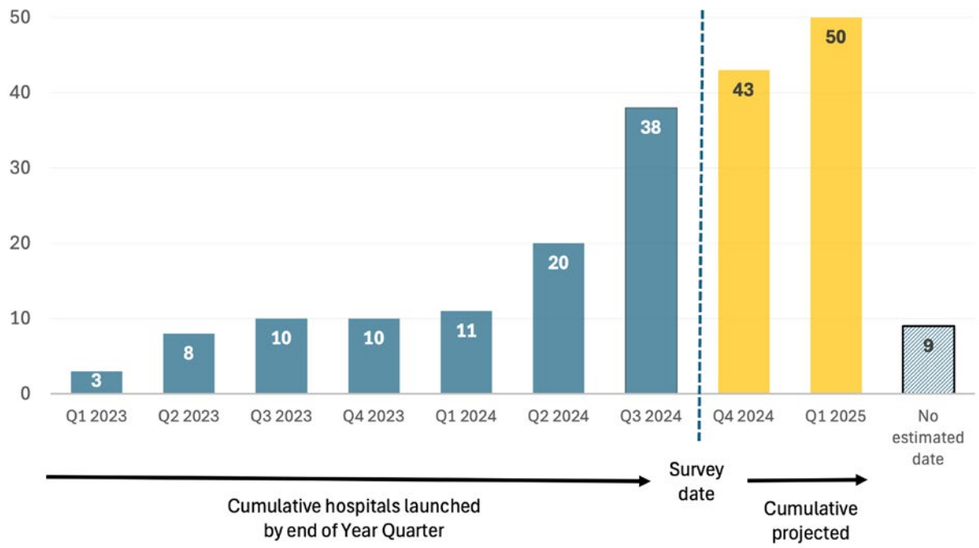
## THE AUSTRALASIAN SIP TIL SEND NETWORK

The Australasian Sip Til Send Network has grown to more than 60 hospitals and 100 members (many of whom are clinical directors of anaesthesia and/or leads for their hospital's Sip Til Send program). The network has provided an avenue for many hospitals to receive assistance from earlier adopters and a forum to discuss more controversial aspects such as whether to include patients on GLP-1 receptor agonists. For many hospitals the resources helped kickstart their journey towards launching Sip Til Send.

## AUSTRALASIAN SIP TIL SEND IMPLEMENTATION SURVEY

We sent survey invitations to all hospitals registered with the Australasian Sip Til Send Network, and other major metropolitan and regional hospitals throughout Australia and New Zealand (totalling 79 invitations). We received 35 survey responses, representing 59 different hospitals across 29 different health services. As of 31 August 2024 (the survey date), 38 hospitals had already launched Sip Til Send, while another 12 were expecting to launch by end of the first quarter of 2025. Nine hospitals were unable to provide an estimated launch date. Figure 1 tracks the cumulative growth and projected growth of Sip Til Send hospitals over time.

Figure 1. Cumulative number of Australasian hospitals running Sip Til Send.



ABOVE

*The Cairns Sip Til Send leadership team from left Marree Porch (nurse lead), Dr Phuong Markman (anaesthetic lead), Dr C'havala Jaramillo (anaesthetist).*

Of the 38 hospitals with established Sip Til Send programs by the survey date (31 August 2024),14 hospitals (37 per cent ) launched within six months of the commencement of planning, 20 hospitals (53 per cent ) launched within six to 12 months, while the remaining four (11 per cent ) took over 12 months. Figure 2 shows the number of hospitals represented in the survey responses, by region.

It is probable that the survey has missed some hospitals with Sip Til Send programs, however, according to data available from communications within the Australasian Sip Til Send Network, we believe that we have captured most hospitals.

**Figure 2. Hospitals represented in Australasian Sip Til Send Implementation Survey, by region.**


## DRIVERS

The most reported drivers for hospitals instituting Sip Til Send were:

- To improve patient care and patient satisfaction.
- To reduce problems related to prolonged liquid fasting.
- The shortage of intravenous fluid (applicable to those implementing during 2024 and beyond).

## PROTOCOLS

Eighty-seven per cent of hospitals allow adults to sip a maximum of 200mL of liquid per hour. No hospital allows volumes larger than that. There is more variability in paediatric protocols, with 63 per cent of hospitals allowing a volume of 3mL/kg/hr while others use ice blocks or age-based brackets to determine allowable liquid volumes.

The most common reasons for excluding a patient from Sip Til Send are specific medical or surgical conditions which increase a patient's aspiration risk, such as the presence of bowel obstruction or swallowing difficulty that necessitates thickened fluids. Only 31 per cent of hospitals are excluding patients taking GLP-1 receptor agonists.

## CHALLENGES

Overall, hospitals have received good support for Sip Til Send from hospital administration, anaesthetics and surgical colleagues, and nursing staff. However, the most common barriers to Sip Til Send rollout were hospital administrative challenges and the initial reluctance from anaesthetists with concerns regarding the logistics or safety of Sip Til Send. The leading causes for staff to be concern about introducing Sip Til Send were the medico-legal implications of Sip Til Send not being included in ANZCA guidelines (this has since been rectified), the potential for increase in aspiration risk, and the consequences of protocol breaches due to the lack of patient or staff compliance.

For those hospitals with an established Sip Til Send program, the greatest ongoing challenge is uncertainty among staff regarding the new protocol. It appears that well-planned and executed staff education prior to launch is the best predictor of a smooth and successful transition to Sip Til Send.

## POST-LAUNCH OUTCOMES

Due to the recency of their program launch, many hospitals had yet to complete post-implementation audits. Table 1 provides a summary of audit data shared by survey respondents.

**Table 1. Hospital de-identified audit outcomes (where data provided by survey respondents). Each row represents one group of patients reported by a survey respondent. Study methods are assumed to be highly heterogenous.**

| Liquid fasting time before Sip Til Send (hours) | Liquid fasting time after Sip Til Send (hours) | Patient population | Change in aspiration rate? |
|---|---|---|---|
| 13 | 2.3 | Adult emergency | No |
| 11 | 2.1 | - | No |
| 11 | - | Fractured neck of femur | - |
| 10.5 | 2.6 | Adult | No |
| 10 | - | Emergency | - |
| 10 | - | Emergency | - |
| 9.6 | - | Emergency orthopaedic | - |
| 8.1 | - | Elective and emergency | - |
| 7.6 | - | Emergency | - |
| 7.5 | - | Paediatric elective | - |
| 7.2 | - | - | - |
| 6.9 | - | Emergency | - |
| 6.6 | - | Elective | - |
| 6.6 | - | Elective | - |
| 5 | 1.1 | Adult outpatient | No |
| 4.1 | - | Elective | - |
| 4 | 3 | Paediatric | No |
| 2.8 | - | Adult emergency | - |
| - | 1.8 | Adults and children. 53% emergencies | No |

Twenty per cent of respondents who had already launched Sip Til Send received reports of patient incontinence in theatre or post-anaesthetic recovery unit. It is not known whether these represent an increase in incidence. One respondent reported a trend of increased case delay/cancellation directly related to Sip Til Send.

## AUSTRALASIAN MULTICENTRE ASPIRATION RISK STUDY (AUSTRALASIAN MARS)

The rapid growth of Sip Til Send demonstrated in this survey has occurred despite a paucity of robust aspiration safety data. This was considered necessary due to the rarity of anaesthesia-related aspiration and attendant challenges of conducting adequately powered studies involving very large numbers of patients. However, before Sip Til Send can stand confidently as "the new norm" for perioperative practice, a sufficiently large multicentre study of aspiration is required to demonstrate its safety. As we amass an ever-increasing number of Sip Til Send hospitals, such a study has now become possible. Plans for such a study, called The Australasian Multicentre Aspiration Risk Study (Australasian MARS), are well under way by a team co-ordinated in Cairns hospital. The team will widely distribute expressions of interest in the new year to hospitals in Australia and New Zealand.

Enquiries regarding the Australasian Multicentre Aspiration Risk Study (Australasian MARS ) or the Australasian Sip Til Send Network are welcome by sending an email to the author.

**Dr Phuong Markman,** FANZCA
Staff Specialist Anaesthetist, Cairns Hospital
Head of the Australasian Sip Til Send Network.
phuong.markman@health.qld.gov.au

**Dr Timothy Nolan**
ANZCA trainee, Cairns Hospital

*"It appears that well-planned and executed staff education prior to launch is the best predictor of a smooth and successful transition to Sip Til Send."*

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webAIRS

# Perioperative remifentanil medication errors

## BACKGROUND

Medication errors in anaesthesia are common with one in 20 perioperative medication administrations resulting in a drug error and one third of these result in patient harm.[1] Opioids are the second most common drug implicated in perioperative medication errors.[1] Remifentanil, an mu opioid receptor agonist, was introduced to anaesthesia practice more than 20 years ago. It is chosen as an adjunct to general anaesthetic agents over its opioid counterparts due to its unique pharmacokinetic and pharmacodynamic properties.

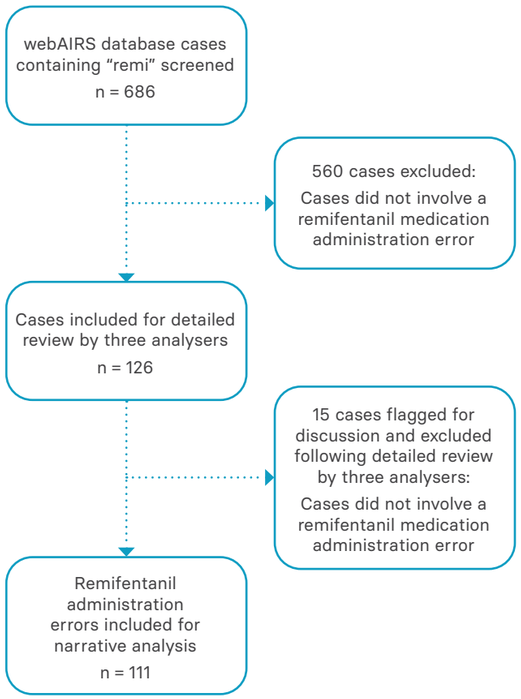
The rapid time to achieve a steady state, context insensitive half time, potent analgesic and sympatholytic properties make it desirable for stimulating procedures and rapid turnover theatre lists. However, the highly variable preparation and administration of remifentanil across anaesthesia providers translates to increased risk for a medication error to occur. Several case reports in the literature demonstrate how a medication error involving remifentanil can result in serious patient harm.[2-7] Remifentanil was noted to be the third most common medication implicated in medication errors in the operating theatre in a recent analysis.[8] This webAIRS review provides an analysis of perioperative remifentanil incidents with the aim of improving patient safety when administering this medication in the operating theatre environment.

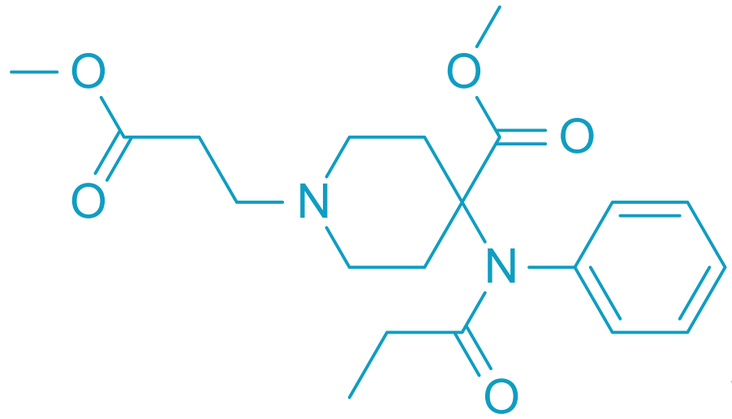
## METHODS

The webAIRS database was screened for all incidents containing "remi" in the narrative from July 2016 to January 2024. Categories were developed for data collection and narratives were assessed independently by two researchers. Medication administration error categories were divided into drug preparation error, drug dilution error, pump program error and delivery error. Additional categories to further analyse the incidents included human contributing factors, the event type (near miss, no harm, harm), effect of error on patient and supportive treatment required. All conflicts were reviewed by a third independent researcher for resolution. Incidents not involving a remifentanil administration error were excluded.

WebAIRS data collection complies with current ethics requirements for collecting de-identified quality assurance data in Australia.[9-10] Additional ethics approval to ensure that data collection meets National Health and Medical Research Council requirements has been obtained from the Royal Brisbane and Women's Hospital Human Research Ethics Committee (HREC/11/QRBW/311) and the Nepean Blue Mountains local health district (HREC/12/NEPEAN/18). Ethics approval in New Zealand was obtained from the Health and Disability Ethics Committee (MEC/09/17/EXP).

Figure 1. Results flow chart




LEFT

*Harbin, Public domain, via Wikimedia Commons*

## RESULTS

A total of 686 incidents containing "remi" were screened. Of these, 111 involved remifentanil administration errors and were included for detailed analysis.

Otolaryngology and neurosurgery involving the head and neck region accounted for almost half the cases. Most incidents occurred under the care of a specialist anaesthetist, in-hours, elective case, in the operating theatre where the procedure length was less than four hours. Incidents occurred in mostly American Society of Anesthesiologists (ASA) grade 2 and 3. Almost one third of cases recorded a body mass index over 30.

The most common administration error was pump program error (55%) followed by preparation errors (23%) and delivery errors (22%). Of the pump program errors, 43% occurred due to wrong drug program where propofol has been programmed in place of remifentanil. This type of drug error is estimated to deliver a remifentanil dose nine-times of that intended, as a bolus. The remaining 12% of program errors were due to incorrect dilution entered and incorrect dose delivered due to incorrect patient details being entered (that is, incorrect weight, age). Failure to reconstitute remifentanil and drug dilution error due to incorrect drug vial concentration were common preparation errors. Delivery errors involving a failure to connect, failure to start the remifentanil infusion and failure of equipment accounted for 22% of incidents.

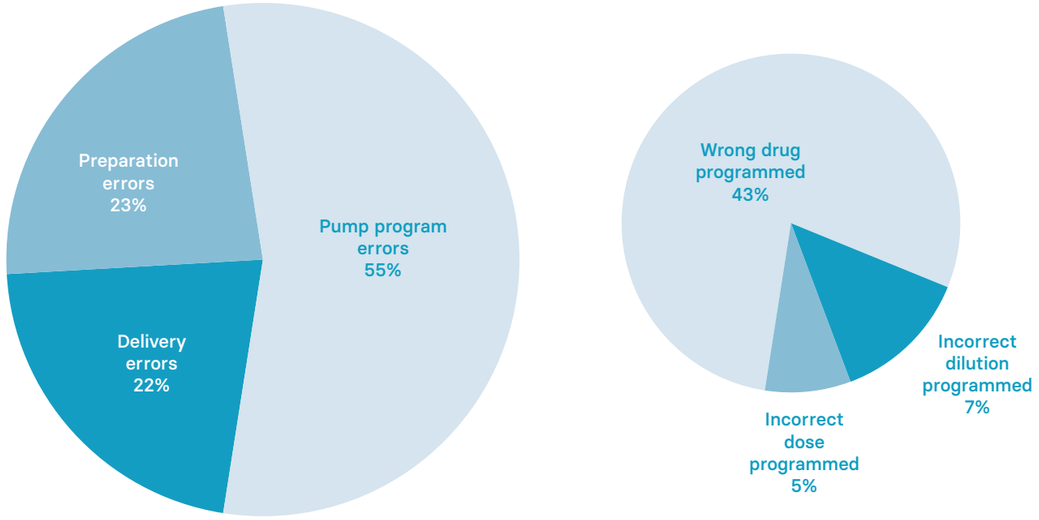
Of the 111 remifentanil administration errors, 63 cases resulted in unexpected physiological adverse effects, of which 56 required immediate intervention. Harm was reported in eight patients. Two cases occurred in patients with an anticipated difficult airway where remifentanil was being used for conscious sedation during awake fibreoptic intubation. A larger than intended dose of remifentanil was delivered due to incorrect infusion pump programming, which resulted in rapid and significant respiratory compromise. Wooden chest syndrome (an opioid-induced chest wall rigidity leading to poor lung compliance) was seen in eight cases, three of which required muscle relaxation to rescue the situation.

Human factors contributing to medication administration errors included distraction, training/teaching case, haste and unfamiliarity with either the medication, pump or program. Almost all cases (92%) were recorded as preventable by the treating clinician.

Table 1. Remifentanil medication error summary

| **Preparation errors** | **n** | **% of 111** |
|---|---|---|
| Omission (failure to reconstitute remifentanil) | 8 | 7% |
| Drug dilution error (wrong concentration vial) | 8 | 7% |
| Substitution (different drug instead of remifentanil) | 4 | 4% |
| Incorrect label on syringe with clear fluid | 4 | 4% |
| Other | 2 | 1% |
| **Total number described in narrative** | **26** | **23%** |
| | | |
| **Pump program error** | **n** | **% of 111** |
| Wrong drug program (propofol instead of remifentanil) | 48 | 43% |
| Incorrect dilution programmed | 8 | 7% |
| Incorrect dose programmed (pt weight, mcg/kg/min) | 5 | 5% |
| **Total number described in narrative** | **61** | **55%** |
| | | |
| **Delivery errors** | **n** | **% of 111** |
| Equipment failure (siphoning, three way taps, incompetent valves, PIVC failure etc) | 11 | 10% |
| Failure to connect | 8 | 7% |
| Residual drug in line | 3 | 3% |
| Failure to start pump | 2 | 2% |
| **Total number described in narrative** | **24** | **22%** |

Figure 2. Remifentanil medication error summary




## DISCUSSION

Strategies to reduce the frequency and severity of remifentanil medication errors in the operating theatre must be practical and specific to the anaesthesia environment to maintain efficiency without compromising patient safety.

The introduction of a dedicated remifentanil training module to improve familiarity with the medication and infusion device including the various dilutions, displays and programs has been shown to reduce the learning curve associated with the use of remifentanil in the operating theatre.[11] Standardisation of remifentanil dilutions, infusion programs and infusion pump brands within an institution is also supported by the Australia and New Zealand College of Anaesthetists.[12] These strategies however must be accompanied by vigilant preparation, administration and observation of the patient's clinical response when delivering remifentanil.

This webAIRS analysis is limited by collection of retrospective, self-reported data, the inability to quantify the frequency of remifentanil medication errors or compare the errors to other classes of medications. The details of the events are reported by the individual anaesthetist with may result in responder bias. In addition, the narrative analysis lends itself to variability between analysers reviewing and categorising the text.

## CONCLUSION

Medication errors in the perioperative space are a common, costly, and preventable cause of patient harm. Remifentanil is prone to medication error. The results of this review highlight that programming an infusion pump is a critical time point which demands the clinicians undivided attention. Human factors, in particular distraction, unfamiliarity and haste can significantly impact patient safety. Implementing remifentanil safety strategies to anaesthesia practice may mitigate the frequency and severity of errors.

