ANZCA
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Bulletin

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

AUTUMN 2025

HEALTH INFRASTRUCTURE
Leading the way in new hospital delivery

Spotlight on the ACT
Making the most of working and living in Canberra

Fellow tribute
We farewell wellbeing trailblazer Dr Di Khursandi

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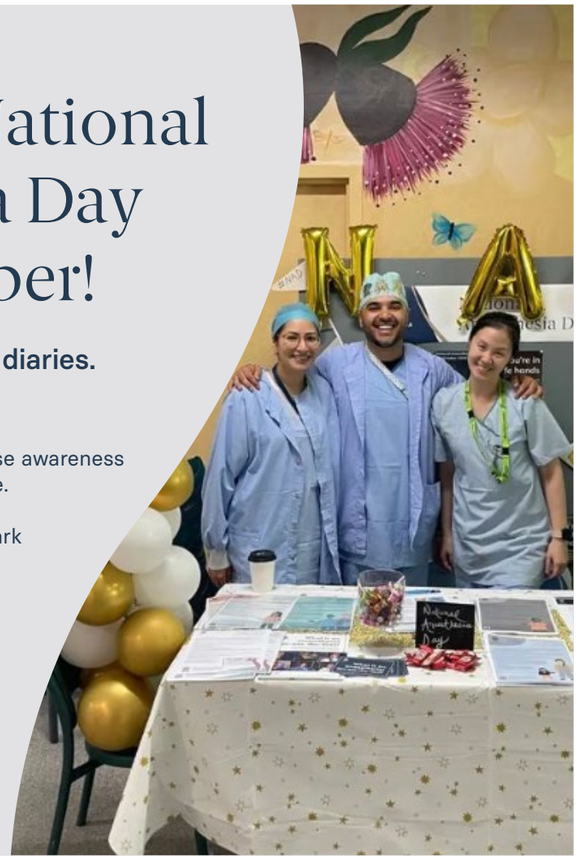
Celebrate National Anaesthesia Day on 16 October!

- **Mark Thursday 16 October in your diaries.**
- **Book your hospital foyer space.**

National Anaesthesia Day is held each year to raise awareness of the crucial role anaesthetists play in healthcare. An ANZCA initiative, National Anaesthesia Day is usually held each year on 16 October to mark the anniversary of the day in 1846 that ether anaesthesia was first publicly demonstrated.

ANZCA will send posters and other material to hospitals in September.

Please contact communications@anzca.edu.au for more information.



RIGHT

National Anaesthesia Day celebrations at Ipswich Hospital last year.

ON THE COVER

Anaesthetist Dr David Bramley on site at the new Footscray Hospital in Melbourne which is due to open later this year. Photo by Penny Stephens.

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.

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Workforce wellbeing must combine system and individual action

"There is significant productivity improvement required in delivery of anaesthetic services...If productivity efficiencies cannot be achieved through other measures, the required reduction is likely to be 4 to 5 EFT positions..."

– Letter from hospital administration to me and others

"Despite repeated calls for a systems approach to physician well-being, health care organizations have continued to predominantly allocate their attention and resources to individual-focused interventions."

– Sinskey et al, *The Wicked Problem of Physician Well-Being.* Anesthesiology Clinics, 2022

"Where staff wellbeing is prioritised, patients are safer."

– Kirk, *Time for a rebalance: psychological and emotional well- being in the healthcare workforce as the foundation for patient safety.* BMJ Quality and Safety, 2024

The quote from the letter that starts this piece was part of a prolonged toxic campaign that left me and others distressed and angry. Terrible for our individual and collective wellbeing.

Conversely the following quotes demonstrate two vital points about medical workforce wellbeing: 1) improving wellbeing involves both individuals AND the health system, which includes ANZCA; and 2) medical workforce wellbeing is associated with better patient outcomes.

To return to one of my recurring themes, the four essential elements of healthcare overlap (think Venn diagrams!): patient journeys, public health, value, and workforce wellbeing.

ANZCA's role in doctors' health and wellbeing includes:

1. **Education:** Incorporate health and wellbeing learning across the lifecycle stages including: professional standards, curricula, continuing professional development (CPD) and learning resources shared with members and broader partners.
2. **Leadership:** Actively engage with our fellows, trainees and specialist international medical graduates (SIMGs) to support the shift in paradigm to a healthful anaesthesia and pain medicine workforce through:
   - De-stigmatisation.
   - The importance of self-care.
   - An evidence-based, risk-management approach.
   - Advocate for changes required in legislation and in workplaces.
3. **Standards and accreditation:** Ensure consistent, clear and achievable health and wellbeing standards are effectively encouraged and monitored through accreditation processes and systems.

While some may dismiss wellbeing as soft and fuzzy, or to use a vague word I hate: "woke", workforce wellbeing is a vital part of contemporary healthcare and a central priority of ANZCA.

As Sinskey and colleagues noted in *The Wicked Problem of Physician Well-Being,* one contemporary definition of wellbeing encompasses the effects of organisational and systemic factors that support a culture and environment where clinicians thrive. They caution however, that hospitals can currently weaponise onus on the individual to blame and shame while successfully ticking "wellbeing" boxes.

Sinskey and colleagues, and Kirk in her BMJ Quality and Safety 2024 commentary, note that because there are no interventions that are easy to both implement and sustain, significant collective effort is required. The college recognises this.

ANZCA is determined to promote system and individual strategies for wellbeing. Last August, the Australian Medical Council (AMC) held a seminar on recent changes to work health and safety laws across Australia that place greater onus on the medical colleges to protect trainee wellbeing including a new emphasis on psycho-social wellbeing.

Our major lever on the hospital employers of trainees is accreditation by the college. A new requirement from the AMC, that we are happy to comply with, is mandatory reporting of major hospital accreditation concerns to jurisdictional governments. This is because it appears that hospital administrators have been neglecting to tell their political masters when major accreditation concerns arose (what a surprise!).

The day after the AMC wellbeing seminar all college presidents met with all Australian health minsters and department heads face-to-face. At that reasonably tense meeting I put to the ministers that we will call out both hospital administrators and government health departments where we think they contribute to major concerns with accreditation standards.

In addition to trainees, for FANZCAs, SIMGs, and rural GP anaesthetists working at accredited training hospitals there is the benefit of systematic accreditation by expert FANZCAs improving the wellbeing of all anaesthesia medical staff.

For those in private practice, the college is also prepared to write to private hospitals and non-training public hospitals where fellows have documented concerns that indicate breaches of ANZCA professional documents.

Beyond their use in accreditation, professional documents are our major levers across the board. This is in part because they are where courts, coroners, tribunals, and (sometimes) governments turn to when looking for expert written guidance.

ANZCA is the principal authority in Australia and New Zealand in safety and quality in anaesthesia and pain medicine.

ANZCA has many excellent resources on wellbeing including a Wellbeing Special Interest Group shared with the Australian and New Zealand societies. College resources on responding to crises for yourself or others include an extensive critical incident debriefing toolkit developed by our outstanding ANZCA Library.

If you require immediate support, please call Converge International on 1300 687 327 in Australia or 0800 666 367 in New Zealand, and identify yourself as an ANZCA fellow, trainee or SIMG.

Professor Dave Story
ANZCA President

ANZCA Council changes

ANZCA Council will feature some new faces at its upcoming May meeting.

Associate Professor Paul Lee-Archer (Queensland) and Dr Mark Priestley (NSW) were elected in our recent ballot. They join re-elected councillors Associate Professor Deborah Wilson (Tas), Professor Leonie Watterson (NSW) and Dr Sally Ure (New Zealand).

Dr Scott Ma remains on council following his nomination and confirmation by the ANZCA SA/NT Regional Committee as the co-opted SA/NT councillor.

The Winter edition of the *ANZCA Bulletin* will feature the new ANZCA Council in more detail.

ANZCA steps up calls for transparency on expedited pathway

Once again, the results of the ANZCA Fellowship Survey, conducted last year, make it very clear what is important to our fellows (see page 34).

The top four items, which more than 90 per cent of our fellows rate as important, in order are:

- Training and fellowship.
- Safety and quality.
- Professional documents, guidelines and statements.
- Continuing professional development.

Interestingly, the fifth most important issue to our fellows is "Representations and submissions to government" which has increased by three percentage points since we last did the survey in 2021.

This is not surprising given the ongoing struggles we are having with government in relation to workforce and the reform agenda being driven by government to seek to redress long-standing systemwide issues.

One of the most challenging issues has been the rapid introduction in Australia of an expedited pathway for specialist international medical graduates (SIMGs) from the UK and Ireland led by the Australian Health Practitioner Regulation Agency (Ahpra) and the Medical Board of Australia. It should also be acknowledged the Medical Council of New Zealand has taken the same measures.

In February we learnt via an article in *Australian Doctor* that eight anaesthetists from the UK and Ireland had been approved to work in Australia via this pathway which bypasses college processes. Information on these new specialists has not been forthcoming from the medical board.

We have asked for – and been granted – a bimonthly meeting with Ahpra to discuss our concerns which centre on the lack of transparency around how this new process will work. We have heard that there are UK and Irish specialists who opted to complete the ANZCA SIMG pathway but been told that the expedited pathway is the only one open to them.

We don't know who will be supervising the SIMGs on this pathway or if there are legal implications for supervisors if something goes wrong, or even whether anyone can decline the "offer" to supervise.

One of the stated aims of the "Kruk report" was to ensure we directed more doctors to regional areas. But there is little we have seen that indicates the expedited pathway SIMGs will be required to go to these areas and the medical board has stated this is not part of their remit.

We have written again to every state and territory health minister about our concerns and will continue to raise our concerns and focus on minimising risks by working with government to consider safety and quality concerns. In May we are meeting with the South Australian Health Minister Chris Picton and in March we met with the NT health minister's staff where the issue was raised.

For example, we want to be involved in the assessments, ensure supervisors are FANZCAs, promote the importance of ANZCA fellowship and ANZCA as a continuing professional development home and ensure a review/evaluation of the pathway is undertaken, combined with promoting the benefit and support as a newly arrived international specialist into a community of practice.

For more information about SIMG expedited pathways and what the college is doing, go to the ANZCA website.

President Professor Dave Story is on the Executive of the Council of Presidents of Medical Colleges (CPMC) and has been vocal about our concerns. CPMC is now in the process of writing a formal complaint to the National Health Practitioner Ombudsman (NHPO) about our concerns.

The Australian Medical Council under ministerial direction is also leading changes to training site accreditation standards which appears to undermine the role of individual colleges and is therefore a major concern. There is an Australian Medical Council forum in coming weeks where we will be able to voice our concerns and seek to positively influence this agenda.

Role substitution and role creep – where scope of practice and traditional roles are challenged – is no doubt not far away. We are already starting to see nurses employed to do roles traditionally in the scope of specialists which is a significant safety issue that the college is watching closely.

In NSW we have been heavily involved in advocating on behalf of our NSW fellows who are facing unprecedented workforce pressures. In February, ANZCA Council met in Sydney where we took the opportunity to meet with heads of department.

This gave us the opportunity to hear first-hand some of the issues. We have compiled a list and we have written to the NSW health minister and health department secretary about our concerns including threats to quality of care and workforce wellbeing. We have responded to our NSW fellows with the college's position and actions.

In New Zealand, there are similar concerns about a struggling health system and how the tumultuous political landscape is impacting this. The New Zealand National Committee is engaged and meetings with the new health minister have been arranged.

It is a challenging time for all specialty colleges. Rest assured we are doing all we can to meet these challenges.

Nigel Fidgeon
ANZCA Chief Executive Officer

AUSTRALIA DAY HONOUR

FPM fellow Professor Paul Andrew Glare (FFPMANZCA, NSW) received a Member of the Order of Australia (AM) in the 2025 honours list for significant service to medicine in the field of pain management and palliative care.

Professor Glare is a former FPM Board member, and a member of the FPM Research Committee, ANZCA Research Committee and ANZCA CTN Executive member.

Letters to the editor

PRAISE FOR ANZCA LEADERSHIP

I would like to congratulate ANZCA President Professor Dave Story on exhibiting great leadership and bravery during the recent meeting with private anaesthetists at a large private hospital in Melbourne to discuss the discontent and negative college perception among our craft group.

At a time when external pressures on our profession are at an all-time high from insurers, government and the Medical Board of Australia, this meeting was timely and important. There was quite honest discourse, with no topic being off limits. Dave listened, objected when there was disagreement and offered alternatives and solutions to issues such as meeting continuing professional development requirements in the private sector.

There was a genuine commitment to collaborate with the Australian Society of Anaesthetisrts and, crucially, to unite with other medical colleges such as the Royal Australasian College of Surgeons to respond to rising out of pocket expenses for patients while insurers raise their fees without indexation for clinicians.

This is pivotal if, we as a medical fraternity, are to be taken seriously when negotiating with other stakeholders such as insurers and government. It is refreshing to see ANZCA recognise that private anaesthetists not only make up a large proportion of members, but also provide anaesthesia for 68 per cent of elective surgery in Australia (2022-23 data AIHW.gov.au).

I hope this example of exemplary leadership will be celebrated and echoed by future leaders of the college.

Thank you David.

Dr Lucky De Silva, FANZCA

CONSIDERATION OF SPECIAL ITEM NUMBERS FOR ANAESTHESIA WITH OBESE PATIENTS

Everything is harder with the obese patient – the cannula, the bag mask ventilation, the difficult airway, the unrecorded pulmonary hypertension, the long surgical time, the transfer off the table, the undocumented sleep apnoea, the high flow in the post anaesthesia care unit – the list goes on.

The college would do well to advocate for special item numbers for anaesthesia in obese patients.

Perhaps starting with patients in excess of 120kg, escalating at 150kg and then again at 180kg for the super morbidly obese, akin to the gradation with the American Society of Anesthesiologists rating.

The added stress and complexity to anaesthesia of obesity is insufficiently recognised.

Dr Catherine Hellier, FANZCA

NEW ZEALAND DECISION TO REQUEST REMOVAL OF DESFLURANE

I am writing to question the recent decision by the New Zealand anaesthetic clinical directors group to request that Pharmac remove desflurane from the Hospital Medicines List, as reported in the ANZCA Te hā New Zealand e-news.

I list the following reasons to keep desflurane as an option for anaesthesia.

- Desflurane has minimal use in New Zealand so has an insignificant effect on the environment if used at 0.5 l/min flow rates.
- As a member of the medical advisory committee of a small private hospital, we have seen two cases of awareness with propofol TIVA and a near miss with remifentanil in less than a two-year period. It doesn't matter how good the algorithm is predicting blood concentration of drug if said drug is delivered to the floor or the anaesthetist has forgotten to put the remifentanil into the syringe. Awareness with an age-adjusted ET MAC of >0.6 is unlikely to result in any awareness which is not only good for my patient but for me not undergoing any investigation and disciplinary action.
- I do anaesthesia for cancer surgery, not infrequently, which takes six to eight hours and am able to have the patient awake before the post anaesthesia care unit to confirm they are comfortable. Not so easy with TIVA.

When you consider the environmental impact of multiple plastic syringes which are used with TIVA it makes the use of desflurane in long cases a much better option.

If desflurane is removed, what is next on the list?

Suxamethonium has bad side effects and many have said it would not be introduced now as a new medicine.

Nitrous oxide is a terrible greenhouse gas but it contributes a maximum of 0.0001% of radiative warming to worldwide N2O emissions. I have used this about five times in 20 years but it is a powerful adjuvant for a gas induction in patients with a high body mass index who refuse to have an IV.

Sevoflurane on its own gives only a short window of opportunity before the patient becomes irritable and difficult to manage.

If desflurane is removed, I am left with only two options for prolonged anaesthesia cases – TIVA with propofol and sevoflurane. Good luck avoiding prolonged waking of patients.

Anaesthesia is art and science. There is nothing wrong with encouraging less use of desflurane but stop eliminating options for me as a practitioner unless you want our profession to end up with one protocol derived anaesthetic option which any monkey could deliver.

Dr Terry Hercock, FANZCA
Napier, New Zealand


Anesthesiology
Editorial Views
Familiarity as a Basis for the Practice of Anesthesiology
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EXPOSURE TO DIVERSE ANAESTHESIA TECHNIQUES VITAL FOR TRAINING

While the letters from Dr Skyrme-Jones and Dr Stewart (*ANZCA Bulletin* Spring 2024) focus on desflurane, they also reflect on the importance of trainees being exposed to a diversity of anaesthesia techniques.

This is not a new issue but one intrinsic to the best training in, and practice of, anaesthesiology.

Dr Nicholas Green was one of the doyens of American anaesthesiology in the last century. In a 1976 editorial (see image above), "*Familiarity as a basis for the practice of anesthesiology*", he wrote: "*the complete anaesthetist, with quiet self-confidence born of experience with many agents and techniques, adapts his* [sic] *management to the requirements of each patient's physical and emotional status and to the requirements of the proposed operation*".[1]

Such advice holds true half a century later.

This editorial, which was the basis for my own practice and teaching throughout my career, should be read by all trainees and teachers in anaesthesiology. While many of the techniques then are now of historical interest only, the underlying principles are fundamental to good anaesthesiology practice and remain as relevant today as they did half a century ago.

"*Anaesthetic agents and techniques are different. Each has peculiar pharmacologic properties. Each has its own indications. Each has its own contraindications.*"

Dr Michael Davis, FANZCA
Christchurch, New Zealand

Reference

1. Green NM. Familiarity as a basis for the practice of anesthesiology. (editorial) Anesthesiology 1976;44(2):101-103.

LACK OF CLARITY ON BULLYING, DISCRIMINATION AND HARASSMENT BEHAVIOURS

I write in response to the recent article in the Summer *ANZCA Bulletin*: "Self matters: bullying, discrimination and harassment (BDH)".

It was well communicated that established initiatives have not done enough to reduce the frequency and impact of BDH on employees, especially in the medical sector. Unfortunately, there remains a lack of clarity among victims, managers and organisations about the types of behaviours which can be prosecuted and how to pursue claims.

Workplace law, anti-discrimination law and the variable law between the states and territories in Australia make this complicated. It is further exacerbated by the fact there have been extensive legal reforms to improve accountability in this area since 2022, largely triggered by the Respect@Work report.[1] The *ANZCA Bulletin* article mentioned that legal recourse for workplace BDH can be pursued under state-based occupational health and safety law.

We can only hope recent amendments might assist in correcting the historical inadequacies in this law for addressing workplace misconduct and incivility. In addition, employees in Victoria, the Northern Territory and the ACT are considered national system employees and fall under the Federal Fair Work Act (FWA). The Fair Work Act provides for a stop bullying order or a general protections claim.[2]

These avenues are not generally available for non-national system public sector employees in the other five states. Until recently, one of the main legal avenues for aggrieved employees alleging gender-based or sexual harassment was to lodge a claim under anti-discrimination law, relying on the human rights framework.

Recent legal reform of the federal Sex Discrimination Act has introduced a new proactive duty for employers and managers to be accountable for gender-based or sexual harassment occurring in their workplaces.[3]

Furthermore, a new part of the FWA now imposes a proactive duty for employers and managers to prevent sexual or gender-based harassment and this part applies to all Australian employees.[4] The FWA also provides for a stop sexual harassment order.[5]

For anyone interested in exploring more about the definitions, duties for employers and legal aspects of addressing workplace hostility and misconduct, there will be a presentation at the 2025 ANZCA Annual Scientific Meeting in the Gender Equity Sub-committee session focusing on these issues.

Dr Maryanne Balkin, FANZCA
Staff Specialist Anaesthesiologist
Department Airway Lead
Unit Coordinator Monash Master of Medicine (Perioperative)

References

1. K Jenkins, Respect@Work: National Inquiry into Sexual Harassment in Australian Workplaces, Report, AHRC, Sydney, 29 January 2020
2. ss789FF, 340 FWA
3. s47C Sex Discrimination Act
4. Part 3-5A, FWA
5. s527J FWA

MYTH BUSTING AND THE LAWS OF PHYSICS

It is interesting how beliefs persist in anaesthesia despite the existence of laws of science that should relegate those beliefs into oblivion. With the start of a new year, a new year resolution could be to do some myth busting with reference to the laws of physics.

It is common accepted knowledge that the body regulates blood pressure in order to maintain organ perfusion. It was also common accepted knowledge for centuries that the earth was flat or that the earth was the centre of the universe. However, the fact that a concept is common accepted knowledge does not make it correct.

Re-learning not infrequently requires unlearning and overcoming observational interpretations.

According to the laws of physics, and particularly Newton's laws of motion, only a force can change the state of motion of a mass (even the Jedi warriors knew this when they articulated "May the force be with you").

Pressure is not a force and therefore, cannot cause blood to move (flow). Instead, it results from the action of opposing forces. The reading obtained from a sphygmomanometer being considered as a measure of the driver of flow is akin to a tape measure reading being considered as the cause of the separation between two points that it measures.

The body regulates flow to organs according to needs, which is accomplished by adjustments in local vascular resistance. Hypotension under anaesthesia is not uncommon and attempts to "restore" blood pressure is ubiquitous and frequently achieved by administration of vasoconstrictors, while overlooking the adverse and counterproductive effects on resistance to flow.

Increasing vascular resistance reduces flow and has only limited clinical application for when the intention is to reduce flow to "leaky" capillaries such as may occur with anaphylaxis or sepsis. The dangers, however, of increasing vascular resistance with concomitant increase in flow velocity and turbulence include myocardial ischaemia and embolic strokes.

The analogy recently presented in a previous issue of the *ANZCA Bulletin*, of anaesthetists being cocktail mixologists was entertaining. In that context, could it be that although nowhere near as extreme, introducing a vasoconstrictor ingredient into the anaesthesia cocktail is akin to using methanol as one of the ingredients in a cocktail?

Like any tool, the sphygmomanometer has its place if the information it provides is understood and used for the purpose for which it was designed – to measure blood pressure and not for deducing blood flow.

A shovel was designed as a tool for digging and not to determine the depth of the hole; although I would not be surprised if there was a desire to dig a deep one for me for challenging such an ingrained belief.

Dr Peter Roessler, FANZCA
Melbourne

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

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ANZCA and government

We work with national, state and territory governments and their agencies to ensure we're appropriately consulted on decisions affecting our members; the health systems they work within; and their ability to provide every patient with safe, high-quality, and culturally competent care.

College update on expedited registration pathway

In late December 2024 the Medical Board of Australia (MBA) announced that specialist anaesthetists from the UK and Ireland that meet relevant criteria, could apply to the expedited specialist pathway for specialist international medical graduates (SIMGs) recognition in Australia. This is in addition to general practice and psychiatry specialisations launched in 2024, with additional specialities to be added during 2025.

While UK and Irish SIMGs almost always assimilate well in Australia, this pathway bypasses existing medical college assessment processes, with MBA to conduct paper-based assessment of SIMGs and then approve them for specialist registration in Australia based on successfully completing:

- Six months of supervised practice.
- Orientation to the Australian healthcare setting.
- Cultural safety education.
- An Effective Management of Anaesthetic Crisis (EMAC) course. The college has strongly advocated for this course to be included as a mandatory item, and we're pleased that MBA has agreed with our recommendation.

The college, and other medical colleges, continue to hold considerable concerns about the readiness of this pathway, our lack of involvement in the design and utilisation of our expertise, insufficient communication on the process and status, and the potential risks to patient safety from a non-anaesthetist paper-based assessment.

As a reminder, in late 2024 ANZCA issued a media release and wrote 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 resulted in productive meetings with some government departments.

However, now that the pathway is operational our priority is to ensure foreseeable implementation and operational risks are minimised and that safety concerns are considered and managed. We have written to the Australian Government requesting support for the following four practical solutions:

1. ANZCA involvement in assessment.
2. Supervisors be FANZCAs.
3. Promoting importance of fellowship and ANZCA as the CPD home to anaesthesia applicants.
4. Implementing a review / evaluation of the pathway, as you would do with any new government pilot or initiative.

