Bulletin

ANZCA
FPM

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

SUMMER 2022

$A2 million for 2023 ANZCA research grants

Retirement ready:
Helpful hints for a successful transition

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Cover image: ANZCA research grant recipients Dr Marta Seretny (left) and Dr Carolyn Deng from Auckland City Hospital (Photograph: Brett Phibbs).

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

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New college strategic plan a roadmap for risk

Over this year ANZCA has created a strategy for the organisation that will guide us from 2023 to 2025. We have moved from our previous five-year strategic plan to a three-year plan in recognition of the rapid pace of change in our environment.

Formulation of the strategic plan involved widespread consultation both within and external to our organisation including a consideration of risks and threats.

Risk is an interesting topic that no serious organisation can ignore but I wonder how many had a pandemic that would stop the world in its tracks on their risk register in 2019?

We certainly didn't but fared well by being responsive, adaptive and relying on the goodwill of our fellows to allow our training program to continue.

Our risk register is a comprehensive document that lists all our known and potential risks and puts them into context by assessing their significance and likelihood and then considering mitigation strategies.

The risk register is a living document that is reviewed and regularly updated by the Finance, Audit and Risk Management Committee and ANZCA Council.

I would like to outline some of the threats and risks for ANZCA that have informed our strategy.

Firstly, we are lucky to have a large volunteer workforce that is essential in allowing us to function and is involved in all aspects of college activity.

I once calculated the time put in by final examiners to prepare and deliver each exam at more than 2500 hours. This would be similar for the primary exam and represents an enormous effort from this dedicated group of individuals who represent just one facet of the volunteer army.

We do this because we see value in the work and understand it ultimately results in better training outcomes and patient care. However, there is a risk that ANZCA does not continue to nurture this relationship with our fellows.

Hopefully our new strategy will continue to support, engage and encourage new fellows to get involved.

The second risk is the potential encroachment of other providers into our traditional workplace. This is an increasing phenomenon, fuelled by COVID-19 and already happening in other areas and specialities such as pharmacy prescribing and the suggested use of YAG lasers by optometrists.

In our specialty the threat of nurse anaesthetists is real, as evidenced by the 50,000 or so certified registered nurse anaesthetists (CRNAs) in the US who are pushing for more independence in the workplace.

These changes are driven by perceived anaesthesia shortages, pressure from other providers and a desire by some to reduce the influence of the specialty medical colleges who are strong advocates of safety and quality. We need to remain strong in this space.

Lastly, there is the ever-changing regulatory environment around us.

It should generally be well known by now that the Medical Board of Australia and the Medical Council of New Zealand are changing continuing professional development (CPD) requirements. One of the main drivers is the concern about doctors who are currently not registered for CPD – highly unlikely for anaesthetists.

The excellent team at ANZCA, led by councillor Deb Devonshire, is well placed to handle these changes but they were essentially introduced with minimal consultation from the specialty colleges and have created problems that may have been avoided.

We have also recently been challenged on use of the term "diploma" by the Tertiary Education Quality and Standards Agency (TEQSA) which is the regulatory body that accredits educational organisations. Many colleges offer diplomas which are often targeted at sub-specialty areas or general practitioners, particularly in rural areas.

This dilemma, which could impact our diplomas in perioperative medicine and rural generalist anaesthesia, is being negotiated.

In addressing these issues and interacting with these organisations we aim to remain a respected and trusted voice.

Every decision we make at council should be consistent with our new strategic plan and be made with a full recognition of the risks.

So as you will see in more detail on pages 20-21, we will Lead, Engage, Support and Sustain from next year when our new strategic plan commences. This will give us a roadmap to complete the many projects we are engaged in and manage any on the road.

As the year comes to an end I would like to thank council, our chief executive officer Nigel Fidgeon, all the ANZCA staff and the many fellows who work tirelessly for our profession.

Have a great festive season, try and have a break and recharge for next year!

Dr Chris Cokis
ANZCA President

Upcoming elections

ANZCA COUNCIL ELECTIONS

Fellows are invited to nominate for four vacancies on the ANZCA Council.

Prior to submission, each nomination form must be signed by two fellows of the college, as well as by the nominee and submitted to the chief executive officer before 5pm (AEDT) on Friday 3 February 2023.

If the number of nominations exceeds the positions vacant, an election will take place from 9am Monday 20 February to 5pm Monday 20 March 2023.

Results of the ballot will be announced at the ANZCA Annual General Meeting which will be held on Monday 8 May during the 2023 ANZCA Annual Scientific Meeting in Sydney.

FPM BOARD ELECTION

The call for nominations, for two elected vacancies on the 2023 FPM Board closed on the 28 November 2022. The number of nominations has exceeded the number of vacancies, so the faculty will proceed to a ballot in January 2023.

Further details on the FPM Board election process can be found on the website.

Results of the ballot will be announced at the FPM Annual Business Meeting which will be held on Sunday 7 May during the 2023 ANZCA Annual Scientific Meeting in Sydney.

ANZCA AND FPM REGIONAL AND NATIONAL COMMITTEE ELECTIONS

The next elections for ANZCA and FPM Australian regional committees and the New Zealand National Committee (NZNC) elections will be held in 2024.

The next FPM NZNC election will be in 2023.

ANZCA TRAINEE COMMITTEE ELECTIONS

The call for nominations and elections for the ANZCA Australian regional trainee committees were held in the last quarter of 2022 and have now closed.

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

2022-2023 ELECTIONS

Election	Nomination period	Election date
Australian regional and New Zealand National trainee committees	10 October 2022 – 28 October 2022	11 November 2022 – 25 November 2022
Faculty of Pain Medicine Board	26 October 2022 – 28 November 2022	14 January 2023 – 30 January 2023
ANZCA Council	9 December 2022 – 3 February 2023	20 February 2023 – 20 March 2023
FPM NZNC	1 February – 28 February 2023	20 March 2023 – 7 April 2023

If you intend to vote in any of the elections, please ensure your preferred email address is up to date on the MyANZCA Portal (www.anzca.edu.au/portal) or by contacting ceo@anzca.edu.au. To avoid your voting keys going to spam folders, please add noreply@electionrunner.com to your safe sender list.

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

Changing landscape a test for us ahead of new year

As 2022 draws to a close it is time to reflect on yet another turbulent year and the environment in which the college continues to navigate.

This year has indeed been busy – made more challenging at times due to the lasting effects of the pandemic and its impact on much of our activities. In 2022 we again successfully delivered the anaesthesia and pain medicine training programs and exams in Australia and New Zealand. That we were able to achieve this in a challenging environment is a credit to our examiners and staff and, of course, the trainees who had to deal with the added stress of ongoing COVID-19 complexities.

The college's Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) reaccreditation process in July involved significant work for college staff and ANZCA Council as we prepared our submission ahead of the on-site assessment.

While we submit yearly reports against the AMC and MCNZ accreditation standards we are required to undergo a full reaccreditation every 10 years. We will be formally notified of the outcome in early 2023, however preliminary results indicate the college will continue to retain accreditation to deliver all training programs for anaesthesia and pain medicine.

The reaccreditation process occurred at a time of increasing compliance and regulation to ensure ANZCA is responsive to the changing landscape by meeting the requirements of various government departments.

We are all aware of how the recent challenges thrown at us by the pandemic have affected the health workforce and our own fellows, trainees and specialist international medical graduates (SIMGs). Not surprisingly, the health sector is taking centre stage in national policy debates in Australia, New Zealand, and globally.

The need to support the wellbeing of frontline health staff and specialists is now recognised as a crucial part of workforce policy and planning. ANZCA has been a leader in this space for some time and our Doctors' Support Program and Critical Incident Debriefing Toolkit are just some of the resources we provide to fellows, trainees and SIMGs.

Governments in both countries at all jurisdictional levels are having to prioritise health reform and resourcing issues to address workforce pressures so they can continue to maintain safe and quality delivery of health services. ANZCA continues to actively engage with governments on key issues including safety and quality of anaesthesia, the provision of prescription medication through Australia's Therapeutic Goods Administration and Medicare Benefits Schedule rebate fees.

ANZCA's involvement in the Australian government's Specialist Training Program also ensures we have a respected voice with government when it comes to workforce planning and the future provision of much-needed specialists across rural, regional and remote sites.

It is likely these pressures will continue into 2023 and beyond as a fatigued workforce readjusts to the "new normal" of the post pandemic world.

The college continues to forge ahead as a world leader in the provision of specialty education and training. There has been significant progress across a range of our strategic priorities including the development of new qualifications in rural generalist anaesthesia, perioperative medicine and the Faculty of Pain Medicine's procedures endorsement program.

These priorities are supported by ANZCA's lifelong learning project. We have been reviewing our existing programs and systems with the aim of improving the online educational experience for our members. The lifelong learning initiative will lead to the implementation of a suite of new electronic interactive platforms that will support all college activities and services.

I would like to acknowledge the significant time commitment provided by ANZCA councillors and the many fellows who contribute so much to the day-to-day role of the college in supporting trainees, committees and professional development for the anaesthesia and pain medicine community.

I would also like to thank the staff of ANZCA who have continued to ensure the work of the college continues, despite the many trials we have all experienced as a result of the ongoing impact of the pandemic and the ramifications this has had on our daily lives.

Here's hoping that 2023 will be a year of fewer surprises.

Nigel Fidgeon
ANZCA Chief Executive Officer

Letters to the editor

VIGILANCE NEEDED ON OFFICE-BASED PROCEDURES

I refer to the report in the Winter 2022 edition of the college *Bulletin* entitled "ANZCA and the coroner; Cardiorespiratory arrest following propofol administration in a dental practice".

The coroner was not able to conclude that the patient's death was preventable.

I am deeply concerned that the inquest was able to conclude that administration of propofol in a private office can be regarded as "reasonable and usual". Is that what we are commonly practising?

Propofol has an extremely narrow therapeutic window. Even in expert hands, it cannot be relied on to provide only "conscious sedation". In my opinion, it should not be used without the facilities to manage the risk of progression to deeper sedation or anaesthesia. This is critically important for procedures involving a shared airway, such as dental work.

It is also relevant to know whether the facilities in the "private office" were compliant with relevant ANZCA guidelines for the safe provision of sedation and/or anaesthesia. The *Bulletin* report did not make this clear. Was capnography used, for example?

As a profession, we need to raise the bar for what we regard as a reasonable standard of quality and safety for office-based procedures.