**Dr Anna Steer** and the ANZTADC Case Report Writing Group

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## Safety alerts

Safety alerts appear in the "Safety and quality news" section of the *ANZCA E-newsletter* each month. A full list is available on the ANZCA website: www.anzca.edu.au/safety-advocacy/safety-alerts.

Recent alerts:

- Australian Impact of regional & global shortage of IV Solutions (26 July)

# Anaesthetist's tutorials still very much alive four years after his sudden death


*"Dr Alan J McLintic was ... someone who never sought fame and recognition but was an outstanding clinician, a fantastic colleague and gave much to his department. He was both brilliant and ordinary."*

What will your legacy be? For many it will be our family, children or grandchildren; their successes and roles in society will bear the hallmarks of our own personal achievements. What about those who have no children? Who will speak for them? Will any of us be remembered at all? What for? Why?

We can all identify some unique and outstanding individuals who achieve national and international success during their professional careers. Such individuals often fill prominent roles within organisations and associations and a few even obtain national honours or global recognition. These individuals will be remembered in their own right but are of course exceptional.

What of the rest of us, the "quiet majority"? Those who are hard-working, caring, professional and diligent, how will we be remembered?

Dr Alan J McLintic was one such person. Someone who never sought fame and recognition but was an outstanding clinician, a fantastic colleague and gave much to his department. He was both brilliant and ordinary.

Enormously talented, he was simultaneously academic, artistic, athletic and musical. As a successful artist his paintings sold in galleries across Auckland and several colleagues still own his work. Despite his commercial artistic success, Alan was an ordinary anaesthetist, constantly looking for intellectual challenges.

He would attend courses on a wide range of clinical and non-clinical topics. Owning this knowledge was not enough for Alan though, and as a brilliant teacher he was able to talk eruditely about any topic, easily engaging listeners in whichever philosophy or statistics paper he had just completed. As such, Alan gained universal acclaim from trainees all over Auckland who were struggling with the part 1 ANZCA syllabus.

Alan had an uncanny ability to make unteachable topics not only teachable, but accessible and entertaining. He delighted in debunking myths, tackling, deconstructing and explaining subjects like physics, statistics and clinical measurement which trainees typically found challenging.

As a result, his weekly part 1 teaching sessions were a regular feature of the Auckland registrar training program for more than 25 years. An attachment as a trainee at Middlemore Hospital gave individuals the chance to work with Alan and chat more deeply about a huge array of topics, which he did gladly and with ease.

**ABOVE**

*Dr Alan McLintic and Dr Craig Birch.*


It is no understatement to say that several generations of trainees (who are now consultants all over the world) owe the passing of their part 1 FANZCA exam (and probably also the part 2 FANZCA exam) to those tutorials and conversations.

Single-handedly, Alan constantly refined, researched and fine-tuned the content and delivery of his tutorials, ensuring that they remained current, entertaining and relevant for the syllabus. In doing so, his concise wit and clarity of thought were ever present, much to the enjoyment of trainees.

In September 2020 in the midst of the global COVID-19 pandemic, Alan did not show up for his weekly tutorial. Something was amiss.

Just the day before he had played golf with colleagues and nothing untoward had been noticed. Unbeknown to us all, Alan had passed away from a cardiac cause in his sleep at home. He was 62. Unmarried and with no children, his only surviving relative was his sister Anne in the US, who also had no children.

Just prior to his sudden death, Alan had been on sabbatical during which he had compiled his tutorial lecture notes into a draft manuscript for a textbook; completed several works of art; and begun preparation for the upcoming summer sporting events – Alan had previously taken part in Ironman NZ, Coast to Coast and many other sporting challenges.

The lecture notes had been studiously and diligently prepared, complete with Alan's drawings and diagrams to illustrate key concepts.

He had spoken to several colleagues about his intention to publish this work, so following his death and with the approval of Alan's sister Anne, we began the process of turning the draft manuscript into a textbook.

Alan had, of course, been meticulous in his preparation of the lecture notes. They remained however *his lecture notes,*

*"There was significant effort required in converting the notes into a readable text and as the pandemic raged the ability to find the time and enthusiasm to keep Alan's dream alive dwindled."*

**ABOVE**

*Two examples of Dr McLintic's artwork.*

*"His concise wit and clarity of thought were ever present, much to the enjoyment of trainees."*

**LEFT**

*An example of one of Dr McLintic's landscapes.*

and concepts were presented as bullet points, his unique explanations and observations often missing or present only in note form. It was these distinctive insights that made his tutorials so special, engaging and valued and it was this aspect of the text which required some work.

Each chapter was edited by a member of our department, some of whom had been fortunate to have been tutored by Alan as a trainee.

There was significant effort required in converting the notes into a readable text and as the pandemic raged the ability to find the time and enthusiasm to keep Alan's dream alive dwindled. Eventually though, with a fully revised and completed text we began to ponder the details of how to publish Alan's work.

It was clear that our target audience would be trainees within the anaesthesia or critical care specialties, but we did not know how to go about publishing, distributing and marketing the book.

The financial aspects were particularly problematic since Anne had graciously handed all aspects of administration of the book to us, but we didn't wish to profit personally from Alan's work.

Many years earlier Alan had written a comprehensive textbook for new starters to anaesthesia which he personally edited and published as "not for profit". He was fiercely protective of the intellectual property of this introductory text and frequently resisted offers to publish more widely.

Instead, Auckland University provided this textbook for medical students on their placement within anaesthesia and, combined with sales to new trainees in specialty training, Alan was able to cover his costs.

After making contact with local and international publishers we were fortunate enough to find both parties were interested in the text. They offered different models managing the publication process and choosing a publisher was not simple.

Soon after selecting the international publisher we were also fortunate to gain approval from ANZCA that the future book would be part of the recommended reading for the part 1 exam.

Everything looked to be progressing well, until over the course of a year or so, communication with the editorial team fizzled out. Commercial pressures at the publication house partly driven by the pressure of the pandemic coupled with re-allocation and resignation of their staff made further progress on the work impossible. So, despite having spent so much time on it already, we were forced to terminate the project.

At about that time, the last cohort of trainees to have been tutored by Alan moved on to other hospitals as part of their rotation, and it felt as if Alan's dream and legacy were unattainable.

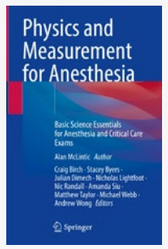
Collectively the editorial group became very despondent about the project as the emotional connection between the department's trainees and Alan's unique teaching style was lost.

Fortunately, we were able to secure a new publisher and re-doubled our efforts to navigate the editorial steps necessary for publication.

Suddenly, the final email arrived to inform us that the book was being made available for publication. Alan had made it. He was now a published author with his book highly recommended reading for the part 1 FANZCA exam.

And yes, he was a brilliant and yet ordinary anaesthetist.

**Dr Julian Dimech,** FANZCA, and **Dr Craig Birch,** FANZCA
Middlemore Hospital, New Zealand

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# Wrapping up the 2024 CPD cycle

As we approach the end of the 2024 continuing professional development (CPD) cycle we'd like to acknowledge the dedication of more than 7000 fellows and CPD participants in this inaugural annual cycle.

CPD has changed a lot in the last two years. The Medical Board of Australia mandated a number of changes for all doctors, with the Medical Council of New Zealand also strengthening certification requirements over the last two years. Our priorities have been streamlining CPD documentation for fellows through development of the CPD application and incorporating feedback from fellows. A big thank you to the many fellows who contributed to developing and implementing new CPD activities.

Many fellows were enrolled in the annual program from 2023, with all fellows transitioning to an annual CPD program in 2024. Thank you for your proactive engagement in adapting to these changes.

## ANNUAL VERIFICATION (AUDIT)

In line with regulatory requirements, seven per cent of CPD participants are randomly selected each year for verification (audit). For 2024, about 500 were chosen with notifications sent in August. The CPD team is here to support a smooth and successful process for those selected.

## COMPLETING YOUR CPD BY 31 DECEMBER

The annual CPD cycle runs from 1 January to 31 December 2024, so be sure to complete all required activities within this timeframe. The CPD team provides tailored support where needed, so please get in touch if you need support at cpd@anzca.edu.au.

## SPECIAL CONSIDERATION

If unforeseen circumstances impact your ability to meet requirements, you can apply for special consideration. Our special consideration policy outlines examples of circumstances that will qualify for special consideration, such as parental leave or illness. Simply email our CPD team with details and, where applicable, supporting documentation (such as medical certificates).

## YOUR CERTIFICATE OF COMPLIANCE

Once your 2024 CPD requirements are met, your certificate of compliance will be available for download from your online CPD portfolio. Those undergoing verification will receive their certificate upon completion of the audit process.

## TRANSITIONING TO 2025

Your 2025 CPD cycle will begin automatically on 1 January 2025, as long as your 2024 CPD requirements are fulfilled. If selected for audit, your transition follows successful verification of your 2024 activities.

For planning, the CPD activity guide and the CPD handbook are resources to help you plan what activities you want to undertake for the year ahead.

## COLLEGE CLOSURE DATES

Our CPD team is here to support you. While new processes can be frustrating, please be respectful to staff. And please note that the college will be closed from Tuesday 24 December 2024 until Monday 6 January 2025.

Thank you for your commitment to our CPD program and to maintaining the high standards of anaesthesia and pain medicine care. We look forward to starting the annual 2025 CPD cycle with you!


## CPD APP

The ANZCA CPD App is available to download from the Google Play and Apple stores.

Apple

Android

# Self matters

## Bullying, discrimination and harassment – enough hinting and hoping

**Will changes in Australian law shift the dial on inappropriate behaviours in medicine?**

Bullying, discrimination and harassment in medicine remain profound, and human, problems – despite significant efforts over the past decade. I am pleased to introduce a hopeful perspective by wise wellbeing thought-leader Dr Tracey Tay and Ms Jen Agars, an expert in work health and safety. A further legal imperative might be what's needed for the intransigent culture of medicine finally to shift.

This is my final *Self Matters*. I started the column in 2020, a tumultuous year which really underlined the importance of systems, peer and individual strategies for taking care of ourselves and those we work with. I'm hugely grateful to fellows, trainees, staff and other colleagues who have written about their wellbeing projects, offered practical tips and highlighted helpful resources, as well as those who have put me in touch with prospective authors. I trust you have gained from these varied perspectives and insights, as I have. It is now time for me to hand over to a new curator to take this wellbeing work forward.

I wish you the best for all your future endeavours – go well!

**Dr Lindy Roberts** AM FANZCA FFPMANZCA

When we feel threatened, undervalued and unwelcome, facing another day at work can feel overwhelming. Teamwork and vigilance may be undermined, risking patient safety. Hospitals face workforce instability as people choose to leave or reduce hours. Many organisations, including ANZCA, have worked hard to raise awareness of the effects of bullying, discrimination and harassment (BDH) and yet rates remain stubbornly high in healthcare workplaces. At least in Australia, recent changes to work, health and safety (WHS) laws mean that organisations will now be compelled to move beyond raising awareness to visible and proactive change.

### HOW BIG IS THE PROBLEM IN AUSTRALIA?

The Medical Training Survey (MTS) is carried out annually by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA). From 2019 to 2024, the percentage of doctors in training who experienced BDH remained around 22%.[1] In contrast, the Australian national average for BDH in 2020-21 was 8.6%,[2] down from 9.4% in 2014-15.[3] The perpetrator in the 2024 MTS report was most likely to be a senior medical staff member (43%) or other medical staff (27%), and most likely to have been in their team (52%) or department (29%). In 40% of cases, the person responsible was their supervisor. Only 33% of those who experienced BDH made a report, of which 48% were followed up. Of those whose reports were followed up, only 66% were satisfied with the response.

### WHAT IS BEING DONE ABOUT IT?

Many initiatives by many groups over many years have approached the issue of BDH largely through raising awareness, education and training.

ANZCA established a bullying, discrimination and sexual harassment working group in 2015 which led to the provision of the Doctors' Support Program for 24/7 advice and support, more clarity about the process of reporting with the ability to contact the chief executive officer directly, and other resources.

The Royal Australasian College of Surgeons has developed a course *Operating with respect* which is compulsory for surgical supervisors and committee members.

There have also been efforts to encourage feedback from peers before escalation to human resources (HR) processes. A number of Australian hospitals have implemented the Vanderbilt University *Speaking up for Safety* and *Promoting Professional Accountability* programs. These related programs use a common language for escalating concern and also create a mechanism for confidential reporting of poor behaviour where a person feels they can't speak up. It incorporates the "coffee cup" conversation, where a peer communicates the complaint to encourage self-regulation.

In 2017, St Vincent's Health Australia developed a related program called *Ethos* which provided an online mechanism for providing feedback for "reflection" (negative) or "recognition" (positive). Both types of feedback are provided by a "peer messenger". Repeated poor behaviour or egregious behaviours are reported through the usual HR pathways. Evaluation of the program after three years showed a 25% reduction in the odds of experiencing incivility/bullying and 32% reduction in extreme behaviours.[4]

In addition, it is unlawful under the Fair Work Act to discriminate (take adverse action) against an employee or prospective employee because of a wide range of attributes including race, colour, social origin and political opinion.

### THIS HASN'T MOVED THE DIAL IN AUSTRALIA, SO WHAT'S NEXT?

Recently, there have been important legislative changes that place a legal obligation on employers and **persons conducting a business or undertaking (PCBUs)** to shift focus from simply managing reports of BDH to preventing it. **Australian hospitals and health services are PCBUs.**

In the workplace health and safety landscape, BDH fall under the wider umbrella term of **psychosocial hazards**. In April 2023, there were significant changes to Australian WHS laws to mandate a proactive risk management approach **(positive duty)** to psychosocial hazards and risks in the workplace. Changes to the *Model WHS Regulations, 2011* (Cth, Div. 11)[7] prescribe how employers must identify, assess and control the psychosocial hazards shown in the figure below, as far as reasonably practicable.

Is this yet another 'toothless' move? WorkSafe WA has recently charged the Western Australian Department of Justice with breaching sections of the WHS Act through not having proactive procedures in place to manage BDH resulting in significant psychological injury to an employee.[5] The potential maximum penalty if convicted is $A3.5 million.

Dr Thomas Haskell experienced significant workplace BDH in Australia. In his recently published paper,[6] he and his co-authors propose a framework for addressing BDH, calling on Australasian specialty colleges to act as PCBUs and to form a single national body that accepts reports, investigates and makes recommendations to facilities.

Addressing BDH will require a whole-of-system and trauma-informed approach. It will need to recognise the drivers of poor behaviour and support managers to proactively control psychosocial hazards.

The new Australian WHS laws may be the lever we need for change.

**Dr Tracey Tay,** FANZCA
Chief Medical Advisor
Calvary Health Care

**Ms Jen Agars**
National Manager Work Health & Safety
Calvary Health Care

**Psychosocial hazards**

| Design or Management of Work | Working Environment | Workplace Interactions / Behaviours |
|---|---|---|
| • Job demands<br>• Low job control<br>• Poor support<br>• Lack of clarity of role<br>• Poor organisational change management<br>• Inadequate reward and recognition<br>• Poor organisational justice | • Remote or isolated work<br>• Exposure to traumatic events or material<br>• Poor physical environment | • Violence and Aggression<br>• Bullying<br>• Harassment, including sexual and gender-based harassment |

Adapted from the *Model Code of Practice: Managing psychosocial hazards at work, 2022* (Cth)[8]

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7. Model WHS Regulations 2011 (Cth). https://www.legislation.gov.au/F2011L02664/latest/text
8. Model Code of Practice: Managing psychosocial hazards at work, 2022 (Cth). https://www.safeworkaustralia.gov.au/sites/default/files/2022-08/model_code_of_practice_-_managing_psychosocial_hazards_at_work_25082022_0.pdf

**HELP IS ALSO AVAILABLE VIA THE**

## Doctors' Health Advisory Services:

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

## Free ANZCA Doctors' Support Program

Converge international

**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/FPM fellow, trainee or SIMG (or a family member).
- Appointments are available from 8am to 6pm Monday-Friday (excluding public holidays).
- 24/7 emergency telephone counselling is available.

### WELLBEING HUBS

**For Aboriginal and/or Torres Strait Islander Peoples**

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

**For Māori**

Kaupapa Māori wellbeing services at https://www.wellbeingsupport.health.nz/available-wellbeing-support/kaupapa-maori-wellbeing-services/
Te Aka Whai Ora website at https://www.teakawhaiora.nz/our-work/advocating-for-change/rongoa/
Te Whare Tapa Whā at https://www.teakawhaiora.nz/nga-rauemi-resources/te-whare-tapa-wha/

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## Register now!

The 2025 Regional Organising Committee look forward to welcoming you to sunny north Queensland.

### Your summer “to do” list for the 2025 ANZCA ASM

- ☑ Visit the website and make a plan for your ASM week in the tropics – there’s something for everyone.
- ☑ If you are a prospective author or researcher, submit your abstract – submissions close 19 January 2025.
- ☑ Register for the ASM – early bird closes 11 March.
- ☑ Finally... enjoy the festive season, it’s been another big year!

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# Research

Dr Fiona Taverner,
Flinders Medical Centre,
South Australia.

# Research grants for 2025

It was pleasing to see a renewed level of grant applications for 2025, following the previous temporary downturn after COVID-19 created multiple challenges for our clinician researchers and the development of their research projects and programs. Applications for new studies across anaesthesia, pain medicine and perioperative medicine were almost up to pre-pandemic levels, with 50 grants received.

The Research Committee has awarded funding of more than $A1.6 million through the ANZCA Foundation for 2025 research grants: the Academic Enhancement Grant, the Douglas Joseph Professorship, 17 new project grants, four second year project grants, two novice investigator grants, the Patrons Emerging Investigator Grant, one Professional Practice Research Grant, the Skantha Vallipuram ANZCA Research Scholarship, and an allocation for ANZCA Clinical Trials Network pilot grants.

Twenty-eight teams will be supported in 2025. Their important research will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong, and is a vital part of ANZCA's continuous advancement of safe, high-quality evidence-based patient care in anaesthesia, intensive care, perioperative medicine and pain medicine, through high quality medical research and its translation and implementation within clinical practice.

The foundation is very appreciative of the generosity of all of its donors and supporters, especially the regular giving of our patrons, and those who provide named research awards, bequests, and major grants: Mrs Rowena and Mrs Victoria Cole, Mrs Indi Mackay, the late Dr Robin Smallwood, the late Dr John Boyd Craig, the estates of the late Dr Nerida Dilworth and Dr Elaine Lillian Kluver, Dr Stan Tay, Dr Peter Lowe, Mrs Asoka Vallipuram, Mrs Jan Russell and the Medibank Better Health Foundation.