As the MBA expedited pathway will not lead to fellowship of ANZCA (that is, FANZCA), ANZCA has developed a pathway to ANZCA fellowship that can be undertaken by MBA expedited specialist pathway applicants if they choose. This can run concurrently with the expedited pathway, and if successful will lead to specialist medical registration and ANZCA fellowship.

Further information on this parallel pathway is located on our website, as well as the benefits of ANZCA fellowship.

The college will conduct regular meetings with the MBA to discuss relevant expedited pathway items.

CONTINUED SIGNIFICANT PRESSURES FACING NSW ANAESTHETIC WORKFORCE

In mid-February 2025, ANZCA Council and key senior staff met with the majority of NSW anaesthesia heads of department to discuss the varied key issues facing the anaesthesia community in NSW. ANZCA appreciates the collaborative sharing of experiences and perspectives.

ANZCA acknowledges that NSW has inadequate working conditions and non-competitive award conditions. During 2024 and continued through 2025, ANZCA has assisted with the following:

- Met with the Australian Society of Anaesthetists (ASA), NSW regional committee members and other key NSW clinicians in June and August 2024 to discuss next steps for a campaign to achieve staff specialist award reform. ANZCA continues to work together with the ASA to ensure end-to-end support for NSW anaesthetists to ensure patient and anaesthetist safety and wellbeing.
- ANZCA Council and senior staff met with NSW anaesthesia heads of department in mid-February 2025 to hear first-hand the issues facing the anaesthesia community in NSW (including award issues).
- Written to the NSW health minister and NSW health secretary in August 2024 to highlight the significant and growing workforce concerns faced by our NSW anaesthetists.
- Following this correspondence, the college president, NSW regional committee chairs and college staff met with NSW Health in October 2024 to discuss award reform and training requirements to meet workforce demands relating to acute and future needs.
- ANZCA will shortly send a follow-up letter to the NSW health minister and NSW health secretary regarding the continued significant pressures facing the NSW anaesthesia workforce, which are expected to intensify further in 2025 if no action is taken.
- We continue to raise the issue in the *NSW Special Commission of Inquiry into healthcare funding (Inquiry)*, multiple targeted information discovery meetings, detailed witness statement and hearing attendances. In late 2024, the inquiry distributed a draft findings document, requesting feedback, to organisations who have contributed to the inquiry (inclusive of ANZCA). The report confirms there is a shortfall in anaesthesia specialists compared with available positions in NSW, however the findings are largely at a system level. As such, ANZCA has provided feedback to request greater tangible or concrete recommendations which can be directly implemented.

ANZCA will continue to work with NSW anaesthetists through 2025 to ensure relevant issues are addressed. This may be through investigating changes where the issues are within ANZCA's remit or through strong advocacy with government in instances that they are beyond ANZCA's direct control.

NEW ZEALAND

The NZ government has identified health as a priority for 2025. The health priorities identified in the Government Statement on Health 2024-2027, including the health and mental health and addiction targets remain the specific focus for all work areas.

Two new ministers have recently been appointed: Simeon Brown as Minister of Health, replacing Dr Shane Reti, and Scott Simpson as Minister for Accident Compensation Corporation (ACC), replacing Andrew Bayly.

Brown announced a major restructure of the public health sector, axing Health Commissioner, Lester Levy, appointed by his predecessor, and reinstating the Health NZ Board that Levy replaced. His plan for developing a closer partnership between the public and private health sectors includes more use of private hospitals and services and longer-term contracts.

Further government changes are anticipated, due to four high profile resignations - Margie Apa, Chief Executive Officer of Heath NZ; Nicholas Jones, Director of Public Health; Diana Sarfati, Director General of Health; and Sarah Fitt, Chief Executive of Pharmac.

At this stage it is unclear whether cabinet will go ahead with the decision on the regulation of physician associates, after the change of health ministers.

The Medical Sciences Council has now published the revised scope, competence standards and associated documents relating to anaesthetic technicians.

Health Informatics New Zealand has released a special report detailing the potential impact of proposed funding cuts of $NZ100 million annually from digital health services. The report warns of significant consequences for patient care and the healthcare workforce, and identifies opportunities for targeted digital investment that could improve efficiency while reducing costs.

The Hauora Māori Advisory Committee has published the first of its population priority monitoring reports, covering three of the nine priorities for Māori health:

- Priority 1 – Māori are protected from communicable diseases across the life-course;
- Priority 2 – Mama and pēpi receive consistent, quality care during pregnancy and into the early years; and
- Priority 7 – Māori are accessing primary and community healthcare early, with positive outcomes and experiences relating to diabetes and cardiovascular disease.

Key insights include:

- Māori are shifting away from getting vaccinated at general practices, with an increase in pakeke (adults) receiving their vaccinations at pharmacies, and pēpi receiving their vaccinations in hospital.
- Workforce pressures are the main barriers to timely access to quality health care for Māori.
- Cost continues to be a barrier to accessing primary care for pakeke Māori, despite 54 per cent having access to discounted general practice visits through either a Community Services Card or a very low-cost access practice.

Phase Two of the *Royal Commission of Inquiry into the Covid-19 Response* is underway; it is primarily focused on the use of vaccines and lockdowns, particularly the extended lockdowns in Northland and Auckland. It will also assess the impact of decisions taken on inflation, debt and business activity. The government has stated its intention not to look at the 39 recommendations resulting from the report on phase one, until February 2026.

Pharmac is consulting on medical devices currently listed in the Hospital Medical Devices List (HMDL) and the Health System Catalogue to develop a closed national HMDL to be released midyear.

SUBMISSIONS AND CORRESPONDENCE

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 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 Medical Council – Model standards and procedures for specialist medical college accreditation of training settings.
- Victorian Department of Health – Proposed amendment of the Australasian Health Facility Guidelines on nitrous oxide.
- NT Minister for Health and Chief Executive Officer, NT Health – Ministerial welcome letter and opportunity to highlight anaesthesia priorities in the NT.
- NSW Special Commission of Inquiry into Healthcare Funding – Feedback on closing submissions outlining draft findings and recommendations.
- Australian Health Practitioner Regulation Agency (Ahpra) – Paramedicine Board of Australia's proposal to regulate advanced practice paramedics to set a national standard of practice (confidential preliminary consultation).
- Commonwealth Department of Health and Aged Care – 2025-2026 Pre-Budget submission to advance Australia's National Strategy for Health Practitioner Pain Management Education.

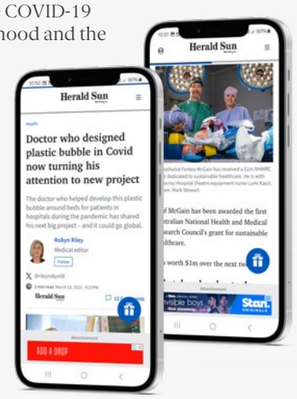
New Zealand

- Medical Council of NZ – Advanced Cardiac life support certification for PGY1 interns.
- Letters to new NZ Health Minister Simeon Brown and NZ Minister for Accident Compensation Corporation – Overview of the college, the faculty, our work and priorities, and requesting a meeting.

What we're talking about

Media

The *Herald Sun* featured an online profile article on 18 March about FANZCA Associate Professor Forbes McGain and his sustainable healthcare advocacy and initiatives. The article highlighted his Australian National Health and Medical Research Council (NHMRC) $1 million sustainable healthcare research grant, his collaboration with University of Melbourne's department of Engineering on the COVID-19 personal ventilation hood and the five projects his NHMRC grant will focus on. The article was syndicated online to the *Daily Telegraph*, the *Cairns Post*, the *Courier-Mail*, *Adelaide Now*, the *Townsville Bulletin*, the *Geelong Advertiser*, *The Mercury*, the *Gold Coast Bulletin* and the *Northern Territory News*.



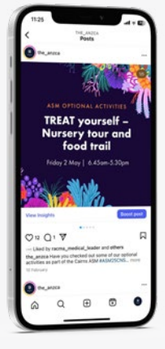
Bluesky

In January we decided to move off Twitter/X and focus on Bluesky instead. We now have both ANZCA and FPM Bluesky accounts. At time of publication the ANZCA Bluesky account had 1230 followers and the FPM Bluesky account had 98 followers. A Bluesky post linking to an ANZCA website news item announcing fellow Associate Professor Forbes McGain's $A1 million National Health and Medical Research Council (NHMRC) sustainable healthcare grant attracted eight likes, two reposts and a link to a California Society of Anesthesiologists podcast "What anesthesiologists can do about climate change" featuring Associate Professor McGain. The grant is the first ever awarded by the NHMRC for sustainable healthcare research and recognises Associate Professor McGain's research and expertise in the field.

Facebook

One of our most popular posts on Facebook (based on impressions) was a story on the Launceston General Hospital's (LGH) perioperative medicine team as featured in the Summer *ANZCA Bulletin*. The post received more than 8200 views and nearly 200 post engagements (reactions, likes, comments and shares). The LGH perioperative medicine team is a success story with more than 200 clinic appointments since 2021. As the tertiary referral centre for Northern Tasmania, it performs around 17,000 surgical procedures annually across general surgery and surgical subspecialties.
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 the ANZCA Chapter of Perioperative Medicine (GChPOM) and this clinic is a clinical immersion site for current GChPOM candidates.

Instagram



Our most popular post on Instagram (based on views) was a post promoting some optional activities at the upcoming 2025 ANZCA Annual Scientific Meeting in Cairns. The post highlighted the Nu Nu cooking class in Palm Cove, a 1.5-hour interactive cooking demo with chef and Nu Nu Restaurant co-owner Nick Holloway. The post received nearly 1500 views and 14 interactions on Instagram. It was also popular on Facebook with 1000 views, reaching nearly 700 people.

‘It’s a RAP’ – reflecting on our first Reconciliation Action Plan

Over the past two years the college has made progress along our reconciliation journey through the implementation of our first Reconciliation Action Plan (RAP) 2023-25. This plan built upon our Indigenous Health Strategy 2018-2022. As one RAP ends and another cycle begins, it’s timely to reflect and celebrate progress, and acknowledge that further actions are needed for meaningful change.

Throughout the RAP’s implementation, we introduced several initiatives to build recognition and understanding of Aboriginal and Torres Strait Islander cultures, knowledges and histories within our organisation and our sphere of influence. Relationships have strengthened, and our efforts to support and grow the Aboriginal and Torres Strait Islander health workforce have expanded.

Some key outcomes include:

Constitution change: ANZCA’s constitution has been changed to enshrine our commitment to reconciliation and to achieving health equity for Aboriginal and Torres Strait Islander peoples in Australia.

Increased interest in anaesthesia: Our consistent presence at conferences and in various fora has led to growing interest among Aboriginal and/or Torres Strait Islander medical students and prevocational doctors, evidenced by communication received via email and Annual Scientific Meeting (ASM) scholarship applications. These efforts have helped the college build relationships with prospective trainees and connect them with the appropriate external support.

Successful scholarships: Our scholarships for Aboriginal and Torres Strait Islander medical students and prevocational doctors to attend the ASM have been a success, with more than 50 per cent of past recipients progressing into the anaesthesia or pain medicine training programs. Work is under way to enhance the program further to maximise its cultural safety and value to participants. In addition, our scholarships for Aboriginal and/or Torres Strait Islander new fellows to attend the ANZCA Emerging Leaders Conference have yielded strong leadership and contributions from past recipients.

Australia-wide career navigator network: A network has been established to provide culturally safe career support to Aboriginal and Torres Strait Islander medical students and prevocational doctors interested in anaesthesia, pain medicine, or perioperative medicine.

First Nations trainee selection pathway: In line with other colleges, work has begun to develop a First Nations trainee selection pathway. This will complement efforts already being undertaken in individual jurisdictions and hospitals.

First Nations-led Career Navigator Network is a welcome innovation

A network of Aboriginal and Torres Strait Islander fellows, senior trainees and allies united to support prospective Aboriginal and Torres Strait Islander trainees. This support aims to create a nurturing environment that respects and integrates First Nations cultural values, ensuring that individuals receive the guidance, mentorship, and resources needed to succeed. By fostering a culturally inclusive approach, we strive to reduce barriers, promote educational and professional growth, and encourage First Nations representation in our specialties.

Keep an eye on the website for more details.

ABOVE

Artwork by Bitja (Dixon Patten) produced for the ANZCA Reconciliation Action Plan.

Strengthened relationship with the Australian Indigenous Doctors Association (AIDA)**:** Through the Specialist Trainee Support Program (STSP) and other initiatives, we have deepened our collaboration with AIDA. The STSP aims to grow the number of Aboriginal and Torres Strait Islander non-GP medical specialists.

Cultural learning integration into continuing professional development (CPD): A cultural learning activity is now mandated within our CPD program, with efforts underway to embed cultural safety across the whole CPD program. Additionally, cultural competency workshops are now imbedded into the ASM, state-based continuing medical education (CME) meetings, and the Faculty of Pain Medicine Spring Meeting. Our Indigenous Health LibGuide is now complemented by new ANZCA & FPM CPD Cultural Safety resources.

Cultural competency training for staff: About 78 per cent of college staff have completed Aboriginal and Torres Strait Islander cultural competency training using a blended learning strategy, online via Your Mob learning and face to face with Koorie Heritage Trust. Staff have also participated in initiatives arranged by the RAP working group that build on their cultural learning such as cultural walks, smoking ceremonies, storytelling events, and guest speakers.

Acknowledgement of Country and flags in all Australian offices: All Australian offices now display an Acknowledgement of Country at the reception area and have a flag set at the reception desk depicting the Aboriginal flag and Torres Strait Islander flag along with the Australian flag. Some offices have also worked with Traditional Custodians to dedicate local language names to meeting rooms.

OUR NEXT RAP

The RAP working group, consisting of college fellows and staff, is developing our next Reconciliation Action Plan for 2025–2027. This plan will formalise our ongoing and renewed commitment to reconciliation, supporting Aboriginal and Torres Strait Islander education, employment, and health. It is intended to innovatively drive reconciliation outcomes both within the college and in the broader community. The new RAP will require us to further embed reconciliation initiatives into our “business as usual” across the organisation and expand this work to grow change within our sphere of influence.

Associate Professor Susie Lord, FFPMANZCA
FPM Board member

Kate Davis,
Senior Policy Officer, Health Equity, ANZCA

We encourage fellows and units to celebrate National Reconciliation Week from 27 May – 3 June 2025. This is a time for reflection, growth and commitment to walking together. Consider committing to individual and/or shared cultural safety learning, local CME relevant to the theme, and starting conversations on reconciliation with friends and family. For more resources visit Reconciliation Australia.

Perioperative medicine

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

POM course numbers continue to grow

BOARD OF PERIOPERATIVE MEDICINE MEETS AS COURSE NUMBERS CONTINUE TO GROW

Things are moving at an exciting pace for our college as we set about embedding perioperative medicine (POM) in college activities.

Our recently relaunched ANZCA website includes a POM section, and perioperative medicine will no doubt be a significant part of the new ANZCA Strategic Plan which is being developed for 2026.

Providing invaluable support to me is past ANZCA president Dr Vanessa Beavis, our new POM Director of Professional Affairs, and I welcome Dr Sean McManus as my POM Board deputy chair.

The chapter now has 752 graduates and the list is growing as we assess GP applicants who had until December 2024 to apply via the recognition pathway.

We received 835 applications overall, a very pleasing indication of how POM is valued at our college and at colleges and societies who are working with us on our perioperative medicine journey. These include the colleges of intensive care medicine, surgeons, the three GP colleges (RACGP/RNZCGP/ACRRM) and the college of physicians with their affiliated societies responsible for geriatricians, internal medicine and rehabilitation medicine.

We are now working on establishing two committees that will report to the board – the Advocacy and Policy Committee, chaired by Dr Jill Van Acker, and the Education and Assessments chaired by Associate Professor Joel Symons.

We have invited the presidents of the key stakeholder colleges or their nominated fellow to join these committees.

The first full year of our Course in Perioperative Medicine was completed in 2024, with 36 anaesthetists, surgeons, physicians and GPs undertaking one or all six units of study. We are now reviewing participant feedback.

This year we have 20 participants doing unit of study 1 (preoperative assessment) and 25 doing unit of study 2 (preoperative planning). Of these, 11 are new applicants and it is pleasing to see an increase in the number of physicians and a GP doing the course.

In recent months we have added Logan Hospital in Queensland, Blacktown Hospital and Liverpool Hospital in NSW, St Vincent's Hospital Melbourne and Waikato Hospital in New Zealand to our network of clinical immersion hospitals, bringing the number to 26.

The clinical immersion component of our course is one of the factors that makes it unique in the world. And we encourage expressions of interest from any other hospitals interested in hosting POM participants. Please email periop@anzca.edu.au.

Dr Chris Cokis
Chair, Perioperative Medicine Board

CHAPTER OF PERIOPERATIVE MEDICINE BOARD

Dr Chris Cokis (chair)

Dr Sean McManus (deputy chair)

Associate Professor Joel Symons – Education and Assessment Committee Chair

Dr Jill Van Acker – Advocacy and Policy Committee Chair

Dr Nicola Broadbent – POM Special Interest Group Chair

Ms Heather Gunter – community representative

Dr Vanessa Beavis – ANZCA Director of Professional Affairs (POM)

Ms Kristy Grady – Executive Director, ANZCA Education and Research

Professor Dave Story – ANZCA President (ex-officio)

ABOVE

Dr Sean McManus and Professor Dave Story at the inaugural perioperative medicine board meeting in Melbourne.

GRADUATES OF OUR CHAPTER (BY COLLEGE)

ANZCA	460
RACP	163
CICM	79
RACS	16
RACGP	14
ACRRM	6
FFPMANZCA	2
RNZCGP	1
Total	**741**

ABOVE

Dr Alka Rani Singh receiving her certification as Graduate of the Chapter of Perioperative Medicine (GChPOM) from Professor Dave Story.

OUR CLINICAL IMMERSION SITES

Australian Capital Territory
Canberra Hospital

New South Wales
John Hunter Hospital
Prince of Wales Hospital
Westmead Hospital
Royal North Shore Hospital
Royal Prince Alfred Hospital
Blacktown Hospital

Queensland
Ipswich Hospital
Logan Hospital

South Australia
Royal Adelaide Hospital

Tasmania
Launceston General Hospital

Western Australia
Fiona Stanley Fremantle Hospitals Group

Victoria
Alfred Hospital
Austin Hospital
Royal Melbourne Hospital
Peter MacCallum Cancer Centre
University Hospital Geelong
Western Health
St Vincent's Hospital Melbourne
Monash Health

New Zealand
Te Toka Tumai Auckland City Hospital
Christchurch Hospital
North Shore Hospital
Wellington Regional Hospital
Waikato Hospital

Streamlining perioperative guideline access: Western Health's journey

Imagine this scenario: in the middle of a busy day in theatre, you are asked by a junior registrar to assist with providing preoperative medication advice for a patient with a complex medication regimen in preadmission clinic - dual antiplatelet therapy, multiple diabetes medications including two types of insulin, and drugs for rheumatic arthritis. You need to quickly access the relevant hospital guidelines to ensure safe, appropriate care.

Western Health is a large health network in Victoria with about 1000 beds across six acute hospitals, caring for more than 800,000 patients and performing 24,000 procedures annually. Being a large health network, good clinical governance demands that both senior and junior medical staff have robust and timely access to hospital policies, procedures, and guidelines (PPG).

Members of the department of anaesthesia, pain and perioperative medicine found that the existing system for accessing PPG posed some challenges for anaesthetists. Limited computer access in some locations, time-consuming logins, and difficulty identifying the correct PPG meant clinicians often resorted to workarounds. Anaesthetists would sometimes rely on recalling guidelines from memory, hastily skim lengthy documents missing relevant sections, or in the preadmission clinic, glance up at outdated laminated guidelines on the wall.

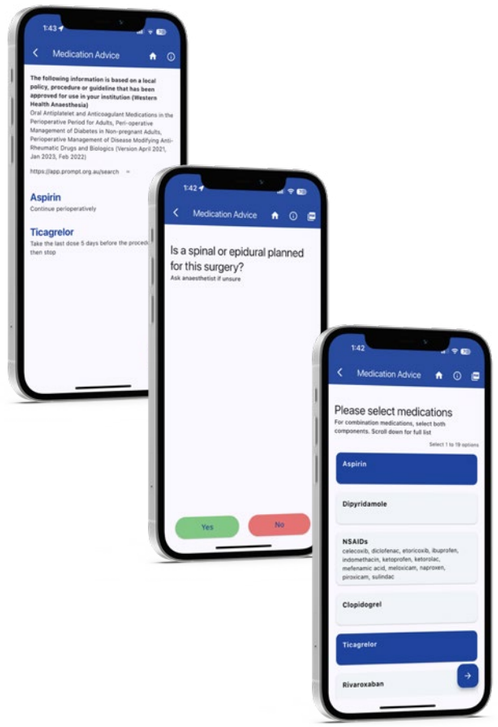
These workarounds introduced potential patient safety risks. Two particularly troublesome areas were the perioperative management of antiplatelet and anticoagulant medications and interpreting rotational thromboelastometry (ROTEM) results for obstetric haemorrhage.

With rapidly evolving therapies and novel medications, antiplatelet and anticoagulant guidelines are complex, requiring a multi-step decision-making process to determine the most appropriate perioperative management. Deciding if and when to stop medications before a procedure depends on the patient's individual thrombotic risk, the procedural bleeding risk and several other factors. Once bridging therapies like aspirin or enoxaparin are considered, the decision-making process becomes increasingly challenging, with numerous potential scenarios to account for. The guidelines are necessarily detailed; however, this complexity made the guidelines difficult to interpret and follow consistently, sometimes resulting in incorrect medication advice and/or day of surgery cancellations.

ROTEM was introduced to help manage coagulopathy associated with obstetric haemorrhage. Supporting anaesthetists to make the best guideline-based decisions

Dr Josh Szental

in the context of significant haemorrhage, required the development of transfusion recommendations and ongoing education. These hospital guidelines focused on rational and targeted use of blood products but required interpretation of multiple data points and several potential pathways for each product, adding complexity to the decision-making process.



THE SOLUTION

In 2020 during the COVID-19 low surgical activity period, several anaesthetists took action, recognising the need for a better solution. They experimented with creating a mobile app that could step staff through local perioperative guidelines, question by question, providing recommendations based on a local guideline at the end.

The prototype, built using Flutter, a cross-platform software development kit for iOS and android, delivered the desired decision support by digitising and distilling the existing guidelines. Modules for managing antiplatelet and anticoagulant medications, and interpretation of ROTEM were created, and over time, more modules were added to provide additional functionality to the department.

The approach proved successful, with positive initial user feedback, and the free app was quickly adopted by anaesthetic consultants and registrars, then spread to other junior medical staff. Clinicians appreciated the convenience and simplicity of accessing established and trusted hospital guidelines via personal mobile devices.

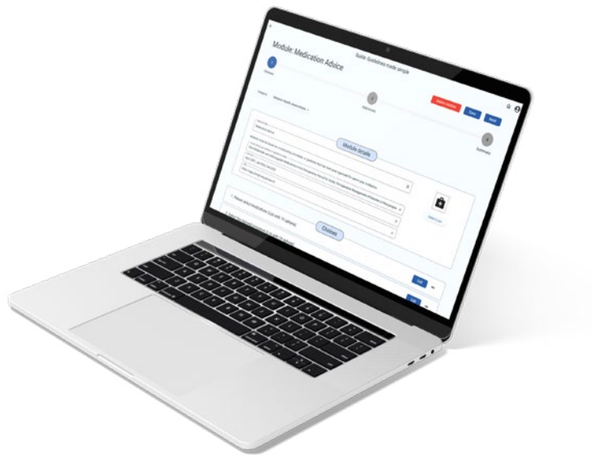
Our health network has significantly expanded access to computer terminals with devices readily accessible in clinical environments; however, a recent survey of the department showed that a majority still use the app on their mobile device to access information on available PPGs. The intranet and the PROMPT system (a document management system developed by Victoria's Barwon Health) are also used frequently. Anecdotally, clinical staff report that since the app has rolled out, it has been a lot easier to find information quickly.