Dr Fergus Davidson FANZCA
Senior Staff Specialist, Anaesthesia and Pain Management
Chair Drugs and Therapeutics Committee
Concord Hospital NSW

A SINNERS' PRAYER

I awoke concerned that I had become an unwitting sinner
Continuing to use Desflurane as the ozone layer grew thinner
It seemed a new Religion was forming
Its followers called it climate change or global warming

They say religion is the opiate of the masses
This religion had no issues with opiates just the volatile gases
I remained in both a moral and ethical confusion
Did my salvation lie in good medical decision or just propofol infusion

I read the meteorological scriptures and sat through climate mass
To try and understand the devil they called green house gas
From its devout followers, I tried to learn more
Even consulting the prophet, they called Al Gore

It seemed not to matter what camp my opinion lay in
As long as I discarded my autonomy into the recycle bin

ECO-Heaven was just an emission ceiling
In a world of judgment and anxiety
Where even food had feeling

For me, care for my fellow man
Extends beyond the discretionary use of the yellow trash can
I hope it's not just the eco- warriors, that this earth will inherit
Just in case, please forgive my sins for a carbon credit

Dr Jonathan Kapul FANZCA MBBCH
Senior Staff Specialist
Queen Elizabeth II Jubilee Hospital, Queensland

ANZCA and FPM media coverage

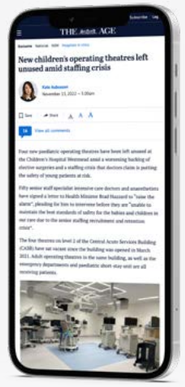
Highlights since the Spring *ANZCA Bulletin* include:

"Australian-first anaesthesia study for children starts in Queensland"

(*THE COURIER-MAIL*, 18 OCTOBER)

Brisbane fellow Dr Paul Lee-Archer featured in a *Courier-Mail* article on 18 October focusing on his children's recovery score trial which was the subject of a National Anaesthesia Day media release. *The Courier Mail* interviewed the mother of his first trial patient, two- year-old Zephyr. The online article was syndicated to nine other News Limited online news sites including the *Daily Telegraph, the Herald Sun, the Gold Coast Bulletin* and the *Northern Territory News*. The article reached more than 600,000 readers.

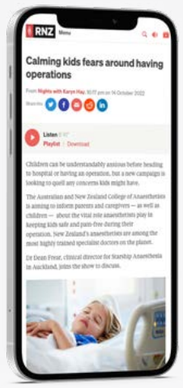
"New children's operating theatres left unused amid staffing crisis"



(SUN HERALD, 13 NOVEMBER)

Staffing issues at Westmead Children's Hospital in Sydney featured in a page 1 *Sun Herald* article on 13 November. The article referred to a letter sent by ANZCA President Dr Chris Cokis and CEO Nigel Fidgeon to the NSW Health Minister Brad Hazzard expressing concern about a worsening staff crisis at the hospital. The college warned there were too few paediatric anaesthetists in NSW, limiting the ability to train new specialists, "leading to the chronic under-utilisation of operating theatres at a time of high demand following the COVID-19 pandemic".

"Calming kids fears around having operations"



(RADIO NEW ZEALAND, 14 OCTOBER)

New Zealand fellow, paediatric anaesthetist Dr Dean Frear from Starship Children's Hospital in Auckland, was interviewed on Radio NZ Night's flagship evening program with presenter Karyn Hay on 14 October about National Anaesthesia Day. The segment ran for nearly nine minutes and focused on this year's theme of anaesthesia and children.

"Pain specialists' meeting explores long COVID, chronic pain"

(ABC RADIO SUNSHINE COAST, 13 OCTOBER)

FPM Dean Dr Kieran Davis was interviewed on ABC Radio Sunshine Coast's Drive program with Annie Gaffney in an 11- minute segment on 13 October. Dr Davis discussed the highlights of the meeting and why long-COVID can have serious implications for people living with chronic pain. The program was also syndicated to other Queensland radio stations including: ABC Far North, ABC North West Qld, ABC Western Queensland, ABC Capricornia, ABC North Queensland and ABC Tropical North reaching over 120,000 listeners.

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

Physician heal thyself (Medice, cura te ipsum)

The limits of self-care and prescribing

The doctor who called us was stunned. They had been reported to Ahpra and were being investigated for self-prescribing. "It's my business if I prescribe to myself; and anyway, these were not Schedule 8 medicines!"

And so began a discussion of how the Medical Board views self-treatment by medical practitioners, and how this has changed over the years.

There is broad recognition that our health and wellbeing impacts on our practice, and we are extolled to accept self-care as a cornerstone of professional life.[1,2] However, there are distinct limits to the self-care we can and should provide to ourselves.

Stepping into providing ourselves care that only a registered health practitioner could deliver, likely means we are stepping outside the Medical Board's Code of Conduct[3] guidelines, with the risk of poor care outcomes or investigation. Every year, there are examples of practitioners who have registration-impacting outcomes at Tribunals resulting from inappropriate self-care and care boundaries.[4]

Section 11 of the Code, a relatively recent addition, talks about managing one's own health. This section reflects similar constraints to the provision of care to close friends, family, and those you work with, discussed in section 4 (which was also updated).

- **Medical practitioners should not be self-prescribing**
  This isn't just a reference to self-prescribing Schedule 8 drugs (which most jurisdictions restrict or prohibit) or select Schedule 4 drugs, including drugs of dependence. It refers to ALL prescriptions by a practitioner for themselves. In addition, practitioners risk breaching the specific, varying, and complex legislative restrictions on self-prescribing in each jurisdiction – ranging from full self-prescribing prohibition (Victoria) through restrictions on prescribing Schedule 8 drugs and some Schedule 4 medicines (Queensland, ACT, NSW, potentially WA/NT); or restrictions on self-prescribing Schedule 8 drugs. Such breaches may be a criminal offence.

- **Health practitioners should have their own GP**
  While I'm sure we all subconsciously self-diagnose at times, the value of independent objective workup, investigation and treatment cannot be overstated. This includes the importance of approaching your treating team for documents like medical certificates, and not issuing these yourself.
- **Seek advice**
  There is additional emphasis on the importance of seeking advice in relation to health issues that could impact your work, including stress, burnout and mental health.
- **Contact the DHAS**
  If you have troubles locating a GP, the Doctors Health Advisory Service (DHAS) in your jurisdiction may be able to assist in finding GPs who have identified themselves as having an interest in looking after the health of their colleagues. They can also provide confidential telephone call-back support in more acute circumstances, such as mental illness, stress, drug and alcohol dependence, and other personal issues.
- **Mandatory reporting reassurance**
  Where doctor-patients follow their treating team's advice on whether their health issue impacts on work and how they should manage this (including modifying their practice), there should be no basis for a mandatory report. Complaints are generally straightforward to deal with if the doctor has sought and followed their treating practitioner's advice. It is more common for doctors who don't have a treating team to find themselves in difficulty if a concern about health impairment is made to a health complaints body. Tragically, we are also aware of terrible outcomes arising when doctors attempt to manage their own substance misuse or significant mental health conditions.

Dr Julian Walter
Senior Medical Adviser – MDA National

This article is provided by MDA National. They recommend that you contact your indemnity provider if you need specific advice in relation to your insurance policy or medico-legal matters. Members can contact MDA National for specific advice on freecall 1800 011 255 or use the "contact us" form at mdanational.com.au.

This case study is based on an actual request for medico-legal advice, however certain facts have been omitted or changed to ensure the anonymity of the parties involved.

1. Black Dog Institute. Self-care planning for healthcare workers. blackdoginstitute.org.au/wp-content/uploads/2020/05/COVID-19_Self-care-plan-for-healthcare-workers.pdf
2. RACGP. Keeping the doctor alive: A self-care guidebook for medical practitioners. racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Keeping-the-doctor-alive.pdf
3. Medical Board. Good medical practice: a code of conduct for doctors in Australia (see sections 4.15 and 11). medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx
4. Health Care Complaints Commission v BXD (No 1) [2015] NSWCATOD 134
   Medical Board of Australia v GMZ [2017] VCAT 902
   Health Care Complaints Commission v Geary [2018] NSWCATOD 15
   Medical Board of Australia v Stephen Hadges [2018] SAHPT 6 (5 June 2018)

ANZCA & Government

Ministerial meetings in Australia and a new health plan for New Zealand

AUSTRALIA

Highlighting our work with government

In the Winter *Bulletin*, a new approach in the way the college undertakes advocacy was outlined. Key to this new approach is a greater emphasis on government engagement, including at the ministerial level, to better represent the needs of our fellows, trainees, and specialist international medical graduates. This is in line with ANZCA's commitment to best practices in terms of training, safety and quality in anaesthesia, the welfare of anaesthesia and specialist pain medicine practitioners and the need to better recognise the college in the decision-making processes of government.

The work undertaken to date with key decision makers is already yielding results in terms of how Australian governments are engaging with ANZCA and the important role of anaesthesia, pain medicine, and perioperative medicine more broadly. This engagement is being increasingly co-ordinated with, and often led by, our fellows.

Of key importance to this advocacy has been highlighting the world's best practices of ANZCA's members in anaesthesia and the need to ensure that training, accreditation, and health-system funding be maintained or increased, so that Australia continues to enjoy its leadership in this field. Similarly, ANZCA's leadership in multi-disciplinary care, pain medicine, and perioperative medicine is increasingly acknowledged and appreciated by health departments and ministers' offices at state, territory, and federal levels.

Ministerial meetings

In late October, Dr Kieran Davis, FPM Dean, and college staff met with the Assistant Minister for Rural and Regional Health, and Mental Health and Suicide Prevention, Emma McBride. ANZCA briefed the assistant minister on the importance of anaesthesia and pain medicine in rural and remote areas, as well as the need for greater funding to pain medicine and multi-disciplinary approaches to healthcare, especially regarding mental health and substance abuse in Australia.

The college also recently wrote to the office of federal health minister Mr Mark Butler, raising concerns around the Medicare Benefits Schedule (MBS) and how key recommendations from the MBS taskforce might be implemented. These letters will help inform discussions with the minister's policy team, ahead of likely meetings between the college and the key ministerial offices in 2023.

Victorian election

Ahead of the Victorian state election, the Victorian regional committees of ANZCA and the FPM sent letters to the state's health minister and shadow health minister. The letters outlined the need for close collaboration and consultation between the college, its fellows, and the Victorian Department of Health, including on the department's planned surgery reforms. The letter also highlighted the potential economic benefits and betterment to patient well-being of perioperative medicine, as well as concerns about burnout and stress to ANZCA's consultants and trainees in the wake of COVID-19. The role of pain medicine in alleviating chronic pain and the risk of adverse mental health conditions and substance abuse was also detailed.

Representation on external boards

ANZCA is also encouraging and supporting its fellows in joining key positions in various advisory boards and commissions at state and federal levels, such as the Therapeutic Goods Administration. Such positions ensure that the college is better represented ahead of critical decisions by agencies, and in key recommendations made to government.

We have been following up with departmental and ministerial contacts to ensure that the college is well recognised and represented, especially ahead of the 2023-24 budget in May 2023. which represents a critical period in planning for government.

NEW ZEALAND

New health plan unveiled

Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Māori Health Authority) recently released Te Pae Tata – Interim New Zealand Health Plan, the first national health plan published under the Pae Ora legislation. The plan has six key priority actions:

1. Place whānau (family) at the heart of the system to improve equity and outcomes.
2. Embed Te Tiriti o Waitangi (the Treaty of Waitangi) across the health sector.
3. Develop an inclusive health workforce.
4. Keep people well in their communities.
5. Develop greater use of digital services to provide more care in homes and communities.
6. Establish Te Whatu Ora and Te Aka Whai Ora to support a financially sustainable system.

Health Minister Andrew Little said workforce was the key priority in the plan, noting there were (as of later October 2022) 3500 vacancies in nursing alone across hospitals. Improving healthcare for rural communities was also a priority, he said. Specific actions detailed in the plan in relation to strengthening the health workforce are detailed below.