In particular, we would like to recognise the establishment of the new W. John Russell ANZCA Research Award, the latest in our ever-growing portfolio of prestigious ANZCA Foundation named research awards, with thanks to Mrs Jan Russell.

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

**Mr Rob Packer**
General Manager, ANZCA Foundation

## NAMED RESEARCH AWARDS

## Harry Daly Research Award


Established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1981. The award may be made in any of the college's research grant categories provided the project is judged to be of sufficient merit. The award is made each year to the grant ranked most highly by the ANZCA Research Committee.

### PROFESSIONAL PRACTICE RESEARCH GRANT

**Creating pstychological safety in healthcare teams: A multicentre, mixed methods study to improve patient safety**

Unintended patient harm in hospital is a leading cause of patient morbidity and death, and this harm could often be avoided if someone had spoken up with a concern or suggestion. Healthcare teams make better decisions if everyone in the team can voice concerns, ask questions and contribute to problem solving and decision-making. The patient, as an expert on their own health, could also be a member of this team. While multiple studies and interventions have focused on helping members of the clinical team to speak up, less attention has been paid to the role of senior clinical staff in creating psychologically safe environments enabling the whole team to contribute to patient care.

In a previous study[1] we explored perspectives of senior operating room staff on their reactions to being spoken up to, how and why they might respond when a staff member voices concerns about their decisions or questions their actions, and how their response may affect ongoing patient care. We produced a grounded theory model of the speaking up interaction. From this model we developed and pilot-tested a questionnaire that prompts critical reflection on being challenged or admitting error. The questionnaire comprised eight statements requiring a rating of level of agreement, and a written explanation of the rating for each statement.

In a multi-centre study in New Zealand and Australia we will invite up to 200 clinical staff from multiple disciplines to complete the critical reflection questionnaire. We will undertake inductive thematic analysis on the written comments and evaluate our reflective questionnaire as a tool to promote critical reflection on leadership and psychological safety in a range of acute healthcare teams. We will evaluate the extent to which it helps uncover bias, assumptions and ingrained attitudes to being challenged and admitting fallibility. This analysis will inform semi-structured in-depth interviews with clinical staff on creating psychological safety in the teams in which they work, and their perspectives on

the role of patients as members of the healthcare team. Synthesis of these two data sets will confirm, extend and/or refine our previous grounded theory model of the speaking up interaction.

Our data on clinician perspectives on the role of the patient as a member of the healthcare team will be the first step in a new body of work on patient perspectives on psychological safety and their role in healthcare teams in acute care environments.

Our results will inform an intervention study exploring critical self-reflection as a vehicle for change. We anticipate a future randomised controlled intervention study, measuring improvement in staff psychological safety, staff perceptions of safety climate, and staff wellbeing.

Our ultimate goal is to build psychological safety in healthcare teams, promoting an environment where specialists, trainees, nurses, anaesthetic assistants and patients do not hesitate to speak up, knowing they will be listened to and their opinions valued.

**Professor Jennifer Weller, University of Auckland, NZ; Dr James Hamill, paediatric surgery, Starship Children's Health, NZ; Associate Professor Andrew MacCormick, University of Auckland and Department of Surgery, Counties Manukau, NZ; Associate Professor Tanisha Jowsey, Bond University, Queensland.**

**$A69,902**

1. Long J, Jowsey T, Garden A, Henderson K, Weller J. The flip side of speaking up: a new model to facilitate positive responses to speaking up in the operating theatre. British Journal of Anaesthesia. 2020;125(6):1099-106.

*Applicants for future Professional Practice Research Network (PPRN) grants are encouraged to contact the PPRN Executive (research @anzca.edu.au) if they have any questions regarding their application or would like mentorship prior to the grant submission date.*

## The Russell Cole Memorial ANZCA Research Award


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

**Optimising oxycodone pain management in cancer patients through metabolic, proteomic, genetic and immune biomarkers**

Pain relief using oxycodone is common in the course of a cancer illness including almost every patient who undergoes surgery and almost 90 per cent of those with advanced illness. About 20 per cent of patients will experience uncontrollable pain and unacceptable side effects to oxycodone, resulting in increased suffering and hospital admissions. The reasons are multifactorial. We have shown in a small discovery study that a normal breakdown product of oxycodone, noroxycodone, appears to be a major contributor to these poor outcomes.

Noroxycodone formation is regulated by cancer-induced inflammation. Headquartered at the Peter MacCallum Cancer Centre, we will study 50 patients who have inadequate pain relief and/or intolerable side effects to oxycodone that normally would require a switch to a more expensive opioid. Using a single blood sample, we will determine (a) how much noroxycodone is in their blood stream, (b) the extent of inflammation and c) their pain and oxycodone genes. This will allow us to start a large scientifically strong international clinical trial to determine which is the best oxycodone dose each individual patient should receive for their cancer pain at the beginning of their pain relief journey, thus bringing precision medicine to this neglected field.

**Professor Andrew Somogyi, Dr Daniel Barratt, Dr Sanam Mustafa, University of Adelaide, SA; Dr Aaron Wong, Peter MacCallum Cancer Centre and Royal Melbourne Hospital, Melbourne, Victoria; Professor Andrew Rowland, Flinders University, SA.**

**$A64,158**

## Douglas Joseph Professorship


This is a prestigious award for fellows who are making an outstanding contribution to the advancement of the specialty to pursue scholarship and research in human anaesthesia in Australia, New Zealand, Hong Kong, Malaysia and Singapore. The tenure of the professorship is one year and Professor Dennis will hold the courtesy title "Douglas Joseph Professor of Anaesthesia".

**The Hopeful Hearts Project – evaluation of haemodynamics in women with untreated preeclampsia using echocardiography**

Preeclampsia is a life-threatening high blood pressure condition that causes heart failure, stroke and premature birth. It is one of the main causes of maternal death. Echocardiography can diagnose and determine heart function abnormalities otherwise undetectable in pregnant people. This project will shed light on the causes of preeclampsia. It continues studies previously undertaken in the US, South Africa and Australia. It aims to further strengthen a new theory explaining the causes of preeclampsia – the constant stimulus adaptive response model of preeclampsia.

The project will use echocardiography, on pregnant people with preeclampsia before they are treated, to determine primary heart function. The potential impacts of this study are to understand the physiology underpinning new onset high blood pressure in pregnant people, a change in paradigm of our understanding of the causes of preeclampsia, bringing echocardiography into the mainstream management of people with preeclampsia, a likely reduction in long term complications of preeclampsia, to advance the use of echocardiography in obstetric hospitals, to strengthen collaborative links between the Brigham and Women's Hospital and Harvard Medical School Boston US, and the Joan Kirner Women's and Children's Sunshine Hospital (Western Health) and the University of Melbourne, and to create collaborations between the medical specialties of cardiology, obstetrics and anesthesiology for the improved care of pregnant people.

**Professor Alicia Dennis, Research Scholar, Brigham and Women's Hospital, US; Joan Kirner Women's and Children's Sunshine Hospital, Melbourne, Victoria; Department of Critical Care, University of Melbourne, Victoria; School of Medicine, Faculty of Health, Deakin University, Victoria.**

**$A69,828**

## John Boyd Craig Research Award


Established following generous donations from Dr John Boyd Craig to the ANZCA Foundation to support a highly ranked pain related research grant.

**PET in persistent pain: Imaging neuroinflammation after limb trauma from acute injury to Complex Regional Pain Syndrome**

Complex Regional Pain Syndrome (CRPS) is a debilitating chronic pain condition that develops in ~5 per cent of people following minor limb trauma, such as a wrist or ankle fracture. Those who experience intense pain in the first week after injury, and still have pain at two months, have a 10-fold higher risk of developing CRPS. Symptoms include burning and shooting pain, as well as fluctuations in temperature, swelling, and sweating of the limb. Current first-line treatments often fail to provide adequate pain relief, and there is low-quality evidence for their efficacy. Furthermore, they do not target the underlying causes of CRPS.

This project aims to understand the neuroinflammatory mechanisms underlying CRPS development using advanced medical imaging techniques like positron emission tomography (PET) and ultra high-resolution functional magnetic resonance imaging (fMRI). It will study 40 post-wrist fracture patients with persistent pain, who experienced severe pain initially, assessing them at two- and eight months post-fracture to observe neuroinflammatory changes as some transition to CRPS. By focusing on the activation of glial cells, like astrocytes and microglia, the project seeks to pinpoint their roles in pain pathways and abnormal brain activity. Our study is expected to identify early diagnostic markers and novel therapeutic targets for CRPS treatment.

**Associate Professor Marc Russo, Hunter Pain Specialists, University of Newcastle, and University of Sydney, NSW; Associate Professor Paul Austin, Dr Zeynab Alshelh, University of Sydney, NSW; Professor Peter Drummond, Murdoch University, WA; Dr Peter Georgius, Sunshine Coast Clinical Research, Queensland.**

**$A70,000**

## Robin Smallwood Bequest


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

**Feasibility of randomisation to different flow targets for cardiopulmonary bypass**

A decline in kidney function is common after cardiac surgery. It is associated with more complications and increased length of stay. Mitigating this decline of kidney function will therefore improve patient outcomes and reduce costs. During cardiac surgery, cardiopulmonary bypass (CPB) is commonly utilised to deliver blood around the body and supply oxygen to vital organs. However, the use of CPB is known to decrease the blood flow to the kidneys compared to the normal state. This puts the kidneys at risk of not receiving adequate oxygen (termed hypoxia) and therefore contributes to loss of kidney function. Increasing CPB flows has minimised kidney hypoxia in small studies. This intervention has no cost and no known harms, and has excellent potential to improve patient outcomes, however, the benefit of routinely increased CPB flows has not been tested in real-world settings. Therefore, increased CPB flows are not routinely practised in Australia or the world.

In order to work towards a large pragmatic trial that applies high CPB flows routinely for patients undergoing cardiac surgery, we aim to demonstrate the feasibility of a pragmatic application of different CPB flow targets during cardiopulmonary bypass in two representative cardiac surgery centres: one from a metropolitan setting, and one from a regional setting. This will allow us to have greater confidence in administering different CPB flow targets in a large trial setting.

**Dr Raymond Hu, Professor Rinaldo Bellomo, Austin Health and The University of Melbourne, Victoria; Professor Robert Baker, Flinders Medical Centre, SA; Professor Jaishankar Raman, Townsville University Hospital, Queensland.**

**$A36,310**

## Elaine Lillian Kluver ANZCA Research Award


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

**Changes in on-going and evoked brain activity during the transition from acute to chronic neuropathic pain**

Chronic pain imposes enormous economic and social burden and current management strategies remain inadequate. It is known that individuals with chronic pain display significant alterations in regional brain structure, function and biochemistry and it is assumed that these differences are responsible for an individual's constant perception of pain. Knowing how and when such changes occur in the brain would greatly enhance our understanding of the pathophysiology of chronic neuropathic pain and provide the platform for targeted and effective treatments that can prevent pain chronification following injury. We aim to use state-of-the-art brain imaging techniques to track the changes in neural activity during the development of chronic pain in an animal model. The proposed studies would be the first longitudinal investigation to track changes in brain structure and function during the development of acute and then chronic pain. These data are critical for our understanding the brain processes that underpin the transition from acute to chronic pain will provide a platform to begin to develop targeted treatments that can prevent chronic pain development and maintenance that results from nerve injury.

**Dr Jessica Barry, Royal Prince Alfred Hospital, NSW; Professor Luke Henderson, University of Sydney; Professor Richelle Mychasiuk, Monash University, Melbourne, Victoria.**

**$A67,525**

## Patricia Mackay Memorial ANZCA Research Award


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

**Evaluating extubation criteria in children less than 10 years of age undergoing intravenous anaesthesia (EXTUBATE Study)**

Emergence and extubation remain high risk periods for paediatric patients undergoing general anaesthesia. It is likely that different criteria may be predictive of extubation success in patients who have inhalational anaesthesia compared to intravenous anaesthesia – either sevoflurane initiated intravenous anaesthesia (SIIVA) or total intravenous anaesthesia (TIVA). This is because these anaesthetic regimens have different pharmacologic mechanisms of actions, and therefore interact with the central nervous system differently, potentially leading to a need for different extubation criteria.

Additionally, intravenous agents likely have less of an effect on airway reflexes and ventilation at light levels of anaesthesia. This phenomenon might be more pronounced in children, since the average length of time of anaesthesia is generally much shorter in children than in adults, increasing the impact of the induction type on the emergence period. This multicentre, prospective observational study will examine the predictive value of various common extubation criteria in the setting of SIIVA and TIVA. Between two US sites and one in Australia (Perth Children's Hospital), 600 children aged under 10 years of age will be recruited. If different extubation criteria can be identified for children undergoing SIIVA or TIVA, this information can help tailor anaesthetic management and improve safety.

**Professor Britta Regli-von Ungern-Sternberg, Perth Children's Hospital, WA; Associate Professor Tom Templeton, Atrium Health Wake Forest Baptist, US; Dr Julia Galvez Delgado, Boston Children's Hospital, US.**

**$A70,000**

## Skantha Vallipuram ANZCA Research Scholarship


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

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

Dr Earlene Silvapulle was awarded the Skantha Vallipuram ANZCA Research Scholarship to support her in pursuing a PhD at the University of Melbourne, with her thesis topic "Cardiac Risk and Myocardial Injury in Surgical Patients".

Dr Silvapulle's study will be the first step to accurately identifying individuals at high risk of postoperative myocardial injury, enabling suitable monitoring and surveillance after surgery. Early identification of myocardial injury will open potential avenues for secondary prevention therapy and long-term reductions in myocardial events.

**Dr Earlene Silvapulle, Royal Melbourne Hospital, Victoria.**

**$A20,000**

## ANZCA Innovation and Technology Research Award


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

**Translation of novel ketamine analogue analgesics**

Currently opioids and ketamine are the mainstay of treatment for acute severe pain. However, these analgesics have significant adverse effects at both individual and social levels; so alternative strong pain relief medication is urgently needed. Over the past decade, Professor Sleigh and Dr Voss have studied the mechanisms of action of different ketamine-like molecules. They have produced a body of knowledge around these analogues and have promising evidence of prolonged pain relief without sedation or hallucinations – seen with one molecule called R5.

Recently Dr Irani has identified a novel molecular analgesic target (the potassium channel TWIK-1), using sophisticated super-computer molecular dynamics simulations. The next steps towards using such drugs in clinical practice will involve a collaboration with Dr Whittle and Dr Oliver at the Liggins Institute, to establish R5 analgesic efficacy, and conduct further computer modelling for potential side effects to exclude early any new candidate analogues with receptor-level effects likely to cause seizures and/or respiratory depression.

**Professor Jamie Sleigh, Waikato Clinical School, University of Auckland, NZ; Dr Nicola Whittle, Dr Logan Voss, Waikato Hospital, NZ.**

**$A69,560**

## W. John Russell ANZCA Research Award


Established following a generous donation to the ANZCA Foundation from Mrs Jan Russell to support a highly ranked grant that aligns with Dr Russell's area of special interests in engineering and equipment in anaesthesia, perioperative or pain medicine or related to patient safety, teaching or clinical pharmacology.

**Investigating direct current (DC) stimulation in neuromodulation and implications of glial cells in pain signalling mechanisms**

Chronic pain affects millions worldwide, often with limited treatment options and significant side effects. Recent breakthroughs in neuromodulation show promising potential in controlling glial cells – key players in chronic pain maintenance. This project aims to investigate a novel approach using direct current (DC) stimulation, which, unlike conventional pulsed waveforms, may provide a more effective method to modulate glial activity in the spinal cord.

We will use a well-established rat model of chronic pain to test the efficacy of DC stimulation. By comparing traditional electrical stimulation methods with DC waveforms, we aim to determine whether DC can reduce pain-related behaviours and influence glial function more effectively. Advanced cell imaging and transcriptomics will allow us to understand how these electrical fields alter cellular responses in the spinal cord.

This research could lay the foundation for a new drug-free therapy, offering long-term relief for chronic pain sufferers.

**Associate Professor Vahid Mohabbati, Dr Mohammadkazem Papan, Sydney Pain Research Centre, NSW; Associate Professor Gila Moalem-Taylor, Dr Felix Aplin, University of NSW.**

**$A65,940**

## ACADEMIC ENHANCEMENT GRANT


**The environmental life cycle inventory of anaesthesia, intensive care, and perioperative medicine**

In the setting of climate change there is growing interest in the financial and environmental costs of healthcare. The perioperative milieu and the intensive care unit are carbon (and waste!) hotspots in healthcare. Anaesthetists in particular, have led efforts to reduce the carbon footprint of our workplace, yet there is much still to learn about the environmental footprint of our daily practice. Further, undertaking life cycle assessments (LCAs) is laborious. We require a library that contains the basic features (composition, mass, country of origin) of several hundred common devices. With the assistance of the newly formed University of Melbourne Healthcare Carbon Lab team we aim to do so.

Through such a library data interested clinicians et al will be able to: estimate the carbon footprint of their daily practice and that of the healthcare institution, and more promptly undertake further LCAs of products and care pathways without the requirement to undertake such efforts de novo. Engineering data about indoor (operating theatres) energy use will also be of benefit. As we have repeatedly found, our prior LCA work has led to other related studies with financial and environmental benefits and fruitful collaborations with clinicians and engineers.

**Associate Professor Forbes McGain, University of Melbourne, Victoria.**

**$A98,899**

## NOVICE INVESTIGATOR GRANTS


**Developing a physiology-pharmacodynamic model of rocuronium dose and cardiac output to investigate the onset time of neuromuscular relaxation**

What dose of rocuronium do you use for your rapid sequence intubations? How long do you wait for it to take effect?

These are common questions uttered in anaesthesia and emergency departments as well as intensive care. In 2000 a study suggested that 1.8 – 2.3 mg/kg rocuronium may be required to achieve "excellent" intubating conditions at 60 seconds in the vast majority of patients. The question of whether these larger doses might be better has not been further investigated.

The primary aim of this study is to clarify, with a semi-physiological kinetic-pharmacodynamic (KPD) model, the relationship between dose of rocuronium for intubation, cardiac output (CO), and onset of neuromuscular blockade. The model might then suggest dosing and expected onset.

Observational data will be collected from 30 adults undergoing general anaesthesia with muscle paralysis. Rocuronium onset time will be defined as 95 per cent twitch depression of neuromuscular monitoring (NMT) electromyography (EMG) at adductor digiti minimi. Cardiac output measurements will be taken from pulse contour analysis of arterial invasive pressure waveforms. Doses of rocuronium will range between 1.2 mg/kg and 2.0 mg/kg.