INNOVATION

While the initial app was enthusiastically adopted, the department identified some key issues to address for long-term sustainability. Keeping the content current and aligned with formally approved clinical guidelines, and mitigation of the 'key person' risk associated with reliance on a single person to manage updates and maintain the application were top concerns.

To solve this, the app was transitioned to a cloud-based platform. The new system features an administrator dashboard that allows authorised department members to create and modify guideline modules through an intuitive web interface. Content updates can be published instantly, ensuring all users have immediate access to the latest guidelines, and there is a testing function and audit trail to ensure the system performs as expected.

What began as an experiment to solve a local challenge has evolved into a platform solution (now called "*Guide: Guidelines Made Simple*") and transitioned into a healthcare startup due to its positive impact at Western Health. The solution is being worked on as part of the Australian Clinical Entrepreneur Program (AUSCEP), an innovation program designed to advance clinician-led transformation across Australia's healthcare workforce.



REGULATORY

The Therapeutic Goods Administration (TGA) regulates medical devices in Australia, including software as a medical device (SaMD) that provides clinical decision support. *Guide* is not regulated by the TGA as it falls under their clinical decision support software (CDSS) exclusion criteria, described by the Therapeutic Goods (Excluded Goods) Determination 2018. The app guides clinicians through local clinical guidelines and does not replace clinical judgment in making diagnoses or treatment decisions. Instead, it serves as a tool to improve accessibility and usability of existing hospital PPG.

WHAT GUIDELINES ARE CURRENTLY USED AT WESTERN HEALTH

Guide now includes a range of perioperative guidelines:

- Perioperative management of antiplatelets, anticoagulants, diabetes medications, disease-modifying anti-rheumatic drugs and biologics.
- Surgical antibiotic prophylaxis.
- Campus suitability guidelines.
- Perioperative management of pacemakers and implantable defibrillators
- Interpretation of ROTEM results.
- Massive transfusion, warfarin reversal and dabigatran associated bleeding guidelines.

Plans are underway to further expand the app's content to include obstetric, paediatric, pain and regional anaesthesia guidelines, and to assess the outcomes of improved guideline accessibility on the standardisation of care and patient outcomes.

By harnessing mobile technology and a user-centric approach, this digital tool has significantly streamlined how clinicians access and use PPG to improve patient care at Western Health. Its success demonstrates the potential for clinician-led innovation to address common healthcare challenges. As many anaesthetic departments face similar challenges with guideline accessibility, *Guide* is well-positioned to support other services in addressing these common hurdles.

To learn more, reach out via hello@getguide.com.au

Guide will be available to other healthcare organisations from mid-2025.

Dr Josh Szental, FANZCA
Western Health, Victoria

A trailblazing life well lived

1941 – 2024

ABOVE

Dr Di Khursandi in 2006 at ANZCA House.

Dr Genevieve Goulding AM, an ANZCA past president, reflects on the passing of her colleague, mentor and friend, Dr Diana Coraline Strange Khursandi.

Di was British and completed her medical training in Oxford, Cambridge and London. She obtained her British fellowship in anaesthesia in 1972 and migrated to Australia with her then husband, Jim Khursandi, an orthopaedic surgeon and three little girls, Isobel and twins Catherine and Alice in 1977. They both took up specialist posts in Maryborough, Queensland.

Di was the only specialist anaesthetist in town for ten years, providing the service along with GPs. Over time she developed an intensive care unit, a pre-anaesthetic clinic, and with passion and determination, set about expanding and modernising the department. Other specialist anaesthetists joined her, and Hervey Bay hospital was then opened as well.

Life was full, extremely busy and demanding. Her priority was her three girls for whom she sought to provide rich and meaningful childhood experiences. In addition to her work and family commitments, she also participated in madrigal singing, violin playing, and crafts including quilting and crochet.

She was elected to the Royal Australasian College of Surgeons Faculty of Anaesthetists fellowship in 1983 and elected to ANZCA Council in 1998 where she served for eight years. Di used her time on council to advocate passionately and persistently for anaesthetists' health and welfare and was successful in forming the Welfare of Anaesthetists Special Interest Group (now the Wellbeing SIG). This was a ground-breaking effort unmatched at that time by any other medical college in our region. The SIG has raised awareness of health and welfare issues and helped foster a culture of care and support in our anaesthetic community, as well as continuing to provide educational resources.

Her efforts in welfare were fuelled by her own experience of severe depression, described in an article published in the *British Medical Journal* in 1998[1] as well as knowledge of many anaesthetists over the years troubled by battles with physical and mental health issues, substance misuse and tragic suicides and deaths.

Other trailblazing efforts include her publication of a study on gender issues in *Anaesthesia and Intensive Care* in 1998[2] and a survey of anaesthesia retirees in 2021[3].

In 1997, Di relocated closer to Brisbane, to Caboolture Hospital. In 2004, she retired from clinical anaesthesia and took on roles as deputy Director of Clinical Training, which broadened her sphere of responsibility and nurturing, meeting the educational and psychological needs of junior doctors working in Queensland Health hospitals.

LEFT

Dr Khursandi (far left, back row) and her fellow ANZCA councillors in 2003.

However, besides founding and being the inaugural chair of the Welfare of Anaesthetists SIG, Di's interests extended way beyond welfare. She held several key roles within the ANZCA structure, in education and training, safety and quality, as Rural SIG chair, and gender equity and workforce issues, particularly for regional and rural services.

She also served on the Australian Society of Anaesthetists' (ASA) Queensland committee (1998-2007). She was a medical adviser for the Queensland Civil and Administrative Tribunal for several years. She was a member of the Postgraduate Medical Council of Queensland's accreditation committee and assessment sub-committee. She participated in pre-employment structured clinical interviews for several years. She was a member of the Doctors' Health Advisory Service Queensland committee as well as a member of the Southern Cross orchestra's board. She was frequently asked to present or facilitate on a range of topics, most frequently doctors' health or retirement, at ANZCA, ASA, Rural SIG and other meetings.

Over the years, Di had been a powerful, passionate and persistent advocate for not only many generations of anaesthetists and trainees, but also junior and rural doctors, as well as international medical graduates.

In 2010, Di was honoured with the ANZCA Medal acknowledging her many years of outstanding contribution.

In addition, she was memorable for her warmth and compassion, her considerable empathy and her ability to make any conversation with her personal and caring. She was humorous and cheeky with a characteristic wicked laugh. She was musical, continuing with her violin lessons up to the last few months of her life. She was a voracious reader and loved telling her many grandchildren stories and sharing their dreams. She loved watching quiz shows. She enjoyed ballet and opera. She enjoyed quilting, making every member of her family quilts they will treasure, and crocheted rugs and squares for charity. She was someone to share stories and troubles with and gave sage advice when sought.

Di's last years were troubled by chronic renal failure requiring thrice weekly dialysis, as well as many other health issues. Still, she bore her hospitalisations and illnesses with great courage and determination, managing trips to the UK to visit her twins and other family members and friends as well as concerts, plays and meetings. She passed away peacefully, in hospital, after a short illness on 23 December, surrounded by her loving family.

Di was a wonderful friend and mentor to me and many others. She is greatly missed.

She is survived by her three daughters, Isobel, Catherine and Alice, their partners, and a host of wonderful grandchildren.

Dr Genevieve Goulding AM FANZCA

References

1. Stars disappear BMJ 1998 August 15;317(7156);48
2. Unpacking the burden: gender issues in anaesthesia Anaesthesia & Intensive Care 1998 Feb
3. Quit while you're ahead – and smell the roses! Anaesthesia & Intensive Care August 2021

Self matters

Burnout and job-person mismatch in healthcare

Auckland anaesthetist Dr Jo Sinclair is the new curator for the *ANZCA Bulletin's* Self Matters column.

Tēnā koutou katoa, I have big shoes to fill. Dr Lindy Roberts started "Self matters" in 2020, and has brought us a series of informative, thought provoking and inspiring articles about topics connected to maintaining our wellbeing in healthcare.

Thank you Lindy, I will try to maintain the high standard you have set.

I am an anaesthetist at Counties Manukau, Auckland, and the Chief Wellbeing Officer at Health New Zealand. I am also on the executive committee of the Wellbeing Special Interest Group and have a career long interest in doctors' health and workplace wellbeing. We have a long legacy of advocacy for the wellbeing of anaesthetists in our college and I am grateful to fellow anaesthetists Dr Di Khursandi, Dr Genevieve Goulding, Dr Rob Fry, Dr Tracey May, Dr Suzi Nou and Lindy who have educated and mentored me over the past decade or more, as I have grown my "subject matter expertise".

This edition is inspired by my summer reading of *The Burnout Challenge* by Christina Maslach and Michael P. Leiter, which explores the concept of job-person mismatch, a key driver of burnout. Misalignment between workers and their roles, such as work overload, lack of control, or value conflicts, erodes emotional resilience and fuels disengagement, something increasingly common in our healthcare workforce.

If you have ideas or initiatives that have helped improve wellbeing in your department, I'd love to hear from you, along with any topics you would like to hear more – Joanna.Sinclair@tewhatuora.govt.nz

"Based on extensive research, we strongly disagree that "fixing the person" should be the focus in dealing with burnout. Solutions must address both the workers and the workplace."

– Maslach and Leiter: The Burnout Challenge

IT'S NOT ME, IT'S YOU: JOB-PERSON MISMATCH IN HEALTHCARE

The term *burnout* was popularised in Silicon Valley's startup culture, where self-sacrifice for short-term gains became the long-term operating model, and, like trying to run a marathon at the same pace as a 100metre dash, proved unsustainable.

In *The Burnout Challenge*, Maslach (of the Maslach Burnout Inventory) and Leiter reframe burnout as a job-person mismatch that leads to chronic stress. Burnout leads to erosion of the workers' ability to cope effectively, to be engaged with their work and to take pride in their achievements. That might sound familiar to some of you.

JOB-PERSON MISMATCH

Maslach and Leiter's research has revealed at least six forms of mismatch between workers and workplaces:

- Work overload: In healthcare, it's especially demoralising if your plate is overfilled with tasks that are not a match for your capability level and do not contribute to your strengths at performing the job you were trained and hired to do. Doctors are generally happy working hard if they are working "top of license" in contrast to "bottom of license" (administrative burden).
- Lack of control: Associated with micromanaging leadership and ineffective teams, or when people are excluded from critical decisions, ignored and undermined. In healthcare, that feeling can arise when patient loads become too great and staff can no longer provide the level of service or treatment they would choose to give.

- Insufficient rewards: We get a lot of intrinsic reward from caring for patients and their families in healthcare, so this is not just about considering extrinsic rewards like pay, benefits or promotions. However, when clinicians have less time with each patient they are less likely to reap those intrinsic rewards, and the demand for extrinsic rewards inevitably increases.
- Breakdown of community: Medicine has traditionally fostered a strong sense of community. However, as hospitals grow larger and busier, siloes emerge, leading to disconnection. Overwork can exacerbate antisocial behaviours such as incivility or bullying, further contributing to a breakdown in community.
- Absence of fairness: Inequities, whether perceived or real, foster cynicism and a sense of exploitation. Systemic biases, often based on race or gender, can further fuel this sentiment.
- Values conflict: Those who choose to work in the public health system are drawn to their work by strong values. When the system pressures them to act against these values, whether due to cost-cutting or overwhelming workloads, the risk of burnout rises.

THE MEDICALISATION OF BURNOUT

Despite this research, organisations usually interpret an individual worker's distress as a problem with that individual. Solutions focus on getting that person help, not fixing the workplace factors that led to chronic stress. It is well known that returning to the same harmful work environment after a break leads to recurring burnout.

We need to be offering both individual help and coping strategies, **and** looking for systems issues that are contributing to burnout – those job-person mismatches.

The easy thing to do is to medicalise burnout as a diagnosis that we can treat and offer up "cures" (that's our business after all) however even as we are doing these things that look like a positive emphasis on worker health, we leave the affected individual likely feeling blamed for burnout.

Burnout is not a personal failure – it's the canary in the coalmine, signaling broader issues. If someone plucks up the courage to speak out about their distress levels, it is imperative that we invest the time and energy into looking at root causes that could be affecting many, not just this individual.

RETHINKING THE RELATIONSHIP AND CREATING BETTER MATCHES

Maslach and Leiter's book dives into all the dimensions of job-person fit, provides an assessment tool to help readers consider their own situation, and lots of suggested approaches to creating better matches. Key features of the change processes are:

- Set attainable goals: something that is meaningful and that people really care about, that has good prospects for success in the near term.
- Start with small but significant issues ("pebbles in the shoes"): what would everyone put on their list of things that need fixing?
- Collaborate and consult: the best solutions emerge from consideration of many solutions.
- Design environments that meet workers' key psychological needs: autonomy, belongingness, competence, psychological safety, meaning, fairness and positive emotions.
- Subtraction: if we add tasks and responsibilities to a job, something else has to be taken away. What is no longer necessary? What can be redesigned to be done more efficiently?

WHAT THIS COULD LOOK LIKE IN OUR HEALTHCARE SYSTEM

Through my work in Health NZ and my training at Stanford Medicine's Chief Wellbeing Officer program, I've seen how addressing workforce wellbeing effectively requires unit-level interventions. This means focusing on what's happening within individual teams, not just addressing large-scale challenges. The issue is that we are not resourced to manage in this way, and so we rely on the discretionary effort of doctors who are passionate about workplace wellbeing to do what they can with no resources, rather than appropriately resourced, evidence-based practice.

Small, achievable changes, guided by meaningful engagement with team members, and led by leaders who can create the psychological safety needed for people to share their ideas, can make a huge difference. We need clear channels of communication, and leaders who truly listen, act and then provide feedback so staff can see what is being done and they feel heard. Frontline staff often have the best ideas for solving problems, and some of those ideas will be cheap and easy because they come from the people who do the work and know how it could be done better.

Ideally, I'd like to see every department in our healthcare system allocating dedicated non-clinical time to a wellbeing team, with support for those teams coming from a multidisciplinary team of hospital wellbeing leads with dedicated formal roles and executive sponsorship.

While this may seem far removed from where many are now, there are green shoots across Australia and New Zealand, and I am proud to see the contribution ANZCA, and ANZCA fellows, continue to make to that progress.

Dr Jo Sinclair, FANZCA

**Dr Sinclair's opinions are her own and do not necessarily reflect those of ANZCA or Health NZ.*

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/

Anaesthetist's skill set integral for new hospital build project

DR DAVID BRAMLEY LOVES A CHALLENGE.

The Western Health anaesthetist – he is deputy director of the department of anaesthesia, pain and perioperative medicine – has spent the past five years working one day a week as the medical lead for Melbourne's new Footscray Hospital development.

His role, which spans clinical, operational and design elements, is to ensure the new hospital reflects the needs of medical staff, patients, and the local community in Melbourne's inner-west. The $1.5 billion project, due to open later this year, is one of Victoria's largest health infrastructure investments.

Dr Bramley is well into the final stages of the development in a role that in many ways seems ready made for an anaesthetist's skill set.

"Anyone who has walked into a new hospital and says, 'why on earth did they put the door here?' or 'why is the gas outlet there?' should take the opportunity to be more involved in these projects," he explains.

"What I've been doing as medical lead is coordinating and supporting the direct engagement of medical staff from all specialties, to ensure we get good design and operational outcomes in the new hospital – though not just for anaesthetists."

Dr Bramley believes anaesthetists with their unique skills and broad clinical knowledge, are well suited to such a role. Anaesthetists' extensive clinical networks, often developed through years of relationships with other medical specialties, nursing, and allied health teams, also make them well-suited to contribute to hospital design projects.

"When you consider the skill set anaesthetists bring to the table it actually makes sense. Anaesthetists are often in positions of clinical leadership; they're involved in safety committees and hospital governance and understand human factors and workflows in clinical environments.

"The broader our roles become in hospital settings and now in perioperative medicine, we are everywhere in the hospital to varying degrees, not only working in theatre or with colleagues in the emergency department or intensive care units. Anaesthetists are often more widely connected than others in the hospital and have an extensive contact book, so it means I had a great start when I took on this role.

"We understand the importance of the finer details, such as electrical safety, medical gases, lighting, and ventilation," he explains.

"At the same time, we're used to keeping an eye on the bigger picture while also addressing immediate requirements."

Through his long-standing connection with Western Health Dr Bramley has witnessed the extraordinary growth of the local population in Melbourne's west and its changing demographic. His previous experience on capital works

"Anyone who has walked into a new hospital and says, 'why on earth did they put the door here?' or 'why is the gas outlet there?' should take the opportunity to be more involved in these projects."

projects, including the refurbishment of theatres and interventional suites at Western Health, and the building of the new Joan Kirner Women's and Children's Hospital, has been invaluable in his medical lead role for the new hospital.

When he took on the role in late 2020 after applying for the position, he was one of five Western health employees who had been seconded to the project team. Since then, he has been a key player in shaping the design and development of the new hospital along with 50-60 medical specialists, including other anaesthetists and surgeons, and nursing and allied health teams.

The new build, with 508 beds, will be nearly twice the size of the existing Footscray Hospital.

With much of the developmental phase now completed he's now working on the logistics of the clinical move and the complexities involved in decommissioning a 70 plus year old hospital and transitioning hundreds of staff to operational readiness for the new hospital.

"I've learned a lot from the projects I've been involved in, and I was keen to apply those lessons to this new development," Dr Bramley reflects.

"We've been exploring different models of how you move an existing hospital and its patients into a brand new one a kilometre down the road while continuing to operate. You just can't 'turn off' a hospital and open a new one.

"The underlying sentiment behind the project is that it is extraordinarily positive. We are getting a brand new hospital and that is exciting."

Creating a new hospital from scratch is a mammoth task involving numerous streams and disciplines, ranging from architecture to engineering, with input required from clinicians across specialties. Collaboration and compromise have been crucial to the success of the project and supporting the engagement of relevant medical representatives to each design stream.

The project is a three-way public private partnership (PPP) between Western Health, the state government (through the Victorian Health Building Authority) and Plenary Health (the private consortium responsible for building and running the hospital).

FROM TOP

Dr Bramley on site at the new hospital.

Starting construction on the new build.

Learning how a PPP works and the challenges involved in large-scale projects involves building and nurturing relationships with stakeholders, including government representatives, architects, health planners, engineers, and consultants.

"In meetings with various stakeholders, from architects to hospital teams it's important that the medical voice is represented at every stage, from planning through to construction," Dr Bramley says.

"Yes, you are forced to make compromises because there are competing demands. A lot of challenges we have encountered are about how we get the best design outcome while serving the needs of multiple stakeholders. That has been challenging at times but also fulfilling because you learn to work around things.

"In some areas the traditional models of hospital design have worked well for more than 50 years despite the new demands of health infrastructure. It's about learning to find a balance between old fashioned but functional design and a new approach.

"From the start, my role has been about facilitating complex decision-making, fostering compromise where needed, and ensuring that every design decision supports the broader vision for the hospital."

Dr Bramley's appointment as medical lead recognises the importance of engaging medical staff early in the development process to advise on safe and practical design of clinical spaces such as consulting rooms and inpatient units, and other support spaces including breastfeeding facilities for staff and patients. He provides medical representation for Western Health, including senior specialists and junior doctors to reflect the evolving needs of modern healthcare.

By ensuring medical perspectives are central to the design process the development covers provisions for future flexibility such as pandemic response capabilities and sustainability innovations including the removal of nitrous oxide piping from the design, to the placement of power points and lighting in the new operating theatres.

Dr Bramley helped establish a core medical reference group — a network of medical professionals who consult on key decisions throughout the project. This collaboration extends to providing regular updates to clinical departments and staff, with Dr Bramley delivering presentations to various hospital leadership groups, senior directors, and clinical teams.

As the project has progressed, the focus has shifted from design to operational readiness. Dr Bramley's expertise as a clinician became essential in ensuring the hospital's medical operations would be seamlessly integrated into the new facility. This has involved him playing an integral role developing an extensive training program for medical staff, which includes building orientations, emergency management training, and simulations of new equipment.

The COVID-19 pandemic challenged the development just as Dr Bramley took on his role, requiring some adjustments to the ventilation design.

"Anaesthetists are often more widely connected than others in the hospital and have an extensive contact book, so it means I had a great start when I took on this role."

"The project contract had been signed in the days before the pandemic broke in early 2020. The design was based around pre-pandemic thinking so very rapidly, the ideas around what best practice design looked like had to evolve. We realised very quickly that hospitals were not built around the management of pandemic-associated respiratory pathogens," Dr Bramley explains.

"We were able to tap into the resources of the Australian Health Design Council and adapt the designs of the new hospital to incorporate what we were learning at a rapid pace – we increased the number of single rooms in the building and the air handling capacities were substantially upgraded. This also meant changes to high level things such as how patients enter and leave the hospital through to very granular details such as the placement of ventilation in patients' rooms or how air moves in the operating theatre.

"You can improve ventilation and control systems but there can be an environmental trade off. By having 100 per cent fresh outside air you pay an energy price for that but we have done a lot to address that by having a highly sophisticated switchable system so the building can switch between pandemic modes and normal operation when required."

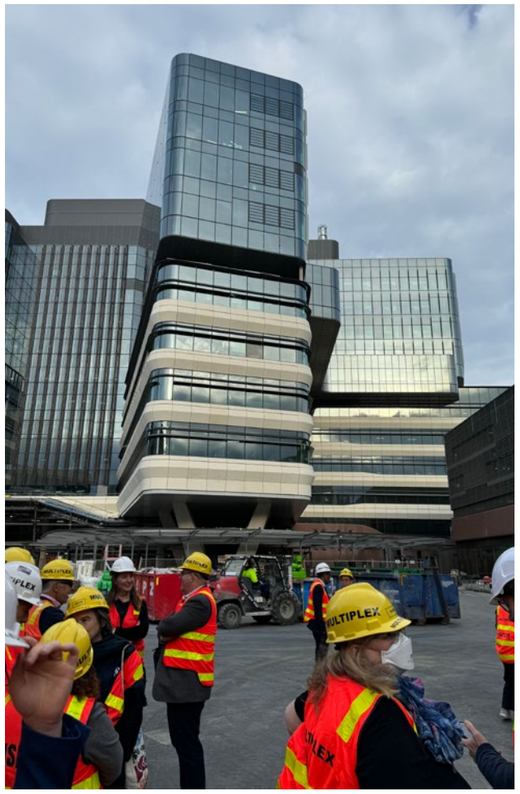
As part of a global trend for anaesthetists to increasingly provide services outside traditional surgical models the new Footscray hospital will feature an innovative integrated perioperative services precinct.

"We've had a small group of anaesthetists who have been working on the precinct," Dr Bramley explains.

"Hospital staff would be familiar with anaesthetists being asked to go to remote parts of their hospital, often to 'dark corners' that were not designed for the delivery of anaesthesia care to support often complex procedures for older and sick patients. So here, the new hospital brings them to us.

"I have been championing this idea from the development of the functional brief of the hospital, arguing for a long time that we need to provide the safest care in the one location. It will be functionally fabulous. There will be an operating theatre but next door will be a cardiology cath lab and advanced interventional suites so critical care resources and anaesthesia support will be combined and built into the one space.

"The Americans use the term NORA (non-operating room anaesthesia) which refers to anaesthetists providing care to patients undergoing, for example, complex interventional radiology or cardiology procedures, or advanced endoscopic interventions."



Another significant part of the planning for the development involved advising on the 'built to scale' prototypes of the new operating theatres and intensive care units.

The models were created in a warehouse in Melbourne's outer-west with production-level finishes so Dr Bramley and other specialists could run simulations to see how the spaces performed and then use these to make adjustments such as sight lines for critical data panels, the placement of pendant lights, power points and anaesthetic machines.

"These prototype simulation sessions were invaluable,' Dr Bramley says.