Strengthening Workforce Whānau
Implement programs to grow the numbers and diversity of the health workforce, including Māori, Pacific and Tāngata whaikaha/disabled people, to meet demand by addressing critical workforce gaps as identified by the workforce taskforce.
Implement a workforce pipeline that is informed by intelligence (including a Common Person Number), works with education providers and professional bodies to ensure education and training programs are in place to grow a quality and diverse healthcare workforce that supports all healthcare providers.
Work in partnership with responsible authorities to standardise professional and regulatory requirements across Te Whatu Ora, Te Aka Whai Ora and the Accident Compensation Corporation to enable registered and unregistered staff to have training and experience pathways to advanced roles and improved interdisciplinary working across urban and rural health services.
Support the government's planning for future investments in pay equity and pay parity to ensure a fair health workforce environment.
Support educational interventions to increase Māori and Pacific access to health professional training, building the workforce pipeline to grow Te Ao Māori and Pacific services.
Implement and monitor a program providing nationally consistent cultural safety training to Te Whatu Ora and Te Aka Whai Ora workforces.
Informed by Te Mauri o Rongo/the Health Charter, implement and monitor actions to improve the workplace experience of the healthcare workforce.

In addition to workforce and health equity, the interim plan intersects with the work of the college in other areas, particularly perioperative medicine (and its importance to a health system that provides greater efficiencies and patient outcomes), and the poor management of chronic pain in the community and its links to alcohol and drug use and mental illness. The college will continue to work with government, Te Whatu Ora, Te Aka Whai Ora and other stakeholders in the implementation of the plan.

SUBMISSIONS

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

AUSTRALIA

- Royal Australasian College of Surgeons: Surgery in children position paper.
- Parliament of Australia, House of Representatives Standing Committee on Health, Aged Care and Sport: Inquiry into long COVID and repeated COVID infections.
- Therapeutic Goods Administration: Public consultation on proposed amendments to the Poisons Standard (paracetamol).

NEW ZEALAND

- Accident Compensation Commission: Kawa Whakaruruhau (cultural safety) policy.

ANZCA works with government on workforce initiatives

Improving the geographic distribution of the health workforce is a key priority of the Australian government's National Medical Workforce Strategy 2021-2031.

The college is committed to working with government and other stakeholders to address the distribution of anaesthetists and specialist pain medicine physicians in order to improve health outcomes and access to services for communities outside of metropolitan areas.

The Commonwealth government invests in several health workforce initiatives and for ANZCA, the most significant of these is the Specialist Training Program (STP). STP provides funding to ANZCA for 42 training posts, with the focus of the program now firmly on building training capacity outside metropolitan areas. The college also receives funding for additional training places under the related Integrated Rural Training Pipeline (IRTP) initiative (eight posts) and Tasmanian Project (four training posts).

In 2022 the college received a new four-year funding agreement from the Department of Health and Aged Care which ensures continuity of the program until the end of the 2025 hospital employment year. Commensurate with the new funding agreement, the department commenced a review of the program across all colleges which is due to be completed in early 2023, with the results informing the national distribution of STP training posts from 2024.

After a two-year hiatus due to COVID-19, college STP staff were able to visit a number of training hospitals to connect face-to-face with fellows, trainees, supervisors of training and administrative staff who help deliver the program around the country. In February the team caught up with Albury Wodonga Health and met fourth-year trainee Dr Jason Kong, who provided an insight into the personal and professional benefits of rural practice. Dr Kong commenced his training in 2019 at Albury Wodonga in a training post established with IRTP funding support and trained at Wagga Wagga in 2020, St Vincent's (Melbourne) in 2021 before returning to Albury Wodonga in 2022.

Later in the year, visits were made to the Royal Darwin Hospital, the Flinders NT Regional Training Hub, Royal Hobart Hospital, Launceston General Hospital, Ballarat Health Services, Alice Springs Hospital, Joondalup Health Campus, St John of God Private Hospital Midland, and the Royal Flying Doctor Service of Western Australia.

In addition to getting back to "business as usual", in 2022 the college was successful in obtaining additional STP funding and support for some initiatives to support the regional and rural workforce.

- The college worked closely with the department's postgraduate training team and the heads of anaesthesia at Ballarat Health Services and Goulburn Valley Health to secure a new IRTP position commencing in 2023. This position will be based in Victoria as part of the Victorian Regional Anaesthetic Training Network, an end-to-end pathway for ANZCA-accredited anaesthesia training across a network of regional hospitals. Funding was also secured to purchase technological infrastructure and support for rotational supervision for the Victorian Regional Anaesthetic Training Network.
- Additional funding will support three ANZCA Critical Incident Debriefing toolkit workshops in 2023 in regional and rural settings for fellows, trainees and supervisors of training. The toolkit is a comprehensive, evidence-based resource on what constitutes critical incidents, how to provide support and how to conduct a hot debrief following a critical incident. The toolkit was launched in October 2021 and has been extremely popular. Access to the toolkit was requested by the Royal Commission into Defence and Veteran Suicide and is now available on their website.

Dr Michael Jones, FANZCA
STP Advisor to ANZCA Council

Above: Royal Darwin Hospital provisional fellow Dr Dom Cauldwell prepares for a procedure.

WHAT IS THE SPECIALIST TRAINING PROGRAM?

The Specialist Training Program (STP) is an Australian government initiative designed to extend vocational training settings for specialist trainees beyond metropolitan public teaching hospitals. The aims of the program are to:

- Improve the specialist workforce by providing quality training posts in different settings to broaden the participants' experiences.
- Increase the number of specialists working in regional, rural and remote areas.

Through the STP grant, specialist medical colleges provide a portion of the salary of trainees in non-traditional training settings, such as those in regional, rural or remote areas, private hospitals, aged care services and community health organisations. There are 920 STP training posts nationally, of which ANZCA receives funding for 42.

As well as the salary component, the STP provides additional funding to health settings to cover extra costs that come with being an accredited training hospital in an expanded setting.

The Integrated Rural Training Pipeline (IRTP) provides 100 training positions across all specialist medical colleges (ANZCA receives funding for eight IRTP posts). Twenty-six training hubs have been established under the IRTP to work with local health services to help stream students through the medical training pipeline. Each IRTP post is designed to support one trainee over several years. The funding enables a specialist trainee to complete at least two thirds of their fellowship training in a rural or regional setting, with only limited metropolitan rotations.

STP is a capped program, with the number of positions held by ANZCA determined by the Commonwealth, with input from jurisdictional departments of health. For further information about the STP please contact the team at stp@anzca.edu.au.

ANZCA's role in the safety of patients being sedated

After 23 months, multiple email exchanges, two rounds of consultation and four Document Development Group (DDG) meetings involving representatives from 29 colleges and key stakeholders, ANZCA's professional document on sedation has been revised. Feedback is now being sought during its six-month pilot phase. It has been one of the more challenging reviews led by Dr Peter Roessler, who has been overseeing the revision and creation of ANZCA professional documents since 2010.

Metaphors serve to illustrate something that is not literally true but help to explain an idea or make a comparison. Many comparisons have been drawn between airline pilots and anaesthetists, so it seems acceptable to build on this.

HOUSTON, WE HAVE A PROBLEM!

Imagine the following exchange (with a modicum of poetic licence) between the Jet-fighter Pilots' Association (JFPA) and the Civil Aviation Safety Authority (CASA).

JFPA: "We wish to draw your attention to a problem that requires action on your part."

CASA "Go ahead JFPA, what is the problem?"

JFPA: "Aircraft are being flown by pilots who are not fighter-trained pilots. We are concerned about the hazards these pilots pose."

CASA: "Are they flying high-performance jet aircraft capable of exceeding Mach 1 (speed of sound, for the uninitiated), which requires specialised skills?"

JFPA: "No, but our highly trained pilots have reported witnessing them flying aircraft capable of speeds close to this. They are of the opinion that on occasions in order for them to successfully complete their tasks they must be operating very close to this level."

CASA: "Have there been any reports of crashes?"

JFPA: "We are aware of some. The non-JFPA-trained pilots counter this with arguments that although crashes occur, the available data supports that the incidence is very low and claim that their safety record is good. Nevertheless, our JFPA pilots have reported witnessing near-misses, which suggests that there are potential risks."

CASA: "Do you have any recommendations to address this?"

JFPA: "Pilots who are not JFP-trained should only be allowed to fly hot-air balloons."

CASA: "We appreciate your concern and recognise your expertise in this area. The JFPA's assistance in identifying the important knowledge and skills for piloting less-than high performance aircraft is most welcome. CASA agrees with the view that only JFP-trained pilots should fly jet fighters and high-performance aircraft. The JFPA's support to train pilots to achieve the competencies and skills necessary to fly other aircraft would have the benefit of satisfying the demands of the community dependent on air services. Likewise, JFPA can contribute to the fine tuning of risk-management plans."

JFPA: "Despite our continued reservations, your approach seems reasonable, and we hope that this addresses flight safety concerns."

Safety is a concern for all pilots and sedationists, but the perception of risk varies according to one's training, skills, and above all, experience. While jetfighter-trained pilots have greater skills, are these same skill levels essential to fly aircraft not capable of the same performance?

WHO SHOULD BE SEDATING PATIENTS?

When it comes to sedation, is there a problem, and if so, what is it? To some extent the perception of problems depends on the perspectives from which the matter is viewed. This could not be any clearer than comparing anaesthetist and non-anaesthetist perspectives.

The professional document *PG09(G) Guideline on procedural sedation* (formerly titled *PS09 Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures*) and accompanying background paper *(PS09BP)* were last reviewed in 2014.

In 2019 stakeholders were invited to nominate their representative to the DDG responsible for reviewing the guideline. The DDG was established in 2020 and comprised representatives of colleges and societies including stakeholders from multiple disciplines from the medical profession, nursing profession and dental profession.

Anaesthetist views on sedation and *PG09* lie on a spectrum ranging from insistence that the document should be a prescriptive document – mandating that only anaesthetists are adequately trained to manage sedation – through to acceptance that *PG09* should be an advisory guidance document applicable to all sedationists.

The prescriptive end of the spectrum is untenable due to the limited authority of ANZCA to mandate clinical management to its own fellows let alone fellows from other disciplines. It is also exceeding the remit of our college.

Stating its position and providing guidance, however, is an essential role of ANZCA consistent with its position to serve the community but it needs to be in the context of an appreciation of the total picture.

In its wisdom, ANZCA recognises that it may be more productive for *PG09* to support sedationists and encourage them to achieve a set of minimum competencies as a risk-minimisation strategy. A good strategy for harm minimisation should not be jeopardised as a result of the actions of a few rogue "pilots". Everyone is a winner if improvements in performance can be promoted and supported.

IMPORTANCE OF COLLABORATION

Who should develop such a document? Logic demands that drawing conclusions is centred on a complete understanding of the subject matter including consideration of scientific evidence and correct interpretation of the underlying science. The *PG09* review has sought to achieve this by gaining a true and complete picture of sedation through engaging participation of the diverse group of stakeholder disciplines.

This approach fostered collaboration between sedationist disciplines including anaesthetists and non-anaesthetists and a relationship conducive to encouraging non-anaesthetists to follow the leadership provided by ANZCA in its advocacy role. It is essential that *PG09* applies to all sedationists and for this to happen requires acceptance by all disciplines, which in turn relies on a good ongoing relationship.