**Dr Clare Hayes-Bradley, Blacktown Hospital, NSW; Aeromedical Operations, NSW Ambulance.**

**$A9,428**


**Postoperative neural injury in non-neurosurgical procedures: A prospective observational study in older adults**

Between 2019 and 2020, one million Australians (37 per cent) aged over 60 underwent surgery. Older patients have a higher risk of postoperative neurocognitive disorders, and whether neural injury from general anaesthetics contributes to these disorders remains controversial. Neurobiomarkers provide a quantitative method to assess neural injury during surgery under anaesthesia, allowing us to understand how anaesthetic techniques impact the aging brain at the cellular level. This could pave the way for anaesthetic approaches that reduce cognitive decline in older patients. However, separating the effect of anaesthesia from the tissue damage of surgery is challenging in clinical populations.

This study will try to isolate the effect of general anaesthesia on neurobiomaker release in the ageing brain. It will compare changes in plasma levels of neurobiomarkers in older patients undergoing vitrectomy surgery using sevoflurane-based general anaesthesia with those receiving eye block with sedation. Fifty patients will be recruited from Royal Brisbane and Women's Hospital and the surgical treatment and rehabilitation service. Blood samples collected before surgery and 24 hours post-anaesthesia will be analysed using SIMOA technology. The results will provide insights into the neural effects of different anaesthesia techniques, offering valuable data for planning future, larger studies on brain health in older patients.

**Dr Michael Boules, Royal Brisbane and Women's Hospital, Queensland.**

**$A20,000**

## PATRONS EMERGING INVESTIGATOR GRANT


**DEARS Study: Depth of anaesthesia in females – EEG biomarkers, Anaesthetic/ hormone relationships and Recovery Score**

Anaesthesia is provided to hundreds of millions of people each year with remarkable safety.[1] However, a key concern of patients undergoing general anaesthesia is the potential experience of awareness.[2] Young females are at increased risk of awareness under anaesthesia compared to males, as demonstrated in our meta-analysis.[3] An implication of this may be that female patients are relatively under-dosed compared to males. Alternatively, this increased risk of awareness in females may arise from an influence of sex hormones on the pharmacokinetics and pharmacodynamics of anaesthetic agents.

Critically, the foremost way to reduce this risk of awareness is to increase the dose of anaesthesia. Stakeholder engagement has revealed that a limitation to adjusting dosing in females is concern that greater doses are associated with more adverse events and poorer quality of recovery. There is a lack of data to establish if deeper anaesthesia is non-inferior than lighter anaesthesia in young patients (as it is in older patients[4]).

In this randomised controlled blinded non-inferiority trial, we will address a critical lack of knowledge about (1) quality of recovery following anaesthesia in young females and (2) the influence of sex hormones on anaesthetic dosing.

**Dr Hannah Braithwaite, Dr Elise Butler, Ms Kaitlyn Kramer, Royal Prince Alfred Hospital, NSW; Professor Robert Sanders, Dr Tom Payne, University of Sydney, NSW; Dr Amy Lawrence, Concord General Repatriation Hospital, NSW; Dr Ben Moran, Gosford Hospital, NSW.**

**$A70,000**

1. Higham H, Baxendale B. Br J Anaesth 2017; 119: i106-i14
2. Rowley P, Boncyk C, Gaskell A, et al. Br J Anaesth 2017; 118: 486-8
3. Braithwaite H. MEDRXIV 2023: 287147
4. Short TG, Campbell D, Frampton C, et al. Lancet 2019; 394: 1907-14

## PROJECT GRANTS


**Does dexmedetomidine influence changes in serum neurofilament light following on-bypass cardiac surgery?**

Around half of patients undergoing cardiac surgery suffer some form of post operative neurocognitive dysfunction, the most common being delirium. The DECIDE trial will assess whether adding intra- and postoperative dexmedetomidine to standard care of these patients alters the rates of delirium and post operative cognitive decline.

Patients who suffer from delirium are known to be at a significantly increased risk of subsequent diagnoses of dementia, however the precise pathophysiology of this is not yet known. One potential mechanism is that the stress and inflammation suffered during the perioperative period leads to a breakdown of neuronal tissue itself. This sub study will measure plasma levels of neurofilament light (NfL) – a biomarker of neuronal injury whose level in peripheral blood has been shown to be consistent with that in the CSF – in the larger DECIDE trial, with the aim of exploring the link between any clinical findings of the main trial, to NfL levels.

This will allow the comparison of NfL levels in not only the dexmedetomidine or standard care groups, but also to various haemodynamic and other anaesthetic factors – potentially informing future care for on pump cardiac surgery.

**Dr Tim Marshall, Professor Rob Sanders, Dr Joanne Irons, Dr Bruce Cartwright, Royal Prince Alfred Hospital, and University of Sydney, NSW; Professor Gillian Heller, Dr Thomas Payne, University of Sydney, NSW; Associate Professor Lis Evered, Weill Cornell Medicine, New York US; Associate Professor Stefan Dieleman, Westmead Hospital, NSW; Professor David Scott, St Vincent's Hospital and University of Melbourne, Victoria; Dr Kate Drummond, Royal Adelaide Hospital, SA.**

**$A69,889**


**CHEETAH – children's health and the environment: Establishing metrics to assess the level of anaesthetic health risk in children**

Perioperative respiratory adverse events are significant causes of morbidity and mortality in paediatric anaesthesia representing a significant resource burden. The CHEETAH observational study is designed to establish the relationships between environmental exposures (air pollution, pollen), socioeconomic risk factors, and the risk of perioperative respiratory adverse events.

Data are being collected from patients undergoing general anaesthesia at Perth Children's Hospital in 2024. We anticipate the final dataset will exceed 9000 patients. This grant will allow the research team to undertake data analysis, including modelling of the associations between pollutant exposure levels and perioperative respiratory adverse event rates. Models will be compared based on model diagnostic tools, predictive ability, and clinical interpretability.

In the case of high rates of missingness, appropriate imputation techniques will be used to mitigate the bias associated with analysis of complete case data. We will explore the feasibility of a secondary more complex analysis utilising spatial air quality modelling outputs to more accurately reveal relationships between pollutant exposure at home and perioperative adverse events. Increasing knowledge about the effects of environmental exposure and socioeconomic risk factors on the risk of perioperative respiratory adverse events could lead to clinical management changes which improve safety for children.

**Associate Professor David Sommerfield, Dr Bojana Stepanovic, Perth Children's Hospital, WA; Ms Daisy Evans, The Kids Research Institute Australia, WA; Dr Nazim Khan, University of Western Australia.**

**$A70,000**


**Stratification of chronic neuropathic pain using individual biological profiles**

More than three million Australians live with chronic pain, with current treatments, particularly for pain following nerve injury, that is, neuropathic pain, largely ineffective. The major roadblock for effective treatment development is our limited understanding of the underlying pathophysiology as well as individual variability. The assumption that when two individuals are classified into the same neuropathic pain category, they have the same underlying neurobiology is not valid. Instead, stratifying individuals based on biological measures would provide the opportunity to develop treatments targeting individual underlying mechanisms.

We propose a series of magnetic resonance imaging combined with quantitative sensory testing, genetic, immune, and psychosocial measures that will provide a unique set of integrated data from the cellular level to the whole brain and from peripheral to central processes. Using these measures, we will define the individual biological characteristics of each chronic pain patient and use machine learning classification models to stratify individuals into groups with similar underlying mechanisms.

An understanding of individual variations in biological processes and a biologically-based classification system is needed. Such a system would significantly improve our capacity for diagnostic stratification, treatment guidance, and novel treatment development to improve overall care.

**Dr Alister Ramachandran, Westmead Pain Management Centre, NSW; Professor Luke Henderson, Dr Lewis Crawford, University of Sydney, NSW; Professor Chris Peck, Dr Hongfei Yang, The National University of Singapore.**

**$A70,000**


**Sympathetic autonomic dysfunction and the risk of hypotension after surgery**

Hypotension after surgery is common and is associated with patient harm including myocardial and kidney injury, stroke, delirium and death. The physiology of postoperative hypotension is poorly understood. Conventional models of the circulation posit that the sympathetic nervous system should compensate for any of the causes of hypotension and restore blood pressure, implicating dysfunction of the sympathetic nervous system in the development of postoperative hypotension.

There are a range of methods to assess sympathetic function, but few are appropriate for clinical practice in patients recovering from general anaesthesia. The isometric handgrip test for sympathetic dysfunction is a promising candidate test, but the feasibility of using this technique in surgical patients has not been established. We are conducting a pilot study aiming to evaluating the feasibility of using the isometric handgrip test to identify sympathetic dysfunction in patients having major surgery under general anaesthesia, in preparation for a large observational study to understand the influence of sympathetic dysfunction on postoperative hypotension.

**Dr Ned Douglas, Associate Professor Jai Darvall, Professor Kate Leslie, Royal Melbourne Hospital and Department of Critical Care, University of Melbourne, Victoria.**

**$A69,311 including scholarship**


**PORPOISE – Physiological monitoring in the OR; predicting outcomes using infra-red sensors: A feasibility study**

In children, deviations from normal physiological parameters during general anaesthesia could lead to negative effects on the brain. Brief modest reductions in brain oxygenation while under anaesthesia have been associated with negative postoperative behaviour changes in children at seven days and may be a marker for neurocognitive damage.

This prospective observational feasibility study is an international collaboration led by Associate Professor Peter Frykholm from Uppsala University, Sweden with Perth Children's Hospital as the only site in Australia. The study will implement a monitoring protocol that includes near infrared spectroscopy perioperatively and a follow-up protocol that includes a post-hospitalisation behaviour questionnaire on postoperative day seven and 30. The researchers aim to recruit 500 children aged six months to five years before elective or acute surgery requiring general anaesthesia.

Researchers hypothesise that it will be feasible to record physiologic changes during anaesthesia and any resulting changes in anaesthesia management in order to identify a potential association between reduced cerebral oxygenation and negative postoperative behavioural changes. Acting on cerebral oxygen desaturation may reduce neurological complications in millions of children undergoing general anaesthesia and improve safety of anaesthesia.

**Associate Professor David Sommerfield, Perth Children's Hospital, WA, Associate Professor Peter Frykholm, Uppsala University Hospital, Sweden.**

**$A70,000**


**Hypoxic enhancement before major surgery (HYPE): A pilot randomised controlled trial of preoperative Roxadustat versus placebo in patients undergoing major noncardiac surgery**

Complications after major surgery are common and decrease survival. Tissue hypoxia is established as a driver of postoperative complications. All complex cells can adapt to low oxygen conditions by activating the highly conserved hypoxia inducible factor (HIF) pathway. Roxadustat is a first-in-class oral prolyl hydroxylase inhibitor that increases HIF signalling, marketed since 2018 for the treatment of anaemia in chronic kidney disease. Brief preoperative Roxadustat exposure stands to prime cells to function well under the anticipated hypoxic stress of major surgery, a clinical insult that is unique due to its precise timing.

The investigators will conduct a pilot study to assess whether a definitive phase 3 randomised controlled trial of preoperative Roxadustat versus placebo in patients undergoing major noncardiac surgery is safe, feasible and justified.

The study will enrol 150 adult patients undergoing major abdominal, orthopaedic or vascular surgery who will be randomly allocated to receive three preoperative doses of oral Roxadustat 100 mg or placebo.

The primary endpoint is any significant acute preoperative illness following first tablet ingestion and/or any postoperative complication within 30 days. Secondary endpoints will include biomarker profiles of organ injury and a comprehensive suite of perioperative core outcome measures.

The results of this pilot study will inform the design of a large international trial to test whether Roxadustat reliably improves recovery after major surgery.

**Associate Professor Andrew Toner, Professor Tomas Corcoran, Royal Perth Hospital, WA; Professor Cormac Taylor, Conway Institute, University College Dublin, Ireland; Professor Simon Keely, The University of Newcastle and Hunter Medical Research Institute, NSW.**

**$A70,000**


**Electrical impedance tomography assessment of lung homogeneity in infant hernia surgery – a prospective cohort study**

Inguinal hernia repair is the most commonly performed operation in infants, a patient population which is particularly vulnerable, with well recognised anaesthetic and perioperative risks.

This multicentre prospective observational study will use electrical impedance tomography (EIT), a non-invasive, radiation free technique to describe the effects of anaesthesia on the lung in infants undergoing inguinal hernia surgery. We aim to look at four different anaesthesia techniques: general anaesthesia with spontaneous or mechanical ventilation, spinal anaesthesia, or high flow nasal oxygen, caudal and sedation.

Previous work by some authors in this group have shown there are ventilation differences in infants undergoing general anaesthesia for a variety of surgeries. This study will go one step further to compare spontaneous ventilation to general anaesthesia and include smaller infants including those born preterm.

Exploring the differences in lung homogeneity with different anaesthetic techniques will provide greater detail to clinicians regarding the impact of anaesthetic techniques in this vulnerable patient group. This study may lead to further research to determine if differences in lung ventilation shown with EIT results in increased risk of perioperative respiratory complications during and after surgery, and then develop ventilation strategies and anaesthesia techniques to reduce lung injury and associated risks.

**Dr Fiona Taverner, Flinders Medical Centre, South Australia; Professor Andrew Davidson, Royal Children's Hospital, Melbourne, Dr Cormac Fahy, Women's and Children's Hospital, South Australia.**

**$A69,345**


**Human brain organoid models to investigate anaesthesia induction and reversal agents**

In previous work, we demonstrated that general anaesthetics (GAs) impair presynaptic neurotransmission, in addition to their well-known role in enhancing inhibitory post-synaptic receptors. Using animal models (flies/nematodes) and mammalian neurosecretory cell cultures, we tested a non-anaesthetic analogue of propofol, "propofluor," which appears to reverse the effects of GAs. This presents a potential opportunity to identify agents that could accelerate recovery from GAs in human patients.

To explore this in a context most relevant to human patients, we are using lab-grown mini-brains (organoids) derived from human pluripotent stem cells. By six to eight months of age, these organoids display complex patterns of electrical activity, recorded via multi-electrode arrays, which can serve as a model for assessing induction and recovery dynamics of GAs. Importantly, organoids can be grown from specific patient populations, such as vulnerable individuals with mutations that make them hypersensitive to anaesthetics (for example, Leigh Syndrome).

In our ANZCA-funded project, we will investigate the effects of two intravenous GAs (propofol and etomidate) on network activity in cortical organoids derived from Leigh Syndrome patients and controls. After characterising anaesthetic induction and recovery, we will test whether candidate reversal agents like propofluor, can counteract the effects of these drugs and reduce the time to full recovery in both types of organoids.

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

**$A69,952**


**Opioids requirements after discharge following surgery (ORADS) study**

Over the past 25 years in Australia, opioid dispensing has increased almost four-fold. The medical community and governments have become increasingly aware of the harm caused by opioid misuse, including dependency, overdose and contributing to chronic pain.

The investigators aim to address the discharge prescription problem, by developing a predictive model to estimate the precise quantity of opioids that surgical patients will require in the seven days after discharge home.

The ORADS study aims to observe 2380 patients undergoing 34 types of surgery in the Southern Adelaide local health network. Patients will receive either an SMS-linked survey post-discharge or follow-up by an ORADS researcher to determine quantity of opioids used, episodes of uncontrolled pain and pain management education recall.

Following data analysis, a prediction model will be created with the final model to be incorporated into an easy to use, free app.

By developing this predictive model, the ORADS study aims to tailor prescriptions more closely to individual patient requirements, thereby minimising the risk of both excess unused medication and undermanaged pain. This approach has the potential to generate more effective pain management protocols, significantly decrease the occurrence of pain crises that lead to emergency department visits, enhancing patient recovery and reducing the burden on healthcare systems.

**Dr Jason Koerber, FANZCA, Flinders Medical Centre, Adelaide, SA; Professor Richard Woodman, statistician, Professor Jonathan Karnon, Health Economist, Flinders University, SA.**

**$A40,000**


**PLATYPUS: Prospective longitudinal assessment of treatment options for young patients with upper airway structural abnormalities**

Laryngomalacia is the most common congenital airway abnormality in young infants and children. It presents clinically as a spectrum that in most cases is self-limiting, with symptoms resolving without treatment by about 12 months of age. In a minority of cases serious complications can arise, necessitating further management, and 10-15 per cent of all patients with laryngomalacia require surgical treatment in the form of a supraglottoplasty. The decision to proceed to surgery is based on the clinical assessment of the severity of the underlying laryngomalacia. Previous retrospective cohort studies highlighted the need to gather prospective data and develop tools to guide clinical decision making, allowing appropriate selection of treatment modalities for moderate to severe laryngomalacia.

PLATYPUS, a collaboration between anaesthetists and ear, nose and throat surgeons is a single centre prospective observational pilot study at Perth Children's Hospital. The aim is to determine to what extent continuous measures of oxygenation and ventilation are feasible in this cohort, and how preoperative oxygenation and ventilation data may be useful in guiding clinicians towards selecting surgical interventions that are most likely to be successful.

Continuous assessment of a supraglottoplasty candidate's preoperative oxygenation and ventilation might provide a useful predictive model for surgical success or failure.

**Associate Professor Neil Hauser, Professor Shyan Vijayasekaran, Dr Phil Sale, Perth Children's Hospital, WA.**

**$A70,000**

# Grant review process

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

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

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

Finally, funding is allocated to the proposed projects considered to be of "fundable" quality in descending order of the final averaged committee member scores, within the limits of the funds available. The success rate consistently averages over 40 per cent, significantly higher than most other grant programs. Inevitably, in any competitive process some applicants are unsuccessful. As with most grant programs, feedback is not provided to any applicant after the committee has finalised its decisions, except to novice investigators. However, detailed feedback on applications is formally provided during the review process through reviewers' comments to applicants, which reflect most of the factors that will influence committee decisions.

Most committee members have themselves experienced many unsuccessful applications to ANZCA and other granting agencies and recognise the disappointment felt when a submission is unsuccessful. However, unsuccessful applications also help applicants to develop grant writing skills for future success, and perhaps it is this persistent pursuit of continual improvement that most characterises all ANZCA grant applicants. The committee recognises the significant time and effort involved in grant writing, extends its thanks and encouragement to all applicants, and strongly encourages all fellows and trainees considering applications to apply for the 2026 grants round which opened on 1 December 2024.

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

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

During 2023, the committee reviewed and amended all ANZCA research grant application forms and guidelines in an effort to make the application process easier for all applicants and reviewers. This process is continuing with further review and improvements expected during 2025.

The contribution of committee members and reviewers are often made in their own time. We would like to express our sincere thanks to all of them, and to the ANZCA Council, president and CEO for their ongoing commitment to research led by our fellows and trainees, as a vital contribution to continuous improvement in quality, safety and patient outcomes.