"For example in the intensive care room prototype we realised that if you installed a dialysis machine and a ventilator in the space it would have to be organised differently on site.

"It was exciting to see the scale of the build, right down to the laying of the vinyl flooring and mock power points and the anaesthetic machine and operating table."

Carolyn Jones
Media Manager, ANZCA

FROM LEFT

Western Health medical staff trial an operating theatre prototype in a simulation session.

The new hospital is now taking shape.

Photos courtesy of Western Health.

What you told us in the fellowship survey

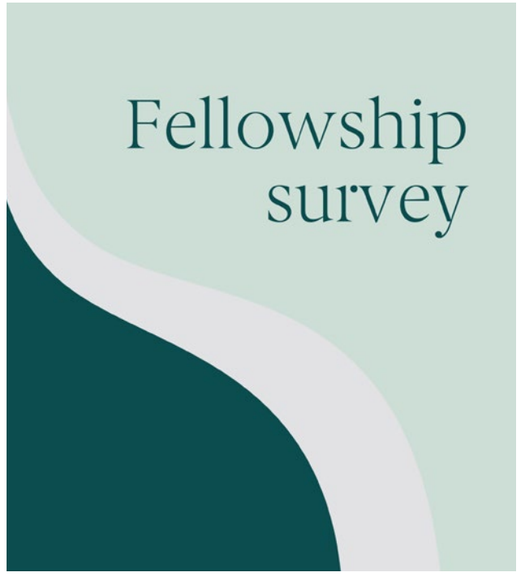
The results are in and will support the development of our new 2026-2028 strategic plan.

The ANZCA and FPM fellowship survey is run every three years to obtain the thoughts and opinions of the fellowship on the priorities of the college. Following a full re-design in 2021, the fellowship survey's purpose is no longer to ask satisfaction-based questions, or questions in relation to operational aspects of the college.

Rather it is a single, shorter, focused survey aimed at taking less than three minutes with a focal question on rating the importance of various college initiatives and then nine questions covering demographics and practice profile, as well as a free text option that gives the opportunity of providing valuable insights and detailed feedback.

Importantly, all information from the fellowship survey remains confidential with only high-level themes and de-identified data reported back to the college. KPMG facilitated the distribution of the survey, reminders and drafting the detailed analysis report in late-2024.

This report includes 2024 responses and longevity analysis between the 2021 and 2024 results.



2024 FELLOWSHIP SURVEY RESULTS

The 2024 fellowship survey was run from 3 September to 22 October 2024 resulting in 2470 responses (ANZCA 2391, FPM 198) with an overall 29 per cent response rate.

The demographics of the respondents (years of practice, gender and geography) were similar to that of the college overall, adding confidence in translating the results to the broader college, whilst being mindful of key fellowship segmentations.

Top five areas

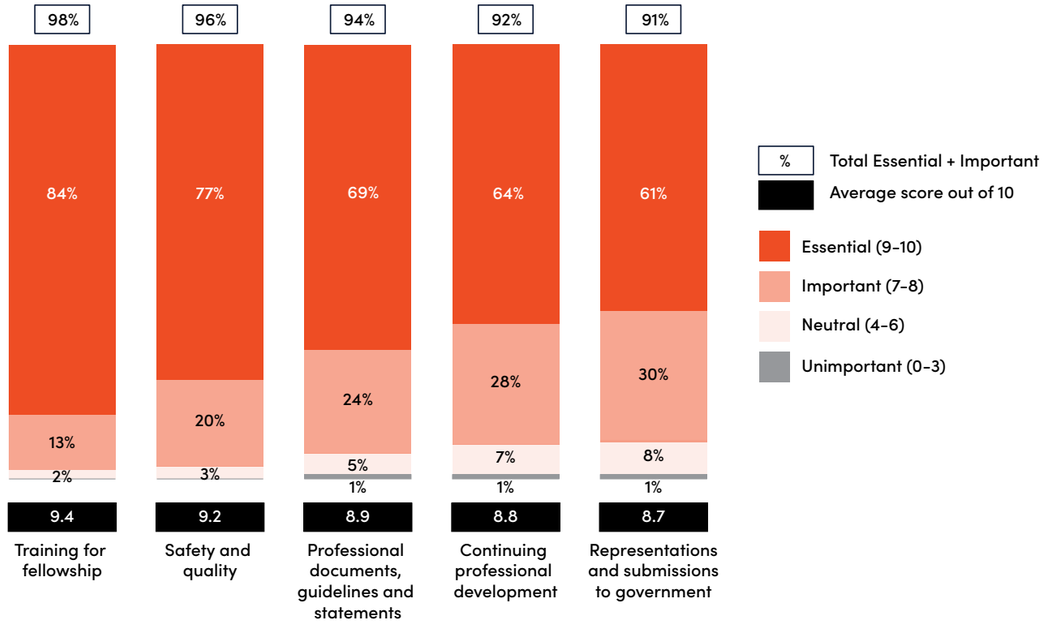
The feedback from fellows on the college's future focus areas remains consistent with the 2021 findings. Training, safety and quality continue to be top priorities (% of total essential and important):

1. 98% – Training and fellowship (97% in 2021).
2. 97% – Safety and quality (96% in 2021).
3. 93% – Professional documents, guidelines and statements (90% in 2021).
4. 92% – Continuing professional development (93% in 2021).
5. 91% – Representations and submissions to government in detail (88% in 2021).

There was a significant increase in the average importance score (out of 10) for *Professional documents, guidelines and statements* to fellows, to an average score of 8.9 for 2024, up from 8.6 in 2021. A similar significant increase was seen for *Representations and submissions to government in detail,* to an average score of 8.7 for 2024, up from 8.4 in 2021.

Digital innovation including use of artificial intelligence (AI) and machine learning, was a new topic added in 2024, resulting in an average score of 6.8 (out of 10). FPM fellows were more likely to view this as essential, with 35% giving a top rating compared to 22% of ANZCA fellows. Only one in four survey respondents (28%, 692 fellows) provided a free-text response providing valuable insights.

2024 ANZCA and FPM fellowship survey – top key areas



The 2024 fellowship survey highlights some statistically significant and strategically notable differences between segments of the fellowship including ANZCA and FPM fellows, tenure (a proxy for generation), and gender.

While there is much agreement between segments for the most important focus areas for the college and faculty, there is a clear divergence in view for key topics relating to well-being, diversity, indigenous health and social issues, which are noted priorities in the 2023-2025 ANZCA Strategic Plan.

Fellowship segmentation

Overall, ANZCA and FPM fellows share a perspective on the top areas

However, there are some differences in the level of importance each group assigns to other topics. FPM fellows gave a significantly higher rating of importance (score 7-10) to the following areas: pain management service advocacy; bullying, discrimination and sexual harassment; public health; Indigenous health; and social justice.

Generational difference exists

Continuing the trend from 2021, a generational difference exists between more recently appointed fellows and longer tenured fellows. With more recently appointed fellows viewing some topics significantly more important than their longer tenured colleagues. These include viewing as essential the college focus on: bullying, discrimination and sexual harassment; health and wellbeing; Indigenous health; environmental sustainability in healthcare; and diversity and inclusion.

Key gender differences

There were key gender differences in the prioritisation of importance, with women tending to place higher importance on topics related to workplace wellbeing and inclusivity, and social issues compared to men. Some of the largest gender differences are seen on: bullying, discrimination and sexual harassment; Indigenous health; environmental sustainability in healthcare; diversity and inclusion; and social justice. Yet, both genders share the common top prioritisation.

HOW ARE THE RESULTS USED BY THE COLLEGE?

The results will be an important guide for the college, ANZCA Council and FPM Board in the development of the 2026-2028 Strategic Plan (work is commencing this year).

The survey has confirmed that fellows have a broad range of opinions but that the majority see most, if not all, of these items as priorities for ANZCA. This aids the college in meeting the needs and expectations of its fellows, and to assist with the prioritisation of strategic and operational planning.

Please see on the next page 'what we are doing' for an indication of the work in the top key areas that are under way, in development or completed.

What we are doing in key areas

The college as a whole is committed to supporting the needs of all fellows and members across all its regions, units and departments. This is only a small snap shot of the vast amount of activities undertaken by the college.

TRAINING AND FELLOWSHIP

- Project ELEVATE will look to transform the training management system, introducing a modular and modernised system to uplift the anaesthesia training portfolio system (TPS).
- Curriculum Review Sub-Committee (CRSC) was established in 2024 and is progressing its workplan and priority activities to review the anesthesia curriculum.
- Online Centralised Exam Preparation Resource (OCEP) project in 2024 delivered a 6-hour online module – Planning for success: A resource for anaesthesia exam preparation.
- Competency-based medical education (CBME) project developed resources to support the introduction of two new assessments for introductory trainees beginning in 2025.
- Patient Clinical Interaction Assessment (PCIA) implementation group developed a suite of resources to support the implementation of the PCIA new assessment in 2025.
- Accreditation Renewal Steering Group produced a standardised definition, philosophy and purpose of accreditation for inclusion in all ANZCA and FPM training program accreditation handbooks.
- New Assessment Governance Committee created to provide strategic direction and advice on college-wide assessment approaches, and to promote the sharing of best practices across college training programs.
- FPM Assessment Framework approved in 2024. The framework reflects contemporary medical education approaches and was developed with consideration of feedback received from trainees, supervisors and the fellowship through surveys and working groups.
- ANZCA CICM Dual Training Pathway work continues to develop a dual anaesthesia and intensive care training pathway in collaboration with the College of Intensive Care Medicine (CICM).

SAFETY AND QUALITY

- An enduring capability to capture, analyse and disseminate information based on de-identified incidents through webAIRS, and support for jurisdictional mortality reporting and review processes.
- Safety alerts are issued when we become aware of an urgent issue regarding the use of particular drugs, agents, devices and equipment in anaesthesia or pain medicine practice.
- Support is provided to anaesthetists to participate in standards development processes through Standards Australia and Standards New Zealand committees and in the development and review of international standards.
- Safety and Quality Committee members and Directors of Professional Affairs provide expert clinical input into representations that are made on behalf of the college to government agencies and regulators.
- Advice is provided on emerging issues such as the perioperative management of patients taking diabetes medications and the introduction of specific connections for neuraxial and other regional anesthesia applications.

PROFESSIONAL DOCUMENTS, GUIDELINES AND STATEMENTS

There are eleven professional documents and guidelines and statements under development/review for 2025, with monthly updates provided on our website.

- *PS19 Position statement on monitored care by an anaesthetist.*
- *PG18 Guideline on monitoring during anaesthesia.*
- *PG56 Guideline on equipment to manage difficult airways.*
- *PG48 Advice on management of substance use disorder in all medical practitioners in anaesthesia and pain management*
- *PG28(A) Guideline on infection control in anaesthesia.*
- *PG46(POM) Guideline on training and practice of perioperative cardiac ultrasound in adults.*
- *PG44 Guideline on advice for retraining or further training in anaesthesia and pain medicine.*
- *PG69 Guideline on perioperative anaphylaxis management*
- *(PM) Scope of clinical practice for specialist pain medicine physicians.*
- *(PM) Statement on provision of pain medicine care to children and adolescents.*
- *PS10(PM) Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain.*
- Statement on spinal cord stimulators.
- Minimum standards for multidisciplinary pain services.
- PS12(PM) Ketamine and chronic non-cancer pain.

Three are piloted for review in 2025:

- *PG47 Guideline on training and practice of perioperative point-of-care ultrasound (POCUS) and PG47BP.*
- *PS15(PM) Statement on the clinical approach to persistent pelvic pain including endometriosis-associated pain and PS15(PM)BP.*
- *PG52 Guideline for transport of critically ill patients and PG52BP.*

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

- New CPD App launched in April 2024, with more than 5600 fellows having downloaded the new app.
- Implemented additional 13 new CPD activities from January 2024, with the majority in the practice evaluation category.
- Revised and expanded CPD Library guide – providing resources for all three categories, launched in September 2024.
- CPD for Clinical Support Roles Library guide – released in 2024 to assist fellows with clinical support roles to match CPD activities with the nature of the work roles that they undertake.
- The 2024 Annual Scientific Meeting (ASM) in Brisbane hosted 2460 delegates including 295 onDemand delegates who heard from speakers in five plenary and 52 concurrent sessions; attended 134 workshops and small group discussions.
- Thirty-one regional continuing medical education (CME) and FPM events, including the FPM Symposium and FPM Spring Meeting, all offering a range of CPD activities, were held in 2024.

REPRESENTATIONS AND SUBMISSIONS TO GOVERNMENT

- ANZCA Advocacy Plan 2025-2027 which sets out the strategic advocacy planning with four focus areas:
  - Enhancing awareness and understanding of what we do (anaesthetists, pain medicine specialists, perioperative medicine and the college in general) and our essential role in the health system.
  - Improving access to specialist pain medicine services
  - Embedding perioperative medicine.
  - Ensuring workforce sustainability, diversity and welfare, and seeking to address rural and regional workforce issues.
- Position on the National Medical Workforce Advisory Collaboration, one of only five medical colleges, that will oversee the ongoing implementation and evaluation of the *National Medical Workforce Strategy 2021-2031*.
- FPM's 2025 Federal Pre-budget submission on Progressing Australia's National Strategy for Health Practitioner Pain Management Education
- The Regional and Rural Workforce strategy reflects our commitment to improving both health outcomes for rural, regional and remote communities and the health and wellbeing of our fellows, trainees and SIMGs living and working in these areas.

Where can I find more information?

The 2024 ANZCA and FPM Fellowship survey results can be found on our website.

Making the survey report available to the college membership remains important for transparency and for fellows who completed the survey to see the results, a culmination of their time, effort and engagement.

We are always interested in hearing from you and not only at survey time. Contact membership@anzca.edu.au with any questions or feedback.

REFLECTIONS ON THE RESULTS

ANZCA President Professor Dave Story

I am proud to have been involved in the 2021 fellowship survey redesign initiative, having worked with the working group to develop a survey that I believe meets the standards expected by fellows in terms of rigour and best practice. This has now provided us with longevity analysis between the 2021 and 2024 results, which is vital to helping establish the foundational components on which we build our next strategic plan. It is only with your participation in the survey that we can endeavour to align the strategic directions of the college that will satisfy and meet your expectations.

FPM Dean Dr Dilip Kapur

My thanks to all the FPM fellows who contributed their time to completing the 2024 ANZCA and FPM Fellowship survey late last year. Your valuable insights will help ensure key priorities and initiatives for pain medicine specialists are included in our next strategic plan. It is unsurprising to see FPM fellows gave a significantly higher rating of importance for Pain management service advocacy, but there is more that unites us than divides us, with training, safety and quality continuing to be highlighted as top priorities.

Fellow Dr Veronica Gin (FANZCA NZ)

These results reflect the current clinical environment, and I can certainly say in New Zealand, there is so much already going on in the workplaces. Any information that has been gathered will be informative, with the themes supporting the college directions. As a binational college we need to ensure all perspectives of our fellows are taken into consideration, while we prepare ourselves for the future – and future generations.

“We have a big city hospital approach but with small regional vibes. Everyone knows each other by their first name and anything and everything you need is here for you in terms of training and support.”

SURF, SNOW AND CULTURE TOP ATTRACTIONS FOR A CANBERRA MOVE

FROM TOP

The main entrance of the Canberra Hospital.

One of the hospital’s new CT scan hybrid theatres.

After spending nine years in Sydney as a cardiac anaesthetist following his specialist training in Canberra Dr Adam Eslick moved back to the nation’s capital with his family two-and-a-half years ago.

Now a senior staff specialist and a deputy director of anaesthesia at Canberra Hospital he appreciates the benefits of having a breadth of practice that not only includes his cardiac sub-specialty but anaesthesia for general surgery, trauma, obstetrics, emergency and paediatrics.

With his colleague Dr Jennifer Hartley, Dr Eslick hopes to encourage more anaesthetists and trainees applying for provisional fellowships to consider the Australian Capital Territory (ACT) as a work and lifestyle choice.

“Here you have that breadth and variety of practice which gives both consultants and trainees opportunities they may not get in a larger metropolitan hospital. On any one day my patient list could start with a young child and then move onto a trauma patient and then a pregnant patient. It means you’re getting exposed to a diverse range of sub-specialties within the space of a few hours.

“And then there’s the advantage of being supported by a community of engaged and invested anaesthetists. It makes Canberra a great place to work.”

The Canberra Hospital is in a unique position. As anaesthesia registrar Dr Aishah Bhadelia explains, “We have a big city hospital approach but with small regional vibes. Everyone knows each other by their first name and anything and everything you need is here for you in terms of training and support.”

The department of anaesthesia, perioperative medicine and pain management has 37 specialist anaesthetists (full-time equivalents) and 34 trainees and is the only tertiary hospital between Sydney and Melbourne. The hospital’s catchment of 650,000 people includes patients on the NSW/ACT border and those from Wagga Wagga and Goulburn. With the exception of solid-organ transplants and paediatric intensive care facilities the hospital covers all areas of surgery and critical care.

The department has five supervisors of training including Dr Hartley who, like Dr Eslick, trained in Canberra and then worked in Sydney specialising in paediatric anaesthesia.

The recent opening of the hospital’s new critical services building with 22 state-of-the-art operating theatres and hybrid theatres ensures the hospital has future proofed the expected growth in population. In addition to North Canberra Hospital which is 15 kilometres from Canberra Hospital, planning is now underway for a new Northside Hospital in the next 10 years at an estimated cost of $1 billion.

Canberra Hospital’s Clinical Director of Anaesthesia, Associate Professor Lance Lasersohn, moved to Canberra from South Africa in 2022 as a specialist international medical graduate before gaining ANZCA fellowship. He now rides his bike to work in 10 minutes in contrast to the hour-long each way commute he had in South Africa. With half of the ACT designated as national parkland, walking, hiking and mountain bike trails traverse the edge of the city.

“Being in a regional centre, Canberra is unique. It has all the benefits of living in a city but with all the lifestyle advantages of a regional centre. It has a reputation as a sleepy town where nothing happens but that is not the reality.

“From a clinical perspective those who come through the anaesthesia department here have a good reputation because they have been exposed to a diverse scope of practice. Trainees are highly regarded nationally because they are exposed to subspecialties throughout their training,” he explains.

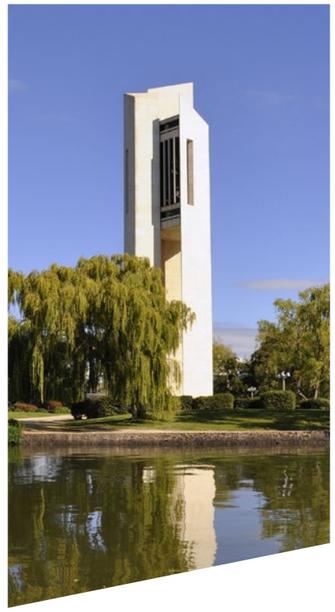
The hospital is an accredited site for the ACT Regional Training (Anaesthesia) Scheme. A training position involves placements at the hospital and North Canberra Hospital. Trainees also have the opportunity for a six-to-12-month regional secondment to either Albury-Wodonga Health or Wagga Wagga Base Hospital.

Dr Eslick says while registrar positions are highly sought after through the scheme, it is harder to attract specialist consultants and provisional fellows, possibly because as a cohort those groups have already established themselves in other locations, often with young families.

“We have capacity to employ more specialist anaesthetists and there is definite scope here to take on more anaesthesia staff. And while we have two provisional fellows we can take another three under our staffing model,” Dr Eslick explains.

TITLE PAGE IMAGES

A – National Arboretum. Photo from Tourism Australia.
C – Building details, National Museum of Australia. Photo by Richard Poulton.
T – Batemans Bay. Credit: Photo from Eurobodalla Coast Tourism.
Background – Skiing is a popular Winter activity for Canberrans. Photo by Andrew Deacon



FROM LEFT

Some of Canberra's landmarks: National Museum of Australia; Gandel Atrium, National Museum of Australia, photos by Richard Poulton; The National Carillon.

"There are unseen benefits of working here. As part of the Australian National University's (ANU) primary clinical school we have unfettered access to the university and we're expanding our research expertise. There is an active and busy anaesthesia community in the ACT that is really punching above its weight so we're doing our best to get the word out. Canberra has all the luxuries of a capital city but on a minor scale."

"You can be in a national forest in 15 minutes and there are bike paths everywhere. The beach and snowfields are two hours away; Sydney is a three-hour drive and Canberra airport flies everywhere."

Dr Hartley explains: "Working here is a great place to be a provisional fellow. We offer a range of highly organised dedicated sub specialist fellowships including upper gastrointestinal (GI), high risk obstetrics and perioperative medicine. There is also a range of general fellowships which can be made to fit around what people want in terms of exposure and experience and we're looking at expanding these to include an orthopaedic and block fellowship."

"These fellowships provide a fantastic range of clinical exposure and experience, are supervised by extraordinarily motivated consultants and provide a way to engage in a structured manner in non-clinical areas."

There are also opportunities to work in retrieval medicine and, as provisional fellow Dharan Sukumar explains, a provisional fellowship can be a pathway to a consultant position.

"The exposure I'm getting here is double what you would be getting elsewhere. The big thing is the breadth of stuff we do here. The case mix is different to what you would see in a metro hospital: we do spine, we do neuro, we do hearts, we do paediatrics, ear, nose and throat and craniotomies."

"When I sat my fellowship exam I could picture all those cases because we do it every day. It was so familiar."

Dr Hartley says the department is highlighting the benefits of working at the hospital and living in the ACT as a way to attract more provisional fellows.

"We know that once we manage to attract people they usually decide to stay and settle here. We have a lot to offer here for provisional fellows. Being supported by a whole community of anaesthetists makes it a great place to work. We have fun as a department but work really hard too."

Registrar Dr Si Yu Xian grew up in Toronto, Canada but moved to Canberra four years ago. He says it took a while for Canberra to grow on him but he now appreciates its laid back lifestyle.

"There's a lot of things to do. Over time you discover all the niche things Caberra has to offer. There's great hiking trails and we also have four distinct seasons here like Canada. Over time you get to realise the breadth of the social amenities here, there are good restaurants, niche bars and museums and galleries. I don't think I am missing anything by being here and there are also a lot of events throughout the year. It seems to be the perfect place to raise a family."

Staff specialist anaesthetist Dr Fabio Longordo grew up in Italy and initially trained in pharmacology before completing a PhD in neuroscience. He studied medicine at the ANU where he became interested in clinical research.

"There aren't many hospitals in Australia that provide the opportunities we have here and that means anaesthetists can maintain a high level of skills across different subspecialties."

Dr Longordo's colleague, Dr Elizabeth Merenda agrees:

"The advantages of being here are that we get to do obstetric anaesthesia and paediatric anaesthesia which is not something that is offered in most other hospitals. The paediatric anaesthesia is quite high level along with obstetrics. We also have high-level general surgery, liver surgery and the hospital is also a major trauma centre.

"As an anaesthetist it's a wonderful place to be."

Carolyn Jones
Media Manager, ANZCA

LIVING IN CANBERRA


Dr Jennifer Hartley


Dr Adam Eslick


Dr Fabio Longordo


Dr Elizabeth Merenda


Associate Professor Lance Lasersohn

Dr Jennifer Hartley: "I have two young children so there are lots of activities for them and beautiful places for running".

Dr Adam Eslick: "With two teenage boys who are into mountain bike riding Canberra is easy. Everything is within a 20-minute drive away. We have all the luxuries of a capital city with restaurants and art galleries but in less than 20 minutes you can be in a national park and in two hours you can be at the beach or the snow."

Dr Fabio Longordo: "Canberra is not as appreciated as it should be, it's considered boring. I grew up in Europe and have worked in different countries in Europe. I appreciate Canberra for a number of reasons: It's a very green city, there's no traffic and you can move around easily. You can have quite a vibrant life outside work with restaurants, museums, concerts and outdoor activities and Sydney isn't too far away. You save a lot of time by not commuting long hours. I have found it extremely pleasant."