Being seen to be dictated to by one's college is likely to be rejected by its members but being dictated to by another college is a sure recipe for failure of any relationship. The 2014 version of this document was viewed negatively with many disciplines refusing to endorse the guideline and accusing ANZCA of being unrealistic. It was subsequently relegated by other colleges and organisations to being an "ANZCA document that does not apply to other disciplines".

For it to be effective in the interests of patient safety, it is critical that *PG09* applies to and is owned by all stakeholder groups whether they are anaesthetists or non-anaesthetists. ANZCA's ability to influence other non-anaesthetist groups will be earned only if it seeks to understand their challenges.

DEEP SEDATION

In the current review, deep sedation has been excluded and guidance on paediatric sedation greatly enhanced.

Given that deep sedation and general anaesthesia are closely aligned it was felt that it was beyond the scope of sedationists and therefore, guidance on deep sedation should not be provided to non-anaesthetists.

In terms of the above metaphor, sedationists are not trained fighter-pilots and therefore, providing them with advice as to how to fly these aircraft is superfluous and potentially dangerous.

PAEDIATRICS

In addition to paediatric anaesthetists and a paediatric dentist on the DDG an expert group was formed that included Society for Paediatric Anaesthetists in New Zealand and Australia (SPANZA) representation and a paediatric physician sedationist. ANZCA led the development of the Safe Sedation Competencies for procedural sedation, which were published in 2021.

However, these were originally strictly adults only. With the expansion of guidance for paediatric sedation in *PG09* the procedural sedation competencies were reviewed from the paediatric perspective and modified prior to inclusion as appendix IV in *PG09*.

PERCEPTION OF *PG09* AS A "GREEN LIGHT" FOR THE UNQUALIFIED

Some stakeholders have identified a few unpalatable issues in *PG09* specific to their discipline.

One of the concerns is the perception that *PG09* serves as a "green light" for certain models of sedation. This is certainly not the case as it is clearly stated in the document that any mention of models and so on is in no way an indication of endorsement or support, but rather the intent is to identify risks and provide risk-management advice in such settings.

Another concern that has been expressed is that *PG09* does not adequately or strongly enough "prohibit" certain techniques, drugs, or models. Such views are predicated on a misunderstanding of the nature and authority of guidelines, which are advisory and not mandatory.

PG09 cannot instruct clinicians as to what they can or cannot do. This is controlled by regulatory authorities and by healthcare facilities who determine clinical scopes of practice. Guidelines recognise the existence of the myriad of clinical circumstances and provide sufficient flexibility for clinicians to administer what is considered to be appropriate in any individual circumstance.

However, if we do not address these in a pragmatic fashion then *PG09* will crash and burn and fail to influence non-anaesthetist sedationists. Worse still, is that any prospect of driving improvements through collaborative audits and so on will vanish as quickly as the exhaust spat out by the jet engines.

PG09 must not revert to being an air balloon, full of hot air.

Dr Peter Roessler
Director of Professional Affairs, Professional Documents

Access to PG09

PG09 and its background paper are now being piloted. They can be found at www.anzca.edu.au/safety-advocacy/standards-of-practice/policies,-statements,-and-guidelines. Feedback should be sent to profdocs@anzca.edu.au.

The decision to exclude deep sedation from sedation document

ANZCA's Safety and Quality Committee discussed the long-awaited revision of ANZCA *PG09(G) Guideline on procedural sedation* at its November 2022 meeting.

Committee members were familiar with the long (almost three-year) gestation of this document, the extensive consultation process that had occurred with many stakeholders and the numerous revisions and amendments that had been incorporated into the final agreed version.

Extra time had been set aside on the agenda for our November meeting, as we expected there would be vigorous discussion about this document. ANZCA fellows care deeply about the quality of care available to patients in our region, and rightly are concerned to "serve the community" by providing influence and leadership in those areas which comprise our expertise.

Quality of healthcare has a number of metrics. The Institute of Medicine describes six domains of quality healthcare – effectiveness (producing intended outcomes), safety (avoiding unintended and harmful outcomes), patient-centeredness (aligning with patients' values and preferences), timeliness (avoiding harmful delays), efficiency (avoiding waste) and equity.

Although direct evidence can be difficult to garner, most broad analysis of population-based sedation services exposes challenges in each of the domains of quality described – including reports and complaints of under sedation (ineffective care), over-sedation resulting in morbidity or (less frequently) mortality, sedation depth which may not be best aligned with patient choice, long delays and inaccessible care. And deaths and other adverse outcomes from sedation are not confined to non-anaesthetist providers. As we know from ANZCA's triennial *Safety of Anaesthesia* reports, as well as other publications, such as those from the NSW Special Committee Investigating Deaths Under Anaesthesia (SCIDUA), sedation-related deaths in the presence of a specialist anesthetist continue to be reported.

Most anaesthetists are well aware of the large volume of longstanding sedation practice, performed by non-anaesthetists, which occurs beyond our training environments, most commonly in the public sector. Many hospitals are also grappling with the post-pandemic reality of demands for "catch-up" surgery, changes in working patterns and practices of many of our colleagues, and the relative shortfall of specialist anaesthesia workforce.

The solution to many of the challenges to provision of quality sedation care is not simply to provide a specialist anaesthetist for every episode of mild or moderate sedation – there are simply not enough anaesthetists, and our expertise is required as a priority for more complex service provision.

Acknowledging these complexities, the Safety and Quality Committee understood the rationale for the relatively tight scope of the current *PG09*, particularly the decision to exclude deep sedation.

Many fellows may be disappointed by this decision, seeing it as a "lost opportunity". However, while the Safety and Quality Committee is aware that deep sedation may be practised by some non-anaesthetist colleagues, we also recognise that the opportunities to influence practice in this area are ongoing. The current version of *PG09* is seen as a step in this journey, and we expect future iterations of this document to expand to include deeper levels of sedation. ANZCA will continue to collaborate with non-anaesthetist colleagues and stakeholders to define and support best practice, high quality sedation.

PG09 was supported by ANZCA's Safety and Quality Committee with minor suggested amendments.

Associate Professor Joanna Sutherland
Chair, Safety and Quality Committee

LIST OF STAKEHOLDERS – PG09

1. Australian and New Zealand College of Anaesthetists (ANZCA)
2. Abortion Providers Group Aotearoa New Zealand (APGANZ)
3. Australian College of PeriAnaesthesia Nurses (ACPAN)
4. Australasian College for Emergency Medicine (ACEM)
5. Australasian College of Dermatologists (ACD)
6. Australian College of Nursing (ACN)
7. Australian College of Perioperative Nurses (ACORN)
8. Australian College of Rural and Remote Medicine (ACRRM)
9. Australian Dental Association (ADA)
10. Australian Society of Anaesthetists (ASA)
11. Australian Society of Dental Anaesthesiology (ASDA)
12. Australian Society of Plastic Surgeons (ASPS)
13. Cardiac Society of Australia and New Zealand (CSANZ)
14. Endoscopy Guidance Group of New Zealand (EGGNZ)
15. Gastroenterological Society of Australia (GESA)
16. New Zealand Dental Association (NZDA)
17. New Zealand Nurses Organisation (NZNO)
18. New Zealand Society of Anaesthetists (NZSA)
19. New Zealand Society of Gastroenterology (NZSG)
20. Royal Australasian College of Dental Surgeons (RACDS)
21. Royal Australasian College of Surgeons (RACS)
22. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
23. Royal Australian and New Zealand College of Radiologists (RANZCR)
24. Royal Australian College of General Practitioners (RACGP)
25. Royal Australasian College of Physicians (RACP)
26. Royal New Zealand College of General Practitioners (RNZCGP)
27. Royal New Zealand College of Urgent Care (RNZCUC)
28. Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA)
29. Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet) Steering Committee, Department of Health

What would you do?

Why we need to consider our moral obligation to support the wellbeing of others

Dr Peter Roessler explains professional documents using practical examples. In this edition he explores wellbeing and domestic violence.

Like climate change, wellbeing is one of those issues at the top of the list of accepted importance. It is an overarching concept spanning many issues including physical, mental, and cultural.

Wellbeing is not an absolute or constant state, and fluctuates in response to many factors including environmental, social, and even weather. Clearly, while some of these are beyond our control, thereby relegating wellbeing in these instances to developing coping mechanisms that determine our reactions to these influences, others are within each individual's control.

As professionals we have a responsibility for our own wellbeing, but we also have a moral obligation to support the wellbeing of others. Part of the process of promoting wellbeing involves influencing behavioural changes within ourselves, including unconscious biases but also in others with due cultural sensitivity.

It is interesting to ponder the motives driving consideration for our fellow human beings. Altruism is an obvious forerunner, but it may go deeper than this alone. Consider soldiers who sacrificed their lives during wars for the sake of others. Such actions have dual benefits. One is the obvious value to the benefactors of these actions but also, oddly enough or paradoxically, enhancing self-worth in the critical moments of the last moments of one's life. Caring for the wellbeing of others is a win-win.

Against this background of wellbeing consider the following scenario.

You come into the theatre tea room and sit next to a colleague with whom you have worked closely and got to know quite well. Instead of the uplifting welcome they usually offer, they sit there quietly, not engaging in their usual manner in the surrounding conversations. Something seems out of place!

Although it is quite warm in the tea room, the colleague is the only one wearing a long-sleeve theatre jacket. As they outstretch their arm to reach for their coffee on the table, you notice the edge of a bandage emerge from under the sleeve and what appears to be a hint of surrounding bruising. Your colleague seems deep in thought and quietly sits there sipping their coffee.

WHAT WOULD YOU DO?

Would you attempt to engage them in conversation, or inquire whether anything is troubling them (even though that is obvious)? Would you go and speak with other colleagues to ascertain if they are aware of any issues? What, if any, support would you consider offering?

What concerns might you consider in this scenario? Possibly an accidental injury, self-harm, bullying and domestic violence, or co-incidental depression?

It becomes evident from another co-worker that the colleague's partner is an employee at the same hospital and that there was an altercation resulting in the colleague sustaining an injury. Now what would you do?

Without knowing the full circumstances of the altercation and whether one party is the victim and another the perpetrator, no definitive conclusion can be drawn.

There are two potential issues here. Is this a case of bullying at work, or is this an outburst against a background of repeated domestic violence?

Bullying is the remit of employers who have a legal responsibility. ANZCA has a policy on bullying, discrimination and harassment applicable to those anaesthetists acting on behalf of the college – CP01(G) *Policy on bullying, discrimination and harassment for fellows, trainees and SIMGs acting on behalf of the college*. However, given that this incident occurred in the place of employment it would be the employer's duty to address this. Nonetheless, the college website provides information on resources to support victims of bullying and can be sourced at www.anzca.edu.au/about-us/doctors-health-and-wellbeing/bullying,-discrimination-and-sexual-harassment.

If this were a case of domestic violence there would be serious concern for the wellbeing of the doctor, both physically and mentally. While there is recognition of paediatric and elder abuse, it was noted that there is little or no recognition of family violence within current medical specialty curricula, prompting a joint approach between ANZCA, the Royal Australasian College of Surgeons (RACS), and the Australian College of Emergency Medicine (ACEM), to the Council of Presidents of Medical Colleges (CPMC) to support a unified position and inclusion in training in Australia and New Zealand.