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

**RESEARCH COMMITTEE MEMBERS:**

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

Associate Professor Matthew Doane, Deputy chair (NSW)

Mr Andrew Brookes, Community representative (Vic)

Dr Douglas Campbell (NZ)

Professor Matthew Chan (HK)

Professor Tomas Corcoran, CTN chair (WA)

Professor Victoria Eley (Qld)

Associate Professor Lis Evered (Vic)

Professor Kirsty Forrest (Qld)

Professor Paul Glare, FPM representative (NSW)

Dr Usha Gurunathan (Qld)

Dr Julie Lee (Qld)

Associate Professor Paul Lee-Archer (Qld)

Associate Professor Stuart Marshall (Vic)

Professor Simon Mitchell (NZ)

Professor Philip Peyton (Vic)

Professor Robert Sanders (NSW)

Associate Professor Justin Skowno (NSW)

Professor Andrew Somogyi (SA)

Associate Professor David Sommerfield (WA)

Professor André van Zundert (Qld)

Professor David Story, ANZCA President (Vic)

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

# Research grants for 2026

ANZCA
FPM

## ANZCA AND FPM FOUNDATION GRANTS PROGRAM

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

**Grants available for 2026:**

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

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

**The closing date for all grant applications is 5pm AEDT 1 April 2025.**

For further information, please contact:
Ms Susan Collins
Research and Administration Coordinator
research@anzca.edu.au

## ANZCA FOUNDATION HONORARY NAMED RESEARCH AWARDS TO BE AWARDED FOR 2026:

Russell Cole Memorial ANZCA Research Award

Robin Smallwood Bequest

Elaine Lillian Kluver ANZCA Research Award

John Boyd Craig Research Award

Patricia Mackay Memorial ANZCA Research Award

W. John Russell ANZCA Research Award

ANZCA Innovation and Technology Research Award

Darcy Price Regional Anaesthesia Award

Provisional New Fellow (PNF) ANZCA Research Award

# New research award announced

## INAUGURAL W. JOHN RUSSELL ANZCA RESEARCH AWARD CONFERRED

The foundation is very pleased to announce that the research committee has conferred the ANZCA Foundation's newest honorary named research award, the W. John Russell ANZCA Research Award, in recognition of ANZCA Robert Orton medallist Dr Walter John Russell's landmark lifetime contributions to engineering, education, and patient safety in anaesthetic practice.

The inaugural award has been made to Associate Professor Vahid Mohabbati, from the Sydney Pain Research Centre, NSW, and his team, for their project Investigating the Effects of Spinal Direct Current Stimulation on Glial Cells for Chronic Pain Neuromodulation.

The award will be made for two consecutive years. The foundation is privileged to be facilitate this prestigious honorary award, made possible by the wonderful generosity of Mrs Jan Russell.

## ANZCA INVESTIGATOR HONOURED AT PRIME MINISTER'S PRIZES FOR SCIENCE

ANZCA's Research Committee chair, Professor Britta Regli-von Ungern-Sternberg, received the 2024 Frank Fenner Prize for Life Scientist of the Year on 8 October for her research into reducing risks and improving recovery for children undergoing anaesthesia and surgery.

Britta, who was also a finalist for the 2025 Australian of The Year WA, is a consultant anaesthetist at Perth Children's Hospital and Chair of Paediatric Anaesthesia at the University of Western Australia. Britta and her expert team's research achievements have included discovering how to identify children at high risk of breathing problems; an important outcome as one in seven children experience breathing problems during surgery.

The foundation warmly congratulates Professor Regli-von Ungern-Sternberg and her research team for the difference they are making in making surgery as safe and pain-free as possible for children.

**FROM LEFT**

*Dr Walter John Russell.*

*Professor Britta Regli-von Ungern-Sternberg.*

## SECOND INNOVATION AND TECHNOLOGY ANZCA RESEARCH AWARD

ANZCA Foundation research funding grants for projects to commence in 2025 also included the second year of the exciting Innovation and Technology ANZCA Research Award, established by the foundation after generous donations from foundation governor patron, Dr Stanley Tay.

The 2025 award was conferred on Professor Jamie Sleigh, Waikato Clinical School, University of Auckland, New Zealand, and his team, for their project "Novel ketamine analogues; Computer modelling to predict side effects and in vivo testing of analgesic efficacy".

Professor Sleigh's study will examine an innovative approach to exploring a viable alternative to opioids through ketamine analogues with potential for prolonged pain relief, without some of the commonly associated side effects. Its focus on computer modelling and prediction is particularly suited to the award's innovation and technology focus.

The award builds on the tradition of advancement in research, innovation, and of technology that has empowered the world leading safety and quality delivered by ANZCA and FPM fellows across anaesthesia, pain medicine and perioperative medicine. The foundation thanks Dr Tay for his vision.

## PRESTIGIOUS ANZCA FOUNDATION NAMED RESEARCH AWARDS DECIDED

Twenty-four ANZCA Foundation research grants were approved by the research committee in September for studies commencing in 2025. These once again represented a sector-leading grant success rate of 48 per cent; an outstanding outcome.

ANZCA Foundation grants are still the best available research funding opportunity for ANZCA fellow and trainee clinician researchers at all levels.

Of the 24 successful applicants, seven applicants also received prestigious ANZCA Foundation honorary named research awards. Details of the preceding studies and their investigator teams are highlighted in this edition of the *ANZCA Bulletin*.

The foundation congratulates the honorary award recipients.

## FOUNDATION RESEARCH GRANTS OPEN FOR APPLICATIONS

Applications are invited for the ANZCA Foundation research grant round, which have now opened.

The ANZCA Foundation and research committee are seeking applications for projects to commence in 2026. Application forms and guides for all grant categories are available on the ANZCA website.

Applications are strongly encouraged and will be received until close of business on 1 April 2025.

## SPECIAL GIFT TO FUND EXTRA CTN PILOT GRANT

The foundation and the ANZCA Clinical Trials Network were delighted to recently receive a special additional gift of $A10,000 from ANZCA Foundation governor Dr Peter Lowe, targeted to provide an additional pilot grant for this amount to the existing three such grants to be provided through the foundation in 2024-2025.

CTN Pilot Grants support studies aimed at generating data to support possible future multi-centre randomised clinical trials, and are often a critical step towards producing trial evidence for future improvements to clinical practice. This will be the first time the foundation has been able to offer four ANZCA CTN Pilot Grants.

## ANZCA FOUNDATION SUBSCRIPTIONS APPEAL

As usual the ANZCA subscription forms will again include an option for fellows to donate to support the high-quality work of our world-leading clinical researchers.

Foundation donors also support fellows who volunteer their time to travel to resource-limited countries to deliver vital training and education in the specialties, and scholarships for anaesthetists and pain medicine physicians from those settings to attend ANZCA continuing medical education meetings, and fellows contributing to the important ANZCA Indigenous health program.

We thank all our generous donors and patrons, who continue to inspire us as they give back to improve healthcare outcomes and access for all to high-quality care.

## CONTACT AND SUPPORT

To donate, please search "GiftOptions – ANZCA" in your browser or scan the QR code.

**For queries, contact:**

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

**Research grants program:**

**Susan Collins,** Research and Administration Co-ordinator, scollins@anzca.edu.au

**ANZCA Clinical Trials Network:**

**Karen Goulding,** CTN Manager, karen.goulding@monash.edu

# Thank you to all foundation donors

**The ANZCA Foundation is once again grateful to its patrons, bequestors, and other generous donors for assisting the vital work of fellows and trainees in research in anaesthesia, pain medicine, and perioperative medicine, Aboriginal, Māori, and Torres Strait Islander health and in global health development.**

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# Regional events highlights

## FOSTERING COLLABORATION AND ADVANCING RESEARCH

Ongoing engagement with the network remains a top priority for the ANZCA Clinical Trials Network (CTN), with several regional events scheduled before the end of the year. Supported generously by the ANZCA Foundation, these meetings demonstrate the value of professional networks like the Anaesthesia Research Coordinators Network (ARCN) and trainee networks, which offer mentorship, education, and collaboration opportunities. They also underscore the importance of fostering collaboration and reaffirm the network's commitment to advancing anaesthesia research across regions and engaging early with trainees.

## ANZCA CTN NEW ZEALAND REGIONAL RESEARCH MEETING

On 2 November the ANZCA CTN hosted the New Zealand regional research meeting in Auckland. The event brought together about 30 attendees from hospitals across New Zealand, spanning from Whangarei in the North Island to Christchurch in the South Island. It sparked a renewed enthusiasm for research throughout the region.

The meeting served as a platform to discuss current and upcoming trials, including CALIPSO, CLIP-NZ-II, TRIGS, LOLIPOP, and SNaPP. Attendees discussed challenges and strategies for effective trial management. Site investigators offered practical guidance on overcoming hurdles and providing the latest updates on governance and regulatory requirements specific to New Zealand.

**ABOVE FROM LEFT**

*Delegates at the ANZCA CTN NZ Regional Research Seminar, Ms Davina McAllister, Ms Leanda Ritchie, Mr Jonathan Termaat and Ms Margie McKellow.*

*Participants at the NSW event, Ms Louise Cope, Ms Heidi Lindroth, Ms Kaitlin Kramer, Ms Queenie Leung and Ms Eleanore Clark-Mackay.*

## NSW ANAESTHESIA RESEARCH CO-ORDINATORS NETWORK

The NSW ARCN group held its second annual meet-up on 25 October, combining collaboration with creativity during a "paint and sip" session. Discussions focused on clinical trial logistics and site-specific challenges across NSW. Key highlights included the emphasis on departmental support and active, engaged principal investigators as critical factors for successful anaesthetic trials.

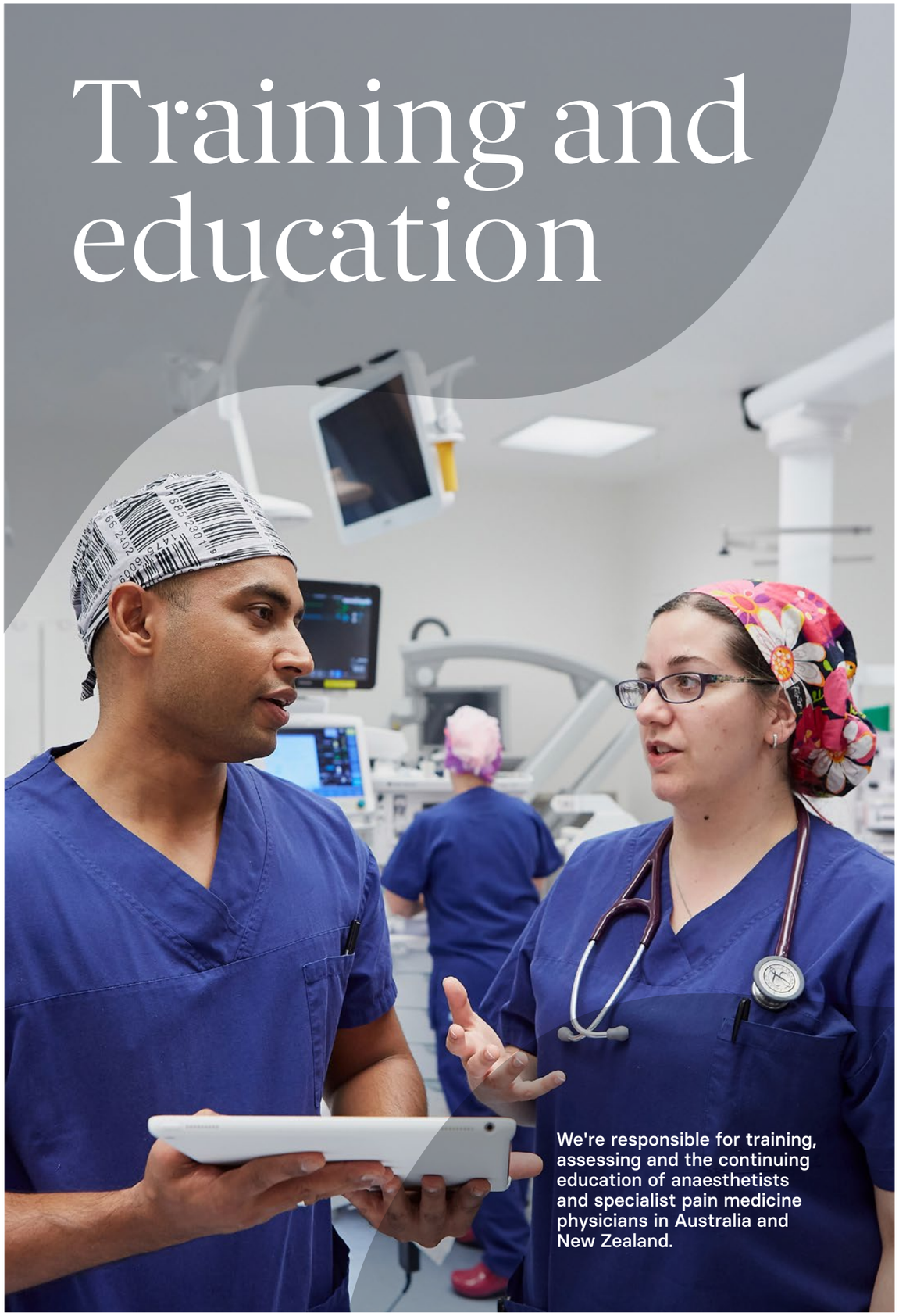
Co-ordinators underscored the importance of fostering a research culture through strategies like regular meetings, newsletters, and stakeholder collaboration. However, these efforts come with the added burden of already demanding workloads. NSW-specific challenges include staffing shortages, delayed recruitment processes, and resource constraints exacerbated by health policy limitations. Co-ordinators also noted inefficiencies from the new Clinical Trial Management Systems, which require duplicate data entry, as well as complexities in consent processes and logistical hurdles for regional participants.

## VIC NETWORKING AND SA/NT TRAINEE EVENTS

The Victorian ARCN event on 20 November in Melbourne brought together research co-ordinators, community members, and executive members. This event gave ARCN members the opportunity to discuss their roles with CTN leaders and the wider community.

The inaugural SA/NT Research Trainee Day in Adelaide on 30 November, inspired anaesthetic trainees to integrate research into their professional journeys. By connecting attendees with experienced researchers from South Australia's anaesthesia community, as well as CTN and college leaders, the event highlighted opportunities in clinical studies and research projects. It emphasised the critical role of research in shaping evidence-based clinical decisions and provided expert insights, practical tools, and a supportive network to empower trainees to begin impactful research endeavours.

# Training and education



We're responsible for training, assessing and the continuing education of anaesthetists and specialist pain medicine physicians in Australia and New Zealand.

## Reflections from the first dual anaesthesia medal exam recipient

**ABOVE**

*Dr Millist today, with his prizes.*

**Queensland fellow Dr Michael Toon recently interviewed retired FANZCA Dr Warren Millist who was the first recipient of both the Renton Prize and Cecil Gray Prize for the part 1 and part 2 anaesthesia examinations.**

I have been fortunate to work with several anaesthetists and trainees who have had their college examination performance recognised through the awarding of the Renton Prize for the part 1 examination or the Cecil Gray Prize for the final examination.

Though few have been awarded both prizes during their training, I have met four  of them and recently spoke with the first person ever to do so, retired anaesthetist Dr Warren Millist.

Dr Millist graduated from Sydney University in 1960 and started his anaesthesia training in Melbourne in 1963. He practised for most of his career at the Sydney Sanitarium and Hospital, known as the "San", in Wahroonga.

Among his many achievements were pioneering advancements in both clinical anaesthesia and patient safety.

One of his first initiatives at the San was to confront the hospital administration and institute by-laws granting practising medical personal admitting "privileges" rather than admitting "rights" which revolutionised the relationship between hospital and doctors with a focus on patient safety.

"There was an enormous vacuum in patient safety. It was ... extremely unsatisfactory. There were very few anaesthetics given by specialist anaesthetists. It was the end of the GP surgeon-anaesthetist era. They resisted change in this area, as you could imagine," Dr Millist explained.

He recalled typing up the first by-laws on his own portable typewriter. He also established the first medical advisory committee for the hospital and was instrumental in establishing tenure for employed anaesthetists, guaranteeing regular work and, in return, participation in an on-call roster at the San.

Dr Millist's interest in anaesthesia was activated as a junior resident, having been given the responsibility of anaesthetising unfasted, unassessed patients with pentothal and no supplementary oxygen.

"In my very first day in anaesthesia I was supposed to give these old diggers pentothal, I didn't even have oxygen, I had no anaesthetic machine and no means of ventilating them if they stopped breathing. The whole thing was a nightmare. I was absolutely terrified, and I thought, well if this is what I have got to do I better learn something about it."

Following this, he made every effort to get his hands on all the anaesthesia textbooks he could find, an initiative that paid off after he won both the Renton Prize while at the Royal Children's Hospital in Melbourne and later, the Cecil Gray Prize.

Drugs that were then the mainstays of the anaesthetic armamentarium  apart from pentothal were d-tubocurarine, scoline (suxamethonium), flaxedil (gallamine) and halothane, which Dr Millist  recalled administering via a trilene vaporizer.

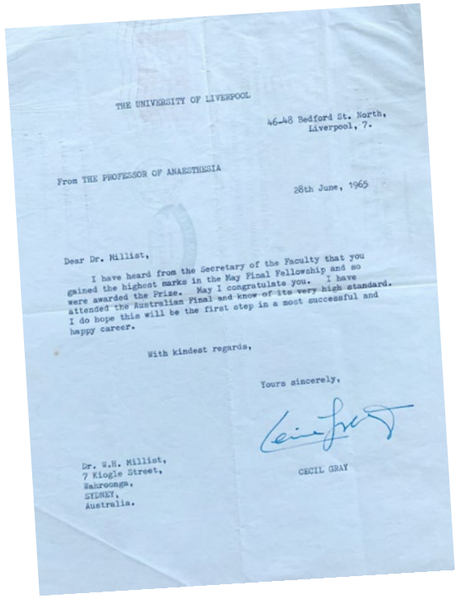
Dr Millist also introduced an epidural service to the San after being trained in this procedure by Dr Kevin McCaul in Melbourne in 1965. Following this he provided an epidural and subsequent anaesthesia care for a mother having a caesarean section that was filmed and shown on a segment on Channel 9's Midday Show with celebrity doctor James Wright, to popular acclaim.

Dr Millist is particularly proud of setting up a training program for anaesthetic assistants.

"The thing was we needed to have people that were specifically trained working under the direction and supervision of the anaesthetist. That chain of command in an emergency was critical."

With lectures and examinations at Royal Prince Alfred, a syllabus and program was designed with their graduates distinguishing themselves in careers throughout Australia and internationally.