Dr Elizabeth Merenda: "With three little kids it is an easy family city, there are heaps of good schools and the children love to get out in nature when we go camping. I'm a swimmer and the beach and pools are not that far away."

Associate Professor Lance Lasersohn: "The lifestyle benefits are significant. I came from a big metropolitan hospital in South Africa where spending an hour each way in the car was normal. I can now be home in 12 minutes on my bike. Canberra is replete with nature trails so it means you can ride on horseback from the top to the bottom of Canberra."

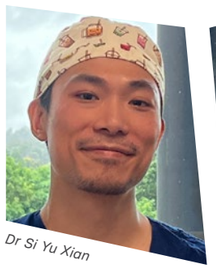
TRAINING OPPORTUNITIES

Dr Si Yu Xian (registrar): "I love the variety of practice here. It's pretty exciting to be able to do everything throughout our training. On any one day you can be in emergency theatre for a trauma case and then a craniotomy or paediatric case. We get frequent, regular exposure to a diverse range of cases and this keeps you on your toes. From a training perspective it builds confidence early."

Dr Aishah Bhadelia (registrar): "A regular emergency shift can involve starting your day with a two-year-old and then finish with a 97-year-old patient. You get such a wide variety of presentations and cases, switching your brain from paediatrics to neuro anaesthesia quite quickly. It keeps you well rounded as an anaesthetist."

Dr Dharan Sukumar (provisional fellow): "I completed my internship here in Canberra, did my anaesthetic training here and then applied for a provisional fellowship here. As a provisional fellow it was quite a transition from being a registrar to being a boss. The fellowship included a six-month upper gastrointestinal (GI) fellowship and I was doing three or four GI lists a week. I felt really well supported so I now feel ready to take the next step to being a consultant."

Dr Rachael Hocking (registrar): "We have a really friendly, supportive department and a wealth of expertise to draw on. The case mix is very diverse and you get exposed to so many different things. We have great teachers here who are really passionate about teaching, lots of primary examiners and protected teaching time. The whole department cheers you on when you're sitting exams."


Dr Si Yu Xian


Dr Aishah Bhadelia


Dr Dharan Sukumar


Dr Rachael Hocking

ANZCA
FPM

2025 ANZCA ASM CAIRNS

FUTURE PROOF

2–6 May | #ASM25CNS

"On behalf of the regional organising committee, I'd like to extend a very warm North Queensland invitation to Gimuy Country of the Yirrganydji people for the 2025 ANZCA ASM and Faculty of Pain Medicine (FPM) Symposium. The theme of the meeting is "Futureproof" and we are looking forward to showcasing the amazing works and developments in our profession against the stunning backdrop of the surrounds that the committee and I are all lucky enough to call our home. Come join us in Cairns, for learning, networking and socialising!"

Dr Andrew Potter
2025 ANZCA ASM Convenor

Register now and FUTUREPROOF this May!

Scan here to register

asm.anzca.edu.au

Gold sponsors:

BD GE HealthCare Medtronic

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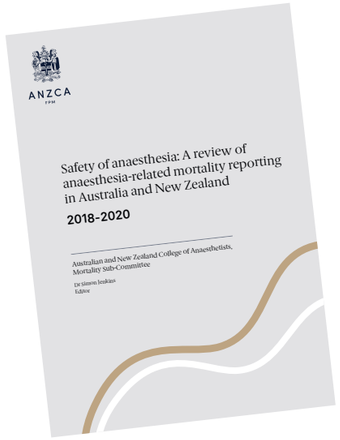
Safety and quality

Mortality report a testimony to our professionalism



In late 2024, ANZCA published its 12th triennial *Safety of Anaesthesia Report*. The report demonstrates that undergoing anaesthesia in Australia and New Zealand continues to be a very safe process.

Australian jurisdictional anaesthetic mortality committees reviewed 2393 reports between 1 January 2018 and 31 December 2020. Of these reports reviewed, 164 (seven per cent) of the deaths were classified as category 1-3 cases, that is, where it was deemed that the deaths were caused by anaesthetic factors at least in part. Of these, 30 (18 per cent) were classified as category 1 cases, that is, where it was believed with reasonable certainty that death was caused by anaesthesia or by factors under the control of the anaesthetist.

It must be noted that over this same period of time, approximately 10.5 million procedures were performed in the jurisdictions providing mortality reports. When the results are considered in this context, the estimated rate of anaesthesia-related deaths (category 1-3) was 1:63, 999. Understanding that variability in data collection between trienniums must be kept in mind, the rate was slightly lower when compared with the last five triennial reports and, overall, is trending downwards.

The American Society of Anesthesiologists (ASA) physical status classification system is used to grade the pre-existing health of patients undergoing surgery. ASA scores of 1 or 2 are considered to be healthy patients or those with only mild systemic disease. Higher scores indicate more significant illness, up to ASA 5, where it is considered the patient is unlikely to survive regardless of the planned surgery. Consistent with previous reports, 96 per cent (157/164) of the anaesthesia-related deaths occurred in cases of ASA-physical status 3-5.

The corollary of this is that healthy patients (that is, those with an ASA-physical status 1 or 2) accounted for four per cent (7/164) of the overall anaesthesia-related deaths during the triennium. Pleasingly, the proportion of deaths in low-risk patients has been trending down over two decades, having fallen from a high of 16 per cent in 2003–05. Previous reports indicate that the majority of surgeries performed in Australia occur in these patients, which gives us even more confidence in the increasing safety of anaesthesia in healthy people.

Also consistent with previous triennial reports is that emergency procedures were disproportionately represented, accounting for 75 per cent of anaesthetic-related mortality. Again, we understand from previous reports that the majority of procedures are performed as planned elective procedures rather than emergency surgeries. Planned procedures are understandably safer than emergencies.

The number of anaesthesia-related deaths increased with advancing age. Patients older than 71 years accounted for 82 per cent (114/164) of all deaths and 36 per cent (59/164) occurred in the 81–90 years age bracket. Older patients tend to more frequently have chronic disease that significantly affects their health (meaning they are likely to be at the higher end of the ASA scale) and suffer from issues requiring emergency surgery. Both contribute to higher overall anaesthetic mortality.

Many cases were considered to have occurred where the reviewers felt there was nothing the anaesthetist could have done to improve the outcome, that is where the technique performed was done well but the patient died despite this. Similarly, in an increasing number of cases the reviewers felt that the patients' overall poor health contributed to the poor outcome, but that there was no way to improve this prior to their surgery.

Specific causes of the 30 anaesthesia-attributable deaths were investigated in detail. Pulmonary aspiration or its sequelae accounted for 15 (50 per cent) of the category 1 deaths, a higher proportion than seen in the past. Anaphylaxis accounted for nine (30 per cent), similar to previous reports. Pulmonary embolus accounted for two cases, cardiac ischaemia/arrest was seen in two cases, post-operative bleeding was noted in one case and respiratory failure also one case. Notably, emergency surgeries accounted for 75 per cent of the category 1 deaths, as they did for the category 1-3 deaths overall.

The results are testimony to the professionalism of our fellowship and commitment to the delivery of high quality and safe anaesthesia and to the robustness of ANZCA's training and standards.

Dr Simon Jenkins, FANZCA
Chair, ANZCA Mortality Sub-committee

WebAIRS

Wrong-route medication administration involving neuraxial and intravenous lines

BACKGROUND

Neuraxial anaesthesia is increasingly utilised due to its opioid-sparing effects and association with improved outcomes. It can be employed either as an adjunct to general anaesthesia or as the primary anaesthetic. These techniques achieve anaesthesia or analgesia via local anaesthetics, often combined with opioids, in various settings including surgery, peripartum care, and pain management.

Wrong-route medication errors, such as intravenous drugs being administered intrathecally, are a particular concern, partly due to the ubiquitousness of Luer-lock connectors. These errors carry significant clinical and economic consequences, including tragic outcomes such as paraplegia, and death. While global studies provide conflicting data on error rates, Australasian data is limited. This case report touches on two neuraxial wrong-route errors reported to webAIRS.

Syringe with Luer connection (left) and syringe with ISO 80369-6 connection (right).

CASES

A patient in their 50s underwent a laparotomy, for which an epidural was inserted pre-operatively. Post-operatively, the patient's pain was inadequately controlled on the epidural, and a fentanyl patient-controlled analgesia was prescribed. Unfortunately, a bag containing both fentanyl and ketamine was erroneously attached to the epidural line on the ward. The following day, the error was noted, and the acute pain service was contacted to review the patient. Clinical assessment revealed that the patient was haemodynamically stable and had no evidence of respiratory compromise. However, they experienced dissociative effects from the epidural ketamine that they had received. A high dependency unit bed was organised for closer monitoring of the patient. The hallucinations eventually resolved, and no further adverse sequelae were noted from the error.

In another case, an epidural was inserted on the labour ward, with a sensory block to ice and good analgesia achieved following a loading dose of fentanyl and ropivacaine 0.2%. A patient controlled epidural analgesia (PCEA) was charted. Several hours later, the anaesthetist was called by the midwife as the patient continued to experience severe pain despite the PCEA. On review, the patient had no sensory block to ice and was in significant distress, but was also noted to have altered conscious state and confusion. Upon inspecting the epidural, the anaesthetist noted that the epidural line was connected to the intravenous (IV) cannula instead of the epidural filter. Local anaesthetic systemic toxicity was suspected, close monitoring of the patient was implemented, and the obstetric team were notified of the event. Open disclosure was performed, close neurological and cardiovascular monitoring continued, and the patient underwent a caesarean section for obstructed labour under general anaesthesia, without further incident.

DISCUSSION

The universality of Luer connectors has led to the unintended consequence of wrong-route medication errors, including intravascular, enteral and neuraxial delivery systems.[1] The inadvertent administration of intravenous drugs into the neuraxial space (either intrathecal or epidural) has been extensively reported,[2] and include (but not limited to) neuraxial KCl,[3] tranexamic acid,[4-6], cardiovascular drugs,[7] muscle relaxants,[8] insulin,[9] and magnesium sulphate.[10]

Some of these errors were associated with catastrophic outcomes for the patients, including death, refractory status epilepticus, or paraplegia and quadriplegia. While wrong-route drug errors involving neuraxial administration remain uncommon, the propensity for harm and the deleterious impact upon patients warrants characterisation of the errors and implementation of strategies to prevent further occurrence.

In the extensive array of case reports and narrative reviews published regarding wrong-route drug errors involving intravenous and neuraxial routes specifically, the main sources of error identified were syringe swaps, incorrect ampoules, and confusion between the IV and epidural lines. Other contributing factors included variable practices of syringe labelling (often poor or unlabelled)[11] and fatigue.[12]

Relevantly, most of the factors that contributed to these errors were modifiable or preventable entirely through simple measures such as separating syringes intended for neuraxial use from IV drugs using separate trays, clear and colour-coded labelling, and checking the syringe prior to each administration. Checking drugs intended for intrathecal administration with a second person is widely recommended and is additionally endorsed by ANZCA in the professional document *PG51(A) Medication Safety*. Importantly, while there is much focus on erroneous administration of drugs via the neuraxial route, events involving the 'directionally opposite error'[13] were also reported. The human factors that are associated with these incidents span widely from organisational factors, inexperience and inadequate supervision, unsafe clinical practices, and failure to follow established medication or departmental guidelines.[14]

The International Organization for Standardization (ISO) has developed a series of connectors (ISO 80369) to ensure incompatibility between the connections for various routes of medication administration, with ISO 80369-6 being specific to neuraxial applications.[15] This overcomes the unintended consequences of universal Luer connectors and acts as a safeguard to prevent many of the cases of wrong-route errors, therefore enhancing the safety in the performance of neuraxial anaesthesia and analgesia. Pertinently, one review found that non-Luer connectors for neuraxial devices would have prevented almost 50 per cent of the errors involving the inadvertent administration of neuromuscular blocking drugs via intrathecal or epidural routes.[16] In this review, syringe swap was the primary cause accounting for the majority of incidents, with perceptual errors being the most common. Eliminating the physical compatibility of the neuraxial connectors with other routes by introducing a non-Luer system has been touted as a strong intervention that would prevent the occurrence of serious adverse patient safety events from wrong-route drug errors. Notably, the disastrous sequelae of intrathecal tranexamic acid would not be mitigated by Neural connector (NRFit®) as the type of mistake involved is an ampoule error.

In addition to the potentially calamitous consequences to the patient of erroneous administration of drugs via the neuraxial route, there are medico-legal considerations that invigorate the need to prevent such mistakes occurring. The devastating outcomes that befell two obstetric patients (Grace Wang in Australia and Angelique Sutcliffe in the UK) from chronic adhesive arachnoiditis was precipitated by erroneous administration of neuraxial chlorhexidine. In 2008, the UK Court of Appeal unanimously upheld a finding of negligence against the anaesthetist involved in Sutcliffe's case,[17] leading to a multi-million pound compensation. The necessity to comply with procedures that were designed to mitigate such errors was expressly mentioned in the judgment.[18]

The webAIRS analysis aims to review incidents involving the unintentional administration of the drugs intended for intravenous administration into the neuraxial space, and vice versa. The primary goal is to identify contributing factors to these wrong-route drug errors, with an emphasis on modifiable causes to inform and enhance patient safety when conducting anaesthesia involving neuraxial techniques. A secondary aim is to quantify the proportion of wrong-route drug errors in the provision of neuraxial anaesthesia and analgesia that would have been prevented with NRFit®.

Dr Jina Hanna, FANZCA
Dr Shawn Chieh Loong Lee

and the ANZTADC Case Report Writing Group

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Continuing professional development

Our world-leading ANZCA and FPM Continuing Professional Development program ensures patients receive cutting edge care from their specialist anaesthetists and specialist pain medicine physicians.

Program update for 2025

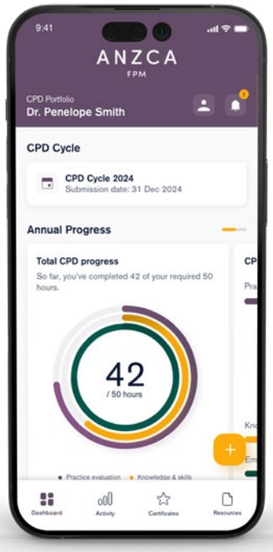
Continuing professional development (CPD) can be challenging for busy medical practitioners trying to balance work, home, leisure and personal commitments.

In 2025 the ANZCA and FPM CPD program will endeavour to expand and update educational offerings for participants. This is collaborative work with special interest groups, societies and other stakeholders.

The revision includes retirement of the outdated COVID-19 emergency response (ER) and a new look opioid induced ventilatory impairment (OIVI) ER. This complements the acute severe behavioural disturbance ER which is of value to our FPM fellows. A specific ER for cardiac perfusion is in the final stages of approval and revised critical bleeding modules are under construction.

Our workplan also includes investigating further paediatric specific ERs. The enthusiasm of our fellowship in developing educational offerings to meet the regulatory fifty hours per annum is a credit to our specialty.

Our 2025 program is required to embed cultural safety, address inequity, and support professionalism and ethics. The acronym is CAPE and our CPD activities will be signposted to support this framework. We are also working to improve the illumination of our CPD program's commitment to the Medical Board and the Australian Health Practitioner Regulation Agency's guideline, *Good medical practice: a code of conduct for doctors in Australia*.



"Time is a precious resource and setting aside one hour per week is a simple rule to enhance professional development and remain current."

Many fellows perform highly valued honorary roles with the college and societies. These roles are being closely examined to improve understanding of how they meet the CPD standards and how they fit with the medical board requirements, especially in practice evaluation, category one. A working group has been tasked with addressing this need.

New policies in special consideration and CPD advice for retraining have been developed in a collaboration between the Directors of Professional Affairs fellows and the CPD Committee. This has been under direction from the regulatory bodies and gives more transparency to ANZCA and FPM processes. The policies will be available to fellows in late 2025 after final approvals.

Time is a precious resource and setting aside one hour per week is a simple rule to enhance professional development and remain current. Utilising the college CPD app is a valuable trick to improve efficiency and performance in 2025, especially when logging activities to the portfolio or accessing online modules.

Warm congratulations are extended to the majority of fellows who completed their CPD annual requirements before the end of year deadline. There was a small tail remaining, so if you are one of the participants who has struggled, please reach out to the college CPD team for early advice and support in the 2025 CPD cycle.

A special thanks to non-committee fellows Dr David D'Silva, Dr Nick Martin, Prof Pam Macintyre, A/Prof Lachlan Miles, Dr Catherine Downs and haematologist Dr Lisa Clarke for their time and enthusiasm in suggesting and contributing to 2024/25 ANZCA and FPM CPD activities.

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

Developing a high-fidelity neonatal eFONA simulator

FANZCA Dr Anita Flynn explains how she and colleagues developed a new neonatal simulator

When managing a "cannot intubate, cannot oxygenate" (CICO) situation, attending medical personnel need to respond promptly using excellent technical skills to prevent prolonged hypoxaemia and associated life-threatening consequences.

Compared to adults or older children, this is especially crucial in neonates and infants who generally have a shorter safe apnoea window due to their higher rate of oxygen consumption and anaesthetic factors which may make pre oxygenation more difficult. Given the rarity of this emergency, simulation for emergency front of neck access (eFONA) as management of a CICO situation is a well-established way to gain and maintain skills for this procedure.

During my anaesthesia fellowship with Starship Children's Hospital in Auckland I undertook a project to develop a simulator to be used for training neonatal emergency front of neck access (eFONA).

Starship's anaesthesia department had previously undertaken extensive market searches and had private correspondence with paediatric hospitals worldwide. This identified that existing commercially available adult models were not only low fidelity but also that they did not adequately meet training needs due to anatomical and size differences. As an alternative solution, many studies and airway courses use rabbit cadavers for this purpose, but, in New Zealand, legislative mandates around appropriate cadaver disposal make regular utilisation of animal cadavers impractical for the training of an entire department.

DEVELOPMENT OF NEONATAL EFONA SIMULATOR

When embarking on this project, I sought advice from many Starship paediatric anaesthetists and then collaborated with Te Whatu Ora (Health NZ) clinical engineering, design and innovation department to develop the simulator outlined below. Key features of the simulator are that it facilitates a high-fidelity simulation, is infant-sized, easily reproducible, has no animal components and is relatively low cost to produce.

FUNDING

Funding for this project was provided by the Starship Anaesthesia Fund for Education Trust. The Douglas Simulation centre also provided Laerdal mannequins and assisted with generating oximetry audio to be used during simulation.

WHAT IS THE STRUCTURE OF THE MODEL?

The model has two main components:

1. A 3D printed neck structure with palpable thyroid cartilage. The original 3D print file was sourced from an open access 'Thingyverse' file which was made available by the 'NZ Clinical Printing Group' then modified to suit our size and anatomical structural requirements. Several prototypes were evaluated by Starship anaesthetists with refinement to produce the latest version.
2. A single-use silicone neck insert comprised of silicone of varying densities which simulate real tissues in an infant's neck. When the silicone is incised, bleeding is simulated with artificial blood. Finally, it has a latex 'trachea' incorporated in the silicone insert which can be intubated with a size 3.0mm ID uncuffed endotracheal tube.

There are two versions of this simulator. One has a 3D printed neck which articulates with the head and body of the *Laerdal 'Baby Anne'* ("Stripey baby") mannequin. The second is a 3D printed head and neck without an infant body. Both models are transportable which makes them suitable for use during fully immersive simulations or for isolated clinical skills training.

USE OF THE SIMULATOR

This simulator has been used for in-house CICO/eFONA emergency response activities for anaesthetic assistants, anaesthetic registrars and paediatric anaesthetists both at Starship Children's Hospital in New Zealand and Townsville University Hospital in Australia. It has also been used to facilitate a CICO and eFONA workshop at the annual Starship Children's Hospital ENT department airway workshop. The consistent feedback received, including from ENT surgeons experienced with infant front of neck access is that this was the highest fidelity simulator that participants had used. The bleeding feature of the simulator is consistently credited as a key to the high-fidelity experience with this simulator.

FUTURE USE

This simulator will be used for the upcoming ANZCA Annual Scientific Meeting infant CICO/eFONA workshop in Cairns. Additionally, following recent publication[1] in the *British Journal of Anaesthesia*, sites from around the world have sought information regarding the design of the simulator with the intent of utilising this simulator for their departmental teaching.

Design information can be shared on request with the hope that this model will provide clinicians who manage infant airways with a way to attain and maintain technical eFONA skills which may be lifesaving.

Dr Anita Flynn, FANZCA
Staff Specialist and Paediatric Anaesthetist
Townsville Hospital

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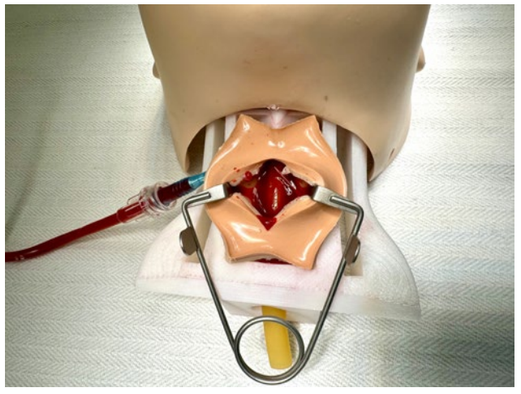


ABOVE FROM TOP

Pre-simulation set up.

Silicone insert in 3D printed neck post incision.

Digital platform advancing collaboration for anaesthetists

Victorian FANZCA Dr Sarah Lee explains how a digital platform is being used to help anaesthetists make informed decisions about patient care.

"Tell me and I forget, teach me and I may remember, involve me and I learn"

An innovative online platform designed to provide medical education and continuing professional development is helping anaesthetists across Australia by offering diverse perspectives on evidence-based patient management.

Launched at Victoria's Eastern Health in 2022, *ADVANCE* fosters collaborative discussions between anaesthesia and other medical specialties.

The free, multidisciplinary initiative brings together experts from different specialties to collaborate, share insights, and make informed decisions on patient care.

It provides a structured environment where specialities can exchange ideas while enabling individual practitioners to reflect on their own clinical practice.

Meeting structure:

- Pre-meeting: Two weeks before the session, participants complete a survey auditing their practice.
- During the meeting: The chair presents collated survey results, alongside a literature review conducted by an anaesthesia trainee. Discussions are interactive, with online polling to address key issues.
- Post-meeting: A summary report, including survey findings and literature insights, is shared with all participants.

Participants actively contribute by sharing clinical experiences, thoughts and opinions. The meetings have been embraced by Victorian and interstate networks, with virtual attendance of more than 200 participants.

Benefits:

• Peer comparison: Participants can audit and benchmark their practices against peers across various networks – locally, interstate and eventually, internationally.

• Multidisciplinary collaboration: Anaesthetists, surgeons, physicians and other specialists provide expert opinions, facilitating well rounded discussions in an informal yet impactful setting.

• Diverse topics: *ADVANCE* has covered a range of themes including ear, nose and throat surgery, obstetrics, paediatrics, upper gastrointestinal and vascular surgery as well as the contemporary issue of environmental sustainability and challengingmanagement of patients on GLP1 agonists and gastric ultrasound.

• Support for private practitioners: Ongoing medical education and peer review are crucial, particularly for anaesthetists in private practice who may have limited access to audit meetings and peer discussions. *ADVANCE* helps bridge this gap.

ADVANCE continues to support clinicians across multiple disciplines, promoting best practices through education and peer review.