Domestic violence has broader ramifications for families as being the leading cause of homelessness in Australia.

Our college is already well advanced with regard to wellbeing, having developed numerous resources and sourced appropriate support organisations. One fundamental document is the recently reviewed professional document *PG49(G) Guideline on the health of specialists, SIMGs, and trainees* (2022), which provides advice and recommendations. It identifies the shared responsibility between individuals, colleagues, departments/private groups, and healthcare facilities. It supports and strongly recommends the appointment of wellbeing advocates and includes multiple useful links. The Wellbeing Special Interest Group has published *RD26* The wellbeing advocate that serves to provide guidance specific to that role.

Another document is the joint wellbeing charter for doctors released by CPMC and co-badged by RACS, ANZCA, ACEM, and the Royal Australasian College of Obstetricians and Gynaecologists. The Wellbeing Special Interest Group was formed to bring together fellows and members of the New Zealand Society of Anaesthetists and the Australian Society of Anaesthetists who have a special interest in wellbeing.

Finally, the critical nature of wellbeing is amplified in its inclusion in the revised continuing professional development program.

Clearly, there is no shortage of resources and support for wellbeing, which reflects the underlying criticality of wellbeing as applied to all doctors and all circumstances that may impact on it including the increasingly recognised impact of domestic violence.

"We are all in it together".

Dr Peter Roessler FANZCA
Director of Professional Affairs, Professional Documents

Three-year plan for the college starts in 2023

The 2023-2025 Strategic Plan was developed over many months from 2020-2022 and involved considerable input from members of ANZCA Council, the FPM Board and staff on the Executive Leadership Team (ELT).

The development of the new plan was also informed by the findings from the 2021 fellowship and trainee surveys, college plans, and an analysis of the current strategic plan.

The impacts of the COVID-19 pandemic mean the college faces several challenges in years to come including increased financial and economic pressures facing governments, increased burdens of disease, workforce challenges and changing community expectations.

The ANZCA Strategic Plan 2018-2022 has served us well, guiding and prioritising the work of the college. It started out as two separate plans for ANZCA and FPM and was later consolidated as part of an effort to build collaboration between the college and the faculty.

The college engaged Resilient Futures to guide the development of the new strategic plan, a process largely undertaken via Zoom due to ongoing restrictions caused by the COVID-19 pandemic.

ANZCA Council settled on a three-year plan in recognition of the dynamic landscape facing the college due to the pandemic and other world events.

Several existing priorities from the 2018-2025 plan have been included in the new plan, for example, the qualifications in perioperative medicine and rural generalist anaesthesia.

ANZCA management will translate the priorities and objectives of the new strategic plan into a business plan that will guide the work of the college. This will be presented at the February ANZCA Council meeting.

The strategic plan will also guide the college's budget priorities for 2023 and subsequent years.

Scan me to find out more!

anzca.edu.au/strategic-plan

PURPOSE

To serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine.

STRATEGIC PRIORITIES

Our strategic priorities were formed from an objective view of the strategic opportunities and risks present in the immediate and emerging conditions – and ensure we will be aligned and equipped to generate long term sustainable value.

1. Lead

Anaesthesia, pain medicine and perioperative medicine

STRATEGIC PRIORITIES

We will lead anaesthesia, pain medicine and perioperative patient care through evidence-based safety and quality standards and guidance, training, and continuing education across Australia and New Zealand.

We will do this using adaptive training and education, engaging with key industry and government partners, developing and implementing evidence-based standards, applying our research outcomes, and working with health professionals and communities.

2. Engage

Workforce, wellbeing, equity and diversity

STRATEGIC PRIORITIES

We will continue to improve health and wellbeing, equity, inclusion and diversity of our fellows, trainees, specialist international medical graduates and staff to enable broad and equitable access to care and delivery of high-quality outcomes for patients and communities across Australia and New Zealand.

We will work with diverse communities, particularly Aboriginal and Torres Strait Islander and Māori peoples.

We will work with key stakeholders including colleges, teaching institutions, hospitals, communities and governments to influence workforce distribution, especially in underserved areas, sustainability, wellbeing and equity in training, practice and care.

3. Support

Fellows, trainees and specialist international medical graduates experience

STRATEGIC PRIORITIES

We will deliver a world class experience to all fellows, trainees, and specialist international medical graduates as an innovative, responsible, and focused leader for the specialist medical college sector.

We will further embed effective engagement practices, training and education, digital and in-person experiences and resources.

4. Sustain

Leading specialist medical college

STRATEGIC PRIORITIES

We will enhance sustainable value by integrating economic, environmental, and social aspects of leading in anaesthesia, pain medicine and perioperative medicine, maintaining our reputation as a foremost model for specialist medical training, education, and professional standards.

We will do this by enhancing our infrastructure, operations, resources, staff capability and culture.

Perioperative Medicine

Diploma's recognition pathway updated

ANZCA has received more than 80 applications from eligible practitioners seeking legacy ("grandparenting") transition to the Diploma of Perioperative Medicine (DipPOM).

The applications from fellows of ANZCA, the Royal Australasian College of Physicians, the College of Intensive Care Medicine, and the Royal Australasian College of Surgeons are being assessed for eligibility by the Recognition Pathways Working Group chaired by ANZCA's Immediate Past President, Dr Vanessa Beavis.

This recognition pathway – or "grandparenting" process – is open to medical specialists who have been engaged in the field of perioperative medicine through education, teaching, research and clinical practice, and leadership.

Those awarded the qualification via this process, will be approached by ANZCA to assist with the diploma by providing clinical supervision and education.

ANZCA has taken a continuous improvement approach to the development of the diploma and its accompanying documents. Therefore, at its last meeting in December, ANZCA Council endorsed amendments to the DipPOM points-based recognition points pathway approved by the Perioperative Medicine Steering Committee.

These changes, as proposed by the Recognition Pathway Working Group, are reflected in the newly updated application form, and include:

- Updates to education activities (category A) such as the inclusion of higher university degrees by research and more detail around recognition of second fellowships, as well as the removal of the eight-year currency requirement since completion of listed education activities.
- The addition of a new activities to teaching/supervision/resource development activities (category B) that recognises supervision of students who have successfully completed a doctorate or masters in a perioperative medicine-related field.
- A new section that recognises leadership-based activities. This is specifically aimed at applicants with leadership-focused experience in the field of perioperative medicine practicing in a clinical setting. This addition replaces an original plan to introduce a separate DipPOM Recognition Exemption Pathway.

More detail on the changes can be found via the renamed "Diploma of Perioperative Medicine – Recognition pathway application" form which can be found on the ANZCA website.

The campaign inviting fellows to apply for legacy transition via the recognition pathway was successfully promoted to ANZCA fellows and trainees via different channels including the *Perioperative Medicine Communique*, the ANZCA President's message, the *ANZCA E-Newsletter*, the Spring *ANZCA Bulletin*, and via social media.

Nearly all the colleges (including societies) represented on the Perioperative Medicine Steering Committee also shared the launch of the recognition pathway through their communications channels and social media.

Pull-up banners and postcards with perioperative medicine information and a QR code linking back to further information on the website have been developed to promote the recognition pathways launch at scientific meetings.

Applications for the recognition process can be submitted until 1 December 2023.

DIPLOMA DEVELOPMENT

Progress on the diploma is continuing with the Content and Assessment Working Group further developing the content for each module. This is nearly complete for the first two topic areas of the program.

The next stage will be to transfer the developed content to ANZCA's new learning management system.

A criterion for hospital involvement is near completion. This includes candidate requirements for completing the clinical immersion component. Engagement with hospitals will commence in early 2023.

VALUE OF PERIOPERATIVE MEDICINE

The Perioperative Medicine Economic Working Group continues to provide advice on the development of a value-based care proposition.

Literature reviews undertaken by ANZCA will highlight the evidence (where it exists) of the benefit of perioperative medicine to patients and their carers and the economic value of the implementation of perioperative strategies to the community.

Credible evidence-based data is one of the aspects that is important in explaining to governments, hospitals and private insurers the financial benefits to organisations of perioperative medicine. It is also an essential promotional tool for potential diploma candidates, the media, patients and a global audience.

NEW CO-CHAIR

Auckland-based Dr Beavis has joined Dr Sean MacManus as the co-chair of the Perioperative Medicine Steering Committee to allow better oversight of the New Zealand perioperative medicine advancement and, share the large workload and commitment of the chair's role.

For more information about the diploma please go to the ANZCA website or email periop@anzca.edu.au, where you can also request to receive updates via ANZCA's regular *Perioperative Medicine Communique* (also available via the *ANZCA E-Newsletter*).

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

The importance of getting it right first time

A new perioperative model of care for orthopaedic patients is being trialled in New Zealand and Queensland hospitals. Here, NZ trainee anaesthetist Dr Emily Craven explains how the "Getting it right first time" program, an initiative of the National Health Service in the UK, is working at Dunedin Hospital in New Zealand. Orthopaedic surgeon Associate Professor Catherine McDougall then outlines how the approach is being used at the Metro North and Hospital Health Service in Brisbane.

HOW IT ALL BEGAN – CONVERSATIONS OVER THE DRAPES

During a routine orthopaedic list, I tune into a conversation from our Scottish orthopaedic fellow as he described the outcomes for a group of Aberdeen elective hip arthroplasty patients who had been treated with an enhanced recovery after surgery (ERAS) approach.

Those patients appeared to have had a very different perioperative experience – they were walking around just hours after surgery with some even going home that night, although most returned home the next day or two. For the patient in front of us in Dunedin Hospital (ASA 2, 65 years old) her expected length of stay was at least three to four days.

With patient-controlled analgesia (PCA) and a urinary catheter limiting mobilisation, she would only be starting to get out of bed when most of the patients in Aberdeen had already gone home.

Our system needed to change, but how, and where to start?

We formed a small working group of interested anaesthesia and orthopaedic clinicians and embarked on a literature review, each working on specific questions related to arthroplasty surgery. One document from the UK stood out: the "Getting It Right First Time" May 2020 guideline "Elective Hip or Knee Replacement Pathway".

Best practice at each stage of the patient journey is detailed, from first presentation through to discharge and follow up. A point of difference is that the guideline speaks to everyone involved in the provision of care: anaesthetists, surgeons, nurses, allied health, and service managers. It presents a service model for a health system recovering from COVID-19. Clinical and efficiency metrics are outlined, with targets that match top decile performance. I was also encouraged to see contributions in the guidance from the perioperative leads of the Royal College of Anaesthetists (RCoA) in the UK.

"As anaesthetists, with our connections across the whole process and understanding of perioperative care, we found we were well placed to champion and communicate change."

WHAT IS "GETTING IT RIGHT FIRST TIME?"

"Getting It Right First Time" (GIRFT) is a National Health Service (NHS) quality improvement program in England, led by frontline clinicians. Procedure specific benchmarking is used to identify top performance, and share best practice that can be implemented to enhance patient outcomes, while delivering efficiencies to the healthcare system.

This initiative was conceived in 2015 by the orthopaedic surgeon Professor Tim Briggs and has grown to include 40 surgical and medical specialties, and several cross-cutting workstreams such as litigation. GIRFT is endorsed by the RCoA and many of the surgical and medical royal colleges.