Dr Millist's know-how and understanding of first principles from the examinations he topped held him in good stead through visits to remote locations in  Nepal and the Solomon Islands. Limitations of drugs and equipment led to a great deal of ingenuity with the team in the Solomon Islands eventually constructing an airstrip in the jungle to service the hospital with resources fundraised by Dr Millist and others upon his return.



THE UNIVERSITY OF LIVERPOOL

46-48 Bedford St. North,
Liverpool, 7.

From THE PROFESSOR OF ANAESTHESIA

28th June, 1965

Dear Dr. Millist,

I have heard from the Secretary of the Faculty that you gained the highest marks in the May Final Fellowship and so were awarded the Prize. May I congratulate you. I have attended the Australian Final and know of its very high standard. I do hope this will be the first step in a most successful and happy career.

With kindest regards,

Yours sincerely,

CECIL GRAY

Dr. W.H. Millist,
7 Kiogle Street,
Hahroongo,
SYDNEY,
Australia.

The site in Nepal was able to embark on cardiothoracic surgery using bypass equipment, an enormous feat given the humble beginnings which involved considerable concerns over electrical safety. He initially encountered the use of a red-hot bar radiator to heat the theatre which was plugged into the skirting board socket using stripped bare copper wire. Given the use of ether at the time, which Dr Millist knew was heavier than air and explosive, the concern was extreme.

"So, what I did, I rigged up a Reuben's valve which I brought up with me and I piped the exhaust oxygen gasses through a large, corrugated tube out through a hole in the wall so we minimised the concentration of ether in the air and put all the electrical appliances up high".

And as for his recollections of the fellowship examination?

"In order to get the information you had to go chasing it. You had to rigorously prepare yourself.  I used to do trial examinations and get people to mark me. It was a very time consuming process. The exam was held at the Royal College of Surgeons in Melbourne. It was a very threatening and forbidding occasion, and I remember it vividly."

It seems that some things have not changed!

**Dr Michael Toon,** FANZCA
Prince Charles Hospital Brisbane, Queensland

**ABOVE**

*From left: Dr Millist and his wife Laurel.*

*Letter from Dr Cecil Gray to Dr Millist, congratulating him on receiving the Cecil Gray Prize in 1965.*

# Successful candidates

## Primary fellowship examination

### 2024.2 Exam

**One hundred and forty-eight candidates successfully completed the primary fellowship examination:**

**RIGHT**

*Court of Examiners for the Primary fellowship examination.*

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Alexandra Claire Ridley
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Christopher Tong Mun Lewis
Hoi Yan Josephine Mak
Richard David Moore
Evelyn Margaret Murphy
Jesse Christof Offner
Cheng-An Pan
Nicholas William Parish
Nathan Alexander Platt
Chathura Bathiya Bandara Ratnayake
Conor William Rea
Meghan Jane Scanlan
Rachael Anne Stewart
Allan Zhi Je Tan
Joshua Jacob Thorn
Jack Jonathan Craig Tisch
Hannah Caroline Elisabeth Toellner
David Wang
George Arthur Weatherall
Nicola Claire Wheeler
Elizabeth Louise Wilson

### MERIT CERTIFICATES

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

David Wang, New Zealand

Alexander Tsymbal, South Australia

Amy Shenyuan Dai, Victoria

Neha Mahajan, New South Wales

# Renton Prize

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

**Varun Venkata Peri, Victoria**

"I completed my medical degree at the University of Melbourne in 2019 and developed a passion for anaesthesia as a junior doctor at Austin Health. I was fortunate to be accepted as a critical care resident at Austin Health and subsequently on to the NorthWest Training Scheme in 2024.

I would like to thank all of the consultants and senior trainees across multiple health networks who gave up their time to help me with exam preparation. In addition, I want to make special mentions of my incredible study group and Dr Stan Tay and Dr Louise Ellard who spent a remarkable amount of time and effort in coordinating primary exam teaching and exam practice.

Above all, I am profoundly grateful to my family, and most especially to my wife, Akansha. Her steadfast support and care have been with me every step of the way, making this journey possible."



# Final fellowship examination

## 2024.2 Exam

**One hundred and nineteen candidates successfully completed the final fellowship examination:**

### AUSTRALIA

**Australian Capital Territory**

Nicholas John Goulding
Cristy Jane Rowe
Si Yu Xian

**New South Wales**

Falko Frederick Adermann
Bardia Aryaie
Myles David Barnett
Timothy Jared Basevi
Andrew Robert O'Halloran Brazier
Brian Koon Kiu Chan
Clara Melanie Chung
Rachel Anne Clifford
Gregory John Collins
Philippa Dossetor
Lachlan James Gan
Jonathan James Daniel Gayed
Nicole Maree Glavan
Stella Maris Catharine Graham
Jaffar Hosain
Gregory Kranias
Jason Chin Yin Kwok
Rachel Ruth Ping Lee
Lachlan Hunter McLennan
Michael O'Donnell
Elsa Louisa Margarita Russell
Victoria Sadick
Peter James Stark
Krishan Subhaharan
Raymond Tann
Clare Ann Dymoke White
Samuel Allan Williams
Ramez Zaklama

**Queensland**

Morvarid Ashtari
Shreyas Rao Boppana
Jessica Lee Byrnes
Alek Rodney Calleja
Damien Daniel Coyle
Sougata Das
Rasmeet Singh Dhaliwal
Brigid Therese Doolan
Daniel Philip Gillespie
Jake Robert Greentree
Catherine Victoria Hampton
Gihan Climaque Hapuarachchi
Harrison Fung Yi Pung Jaa-Kwee
Harrison George Brook King
William Jesse Radford Lindores
Yu-Hsuan Liu
Srey Neth Loch
Paras Lovel
Julian Manuel Luna
Stephanie Margot Mulligan
Joel Alexander Jonathan O'Brien
Daniel Benjamin Patti
Anastasia Bridget Pearce
Norman Rodger Petersen
Peter Petrus
Kristoffer Graeme John Phare
Naomi Piyaratna
Kate Ralfe
Mayank Nikhar Arun Raniga
Jesse Jae Renouf
Dilip Raj Sunder Raj
Anna-Marie Georgette Tanios

**South Australia**

Joseph Benedict De Zylva
Alexandra Claire Fawcett
Amie Patel
Sharmini Michelle Punitham
Michael Andrew Rooke
Richard William Sexton
Jennifer Ann Li Sim
Jarmila Sterbova
Evelyn Joy Timpani
Yadanar Zaw

**Victoria**

Tristan Peter Boonstra
Jenna Jacqueline Godfrey
Tom Joseph Hannan
Jayson Woei-Liang Leow
Zheng Jie Lim
Harry James Pearce
Shalley Anna Robins
Stephanie Gee Theng Sim
Catherine Smale
Angela Temple

**Western Australia**

Annica Bester
Julian Shao Jian Chung
Alexander Athelstan Gadd
Sarah Shu Min Liew
Marie Ellen Timlin
Alex Patrick Wright

### NEW ZEALAND

Peter Nicholas Cameron
Claudia Margaret Crawford
Samantha Laurel Ellis
Luke Douglas Eric Foster
Sarah Katherine Fay Holman
Daymen William Huband
Marije Jansen
Christopher John Logan
Hamish Keith Louis
Andrew Stuart Eric Macpherson
Kyriakos Philippos Matsis
Ciara McCarthy
Aidan Shaun Joseph McGrinder
Hannah Teresa Middleton
Kimberley Amelia Noah
Louis Garvan O'Faherty
Richard Luo Oliver
Katharine Elizabeth Plant
Jolene Ralph
Bhanuka Yasas Jayatilaka Rathnayaka Mudiyanselage
Gwilym Alexander Rivett
Marisa Anna Schubert
Alexandra Ruth Skerten
Nippun Sofat
Caleb Wei Hong Watene
Hannah Elizabeth Widjaja
Nicole Yuen Ern Wong
Sarah Wongseelashote

### SIMG EXAMINATION

Two candidates successfully completed the specialist international medical graduate examination:
Adela Clausen, ACT
Sharon Vanessa D'Souza, Vic

### MERIT CERTIFICATES

Merit certificates were awarded to:

Shreyas Rao Boppana, Qld
Peter Petrus, Qld

**ABOVE**

*Court of Examiners for the final fellowship examination.*

# Cecil Gray Prize

**The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2024 be awarded to:**

**Yadanar Zaw, SA**

"I originally grew up in South Africa and moved to regional NSW before settling in Adelaide.

My interest in anaesthetics began in medical school and I am forever grateful to the Queen Elizabeth Hospital department of anaesthesia for providing me with the stepping stone into clinical anaesthesia and training.

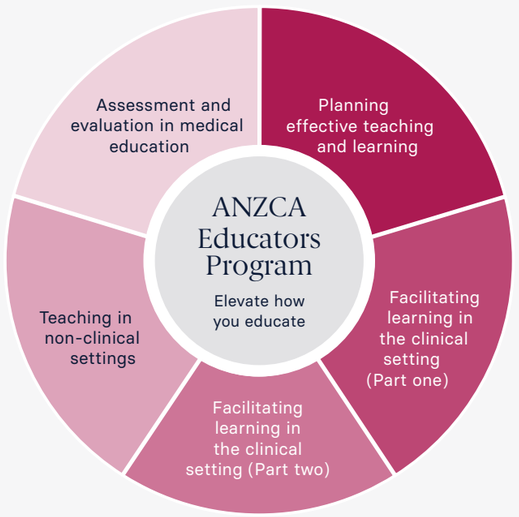
This achievement still feels unbelievable to me! I appreciate all the wisdom, teaching and guidance I received throughout my training in Adelaide and Darwin as part of the SA/NT rotational training scheme, with particular thanks to the Flinders Medical Centre department of anaesthesia where I have spent most of my training.

I share this achievement with my study group, friends, colleagues and family who I am deeply thankful to for their support and encouragement along the way.

And a special thank you to my mum for her forever unwavering moral support."

ANZCA
FPM

## Elevate how you educate




### THE ANZCA EDUCATORS PROGRAM

This is an interactive five module course, delivered over 1.5 days, designed to equip anaesthetists and specialist pain medicine physicians with the knowledge and skills to be competent clinical teachers.

It is available to all fellows, specialist international medical graduates and trainees (other than introductory trainees). The course is delivered in locations around Australia and New Zealand.

The course includes pre-course reading and a post-course activity.

*"From ad-hoc clinical teaching to small group discussions, effective education develops effective practitioners who may one day care for your health."*

**Visit the website to register – anzca.edu.au/aep**





# Global perspectives a highlight of NZ Annual Scientific Meeting

Some of the global stars of anaesthesia and perioperative medicine took top billing in Auckland in November as the New Zealand anaesthesia community came together for its annual scientific meeting (ASM).

The Aotearoa NZ Anaesthesia ASM 2024 was themed "Working together", reflecting the benefits of multidisciplinary team collaboration, working together to provide the best care for patients.

The meeting featured a global speaker line-up, including Professor Ki Jinn Chin from the University of Toronto, Professor BobbieJean Sweitzer from the University of Virginia, Professor Joyce Yeung from the University of Warwick, and Associate Professor Hairil Rizal Abdullah, from Singapore General Hospital.

Professor Chin spoke on decision-making in regional anaesthesia, Professor Sweitzer gave an overview on preoperative cardiac evaluation, Professor Yeung presented on the power of collaborative perioperative research, and Associate Professor Hairil outlined how to navigate data science and artificial intelligence in perioperative medicine.

The ANZCA Invited Speaker was Associate Professor Michal Kluger, who spoke on the concept of a transition pain model of care, its background and context within the ANZCA framework, and potential challenges for anaesthesia as a specialty.

Global challenges in anaesthesia were also in the spotlight, with immediate past president of the Pacific Society of Anaesthetists Dr Lisepa Daulako exploring the challenges she faces working as an anaesthetist at Lautoka Hospital in Fiji.

The program also included workshops as well as sessions on equity and equality in New Zealand healthcare, sustainability, and a closed session trauma roundtable.

Each year, the ASM's opening presentation is delivered in honour of anaesthesia leader and foundation chair of the board of the NZ Health Quality & Safety Commission, Professor Alan Merry.

The 2024 Alan Merry Oration was presented by former New Zealand director-general of health Sir Ashley Bloomfield on "The importance of leadership for health system quality and safety."

Among the prizes announced at the meeting's gala dinner were the BWT Ritchie Scholarship, presented to Dr Elizabeth Turner, and the ANZCA Trainee Prize, presented to Dr Jessica Murphy.

Unique to this year's ASM was the associated one-day Aotearoa NZ Perioperative Symposium, held two days before the main ASM program.

Preparations are already underway for next year's ASM, to be held in Kirikiriroa Hamilton from 13-15 November.

**Reon Suddaby**
Senior Communications Advisor New Zealand, ANZCA



**ABOVE FROM TOP**

*The Aotearoa NZ Anaesthesia ASM opened with a traditional mihi whakatau (welcome).*

*Professor Ki Jinn Chin, from Toronto Western Hospital and the University of Toronto, spoke on decision-making in regional anaesthesia.*

*Professor Alan Merry with former New Zealand director-general of health Sir Ashley Bloomfield, who gave the 2024 Alan Merry Oration.*

*Images by Smoke Photo + Video*

# Global development

We're committed to improving education and training capacity in anaesthesia and pain medicine in response to the needs of low- and middle-income countries.

# Health equity projects fund

**The ANZCA Health Equity Projects Fund supports college activities in global development, Indigenous health and other health equity projects.**

It is a competitive grant process open to all ANZCA and FPM fellows, for projects that support the aims and activities of the Indigenous Health Committee, Global Development Committee and other health equity priorities of the college.

Since commencing in 2019, over $A450,000 has been provided to fund 43 projects.

## 2025 recipients

### GLOBAL DEVELOPMENT PROJECTS

*Anaesthesia education, supervision and support in Samoa*
**Dr Megan Walmsley, Darwin**

*Essential Pain Management training in Bangladesh*
**Dr Moira Rush, Melbourne**

*Leading Emergencies in Anaesthesia in the Pacific (LEAP) Course: Enhanced fidelity simulation based crisis resource management training in PNG*
**Dr Mark Trembath, Brisbane**

*Pacific Paediatric Anaesthesia In-Situ Teams Course Samoa (Pacific PAINTS) in Samoa*
**Dr Nilru Vitharana, Sydney**

*Safer Anaesthesia From Education (SAFE) paediatrics and obstetrics in the Pacific Islands*
**Dr Yasmin Endlich, Adelaide**

*Safer Anaesthesia From Education (SAFE) paediatrics and obstetrics in Papua New Guinea*
**Dr Anna Loughnan, Melbourne**

*Supporting the delivery of Essential Pain Management in Indonesia*
**Associate Professor Roger Goucke, Perth**

*Vital Anaesthesia Simulation Training (VAST) faculty development in Fiji*
**Dr Adam Mossenson, Perth**

### MĀORI HEALTH PROJECTS

*Hauora Māori medical education resource extension*
**Dr Amanda Gimblett, Christchurch**

*Nā MANA ngā pūrākau – The narratives belonging to Māori Anaesthetists Network Aotearoa (MANA)*
**Dr Jack Hill, Auckland**

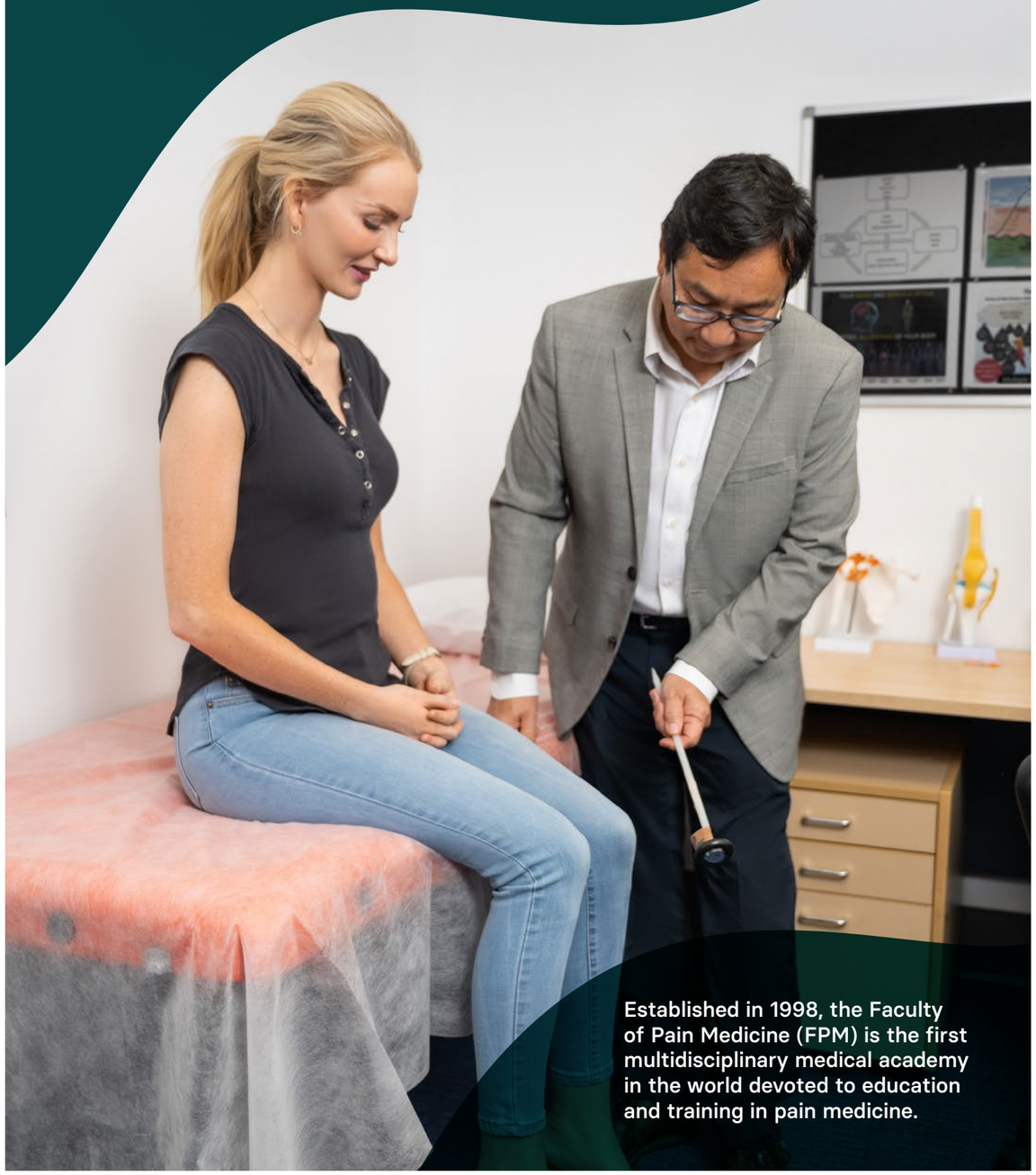
### OTHER HEALTH EQUITY INITIATIVES

*Australian and New Zealand Women's Empowerment and Leadership Initiative curriculum delivery project*
**Dr Tanya Farrell, Perth**

**ABOVE**

*Dr Meg Walmsley with Dr Esjae Sesega at Tupua Tamasese Meaole Hospital in Apia, Samoa as part of her 2024 registrar training support with an HEPF grant.*

# Faculty of Pain Medicine



Established in 1998, the Faculty of Pain Medicine (FPM) is the first multidisciplinary medical academy in the world devoted to education and training in pain medicine.