Register your interest for future *ADVANCE* meetings: **https://forms.gle/aNre1brhqEfrPwRU6**

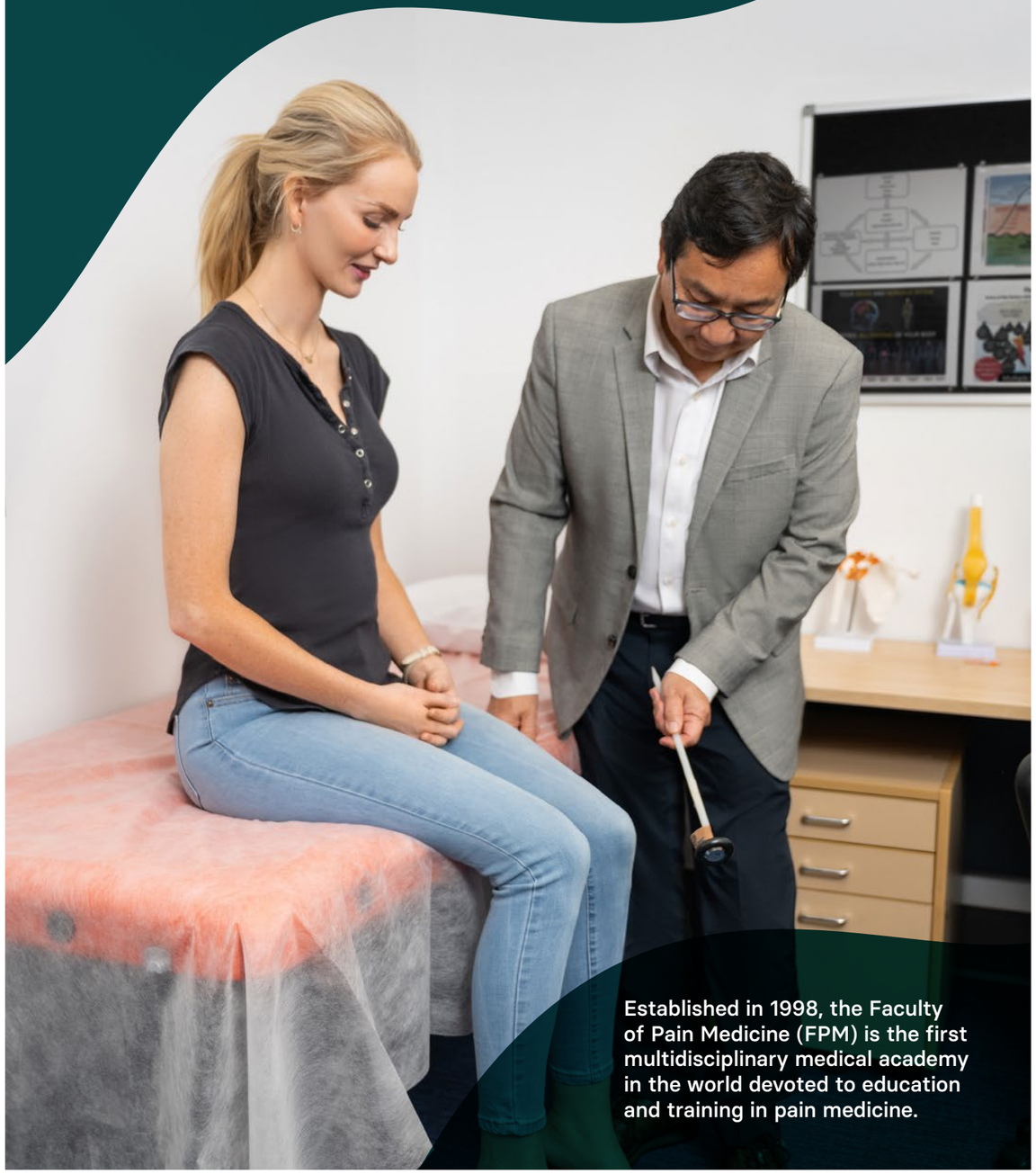
Dr Sarah Lee, FANZCA
Staff Anaesthetist, Supervisor of Training
Eastern Health

ABOVE FROM LEFT

The first face to face ADVANCE meeting with, from left, Dr Kavinay Chand, Dr Niketh Kuruvilla, Dr Sarah Lee, Dr Rebecca Zhao, Dr Kelly Jones.

Collaboration is the key to unlocking innovation, bringing together perspectives, skills and creativity, from left, Dr Stuart Watson, Dr Clive Rachbuch, Dr Sarah Lee, Dr Timothy McIver.

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.

Professional integrity and the value of care

In the second part of a three-part series on professionalism in pain medicine FPM Dean Dr Dilip Kapur examines value in healthcare.

In December 1799, US President George Washington was attended by a group of physicians who represented the pinnacle of medical wisdom. President Washington was gravely ill. It seems likely that he had developed acute epiglottitis, a serious illness even in the modern era but one that posed mortal danger in the late eighteenth century.

President Washington was treated with a variety of manoeuvres, most of them likely futile but relatively harmless. However, as his condition worsened, his physicians decided to proceed with repeated episodes of bloodletting. Litres of blood were removed from the dying president to the extent that further bloodletting became impossible, despite continuing attempts. The president almost certainly died from the effects of irreversible haemorrhagic shock, well before his airway closed. That the process was overseen by some of the most admired medical minds of the day holds important lessons for all of us given the task of providing the best care to patients.

Poor quality treatment, administered with confidence by experts, has been around for centuries. It persists to this day. Various labels have been applied. For example, the US rheumatologist, Professor Nortin Hadler, has used the term "Type II medical malpractice". He defines this as the provision of expert care that is unnecessary or even harmful.

Another term that captures the phenomenon is "low value care". As costs associated with healthcare have continued to increase at a rate greater than the capacity to fund it, a focus on low value care has become inevitable.

Of course, before we can use such terms, we need to consider what "value" in healthcare might represent. It is wrong to assume that care that is cheap offers good value. Similarly, there is very expensive care that, through the means of improving survival, reducing suffering and improving function, can be considered high value. An excellent example of this would be major joint replacement surgery such as total hip arthroplasty.

By contrast, low value care provides little definable benefit. It may even carry secondary risks which can result in worse outcomes than no treatment at all. Such care may be provided under the guise of "trying to help" and can be a relatively easy sell to a patient who is desperate for assistance. However, a clear-eyed analysis must question the integrity of such an approach.

Few would doubt that president Washington received low value care.

It can be disheartening to see areas of low value care being identified with little or no effect on the use of such care. For example, many interventions used in the management of low back pain have very limited evidence of benefit. This was highlighted in a review published by Deyo and colleagues in 2009[1]. Despite this, the use of such interventions, with the exception of opioid therapy, has actually increased through industrialised nations over the past 15 years.

Subjecting patients to low value care may place them at risk. But there are other negative consequences that, while less obvious, cannot be justified. A significant issue is the financial consequence to patients. Patients, ultimately,

pay for healthcare. Claims that health funding comes from insurance premiums or general taxation ignore the fact that such revenue streams are sourced from society. Even where patients may contribute little in terms of financial input, a misallocation of resources to low value care will reduce the capacity of a system to fund better value care elsewhere. Additionally, many low value interventions generate very high value remuneration to health providers.

Figure 1 below shows income distribution in Australia. The positively skewed distribution is seen across most developed nations, including New Zealand.

A full-time medical specialist in virtually any discipline will find themselves positioned far off the right-hand margin of this histogram. This, in itself, is not the issue. We live in a society that values and rewards talent. Where such talent is used to best effect, many arguments can be made to justify the reward. However, no argument can be made for misusing talent through the provision of low value care. In effect, this results in a transfer of resources from the bulk of society's participants, represented in Figure 1, to a privileged group, with no net benefit.

Most societies consider that their most fortunate members carry an obligation to share at least some of their good fortune with the less fortunate. The type of financial transfer I have described above inverts this principle and is unfair.

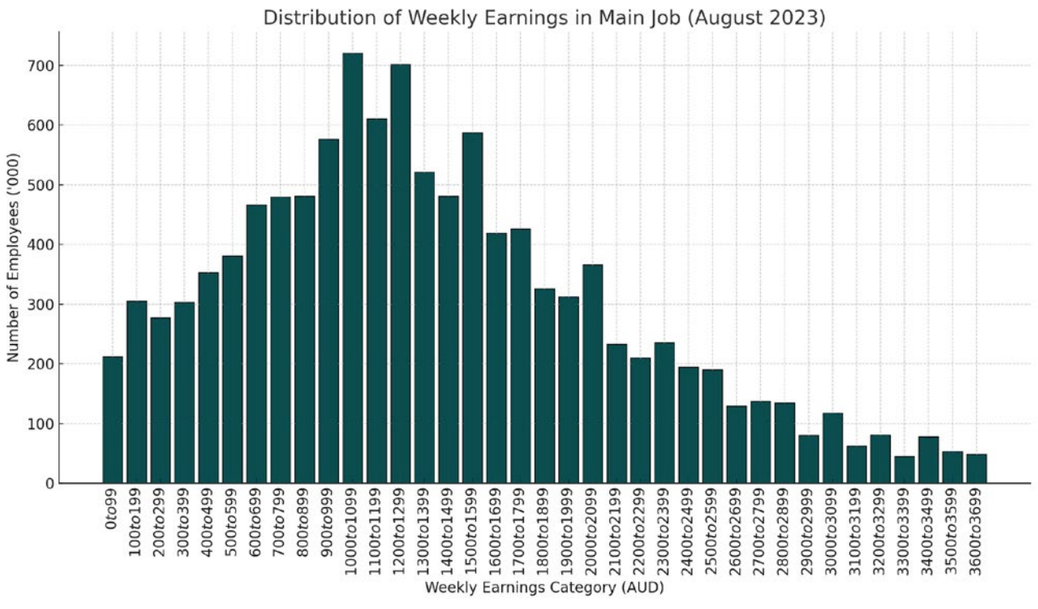
As pain specialists, we encounter patients who have suffered greatly, often over many years. The search for a solution to pain sometimes drives patients to look for solutions at almost any cost. An ethical approach to assisting our patients behoves us to provide evidence-based treatment and advice that avoids the provision of low value care. As healthcare expenditure increases, neither our patients nor the society that supports us will accept anything less.

Dr Dilip Kapur
Dean, Faculty of Pain Medicine

References:

1. Overtreating Chronic Back Pain: Time to Back Off? Deyo, R et al. *JABFM*. 2009; 22:62-68
2. Figure 1 – data from https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/employee-earnings/latest-release#distribution-of-earnings

Figure 1. Income distribution in Australia



FPM news update

2025 FPM BOARD ELECTIONS

The Faculty of Pain Medicine received six nominations, for three elected vacancies on the FPM Board, and proceeded to an election between 18 January and 3 February 2025. The faculty received 263 votes out of a total of 602 voters, a very high 44 per cent response rate.

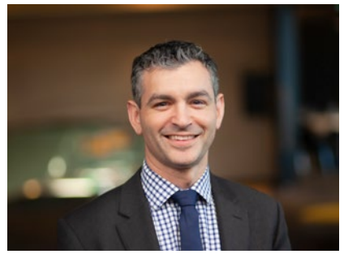
The faculty is pleased to announce that the following three candidates were successfully elected to the FPM Board:

Professor Michael Veltman (WA), Dr Noam Winter (Vic) and Dr Leinani Aiono-Le Tagaloa (NZ).

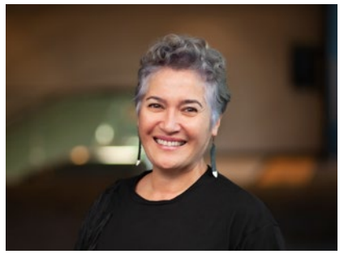
Thank you to all the candidates who nominated for the 2025 FPM Board election and to all fellows who provided a vote.

The result of the ballot will be formally ratified at the FPM Annual Business Meeting to be held in Cairns, on Sunday 4 May 2025.

Professor Michael Veltman (WA)



Dr Noam Winter (Vic)



Dr Leinani Aiono-Le Tagaloa (NZ)

DEVELOPING FLEXIBLE ACCREDITATION PATHWAYS FOR PAIN MEDICINE TRAINING IN RURAL SETTINGS

FPM is seeking expressions of interest from Australian regional unaccredited pain units to be part of the flexible accreditation pilot for 2025. After stakeholder consultations took place in 2024, several flexible options were proposed and have now been approved for pilot this year.

If you have been thinking about exploring flexible accreditation options for your pain unit, we are eager to hear from you!

Having accreditation benefits units and prospective trainees by offering more regional training opportunities and broadening access to funding—helping to grow our regional workforce.

We invite units to reach out to the faculty at fpm@anzca.edu.au to discuss what flexible accreditation might look like for you.

NEW FELLOWS

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

Dr Wee Cheon Ang, FANZCA, FFPMANZCA (NZ)

Dr Mandeep Balbir Singh, FRACGP, FFPMANZCA (SA)

Dr Tom Chan, FHKCA, FFPMANZCA (Hong Kong)

Dr Rao Fu, FANZCA, FFPMANZCA (VIC)

Dr Eugene Henry, FACEM, FFPMANZCA (WA)

Dr Kushlin Higgie, FANZCA, FFPMANZCA (NZ)

Dr Kin Lau, FRACGP, FFPMANZCA (SA)

Dr Chong Han Lim, FRACGP, FFPMANZCA (SA)

Dr Yusuf Mamoojee, FAECEM, FFPMANZCA (WA)

Dr Reshad Mirnour, FRACGP, FFPMANZCA (WA)

Dr Jonitha Nadarajah, FAFRM (RACP), FFPMANZCA (WA)

Dr Estelle Petch, FAFRM (RACP), FFPMANZCA (VIC)

Dr Jonathan Ramachenderan, FRACGP, FFPMANZCA (WA)

Dr Nazmeen Shameem, FAFRM (RACP), FFPMANZCA (NSW)

We congratulate the following doctor on their admission to FPM fellowship through the completion of the Pain Medicine Specialist International Medical Graduate pathway:

Dr Ning Cheung, FANZCA, FFPMANZCA (VIC)

Off-label prescribing guidance document approved

The ethical and legal framework for off-label prescribing in pain medicine has been the subject of considerable discussion for the Faculty of Pain Medicine. The board approved a guidance document for use by specialist pain medicine physicians (SPMPs) and faculty trainees which articulates the ethical and legal responsibilities of off-label prescribing while providing effective treatment. It emphasises informed consent, accountability, and professional judgment when prescribing medications for unapproved indications.

Legally, the Therapeutic Goods Act 1989 (Australia) and the Medicines Act 1981 (New Zealand) regulate therapeutic goods. The Therapeutic Goods Administration (TGA) and Medsafe oversee drug approvals and distribution. Although off-label use is technically "unapproved," legal action against clinicians for prescribing such medications is rare. The TGA regulates pharmaceutical products rather than medical practice, and the principle of *de minimis* suggests that minor legal breaches causing no harm are unlikely to be prosecuted, and that legal resources will not be used to police professional practice unless the lack of professionalism may amount to criminal conduct.

Ethically, off-label prescribing is justified when it is evidence-based or scientifically plausible. However, this increases a clinician's legal and ethical responsibilities. The Council of Australian Therapeutic Advisory Groups (CATAG) classifies off-label prescribing into four risk categories:

- **Routine use** applies to well-supported but unapproved medications, like duloxetine for neuropathic pain.
- **Exceptional use** requires written consent, such as strong opioids for post-herpetic neuralgia.
- **Conditional use** involves data collection for future evidence, as seen in ketamine infusions for persistent pain.
- **Research use** occurs under ethically approved trials with little or no existing clinical evidence.

To ensure ethical prescribing, the faculty has adopted the seven guiding principles for off label prescribing articulated by the Council of Australian Therapeutic Advisory Groups (CATAG) in their 2013 document *Rethinking medicines decision-making in Australian Hospitals; Guiding principles for the quality use of off label medicines* (the Guidelines).

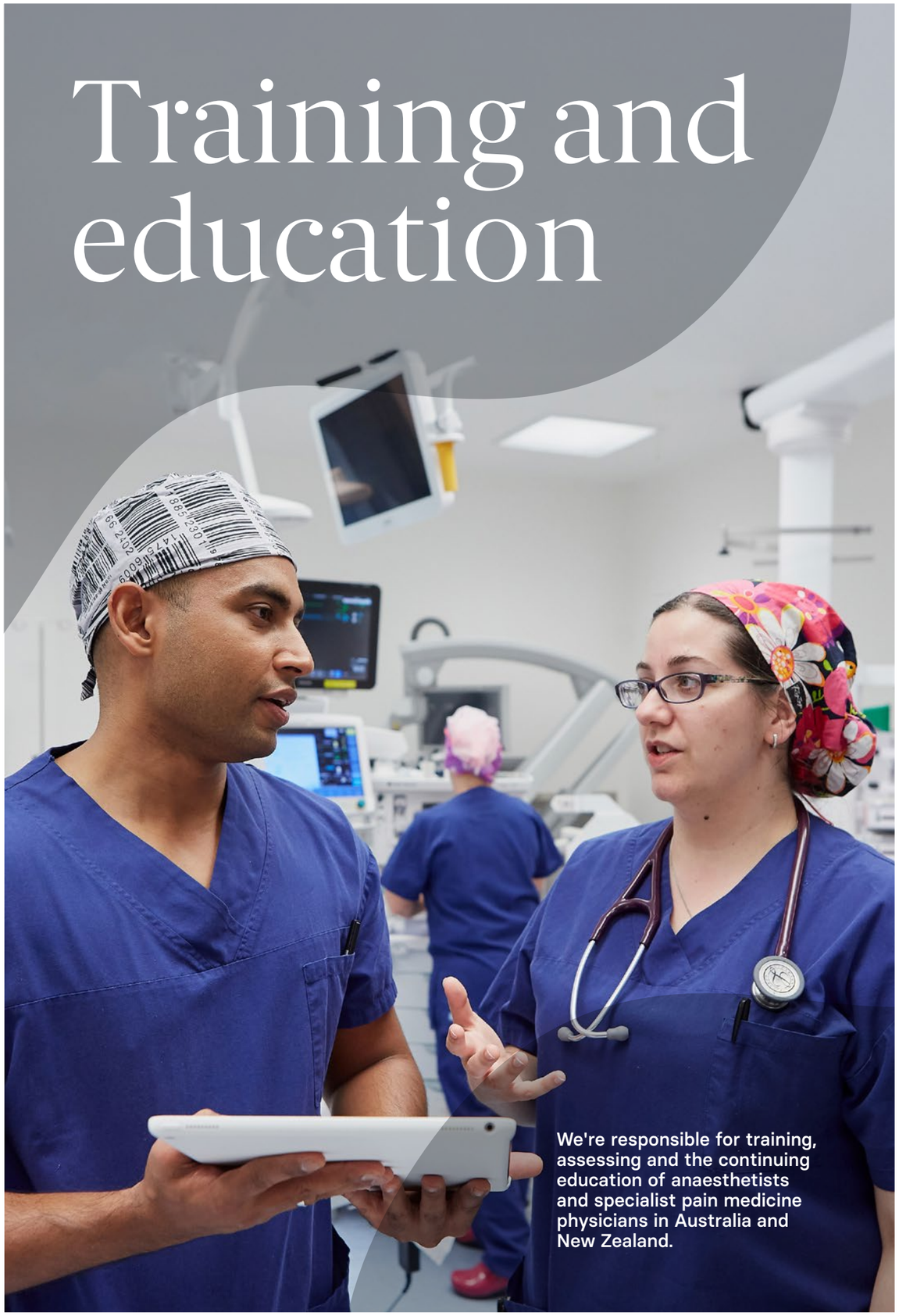
- Off-label medications should only be considered when **approved treatments are unsuitable or exhausted.**
- Decisions must be based on **high-quality evidence**, including clinical studies or pharmacology research.
- **Shared decision-making** with patients and carers is essential, with consent documentation reflecting the level of evidence.
- **High-risk off-label use should involve consultation** with a drug and therapeutics committee, and
- **Clear patient information should be available** in all settings.
- **Monitoring outcomes and adverse events** is crucial for accountability and improving medical knowledge. Clinicians should conduct **regular audits and report unexpected adverse events** to prevent harm.
- Finally, **legal risks must be acknowledged**, with thorough documentation of decision-making, consent, and patient outcomes to protect against legal or professional challenges.

This framework balances **patient safety, ethics, and legal protection** while allowing physicians to offer effective treatments. Given slow regulatory approvals and incomplete evidence for many pain treatments, ethical off-label prescribing remains a crucial aspect of pain medicine.

View the document on our website.

Associate Professor Michael Vagg
Director of Professional Affairs, FPM Professional Affairs

Training and education



The evolution of ANZCA's exam assessments

As he steps down after 13 years as an examiner and two years as chair of ANZCA's Final Examination Sub-Committee, Dr Anthony Coorey reflects on the college's assessment processes in a question and answer session for the *ANZCA Bulletin.*

How have the college's assessment processes changed over the years since you started as a senior final fellowship examiner?

There have been significant changes in assessment processes over my 13 years as an examiner. The most significant of these has been the formalisation of workplace-based assessments (WBAs), which allow for continuous appraisal of learning progress throughout training. The combination of WBAs together with the primary and final examinations allows for thorough and rigorous assessment of the attainment of the competence and knowledge required to have successfully completed ANZCA training.

With regard to the final examination in particular, we have seen greater emphasis on communication to trainees and fellows with regards to standards and standard setting, improving the transparency of the final examination assessment.

We have also developed processes to enhance feedback on examination performance to all candidates (whether successful or unsuccessful) so that the educational opportunities from our examination process can be more fully utilised.

What are your thoughts on the removal of high stakes exams from the assessment process?

Throughout my time as an examiner this has been a topic of conversation. We have the examples of multiple jurisdictions both in Australia and overseas who have tried alternate pathways. My understanding is that in all these systems there is a recognition that there still needs to be a formal assessment of knowledge and judgement and many more radical approaches have been walked back. It appears that it is not appropriate to remove high-stakes examinations from our assessment processes.

I actually think that the college currently sits in a sweet spot with regard to assessment, because learning progress and attainment of expertise is measured in different ways, reflecting the wide range of knowledge, skills and behaviours our specialists require to serve our communities with competence and professionalism. To maintain the high standards of our specialty, together with the confidence of our communities we serve we need a balanced system that includes multiple forms of assessment that are appropriate to the content being assessed. Examinations remain an important part of this wholistic assessment process.

"We are very mindful of the many stresses that modern life places on candidates and also the college staff and examiners and we are constantly striving to improve the balance for all participants."

What steps is ANZCA taking to address candidates' concerns around issues like decoupling.

The final examination is designed and attempted as four separate components (multiple choice questions (MCQ), short-answer questions (SAQ), medical vivas and anaesthesia vivas) which together contribute to one overall examination mark.

Decoupling the final examination refers to the separation of the different exam components from each other so that a candidate has the option to complete these different components at different times throughout training, with each decoupled component becoming a complete examination in itself and a pass required for each of the decoupled sections of the exam.

The Final Examination Sub-Committee has examined two proposals to decouple the examination. One option was decoupling only the MCQ paper from the rest of the examination.

The second option explored involved decoupling the written examination from the viva voce examinations. This second option would create two separate and standalone examinations (written and viva examinations), each of which would have to be individually passed.

The perceived benefits are reduced stress for candidates in terms of examination preparation, and potentially better work/life/study balance.

An important consideration is that a decoupled exam creates separate examination assessments with separate curriculum blueprints, standard-setting processes and the requirement of a passing grade to be successful.

From our analysis, decoupling of either the MCQ only or decoupling the written and vivas will increase the time candidates spend sitting the examinations, increase their costs and has the risk of significantly slowing training progression, partially by way of increased examination attempts after failures.

A decoupled exam would necessitate attainment of a passing grade in each decoupled examination component. Currently, the final examination is scored in a summative fashion, where the scores of all the components contribute to the overall score. Despite the stress of the viva examination, most of our candidates perform well in this section and the mark awarded here augment areas of difficulty candidates may have in the written exams.

Despite our analysis showing no benefit of widespread decoupling of the examination, over the past five years, we have introduced two limited decoupling processes which reflect our commitment to candidate welfare and equity. These are the policies of "viva examination deferral" and "carry-over written passes". Those candidates who have a major life event or illness between the written and the viva examinations can apply to defer their viva sitting to the next examination period. Candidates who attain an overall pass in the written examination but who subsequently fail the viva examinations are permitted to attend the next viva sitting without re-sitting the written, effectively "carrying-over" their written pass mark.