The GIRFT website, www.gettingitrightfirsttime.co.uk, includes a publicly accessible best practice library covering a range of specialties and broader service provision. GIRFT also offers access to dynamic performance data and carries out structured, clinically-led visits to hospital trusts in England to "deep dive" into practice and outcomes, providing data-driven performance reports and recommendations for clinicians engaged in quality improvement.

IMPLEMENTING GIRFT METHODOLOGY AT DUNEDIN HOSPITAL

At Dunedin Hospital we created a strategic vision informed by the GIRFT framework after we had connected with the team at one of the top-performing NHS institutions in England for hip and knee arthroplasty surgery, Northumbria Healthcare NHS Foundation Trust.

The staff at Northumbria are passionate about ERAS, and mentored us through the development of the pathway, sharing their expertise gained through years of development work. Their hip arthroplasty ERAS pathway now facilitates an average length of stay of 1.8 days, with >20 per cent of patients discharged on the same day.

Our project was initiated using existing staffing resources to draw on the knowledge of the newly formed multidisciplinary ERAS working group. We explored local problems, inefficiencies, and frustrations by engaging with staff in a variety of structured meetings, ward-based consultations, and email feedback. Frequent and responsive communication at all levels was key to this process. As anaesthetists, with our connections across the whole process and understanding of perioperative care, we found we were well placed to champion and communicate change.

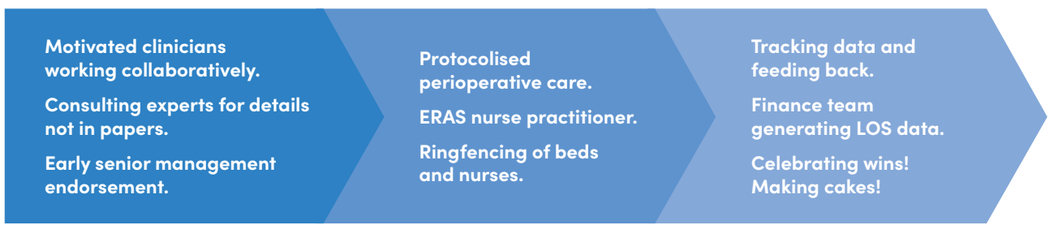
Early involvement of service level and senior management was a key part of the process as this ensured management buy-in for decision-making and future resource allocation.

The working group presented the ERAS vision to senior management and highlighted benefits for our institution, along with key areas of need. The GIRFT framework, and experience from a high-performing institution added context and credibility to our proposal. Something that proved impactful was a Zoom presentation from the Northumbria ERAS nurse practitioner to our working group, allied health, head of orthopaedics and service manager. Each discipline was able to take messages relevant to their role in the change process, sparking enthusiasm for the project in the clinical and management team.

Focusing on anaesthesia, we connected with Northumbria's ERAS anaesthesia lead. Hearing from firsthand clinical experience gave us the confidence to adopt new techniques and develop a standardised anaesthesia recipe prioritising fast recovery and early mobilisation.

The key changes we made were: Standardising anaesthesia to a low dose, opioid free spinal or total intravenous anaesthesia for general anaesthetic; replacing femoral nerve blocks with surgeon delivered local infiltrative analgesia (LIA); no routine PCAs or urinary catheters; consistent multimodal analgesia and postoperative nausea and vomiting prophylaxis.

TIPS FOR SUCCESS



LEARNING FROM OTHERS – NORTHUMBRIA

Northumbria freely shared their perspectives for success, as a pioneering hospital of orthopedic ERAS in England.

Something they emphasised is that effective change includes taking the department with you. This involved generating enthusiasm for the project in the early stages, through sharing the strategic vision with the department, and maintaining momentum once the project was under way.

They communicate regularly with the staff involved, and share key metrics such as length of stay, joint infections, and patient satisfaction, to connect the team with the impact of the changes they are implementing.

A practical pearl shared by Northumbria was the importance of creating a culture of wellness and prioritising an early return to "normality" where patients walk to theatre, eat in recovery, begin their physiotherapy in recovery, and mobilise in their own clothes two hours post op. Family or a support person were highlighted as key in the recovery process, as they are involved from an early stage.

STANDARDISATION FOR EFFICIENT INDIVIDUALISED CARE

A key tenet of the GIRFT philosophy is standardisation. Variations are inefficient and time consuming, particularly for staff delivering post-op care.

Detailed perioperative guidelines have reduced variation in care and have made it easier to identify those that don't follow the pattern and need modification to their care.

FUTURE DEVELOPMENT

Although it is early days for Dunedin, we are starting to see patients smiling, moving just hours after surgery, and some being discharged the day after surgery.

As Dunedin's ERAS evolves, our next steps include developing a day case pathway, and the implementation of a smartphone app and website to educate and empower patients to take an active part in their health journey.

Dr Emily Craven,
Anaesthesia AT2
Dunedin Hospital, New Zealand

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DEVELOPING ERAS PATHWAY – A RECIPE FOR SUCCESS OVER THREE MONTHS

ERAS working group established

Two anaesthestists.
Two orthopaedic surgeons.
One senior nurse educator, one physiotherapist.
Head of orthopaedics, service manager.
Reviewed best practice and benchmarked performance.
Resources: Get It Right First Time, ERAS society, PROSPECT, many more.
Virtually consulted the best performing hospital in the UK – Northumbria.

Formed a vision and communicated widely

Our vision was to reduce length of stay from 4.5 to 2.5 days.
Establish an ERAS protocol that worked.
Consider rapid discharges and daycase surgery.
Ensure quality and patient satisfaction.
Commmunicated to all perioperative staff and senior management.
GIRFT pathway read by many.
We listened to ideas and concerns from our colleagues.

Systematic optimisation of the perioperative pathway

Developed and implemented over a three-month period.
Framework from Getting It Right First Time.
Detailed standardised guidelines.
Bespoke to our hospitals resources, patient demographic and geography.
Review to optimise Māori health.
New collaboratives, for example, DrEaMing.

Measuring outcomes

Metrics – three monthly review ongoing
Length of stay – monthly run chart of average length of stay.
Percentage of patients discharged by day post op.
Surgical complications – readmissions, infections, DVT, revision.
Metrics –development phase only
Anaesthesia – type, spinal failures, standardised drugs given.
Recovery – pain scores, PONV
Ward – pain scores, sedation events, urinary retention, patient satisfaction.

The Queensland GIRFT experience

Improving quality of care and ensuring sustainability by clinician led data review and decreasing unwarranted variation.

In 2019, the Health Improvement Unit (HIU), Clinical Excellence, Queensland Health, began a pilot of the "Getting it right first time" (GIRFT) program in orthopaedics.

The program, well established in the UK, incorporates cyclic peer-to-peer review of facility level data encompassing the whole patient journey – from time of referral, through the operative phase, to post discharge.

The premise is that by identifying outliers, and sharing learnings from exemplar sites, overall quality of care is improved – decreasing complications and achieving efficiencies to ensure our system is sustainable.

The key to the program's success is the engagement of both the clinicians and the hospital executives, so together the teams can collaborate, innovate, and spread contemporary best practice.

The first quarter of 2022 saw us complete the second full round of GIRFT data visits, in 18 orthopaedic departments and their broader hospital communities across Queensland Health. Despite COVID-19 many improvements were realised.

IMPROVING QUALITY OF CARE

Over the course of the program so far, we have seen improvements in the following areas:

- Reduced average time to surgery for hip fracture patients.
- Decreased length of stay for total hip replacement (THR) and total knee replacement (TKR) patients with over 600 days of released bed capacity over 12 months.
- Improved access to dedicated trauma theatres.
- Decreased all cause revision and revision for infection in THR and TKR.
- Fewer knee arthroscopies performed in patients aged >55 years.
- Decreased prosthetic costs from volume-based savings.

Each year the HIU hosts a GIRFT forum where the teams share overall findings and successful or innovative models of care. The program has also assisted in the development of the Queensland Directors of Orthopaedics Group (QDOG), which has allowed the directors of the orthopaedic departments across the state a platform to discuss other issues affecting their departments.

ONGOING PRIORITIES

One of the priorities identified after our first round of GIRFT visits was the need to address surgical infection, including prosthetic joint infection.

Through engagement with our clinical teams and after reviewing the evidence, new Queensland Health guidelines for infection prevention in arthroplasty surgery have been developed and endorsed and most importantly progress has been made in the revision for infection in arthroplasty rates state-wide over the last 12 months.

Orthopaedic trauma demand and access to trauma theatres remains a priority in orthopaedics across the state.

NEXT STEPS

GIRFT Q has made a very successful introduction in orthopaedics and at the beginning of 2022, GIRFT emergency surgery began. We are looking forward to embedding the GIRFT program as a quality improvement program across broader surgical and non-surgical services and continuing the path of improving quality of care by decreasing unwarranted variation.

Associate Professor Catherine McDougall
Orthopaedic surgeon
Clinical Lead GIRFT Q Orthopaedics
Clinical Director Surgery, Surgical, Treatment and Rehabilitation Service
Metro North Hospital and Health Service

Updated CPD program ready for launch

A project led by ANZCA councillor, Dr Debra Devonshire is introducing MBA/MCNZ-mandated changes to our CPD program which come into effect from 1 January.

The Medical Board of Australia (MBA) and Medical Council of New Zealand (MCNZ) have changed their registration and recertification requirements.

So that you meet the updated requirements, we are reviewing the ANZCA and FPM Continuing Professional Development (CPD) program.

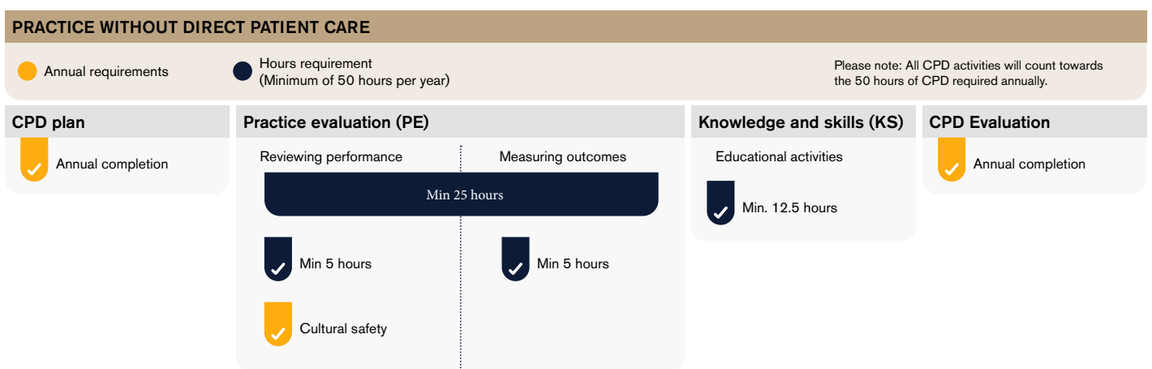
With the updated program now ready for launch for some fellows and other CPD participants from 1 January 2023, this article reviews project progress in 2022 and outlines further work planned for the 2023 transition year.