# Professionalism the bedrock of pain medicine

**In the first of a three-part series on professionalism FPM Dean Dr Dilip Kapur looks at clinical competency in pain medicine.**

Doctors remain one of the most highly trusted professional groups in society. The Roy Morgan *Image of Professions* survey from 2021 recorded that 82 per cent of Australians viewed the ethical standards and honesty of doctors as "high or very high". Other surveys, such as the *Ipsos Global Trustworthiness Index 2023* identified high levels of trust in doctors across the world; doctors are New Zealand's most trusted profession.

Trust in doctors is founded on public perception of the key elements of professionalism that underpin the ethical practice of medicine. Such professionalism is the bedrock upon which all specialties are founded; this includes pain medicine.

There are many elements to medical professionalism. However, clinical competence is a core element. The kindest and most empathetic doctors are of little use if their diagnostic, clinical and technical skills are poor. Conversely, in the practice of pain medicine, our training fosters an approach with a deep understanding of biomedical, clinical, epidemiological, and social-behavioural sciences. Pain medicine at its best can offer insights into the development and persistence of suffering that few other disciplines can challenge.

The first skill that any pain medicine physician must possess is that of listening. I recall being taught as a medical student that 70 per cent of the information needed for diagnosis would be found in the clinical history. My opinion is that this figure is an underestimate and the figure is closer to 85-90 per cent. But of course, the information will only be revealed to a clinician whose capacity to listen to, and understand a patient has reached a high standard. Small cues in the narrative may be vital, but are easily missed. Failing to place a patient's narrative within their cultural background can also lead to crucial clues being overlooked.

In pain medicine, the skill in obtaining the patient's history carries extra weight due to the need to identify the social and psychological factors that modulate the pain presentation. Again, understanding how to approach such matters with tact and humility is a special skill.

Conducting a skilled and appropriate physical examination of a patient is no less important than recording the detailed history. As with the skills needed to record the history, physical examination skills are demanding. They require constant practice if one is to be able to detect the often subtle abnormalities occurring in chronic pain states.

I have emphasised the importance of clinical skills for one simple reason. Many patients presenting to specialist pain services have spent years consulting with multiple clinicians. It is not at all rare to meet with patients who have neither been interviewed properly nor examined over a long period. It is a regrettable fact that the term "chronic pain" seems to be an acceptable reason for some clinicians to suspend both their intellect and empathy. Consequently, the skilled pain physician is often the first person to identify an important, and often treatable, condition.

It is rare that patients object to providing a detailed history about their condition. Indeed, it is something they expect in a medical consultation. Similarly, it is uncommon for a patient to object to undergoing a skilled physical examination. Even where the process of careful assessment does not reveal anything unexpected, the demonstration of core clinical competence is important for patients. The knowledge that a doctor has taken an interest in them is immensely reassuring. This allows patients to place their trust in a competent doctor. In such a setting, they are far more likely to follow recommendations for investigation and treatment than if they feel the doctor has neither the time nor the curiosity to help address their problems.

Demonstrable clinical competence also helps address the difficulties that arise where a patient's wishes may conflict with good medical practice. This is a common problem in pain medicine, particularly in settings such as opioid therapy. A satisfied patient is not always the same as a safe patient. In a widely cited study from the US, patients rating their treating doctors in the top quartile of satisfaction scores were, after correction for factors such as disease burden and health status, seen to have a 9 per cent higher cost of management and a 26 per cent higher mortality than the mean for the entire group.

Good pain medicine starts with high levels of clinical competence. Our patients, who are the people who actually employ us, expect nothing less.

We should never forget that.

**Dr Dilip Kapur**
FPM Dean

# Reflections on the birth of the International Association for the Study of Pain

**Emeritus Professor Laurence Mather writes about how the report by Dr Irina Hollington in the Spring 2024 edition of the *ANZCA Bulletin* that "more than 30 FFPMANZCAs and FANZCAs" participated in the International Association for the Study of Pain (IASP) 2024 World Congress on Pain[1] is truly significant for the local growth of this subdiscipline.**

Although I haven't participated in an IASP Conference since I retired, Dr Hollington's article nevertheless brought back some "I was actually there" memories.

Among her nominated highlights of the conference, Dr Hollington reported that "'Speakers Dr Jane Ballantyne and Dr Allan Basbaum started the opening plenary with "It all began 50 years ago in Issaquah", explaining how a group of physiologists, physicians, psychologists and philosophers met to nut out the basics of pain medicine on Dr John Bonica's hobby farm in Washington State.'" Well, it did...and it didn't.

The Issaquah meeting, held between May 21 and 26 in 1973, was the creation of Dr John Bonica, founding chair of the department of anesthesiology at the University of Washington (UW) in Seattle. The indefatigable Ms Louisa Jones, originally appointed in 1967 as manuscripts secretary/editor to John Bonica,[2] was appointed as treasurer for that meeting and subsequently became the executive secretary of the IASP which emerged from that landmark gathering. Louisa subsequently published an account of the Issaquah meeting in a personal memoir that includes an appendix of the (339) delegates' disciplines and places.[3]

Regarding disciplines, the appendix reveals that delegates embodied a wider intake than "physiologists, physicians, psychologists and philosophers", and included nursing, social work, biology, chemistry, pharmacology (the latter two being my own), work-place administration, and even research grant assessment. This wider range of disciplines reflects the spheres of influence that the IASP has subsequently enveloped.

Regarding places, Louisa's memoir begins with the words "Where on earth is Issaquah, Washington?" – this was not an unexpected question for the 70 per cent of delegates who came from outside the Seattle area. Although the US was, unsurprisingly, the most highly represented country, delegates came from many countries including the UK, Japan, Europe, Canada, and New Zealand – but not Australia. However, three Australians were delegates at the meeting: Dr John Stamell, Dr Michael Stanton-Hicks, and me. All were then working at the UW in Dr Bonica's department.

John Stamell, who had graduated in medicine from the University of Sydney in 1965, was an anaesthetist working on a two-year clinical fellowship. Mike Stanton-Hicks, an anaesthetist originally from Adelaide, went on to leadership roles in anaesthesia and pain management at the universities of Massachusetts and Düsseldorf and the Cleveland Clinic where he is still active, having recently published yet another book on pain management.[5] My role at the UW was as a pharmacologist, particularly in regional anaesthesia research.[5] In fact, two other British members of our UW research group, anaesthetist Dr Terry Murphy and research pharmacologist Dr Geoff Tucker were also delegates at the Issaquah meeting, as was New Zealand delegate Dr Bob Boas who had worked at the UW in the early 1970s and had recently returned to New Zealand.[6] The inaugural 1975 IASP conference in Florence included a research paper from our UW regional anaesthesia research group presented by Terry Murphy.[7]

Unfortunately, the description of the Issaquah place of assembly "on Dr John Bonica's hobby farm in Washington State" isn't correct. Those who knew Dr Bonica in the 1970s would know that he was never "in town" long enough to make use of a "hobby farm" (and Dr Ballantyne and Dr Basbaum were not among the delegates at the gathering). Louisa Jones wrote that the venue was at the "...Providence Heights Conference Center in Issaquah, a town about 20 miles east of Seattle... The centre was the regional headquarters of the Sisters of Providence, a nursing order of Catholic nuns who no longer had enough novices to fill the small college campus, but still needed to maintain their headquarters. They had turned it into a conference centre, and because it was in a semi-wilderness area with almost no local transportation, delegates not from the immediate Seattle area were essentially sequestered for five days...". Not quite a "hobby farm", but it nevertheless corralled together a strange collection of specialised people (rather than quadrupeds).

The IASP evolved from that meeting in two steps. As Louisa Jones put it "giving the new association a name required little discussion. It was agreed that "Study of Pain" should be part of the title, and the first suggestion was "World Association for the Study of Pain" with the acronym "WASP," which in English is an insect whose bite is quite painful. Unfortunately, in the United States "WASP" has another meaning stemming from the early days of the country that is not always positive: "White Anglo-Saxon Protestant." Thus, the word "International" was substituted, giving us the "International Association for the Study of Pain" of today."

ABOVE

*Photo from the era shows members of the John Bonica regional anaesthesia research group, a few months before the Issaquah meeting in 1973.*

And it was good to read that Dr Hollington also included the note that "...Dr Ballantyne acknowledged the far-reaching influence of Dr Bonica's inclusive mentorship which included our own giant of Australasian pain medicine, Professor Michael Cousins, who died earlier this year." As noted recently, Michael Cousins soon became a major influence in the direction of the IASP, and indeed, its fifth president (1987-1990).[8]

So, as a result of this rather odd collection of professionals devoted to the better management of pain, in that semi-rural former nunnery in Washington state, in May of 1973, Dr Hollington was able to report that "more than 30 FFPMANZCAs and FANZCAs...travelled to Amsterdam to commemorate 50 years of working together for pain relief at the International Association for the Study of Pain (IASP) 2024 World Congress on Pain..."

The Faculty of Pain Medicine has indeed matured, and Michael Cousins would have nodded approvingly.

**Laurence E Mather** OAM, DMedSc, FANZCA, FFPMANZCA (Hon), FRCA (Hon), FASRA
Emeritus Professor, The University of Sydney

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3. Jones LE. First Steps: The Early Years of IASP, 1973-1984. IASP Press, Seattle, 2010, pp 55.
4. Stanton-Hicks MD. The Evolution of Complex Regional Pain Syndrome: From Schloss Rettershof to a New Clinical Language. Springer Nature; 2024, pp 167.
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6. Merry A. Robert (Bob) Albert Boas, ONZM. Obituary, ANZCA Bulletin, Winter Edition, 2024; 95.
7. Murphy TM, Mather LE, Stanton-Hicks MD'A, Bonica JJ. The duration of sympathetic blockade following peridural anesthesia with different local anesthetic agents. Oral presentation at the First International Symposium on Pain, Florence (Italy), 5-8 September 1975.
8. Baker B, Mather L, Jones D. Michael John Cousins. Obituary, ANZCA Bulletin, Winter Edition, 2024; 23-5.

# FPM news update


## EVOLVING THE ASSESSMENT STRUCTURE OF THE PAIN MEDICINE TRAINING PROGRAM

The FPM Learning and Development Committee has reviewed the assessment philosophy and structure of the training program to identify where changes are required to ensure it remains aligned with contemporary medical education practice and in consideration of assessment load both on trainees and fellows. The review also considered the requirements identified by the Australian Medical Council and Medical Council of New Zealand during the college reaccreditation process in 2022, in particular adopting a more competency-based medical education approach to assessment and embedding cultural safety training.

Four working groups were established in 2023 covering activities in the workplace, group decision making, the written component of the examination and expanding the options for trainees from a clinical case study to a suite of 'scholar role activities'. Recommendations from these working groups, in conjunction with feedback collated from a survey to supervisors and trainees, were discussed and prioritised by the FPM Learning and Development Committee in 2024. An assessment framework has been developed and will become a living document maintained by the committee.

Some minor changes are being introduced into the training program for 2025 while work on structural changes is progressing. The roadmap of changes is outlined below.

### Activities in the workplace

Introducing a requirement for trainees to undertake regular cultural safety activities from 2025. This is in line with the expectations of the Australian Medical Council and Medical Council of New Zealand and will include the same suite of optional activities that fellows complete as part of their continuing professional development requirements.

There was support for the workplace-based feedback tools utilised in the program. Changes for 2025 include ensuring that trainees receive feedback using these tools across the breadth of the curriculum. The numbers in the rating scale are being removed to facilitate trainee 'development' and encourage trainees to extend their practice rather than undertaking activities with which they are familiar.

The skills assessed in the general physical examination assessment will change for 2025 to a cranial nerve examination, a cervical spine examination and a pain oriented sensory testing (POST) examination. The timeframe that this needs to be completed will move from the first three months of training to the first six months of training and the title of the activity will be amended to "Physical Examination".

The use of the multisource feedback tool for progression through the training program is being enhanced.

Work has started on developing "Entrustable Professional Activities". These are activities occurring within the workplace that are core to the role of the specialist where the trainees are assessed for independent practice. Potential topics have been identified and discussed at the recent supervisor of training workshop at the FPM Spring Meeting in Auckland. There will be opportunities for fellows and trainees to shape these tools as the work progresses.

### Group decision making

While the committee can see enormous benefits of introducing group decision making into the program, it was felt that other changes should be embedded first. Eventually it is intended that progression decisions will be made by committee. For now, this will remain on the roadmap for consideration.

### Clinical case study

The clinical case study has inadvertently become a barrier to progressing to fellowship as many trainees leave it until all other requirements have been completed. A transitional approach to replacing the clinical case study with a suite of scholar role activities that trainees can select from has been agreed on.

From 2025 trainees can elect to complete the clinical case study or a clinical audit related to their pain medicine practice.

From 2026 additional activities from which trainees can select will be added.

### Written examination component

It has been agreed to retire the short answer question paper of the fellowship examination and introduce a multiple-choice question paper that is aimed at trainees earlier in their training journey.

Work on this transition has commenced and it is envisioned that the change will be made in 2026.

Trainees currently in the program are strongly encouraged not to delay sitting the fellowship examination based on this change.

On behalf of the FPM Board, I would like to express my thanks to all the fellows, trainees and staff who have contributed to this body of work to date. We are a small faculty and are very aware that as we make changes to improve the training program this can create additional work for our fellows to develop and deliver the changes. We hope that the transitional approach will help reduce this burden and allow us to refine processes as we receive feedback.

**Dr Tipu Aamir**
Chair, Learning and Development Committee

## NEW FELLOWS

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

Dr Ashveer Dunpath, FANZCA, FFPMANZCA (NZ)

Dr Yiu Chung Lau, FHKCA (Anaesthesiology), FFPMANZCA (Hong Kong)

## DEVELOPING FLEXIBLE ACCREDITATION PATHWAYS FOR PAIN MEDICINE TRAINING IN RURAL SETTINGS PROJECT

**Expression of Interest**

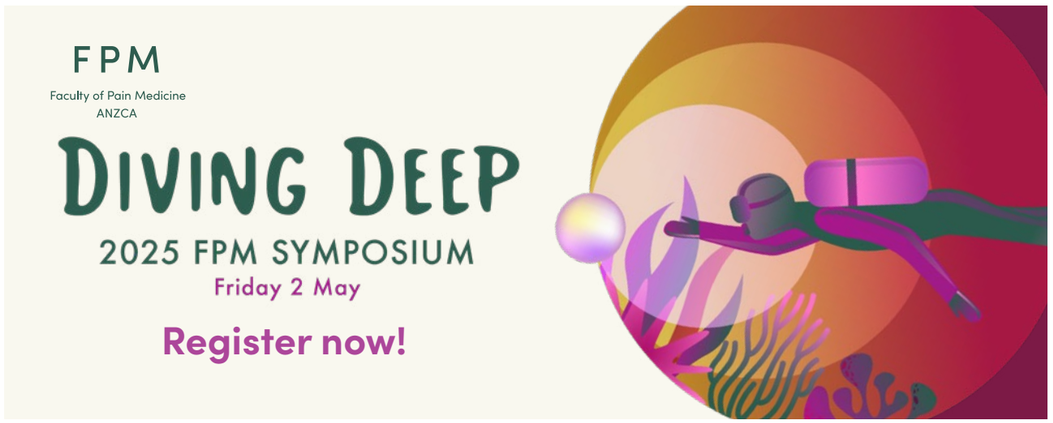
Thinking about exploring flexible accreditation options for your pain unit?

Are there fellows in your network who might be interested in flexible accreditation?

Want to hear more about how you could support regional trainees?

Paving the way for greater access to rural pain medicine.

To hear about the 2025 pilot, email us at fpm@anzca.edu.au



## 2024 FPM FELLOWSHIP EXAMINATION

Twenty-seven candidates were invited to the oral section of the fellowship examination, following the written exam on 12 September 2024. The viva voce examination was held at the Peter MacCallum Cancer Centre on 9 November.

The faculty acknowledges the examiners' contribution to the delivery of the examination and the support offered by supervisors and fellows preparing candidates.

**ABOVE FROM TOP**

*The FPM 2024 trainees.*

*The FPM examiners.*

*Merit Award recipient Dr Mohnish Jain (right) with FPM Associate Professor Charles Brooker, Chair of the FPM Examination Committee.*

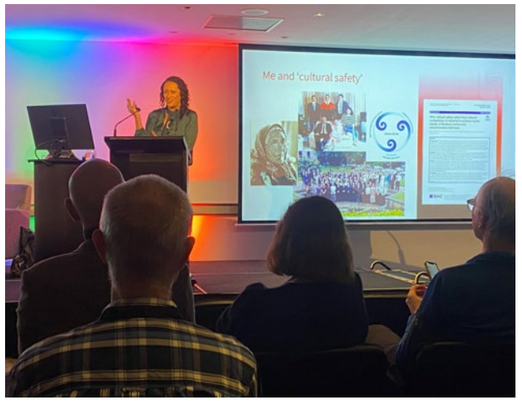
*Merit Award recipient Dr Goran Medvedovic and FPM Associate Professor Charles Brooker.*

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

| | |
|---|---|
| **ACT** | Dr Andrew Mcmahon |
| **SA** | Dr Mandeep Balbir Singh<br>Dr Taras Hembram |
| **Victoria** | Dr Chirstopher Arnott<br>Dr Luke Arthur<br>Dr Rohan Karkala Kamath<br>Dr Maleeka Khullar<br>Dr Goran Medvedovic<br>Dr Estelle Petch<br>Dr Victor Yi |
| **New South Wales** | Dr Melani Mahendran<br>Dr Appukutty Manickam<br>Dr Izzy Ratnayake<br>Dr Anna Robertson |
| **Queensland** | Dr Sananta Dash<br>Dr Mohnish Jain<br>Dr Zeyin Li |
| **Western Australia** | Dr Eugene Sharma Henry<br>Dr Matthew Quo<br>Dr Jonitha Nadarajah<br>Dr Daniel Yang |

The Examination Committee and Panel of Examiners would like to thank retiring examiners Dr Clayton Thomas and Associate Professor Greta Palmer for their contributions and service.