The Final Examination Sub-Committee (FESC) and the Education Executive Management Committee (EEMC) are constantly working to provide the most equitable and efficient process with examinations to reduce the burden on our candidates.

From a candidate's perspective are there any issues/concerns that are regularly raised about the assessment process?

The most common theme expressed by candidates via the trainee survey and to the Australian Medical Council has been about the desire for all candidates to receive feedback about their exam performance. We have listened to this and from 2025.1 we will be able to provide individualised semi-quantitative feedback to all candidates to assist them in identifying areas of competence and also those that need improvement in their remaining training.

This has required a very large body of work with regards to reporting but is an extremely worthwhile initiative and we hope all candidates will enjoy the benefits of it.

We specifically avoided complete quantitative feedback (that is, providing overall exam scores). Passing the final examination is sufficient information to reassure prospective employers or any other interested parties that the candidate has reached the level deemed competent. We were very concerned that the examination score not be used for assessing employability or workplace performance as this was not the intended purpose of the examination.

From an examiner's perspective are there any issues/concerns that need to be addressed or that we have addressed?

The examiner workforce is entirely voluntary and represents a broad spectrum of our fellows. We aim to represent all geographical regions, genders, subspecialty experience and practice models.

The workload for a final examiner is at minimum about 100 hours per year and significantly greater for examiners who serve on FESC.

We are very mindful of the many stresses that modern life places on candidates and also the college staff and examiners and we are constantly striving to improve the balance for all participants.

What impact did COVID-19 have on the college's assessment processes and has the assessment process for candidates improved as a result?

COVID-19 was an extremely disruptive process for examinations. As a communicable disease the greatest risks for mass transmission were our medical vivas (where our patient volunteers faced unacceptable risks from acquiring COVID-19) and the nature of our interpersonal and group interactions.

Unfortunately, the pandemic did result in the cancellation of some examinations, however we strove to minimise the disruption to trainees by utilising technology to facilitate changes around some of the group interactions. We relied on examiners and candidates to act responsibly and ethically to minimise risk over this time.

The greatest change in our exam to emerge from the pandemic was the replacement of the old clinical medical viva with the new medical viva, where we no longer use patient volunteers as examination subjects. This has actually represented an enormous benefit for candidates. The new assessment is much easier to standardise, producing enhanced reliability and consistency. It has reduced location bias and produced a fairer assessment. We initially had great

ABOVE

ANZCA's Final Court of Examiners with Dr Coorey in front row, centre, June 2024.

"From 2025 we will be able to provide individualised semi-quantitative feedback to all candidates to assist them in identifying areas of competence and also those that need improvement in their remaining training."

concern about the loss of the clinical assessment component of the old medical viva, however we are very happy to see the introduction of the patient clinical interaction assessment this year to address this.

What is ANZCA doing now and in the future to demystify the exam process for candidates so they are better engaged with the assessment process?

I am writing having just retired from examining and having served as chair for the past two years. In that time and with the support of the college and EEMC we have been able to improve our reporting of standards, feedback and standard-setting processes.

Final examiners have always willingly provided timely feedback to unsuccessful candidates.

I have also facilitated workshops at various annual scientific meetings to teach supervisors how to support their candidate's preparation and have contributed to podcasts on the same themes.

We have engaged with the trainee committee, education officers, and presented at supervisor of training meetings, and final examiners are involved with all the peak education and assessment teams at the college including EEMC, the Education Development and Evaluation Committee and the Curriculum Review Sub-committee.

At the end of the day, I can say that the college, final exam team and the court of examiners have worked tirelessly to provide a final examination that is fair, equitable, reliable and reproducible.

We recognise the life disruptions that the exam presents for many candidates. However, we are also confident that the examination serves the purpose of both driving learning and for assessing the knowledge and skills required to become a specialist anaesthetist.

We are proud of the quality of our trainees and the high standard that attaining a fellowship of ANZCA represents.

Dr Anthony Coorey, FANZCA
Immediate past chair of the ANZCA Final Examination Sub-Committee

Reflections on an SIMG's journey

FROM LEFT

Dr D'Souza with her daughter Ariadne (left), husband Dr Brendan Dias and daughter Anneke.

Dr D'Souza and Dr Scott Ma, ANZCA's SIMG Committee chair.

When Dr Sharon D'Souza and her husband moved to Australia in 2019 for clinical positions they hadn't ruled out returning to continue practising their specialties in India.

Six years later Dr D'Souza, an anaesthesia registrar, and her husband Dr Brendan Dias, a urologist, are working and living in Melbourne, having completed their transition from specialist international medical graduates (SIMG) to fellowship.

Both now work at Western Health and at the time of publication Dr D'Souza was finalising her SIMG clinical practice performance assessment, the last step before ANZCA fellowship.

Reflecting on her journey from SIMG to ANZCA fellowship Dr D'Souza says her extensive exposure to clinical practice in Australia, first as an intensive care unit registrar in Adelaide and then as an anaesthesia registrar in Melbourne, has been invaluable in adapting to the local hospital system.

"I found that being exposed to the system, having had all that time before I sat the fellowship exam, has been very helpful, otherwise it can be easy to get a bit lost," she explains.

"Looking back now, everything looks easy. At the time you don't know if you're on the right path or if what you are doing is right. It can be very daunting for a person coming into a new country and trying to learn the system of doing things and adapting to a new way of doing things which may be slightly different.

"I realised that in general, the consultants and anaesthetic nurses are very knowledgeable and sometimes all it takes is to start a conversation about a case and that clarifies a lot of things in your head and can help you go a long way.

"Our initial plan was to go back to India as we thought we would do upskilling here and then return after two years. We didn't know what the situation would be here and whether we would get into the system and how far we could go.

"As we spent more time we soon realised we wanted to stay on longer."

After moving to Melbourne from Adelaide in early 2020 Dr Dias started his SIMG process. Their first child Anneke was born in March 2020 just as COVID lockdowns began.

"Everything came to a standstill. I had taken some time off after having my first baby and it was difficult to work without family support.

"I waited for Brendan's process to be completed and then in the midst of all that we had our second child Ariadne in 2022. My ANZCA SIMG assessment was competed in November 2023 and I then took one year of study before I sat the vivas in November 2024. And before that we were both working full time because my parents were able to come over and help out."

Dr D'Souza credits the I-Excel SIMG exam coaching platform, the Australian Society of Anaesthetists' final exam support sessions and the ANZCA Library as invaluable resources for her assessment process.

"As an SIMG there are a lot of resources available to you. It can be difficult knowing what to do and how to use your time particularly if you are working full time as you have to make time to both work and study."

Carolyn Jones
Media Manager, ANZCA

Global development

Celebrating our shared successes in the year ahead

ANZCA's Global Development Committee offers and promotes scholarships and funding to support colleagues in low-middle income countries. Here, committee chair Dr Yasmin Endlich explains how collaboration supports anaesthetists who are our Pacific neighbours.

Collaboration is the cornerstone of progress in global health, and nowhere is this more evident than in the partnerships between Australia, New Zealand, and our Pacific neighbours.

The ability to share knowledge, resources, and expertise across borders strengthens our healthcare systems and improves patient safety for all. In particular, the combined efforts of ANZCA, the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA) in global health initiatives across Papua New Guinea (PNG) and the South Pacific have demonstrated how working together can bridge gaps in education, training, and professional development.

The ability to share knowledge, resources, and expertise across borders strengthens our healthcare systems and improves patient safety for all.

Over the last few years, the ANZCA Global Development Committee (GDC) has supported anaesthetists from PNG in attending the meetings of the Pacific Society of Anaesthetists (PSA) in Fiji to foster collaboration and networking between the regions.

This year, members of the PSA are invited to attend the PNG Anaesthetic Society meeting to further strengthen the ties among the Pacific anaesthetists. Equally, members of the ANZCA GDC have participated in the PSA meetings in Fiji, and this year, members of the ASA's Overseas Development and Education Committee are planning an education session at this year's anaesthetic meeting in Port Moresby.

We will also welcome several anaesthetic colleagues from PNG to this year's ANZCA Annual Scientific Meeting in Cairns. A 90-minute lecture session will focus on various advancements in anaesthetic care in PNG.

Topics will include the management of difficult airway cases, the development of the interventional cardiology unit in Port Moresby, paediatric anaesthesia, and local education and training initiatives. Come and say hi to our closest neighbours, hear their stories, and explore opportunities to get involved.

The ANZCA Health Equity Project Fund (HEPF) is another pathway for ANZCA fellows to support projects in anaesthesia and perioperative care in low-middle-income countries. These funds allow fellows to apply for a grant to support anaesthesia and perioperative care projects. Health equity funds can also support educational programs, training workshops, and other education programs.

As we continue to foster our collaborative relationships, it is crucial to celebrate our shared successes. The commitment of ANZCA, ASA, NZSA, and their Pacific colleagues demonstrates the power of partnership in advancing healthcare equity and improving patient outcomes.

By investing in education, training, and mutual support, we are not only enhancing our own capabilities but also contributing to the sustainable development of healthcare systems in our region.

Together, we can create a brighter future for anaesthesia and perioperative care, ensuring that high-quality medical services are accessible to all.

Dr Yasmin Endlich, FANZCA
Chair, ANZCA Global Development Committee

To donate to global development search 'support our work' on the ANZCA website or scan the QR code.

Building skills for simulation-based education globally

Globally, many adverse healthcare outcomes could be mitigated by improved access to high-quality health care services. Simulation training can be used to support healthcare providers in developing systematic approaches to urgent clinical situations and for focusing on life-saving non-technical skills such as team working, decision making, and situational awareness.

Vital Anaesthesia Simulation Training (VAST) is an Australian not-for-profit company and registered charity focused on overcoming the many barriers to using simulation-based education in low-resource countries. I spearheaded the design and pilot of the VAST Course in 2018 during my year as a Dalhousie anaesthesia global health fellow.

VAST's approach is underpinned by the intentional use of easily accessible teaching resources, dedicated upskilling of the local healthcare workforce as program leads, and scenario design that reflects the most common urgent and emergent cases around the globe. This enables VAST to bring the benefits of simulation to almost any setting. VAST programs now include:

- **VAST Course,** a three-day program offering immersive simulation for perioperative teams to strengthen performance in core clinical and non-technical skills
- **VAST Facilitator Course,** a three-day course focused on rapidly developing skills in the design, delivery and debriefing of simulation scenarios
- **The VAST Foundation Year,** an integrated simulation-based curriculum of 48 modules aimed at first year anaesthesia trainees, and
- **VAST Wellbeing,** a one-day program focused on healthcare provider wellbeing and burnout prevention.

Through the tireless efforts of volunteers and the generous support of organisations such as ANZCA, VAST's programs have now been conducted in 19 countries. More than 500 healthcare providers from 35 countries have been involved in VAST's simulation facilitator training.

In 2022 we conducted the first VAST SIMposium in Rwanda, aimed at reinvigorating our community following the COVID-19 pandemic. Since then, VAST's reach has expanded, yet with this growth we have reflected on key questions bubbling at the surface in our community: "What does effective facilitation look like?" and "How can we foster reflection on simulation facilitation to support skill development?" These questions led me to undertake a PhD focused on codifying the elements of effective simulation facilitation practice in low-resource settings and integrating them into a framework that supports development of these skills. This led to the VAST facilitation observation and rating method (VAST FORM), which has been integrated into our facilitator training and learning resources. We needed an opportunity to test its application in scale and research to build an argument for integration of the VAST FORM within our community of practice.

Supported in part by an ANZCA Foundation research grant, we decided to repeat the success of the 2022 VAST SIMposium, hosted by friends at Aga Khan University in Nairobi, Kenya. In October 2024, we united 60 educators from 21 countries and six continents for the second VAST SIMposium. Delegates at the VAST SIMposium were invited to participate in this multi-national research project. We coordinated four simultaneous simulation rooms and debriefing spaces. There was opportunity to practice scenario facilitation and post-simulation debriefing and

FROM LEFT

Participants at the VAST SIMposium in Nairobi, Kenya; A team works on developing skills in simulation-based education.

to use the VAST FORM to support peer-assessment and conduct of reflective learning conversations on the process of facilitation. SimCapture was used to record all debriefings for subsequent formal analysis of the reliability of the VAST FORM in assessing facilitation performance.

Most of the SIMposium delegates were anaesthesia providers, however there was also representation from nursing, surgery and obstetrics and gynaecology. The program was diverse and not limited to simulation scenarios. The event was designed for knowledge exchange on implementation of VASTs programs. Presentations focused on successes and challenges in offering VAST in diverse settings.

Updates were shared about how people can continue to contribute to the community of practice through, for example, the VAST Meta-debriefing club (an online forum for feedback on debriefing), the VAST steering committee and the VAST scenario bank. New additions to VAST's learning curriculum were also introduced and tested, such as the card game "Take home messages", a novel initiative to gamify and practice core elements of debriefing. Finally, working in small groups of colleagues from the same country, delegates were encouraged to develop five-year implementation plans to support the sustainable future rollout of VAST in their regions.

Enthusiasm during the SIMposium was high. Delegates delighted in engaging with a diverse group of colleagues from around the world who are all bonded with the shared common goal of improving the quality of healthcare and contributing to patient safety globally. I left feeling elated having witnessed the strength and depth of our community. I eagerly await the ongoing work in analysing the data collected during the SIMposium and hope that we will be able to promote another useful resource that advances the quality of healthcare education across the globe.

Dr Adam Mossenson, FANZCA
Consultant Anaesthetist, St John of God Midland Public and Private Hospitals
VAST's founder and managing director

PARTICIPANT FEEDBACK:

"Brilliantly diverse crowd enabled a range of opinions and discussion points raised as well as solutions suggested for different contexts."

"Exposure to a proper and well-structured framework about how to carry on simulation training."

"The interactions with others from varied backgrounds and hearing our common educational challenges."

"Another fantastic day of learning from each other; the wealth of experience in the SIMposium is so enriching."

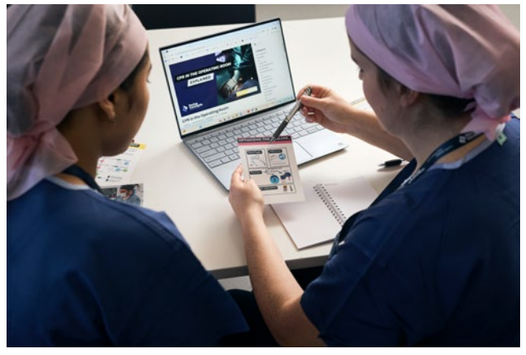
Education in Fiji – an online solution for an urgent problem

A sick child always feels safer in the light of day. When the sun rose on Denarau Island after a sleepless night in 2023, I immediately felt some of the dread lift. My son was 18 months old, febrile and drowsy. We took him to the closest hospital, where a kind local doctor examined him, initiated treatment, and reassured us with a smile I'll never forget. My son improved quickly, and when we left Fiji, I was determined to return a favour one day.

Periop Concepts, a widely used Australian online learning management system (LMS) for perianaesthesia nurses, has a curriculum based on ANZCA's *PS08 (A)* Position statement on the assistant for the anaesthetist, and is endorsed by the Australian Society of Anaesthetists (ASA), the Australian College of Nursing, and the Australasian College of Perianaesthesia Nurses. Its LMS has the unique advantage of overcoming geographical barriers in the education and training of anaesthetic assistants, which has solved significant challenges for Australian rural health networks in recent years.

In late 2023, we discovered there was an urgent need for a structured education program for anaesthetic assistants in Fiji. The ASA's Overseas Development and Education Committee connected us with Dr Akuila Waqanicakau, a Fijian anaesthetist overseeing the training of Fijian anaesthetic technicians. Dr Waqanicakau explained that a sudden shift in local policy had resulted in the existing cohort of anaesthetic technicians being removed from their positions.

Despite sound clinical experience they lacked formal certification from an endorsed training program. The result was devastating f or anaesthetic technicians and Fijian anaesthetists, many of whom have since been practising without a trained assistant. In this meeting, I saw an



opportunity to return a favour to the Fijian health system, and that lovely Fijian doctor who helped my sick son earlier that year.

Fiji, an archipelago in the South Pacific, consists of over 300 islands and has a population of about 900,000 people, with the majority residing on the two largest islands, Viti Levu and Vanua Levu. Its scattered geography presents unique challenges for healthcare access, as well as education and training of healthcare workers. The main referral hospital, Colonial War Memorial Hospital, is in Suva, while Lautoka Hospital serves the western division, and Labasa Hospital provides care for the northern region.

FROM TOP

Dr Jack Madden onboarding perianaesthesia nurses in Hobart during a site visit.

Exampes of the physical and online resources sent to Fiji as part of the Periop Concepts curriculum.

As we have learned through our organisational partnerships in remote areas of Australia, provision of education and oversight of geographically dispersed learners is exceptionally challenging. The Periop Concepts LMS overcomes these challenges by providing an online education program with a "central command hub" for the primary educators. Each learner is empowered with their own library of curriculum-based, on demand content. The supervisors are empowered with comprehensive performance data from their control centre.

To be considered, our global outreach prospects must have:

- An established anaesthetic assistant role in the operating theatre.
- Access to internet with video-streaming capabilities.
- English speaking learners.
- A central supervisor who can distribute and oversee access to the platform.
- A desire to improve safety through online learning.

Fiji met all five criteria for a global outreach partner. We subsequently met virtually with Dr Waqanicakau and a group of anaesthetists based in Suva, Labasa and Aspen Lautoka and upskilled them on the Periop Concepts LMS. We modified the curriculum to suit the region, enrolled 30 anaesthetic technicians and posted a box of our *Anaesthetic Assistant Handbooks* and *Airway Management Guide for Anaesthetic Assistants* to Suva (which took nearly three months to arrive at Akuila's doorstep).

As our curriculum is entirely online, the learners work through the modules on any device, in their own time. Each module has a video lesson with subtitles, a PDF summary document, and a multiple-choice assessment. When an assessment is completed, the learner is emailed their continuing professional development certificate, and their progress is registered on Dr Waqanicakau's educator dashboard providing complete and live oversight.

We would like to extend our gratitude to the motivated group of anaesthetists working with Dr Akuila Waqanicakau to improve the safety standards for anaesthetic assistants in Fiji, and the ASA's Overseas Development and Education Committee for connecting us.

We are confident this program will allow all three Fijian hospitals to reinstate their network of anaesthetic technicians and elevate the safety profile of anaesthesia in Fiji.

Build knowledge. Improve safety.

Dr Jack Madden FANZCA
Founder, Periop Concepts
jack@periopconcepts.com
www.periopconcepts.com

Dr Madden is the founder of Periop Concepts, an online education provider for anaesthetic nurses and technicians. Dr Madden is an anaesthetist based in Hobart.

ABOVE

Anaesthetic technicians in Suva enjoying online modules in the Periop Concepts Learning Management System.

Advancing research and collaboration: Recent highlights

The ANZCA Clinical Trials Network (CTN) continues to advance medical research and collaboration through recent events, including the SA/NT Trainee Research Day and the 8th Global Alliance of Medical Excellence (GAME) meeting. These initiatives highlight the network's commitment to evidence-based practice, international partnerships and improving patient care in perioperative medicine.

SA/NT TRAINEE RESEARCH DAY

The SA/NT Trainee Research Day convened by Dr Amy Chapman provided a valuable opportunity for 20 early-career trainees to engage with research and explore its potential impact on their careers.

The November event (see page 74 for more) featured an impressive lineup of ANZCA CTN speakers who shared their expertise and practical advice. Dr Fiona Taverner emphasised the transformative role of research in clinical practice, highlighting the rewarding opportunities for global networking, conferences, and lifelong connections. Dr Kate Drummond provided guidance on clinical trials, covering governance, ethics, and opportunities such as contributing to *Australasian Anaesthesia*, also known as the "Blue Book".

Emeritus Professor Pamela Macintyre inspired attendees with reflections on her lifelong dedication to evidence-based practice and advancing pain medicine, while Professor Tomás Corcoran discussed the importance of critically evaluating research to ensure robust findings. He addressed research waste, harmful practices, and the critical role of randomised controlled trials in evidence-based medicine.

Dr Adam Badenoch delivered an insightful session on mitigating biases in clinical trials, the importance of statisticians in research design, and the value of pursuing a PhD to develop expertise in research methodologies. Mr Rob Packer shared information on grant and mentoring opportunities, and Ms Karen Goulding outlined CTN's achievements.

The day also featured a workshop on storytelling skills, equipping trainees with tools to effectively communicate research narratives to diverse audiences. Networking opportunities enabled trainees to connect with peers and mentors, leaving them inspired to pursue research pathways that enriches clinical practice and improves patient outcomes.

8TH GLOBAL ALLIANCE OF MEDICAL EXCELLENCE (GAME) MEETING

Professor Paul Myles delivered the keynote address at the 8th Global Alliance of Medical Excellence (GAME) meeting, hosted by Monash University. GAME is a global network of eight universities dedicated to advancing medical research and education, including institutions from Australia, Italy, Hong Kong, the Netherlands, Sweden, Japan, the UK and Germany.

Professor Myles' presentation, *"Australian and New Zealand College of Anaesthetists Clinical Trials Network (ANZCA CTN) – A Clinician's Perspective,"* showcased ANZCA CTN's achievements and its commitment to collaboration. The event highlighted the value of global partnerships in advancing medical science.

Earlier, Professor Myles hosted Victorian Health Minister Mary-Anne Thomas at The Alfred hospital, discussing perioperative clinical trials and their integration into public hospitals to inform clinical practices.

ABOVE

Professor Paul Myles delivering the keynote address.

SA/NT trainees learn how to get a start in research

When questioning a trainee on their current priorities, the responses usually focus on improved regional skills, gaining further independence in complex cases or finally figuring out how to crack the propofol vial without it shattering into a million pieces.

For many trainees, research can seem like a daunting challenge that is difficult to overcome.

On 30 November South Australia held its first research day for trainees at the Lion Hotel in Adelaide. The premise was simple: Research is important and here's how to get started in it.

Topics covered included focusing on why research matters, the benefits of research to a clinician, how to approach a higher degree by research, finding a topic of interest, utilising the ANZCA Library for research, recognising poor-quality research and how to begin thinking about statistics.

Trainees also learnt about the many avenues for research including WebAIRS, *Australasian Anaesthesia*, also known as the "Blue Book", case reports and single-centre trials.

The ANZCA Clinical Trials Network ran a panel on the many opportunities for a novice investigator to get involved in multi-centre randomised controlled trials and discussed the CTN strategic workshop in August 2025 which will have a special section for trainees.

The ANZCA Foundation also discussed the avenues for grant funding.

Trainees ended the day equipped with an understanding of their place in the research world and a pathway to take the next steps in their journey.

There is a lot of support from ANZCA and its members to help trainees.

Events such as the research day depend on the passion our speakers bring to the day and trainees were fortunate to hear from some of Australia's best doctors.

Thanks to our sponsors: the Australian Society of Anaesthetists, GoLocum, Ashford Private Hospital and Advanced Resuscitation Training.

Thanks to ANZCA's Alison Cook for organisational assistance and thanks also to our speakers Dr Yasmin Endlich, Dr Mark Plummer, Dr Kate Drummond, Associate Professor Edoardo Aromataris, Dr Fiona Taverner, Dr Adam Badenoch, Professor Bernd Froessler, Emeritus Professor Pamela Macintyre and Dr Ben Lewis, and to CTN's Professor Tomas Corcoran and Karen Goulding.

Thanks must also go to the ANZCA Foundation's Rob Packer and the Emerging Investigators Sub-committee for their support.

We can't wait for the next trainee day.
Dr Amy Chapman,
anaesthesia trainee
Convenor, ANZCA SA/NT Trainee Research Day

If you would like to support grants for our emerging investigators, please donate via "GiftOptions – ANZCA" in your browser or scan the QR code

ABOVE

Participants at the ANZCA SA/NT Trainee Research Day.