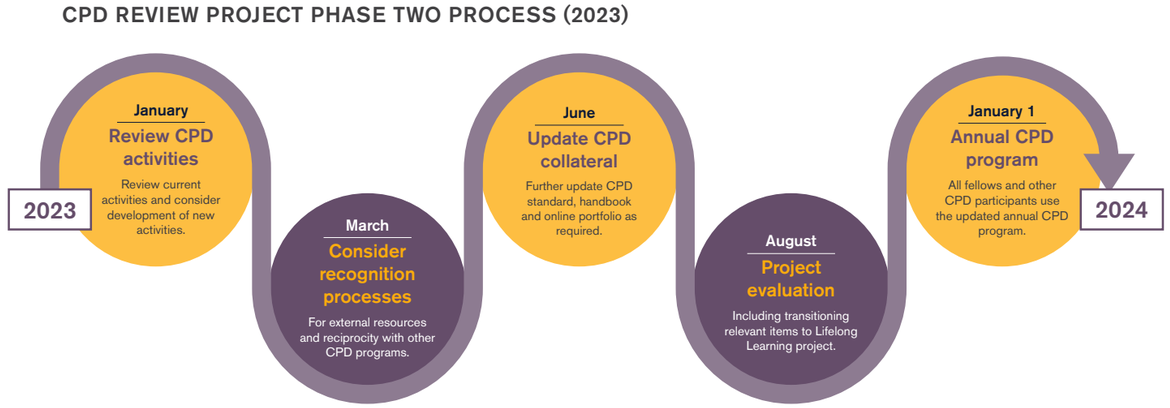
The CPD Review Project Group (CPD-RPG) adopted an evidence-based and member-centred approach when reviewing the program. During the first project stage, group members evaluated the existing CPD program by:

- Reviewing **qualitative data** from the CPD survey to understand fellows and other CPD participants' views on the program and the online CPD portfolio.
- Analysing **quantitative data** from CPD portfolio records, including the number of activities claimed each triennium and the hours spent on CPD activities.
- Conducting a **literature search** to identify global trends in professional development.

Findings from the evaluation stage fed into the updated CPD framework. When determining the framework, the CPD-RPG and CPD committee considered two proposals to meet the updated regulatory guidelines. The proposals were shared for wider consultation, with respondents representing a broad range of fellows and other CPD participants. The final proposal was approved by ANZCA Council in July 2022.

Group members then updated the CPD standard and policies, the CPD handbook, and online CPD portfolio to reflect the revised program requirements, ready for the updated program launch from 1 January 2023.





CPD PROGRAM UPDATES

As shared in previous communications, from 1 January the updated ANZCA and FPM CPD Program will:

- Transition from a triennial to an annual program.
- Measure CPD activities in hours instead of credits.
- Require an annual plan and evaluation.
- Include an annual cultural safety activity.

We're implementing a staged transition process to move the three active trienniums across to the annual program. Your transition date will either be 1 January 2023 or 1 January 2024, depending on your current triennium. To give you time and space to adjust, 2023 will be a transition year with neither the college nor the regulators conducting audits.

More information on the specific requirements for the clinical practice type and the transition process for all fellows and other CPD participants is on the dedicated 2023 CPD program webpage – www.anzca.edu.au/cpd.

PRACTICE WITHOUT DIRECT PATIENT CARE (NON-CLINICAL) REQUIREMENTS

A familiar aspect of the ANZCA and FPM CPD Program is that it caters for different contexts, with amended requirements for those who practice without direct patient care.

The CPD-RPG and CPD committee updated the name of this practice type in recognition of the fact that "clinical support" roles include teaching, research, leadership, management and other activities. While these do not involve direct individual patient management, they are vital to support high quality and safe clinical care. The term "practice without direct patient care" better reflects this than "non-clinical".

The MBA and MCNZ definitions of "practice" are very broad and include any work that uses medical skills and training. If you maintain practising medical registration, the CPD requirements set by the MBA and the MCNZ are the same regardless of whether your practice involves direct patient care or not.

Outlined in the diagram, the updated ANZCA and FPM CPD Program requirements are designed to meet the regulatory guidelines.

Please note that those who practice without direct patient care don't have to complete the annual emergency response activity or mandatory practice evaluation activities.

In late November, CPD-RPG members Dr Lindy Roberts and Dr Stephanie Oak held a webinar focusing on how those who practise without direct patient care can meet their updated CPD requirements. The recording is available on the college website for those who couldn't join on the day.

WHAT'S HAPPENING IN 2023?

Throughout 2023, the college will continue to support fellows and other CPD participants become familiar with the updated program requirements. We'll have guidance and resources available on the website and will continue communicating widely.

The CPD review project will move into the next stage, with planned tasks including:

- **Reviewing current CPD activities** and developing new activities. We will particularly focus on expanding emergency response activity availability, with more activities offered online.
- **Curating resources** (such as measurement tools and guidelines) to assist those who practice without direct patient care in meeting their CPD requirements. We hope these resources will also help those who practice clinically but assume some roles and responsibilities without direct patient care.
- **Considering the development of recognition processes** for externally produced educational resources and reciprocity with other CPD programs.
- **Evaluating the CPD review project and the updated CPD program** as we move through the 2023 transition year.
- Transitioning to business as usual ready for all fellows and other CPD participants to use the updated CPD program from 1 January 2024.

We're always happy to hear from fellows and other CPD participants regarding your CPD program. If you have any feedback on the project so far or would like to be involved in consultations or reference groups in 2023, please email the CPD team – cpd@anzca.edu.au.

Self matters

Finding the right retirement fit for you

Dr Lindy Roberts, ANZCA's Director of Professional Affairs, Education explores doctors' health by highlighting practical ways to support anaesthetists' and pain specialists' wellbeing and how it impacts private lives. Here she focuses on retirement and how to plan for it.

RETIREMENT!

Many factors contribute to wellbeing in this important phase of our lives, some we can control and others we sadly can't. Financial planning is obviously crucial, needing trustworthy expert advice. Important also are strategies for healthy ageing. However, my focus in this piece is on the psychological aspects of retirement – how we prepare ourselves for changes in our identities, relationships and sense of purpose. Ultimately, such planning is affected by individual circumstances and preferences. In writing this, I recognise my privilege, broadly speaking and in relation to having choice about timing. It must be much harder where retirement is forced, especially as this is often due to ill health or caring for others.

I'm not pretending I have all the answers – who does? My planning and thoughts remain very much a work in progress. However, I share my perspectives and some ideas I've gained from research, noting that the current literature on physician retirement is mainly from North America and focuses on white male baby boomers. There are emerging studies of medical women, but very little on more diverse subsections of our profession.

Perhaps this column will provoke some thoughts in you and ignite conversations among colleagues and with your friends and family – it's never too early for these!

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

Dr Lindy Roberts AM
ANZCA Director of Professional Affairs, Education

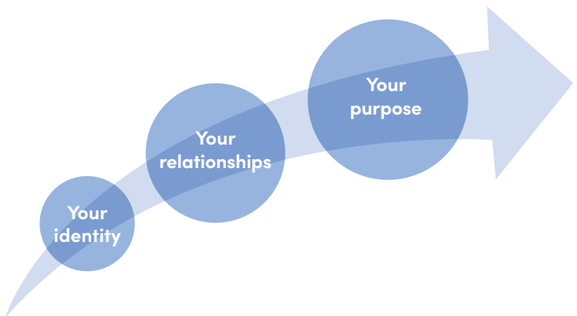
LIFE BEYOND WORK: TIME TO START THE CONVERSATION

On turning 50, I realised that my remaining working years were likely to be fewer than those already passed, but retirement remained a vague future event. As 60 looms, it's become more "real", even if still a few years away. I've started to wonder how I will fill my days, what will it be like without work routines and colleagues, and how I will feel without the satisfaction that comes with a caring job well done. I've consumed books, articles, workshops and podcasts. It's a common topic of conversation among similarly aged friends.

Looking around me, I see (and hear of) diverse experiences for older colleagues. Some appear to be managing retirement with ease, and others struggle. Often (and not surprisingly) there's an early period of obvious upheaval. This is the nature of transitions, reflecting the necessity to let go, a period of disorientation followed by reorientation to a new normal, often accompanied by mourning for the old[1]. So how should we approach this last career transition, what resources can help and how should we prepare ourselves?

Professor Nancy Schlossberg, in her qualitative studies of the challenges retirees face, has developed a model of a psychological portfolio (figure 1). Analogous to the well understood concept of a financial portfolio, this is a way of considering the assets we need for a satisfying post-work life. She recommends that, ideally, each of the three components – identity, relationships and purpose – will be equally strong.

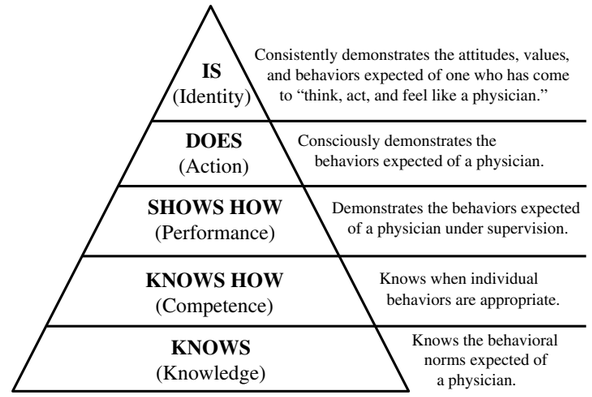
FIGURE 1: A PSYCHOLOGICAL PORTFOLIO (AFTER SCHLOSSBERG, 2017[2])



IDENTITY

Our identities are "subjective self-definition[s], constructed over time through the complex interplay of affective, cognitive and sociocultural factors"[3]. According to Breakwell's Identity Process Theory, there are six factors ("motives") that drive identity formation – self-esteem (or self-worth), self-efficacy (feeling competent), continuity (consistency over time and circumstance), distinctiveness (differentiating ourselves from others), belonging and meaning[3]. Cruess and colleagues conceptualise our socialisation into medicine by adding a pinnacle to the familiar Miller's pyramid-identity, "thinking, acting and feeling" like a doctor[4].

FIGURE 2: CRUESS AND COLLEAGUES AMENDMENT OF MILLER'S PYRAMID TO INCLUDE IDENTITY[4]



Reprinted with permission from Cruess RL, Cruess SR, Steinert Y. Amending Miller's Pyramid to Include Professional Identity Formation. Acad Med. 2016;91(2):180.

Our strong professional identities support us doing a good job for our patients but may also create challenges when leaving these professional roles. This then becomes the first challenge for our portfolio – creating identities that don't rely on doctoring. My thoughts:

- Breakwell's motives (see above) guide us to things outside medicine that sustain us. Some questions to ask (or conversation starters perhaps) are in box 1.
- We might need help. I'm back in therapy, partly to deal with these questions. As previously, my sessions are focused on self-knowledge, especially understanding the impact of my family of origin, my orientation to the world and recognising how these influence my (often subconscious) motivations and behaviours (perfectionism and high standards – who would have thought?!) I've also found useful the School of Life app[5], as a daily practice for self-understanding (and realising that everyone else is also a "hot mess" as a dear mate has put it). There are clinical psychologists out there who specialise in life transitions. Your GP will know ... and it's worth "shopping around" to find someone you click with.
- It takes time and effort to build up new identities and activities, hence the common practice of a gradual reduction in working hours in the years prior to finishing up. (This has other benefits like accommodating the "morningness" of ageing[6]).