# Faculty holds Spring Meeting in Auckland





The Faculty of Pain Medicine has taken its annual Spring Meeting to New Zealand.

The meeting, held in Auckland from 18-20 October, was attended by nearly 100 faculty members from Australia, New Zealand and Hong Kong.

Following a traditional Māori pōwhiri, convenor Dr Wei Chung Tong welcomed attendees to the meeting, which carried the theme of "Collegial intelligence in pain medicine."

The use of psychedelics in pain medicine was a recurring theme of the meeting's opening day, which included sessions focussing on psychedelics and chronic pain, psychedelic-assisted therapy in research trials, and addressing addiction and pain amid the rise of novel psychoactive substances.

The host country took its moment in the spotlight with a plenary session dedicated to pain research in New Zealand. Presentations included co-designing Māori whānau stories of tapering opioids with chronic non-cancer pain, and New Zealand perspectives on persistent pain after breast cancer surgery.

Particularly popular were two activities which bookended the meeting's extensive program. A series of pre-meeting emergency response workshops were well-attended, while the final plenary session on cultural safety, cultural competency and Hauora Māori, run by Associate Professor Elana Curtis, was a highlight for many.

Faculty of Pain Medicine Dean Dr Dilip Kapur said the meeting was a fitting exploration of its theme.

"I really enjoyed what was a very cohesive meeting. The meeting theme of collegial intelligence was followed to the letter with excellent sessions from colleagues across a range of disciplines.

"It was all rounded off by a warm and very genuine Māori welcome to the event."

Representatives from regional and national committees made an early start on the Saturday morning to come together at a breakfast forum, with each region or country presenting a profile of their area and outlining their key achievements and challenges.

As always, the social calendar was another attraction, with both the Friday night welcome reception and the Saturday meeting dinner at the Royal New Zealand Yacht Squadron, overlooking the picturesque Westhaven Marina, proving popular.

The faculty is grateful to all those involved in the successful running of this year's meeting. Preparations are already well underway for next year's Spring Meeting, to be held in Fremantle, Western Australia from 24-26 October.

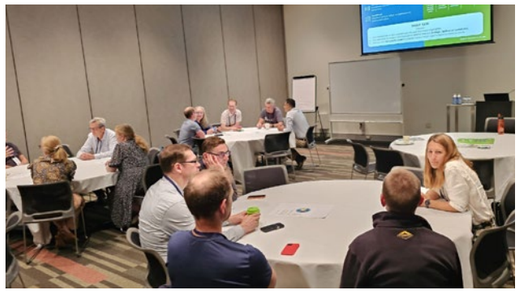
**Reon Suddaby**
Senior Communications Advisor New Zealand, ANZCA

**ABOVE FROM LEFT**

*Associate Professor Elena Curtis.*

*Convenor Dr Wei Chung Tong.*

# Environmental Sustainability Network highlights of 2024




The ANZCA Environmental Sustainability Network (ESN) has moved from strength to strength since its establishment in 2022, and now has more than 370 members across Australia and New Zealand.

A key highlight for 2024 is the integration of TRA2SH (Trainee-led Research and Audit in Anaesthesia for Sustainable Healthcare) into the ESN as its trainee stream. The TRA2SH committee is chaired by Dr Sukhi Hegde (NSW) and will be ramping up activity in the coming months. TRA2SH will continue to allow trainees to get involved in sustainability activities under the governance and with the support of college resources.

## ADVANCING SUSTAINABLE PRACTICE

ESN Executive members have been involved in several high-level advocacy efforts this year, including:

- Consultation on the National Climate and Health Strategy and the subsequent Australia National Health Adaptation Plan.
- Representation on the Royal Australasian College of Physicians (RACP) Climate Change and Health Multi-College Advisory Committee.
- Representation on the Council of Australian Therapeutic Advisory Groups (CATAG) Desflurane Expert Advisory Group.
- Development of a nitrous oxide mitigation working group with international and multidisciplinary membership.

Development of desflurane statement summarising its environmental impacts and clinical evidence base (see box opposite). We have also had opportunities for local and international collaboration with the Royal College of Anaesthetists (RCoA), the International Association for the Study of Pain (IASP) and the Australian Society of Anaesthetists (ASA).

## SUPPORTING SUSTAINABILITY EDUCATION

ESN members convened two interactive educational webinars focusing on topical areas of interest this year.

- "Time to gown up, sustainably" – addressing the environmental impacts of single-use surgical gowns and the use of sterile gowns for neuraxial anaesthesia. This webinar featured Dr Marion Kainer (Vic), Dr Forbes McGain (Vic), Dr Cliff Shelton (UK) and Dr Ben Dunne (Vic).
- "Clearing the air: understanding and managing nitrous oxide leaks" – addressing the mitigation of nitrous oxide leakage and decommissioning of piped nitrous oxide. Speakers included Dr Paul Southall (UK), Dr Wyn Strodbeck (NZ), Ms Kellie Williams (QLD) and Dr Eugenie Kayak (Vic).

Recordings of both are available on the ANZCA Library Environmental Sustainability LibGuide.

The ESN also presented a range of educational activities at the 2024 Annual Scientific Meeting (ASM) in Brisbane, including fully-subscribed workshops on theatre sustainability projects, nitrous oxide mitigation and net zero leadership, and a concurrent session themed "Reuse, Renew, Rethink – Limitless Opportunities".

## PROMOTING SUSTAINABILITY RESEARCH

The Environment and Sustainability Research Grant is the initiative of a group of anaesthetists to encourage and support research activity to evaluate the environmental impact of current practice, and initiatives to implement models of environmentally sustainable care with equivalent or better patient outcomes and cost. The ESN provides support and information to potential applicants and can assist in promoting research projects in sustainability wherever possible.

## WHAT'S NEXT FOR THE ESN?

2025 will no doubt be another big year – already we have a full 2025 ASM program with sustainability interlinking with the meeting's theme of "Futureproof". There are many plans for education, networking, cross-disciplinary and international collaboration.

We invite all interested anaesthetists and perioperative staff to join the ANZCA ESN via our dedicated webpage.

I would like to take this opportunity to thank all members of the ESN Executive Board, TRA2SH Committee and our ANZCA committee support officers for their tireless work in improving the environmental impacts of our college and our practice.

**Dr Archana Shrivathsa,** FANZCA
Chair, ANZCA Environmental Sustainability Executive
enviro-sustainability@anzca.edu.au

# WA nitrous oxide efforts recognised

The Sir Charles Gairdner Hospital's nitrous oxide infrastructure decommissioning team was recently awarded a WA Health Excellence award in sustainability for their work. A multidisciplinary team that included the department of anaesthesia and the hospital's facilities management team identified a process to test and decommission piped nitrous oxide to operating theatres.

The project has led to a reduction in greenhouse gas emissions equivalent to 288 tonnes of carbon dioxide per year.

The team was recognised for demonstrating how it can deliver sustainable healthcare without impacting clinical practice. The team has also contributed to a safer physical environment for staff and patients and provided annual cost savings.

The WA Health Excellence Awards are designed to celebrate excellence and innovation in service delivery across the WA health system.

**ABOVE FROM LEFT**

*Participants at one of the ESN events.*

*Webinar about to get under way.*

## ANZCA'S STATEMENT ON DESFLURANE

ANZCA's statement on desflurane supports the continued education and actions to reduce desflurane usage. It is a consensus statement that seeks to balance the current evidence and perspectives on administration of the greenhouse gas desflurane as an anaesthetic agent and to reinforce our ability as clinicians to exert positive change and mitigate environmental impact.

The college recognises the need for urgent action on climate change, and mitigating the effects of desflurane on planetary health is one initiative of a wider comprehensive suite of strategies.

Anaesthetists continue to demonstrate leadership to decarbonise healthcare with ANZCA's Environmental Sustainability Network (ESN) Executive Committee instrumental in the development of this statement.

This statement is supported by ANZCA *PS64(G)* Position statement on environmental sustainability in anaesthesia and pain medicine practice 2019, the ANZCA Council Statement on Climate Change and the recently published Joint Statement: Working together to achieve sustainable high-quality health care in a changing climate.

The desflurane statement explores the clinical/social, economic, and environmental effects concluding that the by reducing its use represents a 'quick win', that is easy to maintain and well within our direct control as anaesthetists.

Visit the ANZCA website to review ANZCA's statement on desflurane and further information on ANZCA and ESN executive actions.

# Library news

## A FOCUS ON PAIN MEDICINE

The ANZCA Library is committed to supporting pain medicine specialists in their practice and continuing education, and offers a comprehensive collection of resources dedicated to pain medicine, catering to the needs of fellows and trainees, researchers, and educators in the field. Our collection includes e-books, journals, databases, and guidelines to support evidence-based practice in pain management.

### E-books

A wide selection of core texts covering various aspects of pain medicine, including acute and chronic pain management, interventional techniques, and pharmacology.

### Journals

Access to leading peer-reviewed journals including *Pain Medicine*, *Pain*, *Regional Anesthesia and Pain Medicine*, and *Neuromodulation*. These journals publish the latest research findings, clinical studies, and reviews on pain management practices.

### Online databases/guidelines

A range of key databases such as AusDI, Ovid Medline, Cochrane Library, ClinicalKey, Therapeutic Guidelines and Trip Pro. These platforms provide access to thousands of articles, drug information, systematic reviews, and clinical guidelines related to pain management.

### Multimedia resources

Access to educational videos, webinars, and presentations on pain management techniques, new research developments, and case studies. These resources enhance understanding and provide practical insights into managing pain.

### Patient education materials

A variety of resources designed for patients, outlining common pain conditions, treatment options, and coping strategies. These materials aim to empower patients in their pain management journey.

### Research support and services

Literature searches: The library staff can assist with tailored literature searches on specific topics in pain medicine, ensuring access to the most relevant and up-to-date information.

Workshops and training: Regular workshops on using library resources, literature search techniques, and referencing help are offered to enhance research skills.

Interlibrary loans: If a specific resource is not available in our collection, we offer interlibrary loan services to procure articles from other libraries.

## WHAT'S NEW IN PAIN?

The **Psychiatry Online: DSM-5 Library** contains full-text access to a collection of DSM-5-related texts including *Diagnostic and Statistical Manual of Mental Disorders, 5e, Text Revision* (DSM-5-TR) – the most comprehensive, current, and critical resource for clinical practice available to today's mental health clinicians and researchers.

The ANZCA Library has recently updated a number of our dedicated pain medicine resource guides – all of which can be easily accessed via our pain medicine hub: https://libguides.anzca.edu.au/painmedhub

Access key pain medicine resources via our pain medicine basics guide; the latest evidence and resources on cancer pain; and managing psychological pain management in chronic pain.

For more information or to access these resources, please visit the ANZCA Library website or contact our staff for assistance.

# Latest books

For the latest updates and a complete list of new titles check out the library news page: libguides.anzca.edu.au/news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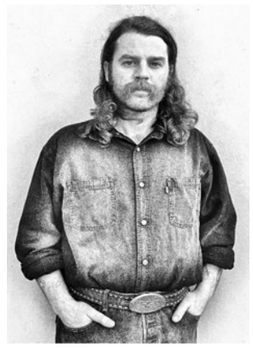
# Geoffrey Kaye Museum of Anaesthetic History update

## NEW EXHIBITION

The museum aims to curate temporary physical exhibitions which are also available online. Most exhibitions focus on niche thematical topics, however we were aware we didn't have an online exhibition solely dedicated to the history of early anaesthesia. On 16 October, to coincide with the 2024 ANZCA National Anaesthesia Day we launched "Without Sensation? A brief history of early anaesthesia". This exhibition explores the period from anaesthesia's discovery to before the trenches of World War I. It draws examples from within and beyond the museum's collections and celebrates the trailblazers of anaesthesia without whom we would not be where we are today.

## HISTORY AND HERITAGE RESEARCH GRANT

In this year's round of the History and Heritage Research Grant, word is clearly spreading as we received more submissions than usual. The museum was delighted to have so much interest in this field and this year's grant was awarded to Callum Royle, an immersive photographic artist and writer. His research proposal is titled "A Life with pain" and aims to document pain, not through clinical analysis, but through intimate portraits, moving image and audio interviews using the museum's collection.

## ORAL HISTORIES

Each year the museum is also responsible for organising oral history interviews with key figures from anaesthesia and pain medicine. Early on this year we had the privilege to arrange an interview with Associate Professor Leigh Atkinson, a specialist pain medicine physician and neurosurgeon, and past dean of the Faculty of Pain Medicine. Associate Professor Atkinson was interviewed by Associate Professor Michael Vagg and the interview is now available on the FPM YouTube channel.

## CONSERVATION INTERNS

The new museum curator wanted to embrace the museum's historic connection with the University of Melbourne and arranged for Melbourne University's Masters of Cultural Materials Conservation students to complete an internship at the museum. There are only two universities in Australia offering this degree, and the museum is incredibly grateful to Elizabeth Anderson-Wisely and Wilson Fok who interned from September to November this year. The students worked mainly with the collection of plastic and rubber oropharyngeal airways, and a PHYWE teaching model, writing up best methods for conserving these objects and applying preventative conservation methods.

**ABOVE**

*From right: Online exhibition: Without Sensation?*

*Callum Royle, 2024 History & Heritage Research Grant recipient.*

*Oral History Interview still – Associate Professor Mick Vagg (on left) and Associate Professor Leigh Atkinson.*

# Thomas "Tom" Aird Fraser

**1932 – 2024**


**ABOVE**

*Tom Fraser administering his last anaesthetic. Photo: AB Baker 2000*

Tom Fraser was born in Balmain, Sydney on 14 November 1932 some months after his father, an engineer, had been electrocuted in an industrial accident at the Balmain Power Station. He was brought up in Balmain by his mother, two doting aunts, and his "very dominating" grandmother who had previously migrated from Scotland with her family to Australia where she quickly left her husband and returned to Scotland, and then just as quickly remigrated to Australia!

Thus Tom never knew his father and grew up in a household of women. Tom's formal education was at Duke Street Balmain Primary School, with his secondary education at Fort Street High School Petersham. He then enrolled with a state exhibition as a medical student at the University of Sydney graduating in 1956 (final year 1955). His yearbook entry regaled his "passion for Sibelius" with "strains of the Fifth Symphony often disorganising the rhythm of the labour ward" and his "camping expeditions", though also reporting his golf "as ardent rather than championship"! His other sporting interests at this time were tennis, sailing and riding.

On graduation Tom spent two residency years and two anaesthetic registrar years at the Royal Prince Alfred Hospital (RPAH), during which he married Sue Dorsch a medical graduate two years his junior. Tom and Sue entered general practice at Harden – Murrumbah near Cootamundra west of Canberra for five years, before travelling to the UK where he passed the DA(Lond) in 1966 and enrolled in the Faculty of Anaesthetists, Royal College of Surgeons' (RACS) courses in London for the primary and final FFARCS examinations, which he passed in 1967 while working at the Hammersmith Hospital. The family then returned to Harden and general practice in 1968, but after a year Tom decided on a career in anaesthesia rather than general practice and he obtained a staff specialist post at RPAH in 1969, which he held until a devastating day in 1976.

During the Anzac Day weekend that year the Frasers were in Cootamundra for the picnic races and to inspect a horse which they intended to buy for riding on a farm they owned at Wilberforce, north of Windsor NSW, where they bred racing quarter horses. Tom was mounting the prospective purchase when, spooked by a barking dog, the horse bolted and jumped a fence throwing Tom. He sustained a T4 spinal fracture/dislocation with paraplegia and was taken by air ambulance to the Royal North Shore Hospital spinal unit. During the three months that Tom spent in the spinal unit, Bruce Clifton[1], then the senior staff specialist in the department of anaesthetics at RPAH and effectively running all the clinical activities, researched wheelchair anaesthesia.

At that time there was only one world renowned wheelchair anaesthetist, Professor Alon Winnie[2] of Chicago, who was not paraplegic but was severely compromised by old poliomyelitis, and who was able to stand if necessary to administer anaesthesia. Professor Winnie, however, normally administered anaesthesia from his wheelchair. Bruce Clifton eventually made all the arrangements necessary to accommodate wheelchair access, and then spent an entire fortnight strapped into a wheelchair while he administered anaesthesia in all areas that Tom Fraser would need to enter to recommence work as an anaesthetist, thus demonstrating to the hospital administration and to Tom that wheelchair anaesthesia was both possible and safe. This preparation allowed Tom to continue his professional life.

We believe he was the first paraplegic anaesthetist to continue to practice anaesthesia after sustaining paraplegia. Since then, there have been other paraplegic anaesthetists around the world who have followed Tom's example back into practice, and many of these have sought information and inspiration from Tom Fraser.

Following his accident and rehabilitation, Tom became a visiting medical officer anaesthetist for the next 24 years, practising anaesthesia mainly at RPAH in obstetrics, gynaecology and vascular anaesthesia. He also spent one day each week at St Luke's Hospital Potts Point anaesthetising for plastic surgery, and occasional sessions at the War Memorial Hospital Waverley. At RPAH Tom was involved with the introduction of endoluminal aortic surgery as the RPA vascular surgeons led by Professor Jim May were one of the two leading vascular units worldwide who developed the endoluminal techniques, initially using handcrafted grafts built in the operating theatre as the surgery progressed.

In those early days, there was much blood loss in the process and the anaesthetic management was often complicated and certainly far from straightforward. Tom had the personality to match those demands, dealing with difficult situations with his characteristic calmness and good humour. At the end of an often long operating session, Sue would be patiently waiting to take Tom home without complaint despite the unexpected delays. The great affection held for Tom by all theatre staff was evident when he retired in 2000.

Tom found time for his interests outside anaesthesia, particularly at the farm in Wilberforce. He also collected paintings and antiques, often attending galleries and auctions in search of further treasures.

Tom Fraser died on 3 October 2024 at the age of 91. He was a fantastic role model for trainees whom he loved to tutor and mentor, and who were devoted to him. He was a great departmental colleague and a passionate member of the RPAH family.

He is survived by his wife, Emeritus Professor Susan Dorsch, herself famous within the University of Sydney in the field of pathology and as a former deputy Vice-Chancellor, and his children Thomas, Karl, Carrie and their families.

The department of anaesthetics at RPAH will long remember his life and dedication to the specialty.

**AB Baker** AM
Emeritus Professor of Anaesthesia, University of Sydney, Honorary Historian ANZCA

**JP Harris** AM
Emeritus Professor of Vascular Surgery, University of Sydney.

*With thanks to Emeritus Professor Susan Dorsch for help with details of Tom's life.*

References

1. Baker B & Fraser T 1928-2017 Obituary: Bruce Stewart Clifton ANZCA Bulletin 2017;26(2):94-95
2. Candido KD In Memoriam: Alon Palm Winne Regional Anaesthesia & Pain Medicine 2015;40 (40):301-305 management.

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