Library news

FREE OPEN-ACCESS PUBLISHING NOW AVAILABLE

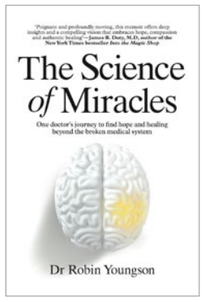
ANZCA has signed an agreement with *Springer Medicine* publishing which provides ANZCA researchers with the opportunity to publish their articles open access at no-cost in Springer/Palgrave hybrid journals.

This includes such journals as: *Journal of Anesthesia, Canadian Journal of Anesthesia, Current Pain and Headache Reports and Intensive Care Medicine,* plus many more.

This deal provides publishing opportunities for ANZCA (and CICM) fellows and trainees who may not have access to deals available through most Australian and New Zealand universities.

This arrangement is the first in what is hoped to be a series of deals with all our major journal vendors, that allows our researchers to make their publications freely available for anyone to read.

For more information on this deal and how to access the no-cost publication option, see our new *Open access publishing via ANZCA* guide.



THE SCIENCE OF MIRACLES

Dr Robin Youngson, FANZCA, the recipient of the 2016 NZMA Chair's Award for outstanding contribution to the health of New Zealand' has recently published his memoir *The Science of Miracles.*

His memoir is a riveting account of his many struggles to improve healthcare quality and safety, to enhance compassionate caring, and ultimately to help people heal.

It shows how trauma and PTSD can be rapidly cured, including the relief of chronic pain and other physical health conditions. Anaesthetists attending his clinic have described the experience as "life-changing".

Dr Youngson has kindly donated a copy of his book to the NZ Office and a second copy has been purchased for the Australian office. Both copies will be available for loan and can be requested at the following link: https://anzca.on.worldcat.org/oclc/1492589560

TRAINING GUIDES UPDATE

The Assessments section of the Anaesthesia Training Resources (ATR) guide has been updated to include a new Introductory Training (IT) assessments page. This page contains the learning outcomes, forms and resourcing to be used with the assessments.

The new Patient Clinical Interaction Assessment (PCIA) page is also in place and contains the PCIA implementation guide, forms and resourcing to be used with the PCIA assessment.

Stay up-to-date on any ATR guide and resourcing updates with the newly added updates blog feature. Trainees and anyone involved in training can subscribe to this blog to receive notifications of information and resource updates via e-mail.

Both the Pain Medicine Training resources guide and the Perioperative Medicine guide have also been updated with latest news/blogs pages, which also allow users to subscribe to any updates made.

Latest books

For the latest updates and a complete list of new titles check out the library news page: libguides.anzca.edu.au/news

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

Geoffrey Charles Mullins

1943 – 2025

Dr Geoffrey Mullins grew up in Moonee Ponds, Melbourne where he attended a technical school for his early high school education before being accepted into University High School. Aged 16 he was awarded a Commonwealth scholarship to study medicine at the University of Melbourne and in 1967 was awarded a Bachelor of Medicine, Bachelor of Surgery.

Geoff courted Suzanne Gordon throughout his study, and they married in 1968. Geoff undertook his medical residency in Hobart where he and Sue had their first child, Sophie. Geoff's medical career spanned Tasmania, Western Australia, Victoria and Canada.

In 1970 he worked as a medical registrar in respiratory medicine at Sir CharlesGairdner Hospital in Perth.

In 1971, having returned to Melbourne, he pursued training in anaesthesia at St Vincent's, the Royal Children's Hospital (RCH) and the Royal Women's Hospital.

Geoff completed his fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1972 and took up an appointment as staff anaesthetist at the RCH, largely cementing his career in paediatrics.

From 1974-1975, Geoff held appointments as medical officer to the intensive care unit (ICU) and staff anaesthetist at the RCH as well as working as a visiting anaesthetist at St Vincent's Hospital. He credited his interest and clinical skills in paediatric intensive care to his association with the late Dr John Stocks.

Geoff took over from Geoff Barker as director, ICU at RCH in 1976 and held the position until 1981.

Paediatric intensive care was considered a very new specialty then and Geoff can rightly be considered one of its pioneers. He was an astute clinician, technically adept, a superb teacher and above all, a compassionate doctor. By 1977 when he was named the Victorian Father of the Year he had four children: Sophie, Kara, Luke and Sean.

In 1981, Geoff relocated with Sue and their four children to Toronto as assistant director, ICU at the Hospital for Sick Children (HSC), a position that he held until 1987, when he returned to fulltime paediatric anaesthesia at HSC.

Geoff returned to Perth in late 1992 as director, paediatric anaesthesia at Princess Margaret Hospital (PMH). Geoff embarked on expanding the department and served as an ANZCA examiner for 12 years while continuing to pursue overseas medical aid work.

From 1998 to 2002, Geoff worked as a consultant anaesthetist in Warrnambool, Victoria. Geoff had a love of the Western District farmlands and enjoyed family connections there. Warrnambool was also where he met Kylie Mahony who was to be his partner for the rest of his life. He returned to Perth and the anaesthesia department at PMH in 2002 to be close to his four children and their families.

Later in his career Geoff undertook teaching at the University of Notre Dame Medical School in Fremantle. He enjoyed investing his time and energy in bringing out the best in aspiring doctors.

Geoff had a great adventurous spirit. This took him to many fascinating and diverse places. As a doctor he provided medical expertise and aid to the Papua New Guinea Highlands, East Timor, Japan, China, Kenya, Honduras, Micronesia, United Arab Emirates, Saipan, Taipei, Cuba and remote northern parts of Canada.

Outside work Geoff had a lifelong passion for running, cross-country skiing, swimming, rowing and kayaking.

On top of these passions, he and his partner Kylie were avid long-distance walkers and together they covered thousands of kilometres hiking through multiple different countries. His favourite distance walks were the camel treks across Australia's Simpson Desert. Geoff also loved to both read and write. He had published works in multiple medical journals and newspapers. Most of these publications were funny and heartfelt stories that he drew on from his extraordinary medical career. These stories gave an insight into Geoff's compassion as a doctor and as a person.

Geoff will be remembered by many medical colleagues, students and patients for his kind and compassionate approach. His partner, friends, family, four children and seven grandchildren will remember him for his kind and loving nature, generosity, humility, wisdom, sense of humour and his zest for life.

Dr Alan Duncan AM
on behalf of Kylie Mahony and the Mullins family

Edward Hunter "Ted" Morgan

1926 – 2024

Ted Morgan was the last of the original directors of anaesthesia.

In the 1960s, hospitals began formalising departments of anaesthetics and appointing directors. Doug Joseph, firstly at Sydney Hospital and then at Prince Alfred; Brian Dwyer at St Vincent's and Ted Morgan at Royal North Shore.

In Ted, Royal North Shore found a great administrator, a compassionate caring man who was fiercely loyal to his staff.

They were exciting times. The hospital was about to graduate from a cottage hospital to a modern tertiary institution. In 1971 work began on the new building, with the promise of modern theatres and, for the first time, an intensive care unit.

In 1974 potential disaster struck, the builder went broke.

Fortunately, led by Sir Lincoln Hynes, the hospital board sprung into action. Within days the hospital superintendent, Roger Vanderfield and Ted Morgan were the owner builders of the new building, which was successfully completed.

Ted had had an accident as a youth and had a glass eye. Some wag had placed a sign above the entrance to the theatres, which read "In the land of the blind the one eye man is king". Many in theatres thought this was appropriate.

In the 1970s there were no mobiles, no faxes, no emails – just phones. Ted would occupy a seat by the theatre phone, overindulge in milk arrowroot biscuits that he had lavishly covered in butter and run the Australian Medical Association, which he was president of.

In those days the hospital supplied lunch and morning teas – thus the biscuits. This inevitably led to a weight problem to be followed by a period of severe calorie restriction and great irritability.

We learnt to tread carefully when Ted went on a diet.

In 1974 Michael Cousins returned from Stanford University in the US and started a chronic pain clinic. Within a year Michael was offered the professorship at Flinders Medical Centre in Adelaide and Ted became the director of a fledging chronic pain clinic. The concept of chronic pain was very new and Ted and myself had no training in this new field.

We muddled through and Ted's compassion for his patients greatly helped, even, as many a time, we felt not a lot was being achieved.

Ted retired at 65, compulsory at that time, to enjoy another 30 years of companionship with his beloved Claire, charitable work and his church.

Dr David Cay, FANZCA

Geoffrey Joseph Long

1935 – 2024

Photo: Courtesy Long family.

Geoffrey (Geoff) Long, who died on 23 September 2024, was one of the first generation of anaesthetists involved in multidisciplinary human pharmacological research on clinical anaesthesia in Australia. Such research began in the US during the 1950s, most notably at Columbia University-Presbyterian Hospital, New York, in other centres such as Montreal and Edinburgh in the early 1960s, and then in Sydney, London and Seattle in the mid-1960s.

Geoff was born in Cootamundra, NSW on 3 July 1935 to Michael Long, a station master, and Frances née Bermingham, as the youngest of three sons. The middle son Peter, who was three years older, died aged three. At St Ignatius College Riverview where he completed his secondary education Geoff was encouraged by one of the priests to study medicine, as his older brother Frank had done. At Riverview, Geoff absorbed Jesuit intellectual ideals and respect for rigour which would later cause him, in some eyes, to be branded as a "troublemaker"[1]!

While studying medicine at the University of Sydney (1953-59), Geoff became interested in film. He continued with this passion throughout his life, including completion of David Stratton's five-year Sydney University course on the history of cinema. As a fourth year student he met Ann Burn, then a first-year medical student. They married in 1962 after Ann had graduated and then travelled to London where Geoff undertook the primary and final courses for the fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) examinations, with anaesthesia training at the Middlesex Hospital.

In September 1964 the family moved to Philadelphia for Geoff to work at the University Hospital where Robert Dripps, coauthor of the famous textbook *Introduction to Anesthesia*[2], was chair of the department. The following year Geoff became a fellow at the world-renowned Philadelphia Children's Hospital where Jack Downes, later its chair and eminent visionary figure, was a young staff member. At that time these were two of the top training jobs in anaesthesia anywhere in the world. To extend his knowledge, during his time in Philadelphia, Geoff also attended a course in Chicago on medical education run by the world-famous educationalist George E Miller, initiator of the famous education pyramid[5].

In April 1967 the family returned to Sydney where Geoff took a staff position at King George V (KGV) Hospital (obstetrics) within the Royal Prince Alfred Hospital (RPAH) to provide anaesthesia specifically for obstetrics and gynaecology. At that time there was no obstetric epidural service at KGV, and Geoff instituted this service when the only other such service in Sydney was being run by Dick Climie at the Royal Hospital for Women. There was resistance to this service from other members of the anaesthesia department at RPAH[4], and so Geoff had to provide it around the clock, week in, week out. After years of unsuccessfully petitioning for additional help, he had enough and resigned. Almost immediately, the extra staffing was provided to continue the service!

Geoff was also responsible for improvements in neonatal resuscitation and care, driving the introduction of the John Spence Neonatal intensive care unit in 1971[4]. In 1969-70, he was part of a departmental group of four led by Professor Douglas Joseph that produced the report *on Training of Anaesthetic Residents & Registrars*, which had a major influence on the Faculty of Anaesthetists of the Royal Australasian College of Surgeons as it was the only academic anaesthetic department in Australasia at that time.

Almost from the start at KGV, Geoff introduced new techniques. One of these was using a metered dose of topical lignocaine spray to the vulva and perineum for analgesia during delivery and for episiotomy repair[5]. His curiosity about the systemic absorption of lignocaine from this procedure led him to participation in a recently formed collaborative research program initiated by Dick Climie and John ("Jack") Thomas, who was then senior lecturer in medicinal chemistry at the University of Sydney. This collaboration essentially became the "genesis of chemical-clinical pharmacology in Australian anaesthesia"[6]. Geoff's next collaborative contributions came with studies of the then-new local anaesthetic agent bupivacaine and the older agent mepivacaine. These will remain among his major contributions to Australian anaesthesia research.

The initial collaborative research group was soon joined by Colin Shanks, also a staff anaesthetist at RPAH. Not only did these early collaborations lay the groundwork for human pharmacological research in anaesthesia they also provided the framework for University of Sydney postgraduate research degrees for 10 scientists, many of whom continued with similar research in other departments, thus spreading the collaborative research model in anaesthesia throughout Australia and New Zealand.

The lack of support from colleagues at RPAH led to Geoff's resignation to take a position as medical officer to the Australian Embassy in Rome in 1974, a move he acknowledged wasn't ideal professionally but proved invaluable and beneficial for his family[1].

In November 1975, Sir John Kerr sacked Gough Whitlam, and the new Fraser government disestablished the medical officer position in Rome. On his way back to Australia Geoff returned to Philadelphia in 1976 for a year to update his anaesthetic practice. While there he also undertook training in hypnotherapy, which became a part of his medical practice.

Around this time Geoff was offered a position as an obstetric anaesthetist at the then-new Flinders Medical Centre, but this was soon withdrawn because of his "reputation" mentioned earlier[1,4]. In 1977, Geoff took a half-time position at Lewisham Hospital, and also developed his hypnotherapy practice, accepting that his Rome appointment had effectively ended his wish to return to obstetric anaesthesia. When Lewisham Hospital closed in 1987, Geoff planned and set up the anaesthesia services for the new Warringah Mall day surgery which opened in August 1989, retiring from that position and anaesthesia at the end of 1995. Until his retirement he continued with his hypnotherapy practice which he found rewarding.

In 1966, their second year in Philadelphia, the family lived in a Civil War mansion on 300 acres which had been gifted to the city to become the Schuylkill Valley Nature Centre. This experience led to Geoff's interest in all things botanical and eventually to an intense interest in Australian flora. In retirement, the Longs regenerated rainforest at Foxground on the escarpment near Gerringong, NSW, with indigenous plants of the Illawarra Region and provided seedlings to the national, Wollongong and Sydney Botanic Gardens.

Geoff was the botanist on several conducted trips on WA wildflowers and organised talks for the Friends of the Botanic Gardens. He was made a director of the Australian Shareholders Association (yet another ASA!) in 1998, and organised their educational sessions for many years. In 2016, Geoff and Ann left their regeneration project to downsize to the historic Astor Apartments near the Sydney Botanical Gardens. It was from here that they wrote their submission to the NSW Standing Committee on Social Issues about concerns over loss of heritage due to government sanctioned development[7]. Geoff had been concerned about climate change for many years and, because of that, chose to have his remains aquamated.

Geoffrey Joseph Long is survived by his wife Ann, children Airdrie, Naomi, Elisha, Toben, Georgina, and Quentin, 16 grandchildren and one great grandchild.

We salute one of the pioneers of human pharmacological anaesthetic research in Australia.

AB Baker AM
Emeritus Professor, University of Sydney

LE Mather OAM
Emeritus Professor, University of Sydney

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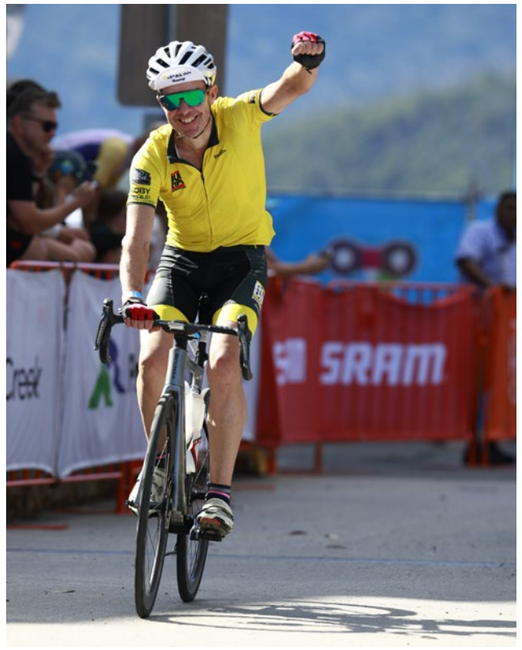
Michael Hicks

1972 – 2024



Michael Hicks, best known to us as Hicksy, but as Mike to his wife and family, was born in Papua New Guinea in 1972 and grew up in Sydney. A bright and sporty child who excelled in maths and all forms of physical activity, he was dearly loved by his parents and little sister Sophie.

His first career was as a metals trader with Macquarie Bank. After a decade of doing whatever it is that metals traders do (we wish he was still here so we could ask him), Hicksy felt unsatisfied with his work; he needed to do something else with his life. And so he left the corporate world to study medicine at the University of Newcastle.

He graduated with distinction in 2009 and went on to undertake his anaesthesia training at John Hunter Hospital in Newcastle. From all accounts, Hicksy made training look easy. He sailed through his exams, before completing a fellowship with the Hunter Simulation Centre in 2017, where he honed his encouraging and thoughtful teaching style. He features in many of the simulation centre training videos and he enthusiastically, with the tiniest of nudges, took on the role of researcher. A passionate educator, on one occasion he combined his athletic ability and educational skills to teach a registrar how to swim.

He met his future wife Sammi during this journey through training, and they welcomed their first child Joe into the world in 2009. Their family grew with the arrival of Phoebe in 2014. Hicksy adored his kids. He was a proud dad who loved to share stories of their achievements, such as when Joe was interviewed for his volunteer work, or when Phoebe cleaned up at the swimming carnival. He shared his brilliant sense of humour and a deep love with his wife Sammi.

Hicksy was competitive. As a triathlete he competed in multiple Ironman races, pushing himself to be the best he could be. He was into cycling before it was cool. In 2024 he contested the Peaks Challenge, a gruelling cycling race in Victoria's high country. Despite all the jokes about his old man status he outperformed most in brutal conditions. He loved training, racing, and watching almost all sports. He was a tragic Swans and Eels fan, and if there was a bet to be made, that's where the old Macquarie Bank Hicksy came out, sniffing out arbitrage at any opportunity.

Hicksy was a listener, one of the rare people who gave you their full attention when you were talking. He made you feel valued and important, as long as what you were saying made sense. Otherwise he would give you "the look"– a cock of his head to the side, a half-smile and a "are you sure about that?". He was intelligent and insightful, and passionate in his ideas and opinions. He had a deep appreciation for good journalism, likely borne from his father's career at the *Sydney Morning Herald*.

Hicksy was a wonderful anaesthetist. He would be remembered by patients for his kindness and friendly nature, name checked on subsequent theatre visits. He would ask patients for their favorite song and play it as they went off to sleep. His theatres were relaxed, friendly and supportive, full of word games and humour. For many of his colleagues, he was the anaesthetist they asked to look after family members, the highest mark of respect in our profession.

Hicksy was a father, a husband, a friend, an athlete, an anaesthetist. He was kind. He was the inspiration for a Kickr bike purchase. He loved talk-to-text. He hated talk-to-text. He relished word puzzles. He was a BBQ connoisseur. He was the king of one liners. He was never afraid to mince words. He could quote from any song or movie. He was obsessive about perfect grammar. He could sing. He was beaten by his primary school-aged daughter in a swimming race. He loved to go for a run with his teenage son. He adored his wife.

Hicksy, for all of his light, carried a deep sadness too. And this was what took him from us, our wonderful friend, husband, father, colleague.

It has been so clear in the months after his death how deeply loved he was. The loss we feel, the hole in our lives, is indescribable. But life continues on regardless of the pain and hurt, and so all we can do is try and honour our friend – by being good to one another, finding the humour in everything, and really, really listening, the way Hicksy would.

Dr Danielle White, FANZCA

Dr Dana Perrignon-Roth FANZCA
Department of Anaesthesia and Pain Medicine
John Hunter Hospital

Support services are available through the following 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

Keith Chan

1966 – 2025

We share with you the recent passing of Dr "Keith" Kwai Tung Chan, an esteemed and well-known specialist in rehabilitation medicine and pain medicine in Canberra and the surrounding region. His passing allows one to reflect on the diversity and breadth of specialists in pain medicine, particularly of and for those not of anaesthetist background.

With his young family, Singaporean Keith arrived here in 2007 having trained extensively in the United States (original medical degree obtained in Dublin), having obtained board certification in both of these specialties, including some interventional pain. Each of these were subsequently recognised in Australia. Keith was recognised as a fellow of the Australasian Faculty of Rehabilitation Medicine (AFRM) in 2004, and a fellow of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists in 2014. He was a 25-year member of the American Academy of Physical Medicine and Rehabilitation (AAPM&R), and published several academic research articles in this field between 2000 and 2006, while at the Baylor College of Medicine, Houston, Texas. He was also a clinical senior lecturer at the ANU Medical School.

He provided an invaluable service primarily as a staff specialist in rehabilitation medicine at the Canberra Hospital. He played a big role in the transition of inpatient rehabilitation from the Canberra Hospital to the specially designed and built subacute care University of Canberra Hospital.

His expertise was critical in establishing a multi-disciplinary spasticity assessment clinic. He was responsible for the mentorship, supervision and training of dozens of medical officers and advanced trainees throughout his career. He also trained other Fellows in procedural skills, passing on his knowledge with self-deprecation, humour and enthusiasm.

Keith was a kind and humble physician who advocated for holistic care – not just physical recovery, but emotional and psychological wellbeing. His clinical philosophy was centred on kindness and respect for the dignity and autonomy of his patients, and advocacy for a patient centred approach. We all know of patients who had the opportunity to try, fail, try again, succeed and ultimately thrive, as a result of Keith's advocacy, expertise, judgement and compassion. With Keith's support, many patients were able to regain independence and reintegrate into their homes and communities, and avoid a lifetime of dependency and institutionalisation.

Much of his private practice was in pain medicine at Capital Pain and Rehabilitation Clinic where he excelled in patient-centred care with judicious use of medications and interventions in the context of educating and optimising a patient's self-management and self-care. As happens with physiatry training in the US he provided a valuable clinical electrodiagnostic neurophysiology service along with his interventional pain expertise, reflecting his multiple talents so humbly applied.

With his passing and making his peace with his medical condition, we his colleagues, staff and most obviously his patients, who were so important to him, strive to maintain his ethos of good will, equanimity, great humour, ever-ready sage and calming advice, and easy-going view of the world. His enthusiasm for the themed annual Christmas events at Capital Pain and Rehabilitation Clinic are seen in the accompanying example, left, another time being how none of us recognised his arrival as Eminem with associated mimicry!

He has left a profound and lasting legacy, in his high standard of clinical care, his mentorship and leadership, and in the many lives that he has touched.

Our heartfelt condolences are shared with his wife Lynn, daughter Janine, and son Sean.

Vale, Dr Keith Chan.

Dr Geoffrey Speldewinde, FFPMANZCA, FAFRM(RACP),
Capital Pain and Rehabilitation Clinic, ACT Canberra

Dr Phillip Gaughwin, PhD, FAFRM(RACP),
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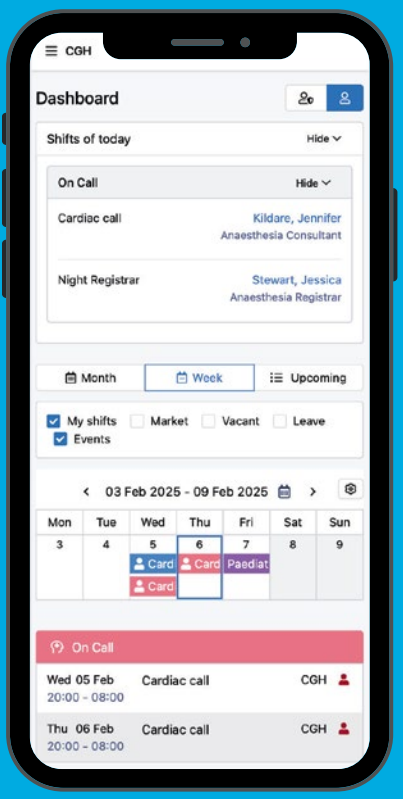

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