BOX 1. QUESTIONS TO ASK YOURSELF AND DISCUSS WITH OTHERS YOU TRUST[7-9]

Where do I find my identify and self-worth?[9]

Where is "value" found for me beyond my career'?[9]

Thinking back to a time before medicine, what did I enjoy?

If I hadn't become a doctor, what would I have done?

In speaking to retired friends and colleagues, what were their first six months like? What were their "greatest joys"? "Greatest challenges"? Do they have any advice or suggestions?[7]

RELATIONSHIPS

Since I ceased my clinical role last year, I've noticed how big a part the casual society of the hospital plays – chatting with anaesthesia technicians, with surgeons during and between cases, running into colleagues in the corridor, tearoom conversations, the acute pain nurses ... and listening to patients.

My continuing roles with the college and the Australian Medical Council provide rich sources of collegial interaction, but the loss of my hospital role has given me insight into what's coming when I cease work altogether.

One strategy has been to keep in touch with trusted colleagues, with whom I've redefined relationships. Non-work friendships and planned activities beyond work are also critical. Retired friends have joined sporting clubs or groups around creative activities like writing and reading. Some have taken on university study.

For those who are partnered, retirement is a family affair. Women in medicine tend to retire earlier, after more interrupted careers, adopt carer roles (especially for grandchildren and older relatives) and are more likely to be single; if partnered they are more likely to follow a spouse into retirement[10].

While retirement is experienced differently by each partner, the key to your partner's adjustment depends on your adjustment[11]. Two working spouses should consider whether to retire at the same time or sequentially. There is also the question of how much time you will spend together, and how much apart.

PURPOSE

In many ways, this is the biggie! It's allied to the other areas and so similar strategies are required. My biggest concerns – no longer being "needed" and "important" (common among doctors) and being alone. Considerations – volunteering, artistic pursuits (in my case film criticism, playing the clarinet), formal study (history and film perhaps?) We all need to redefine what "purpose" means for us and, for me, that remains a work in progress.

CONCLUSION

There's a lot of life to look forward to ... retirement should be conceived as a new and exciting phase of life, not the beginning of the end. I'm struck by the following quote from Dr Ray Moynihan, a journalist and health researcher, that speaks of the richness beyond a medical career:

"While it seems all consuming ... [your] career trajectory is just one part of a much broader, richer life that involves dancing and music and sport and travel and love and despair and suffering and all of that stuff"[12]. Go well!

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Safety & Quality

Paediatric fasting for elective surgery – an update

In this update of recent trends and evidence around paediatric fasting for elective surgery, paediatric anaesthetist Dr David Stoeter outlines the implications for clear fluids, and breast milk.

ANZCA's professional document *PG07(A) Guideline on pre-anaesthesia consultation and patient preparation* has recently been revised and includes some important updates around paediatric fasting.

Breast milk in infants over six months is now permitted up to four hours before surgery instead of six hours.

This is supported by international consensus guidelines and systematic review of the evidence to date[1,23]. *PG07* also now emphasises the importance of avoiding prolonged fluid fasts in children.

In the past five years, a growing international consensus has emerged that a one-hour (versus two-hour) clear fluid fasting rule in elective paediatric settings is safe and effective at reducing fasting times in children[1-4]. This applies to both general anaesthesia and sedation.

Consequently the Society of Paediatric Anaesthesia in New Zealand and Australia (SPANZA) has endorsed a Joint British, European and French Consensus Statement[4].

Precipitants for this change include a recognition that prolonged fluid fasts are common and frequently far in excess of prescribed rules (figure 1)[1-3]. More liberal fasting guidance not only reduces average fasts (figure 1) but also the variation in fasts, ensuring a greater number of children benefit from shorter fluid fasts (figure 2).

Liberal fluid fasts have included one-hour rules but also more flexible variations including no limitation on clear fluid type or volume with a "drink until called to theatre" or a "drink until premedication" rule ("0-hour").

The oft purported benefits of reduced fasting have been those of reduced ketone production and lower incidence of hypotension post-induction. Unlike adults, the significance of these in the context of the vast majority of paediatric patients seems doubtful except in the minority with very specific disease entities for example, metabolic conditions, specific congenital cardiac lesions or organ-specific flow-limiting disease such a Moymoya.

However, as the concept of enhanced recovery after surgery (ERAS) begins to gather momentum, moving from the adult to the paediatric surgical world, it seems likely that one of its facets; reduced fluid fasting (carbohydrate containing drinks and water), may have similar impacts (for example, reduced length of stay, earlier return of bowel function) and mirror some of the existing paediatric evidence surrounding the lower incidence of post-operative nausea and vomiting (PONV) in those for whom perioperative hydration is well maintained[5-8].

In addition, minimising fasting perioperatively may also improve overall behaviour, compliance and satisfaction among families[1,2,9].

Finally, it is also likely that more liberal regimens improve patient flow and staff workload through allowing children and parents to self-administer fluids until surgery approaches

without the need for repeated and variable communication between theatre and admitting teams. Applying such approaches does not appear to impact cancellation rates[10].

A significant bulk of the evidence that has led to the transition from a two to one-hour rule involved studies in which the most liberal "fast until called to theatre" rule was applied without limitation on volume or indeed type of clear fluid ingested[11-13]. Large volumes of patients were involved in these studies with apparent subgroups fasting less than one hour.

Furthermore, a complex analysis of nil-by-mouth status in almost 140,000 children undergoing sedation (ranging to deep sedation or anaesthesia for endoscopic procedures) included a significant group falling under a more liberal regimen[14]. In all these studies there appeared to be no significant impact of more liberal fasting processes on regurgitation or aspiration events.

Given aspiration is rare and in those children who do aspirate, sequelae are not usually severe or long-lasting, overall there appears to be a margin of safety attached to more liberal regimens[1,2].

The role of potential risk factors in modifying gastric emptying remains unclear. In comparison to adults, risk factors seem likely to be highly specific and infrequent, for example, neurologically-impaired gastrostomy-fed, oesophageal stricture or achalasia[1].

In summary, in developing local quality improvement processes aimed at optimising paediatric fasting times, an awareness of the population served and local timeframes in surgical flow may allow more liberal regimens to be applied to best avoid prolonged fasts.

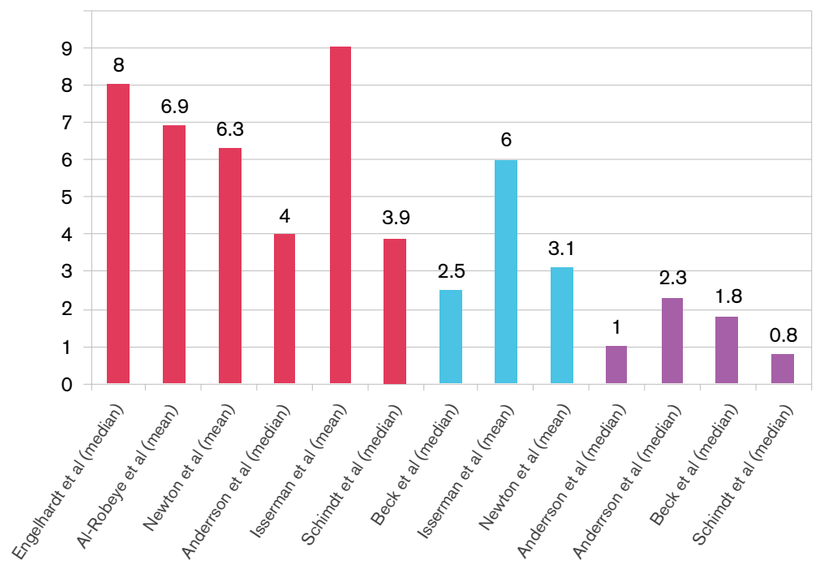
Drinks offered in waiting areas may be helpful. Limits on volume (≤3ml/kg/hr) and energy density (≤0.5kcal/ml) may add an additional margin of safety[1-4,15-21].

Intensive face-to-face education for and engagement with staff involved in the patient's journey is highly effective. Use of varied media to educate and inform families might include videos such as "little deep sleep"[22] and timed mobile phone texts to parents.

Local audit should include monitoring of regurgitation and aspiration events and the number of patients fasting less than one hour as well as average fasting times and variation in fasting.

Dr David Stoeter, MBChB FRCA FANZCA
Townsville University Hospital
SPANZA Guideline subcommitee

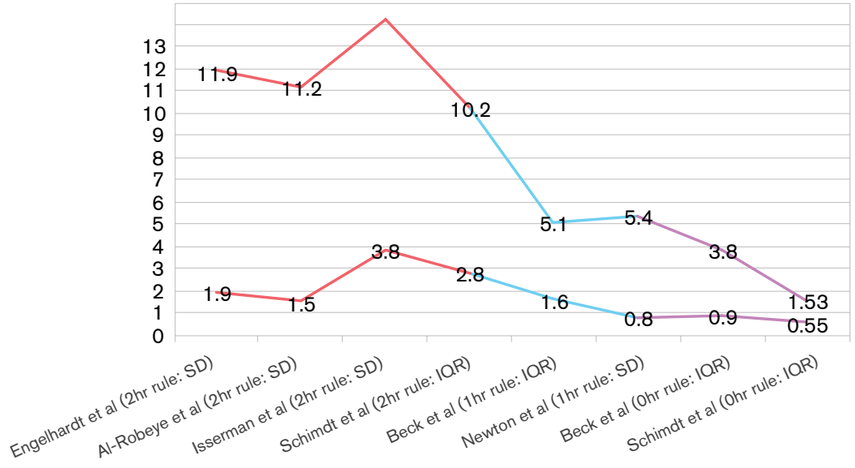
FIGURE 1. STUDIES APPLYING TWO, ONE AND "0" HOUR FLUID FASTING RULES AND RESULTANT AVERAGE REAL-WORLD FASTING TIMES.



(References within figure are described and referenced in reference 1.

hrs = hours.
hr= hour.
Colour coding:
Red = 2 hour rule
Blue = 1 hour rule
Purple= "0" hour rule)

FIGURE 2. STUDIES APPLYING TWO, ONE AND "0" HOUR FLUID FASTING RULES AND RESULTANT REAL-WORLD FASTING VARIATION AS MEASURED BY UPPER AND LOWER LIMITS OF INTER-QUARTILE RANGE AND ONE STANDARD DEVIATION1.



(References within figure are described and referenced in reference 1.

Hr = hour.
SD = standard deviation.
IQR = Interquartile range.
Colour coding:
Red = 2 hour rule,
Blue = 1 hour rule,
Purple = "O" hour rule)

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WebAIRS: Learning from adverse events

Globally, an astonishing 310 million major surgeries are performed each year, and estimates assume that eight million patients die perioperatively yearly and up to double that number might experience postoperative complications.

Therefore, assessing perioperative anaesthesia morbidity and mortality is equally important, which is not a new concept and had already been recommended by Professor Sir Robert Macintosh in a published letter to the *British Journal of Anaesthesia* in 1949. In this letter, he states the importance of collecting information on anaesthesia incidents and deaths to help learn from our mistakes.

In Australia and New Zealand anaesthetists can do that via webAIRS, a bi-national anaesthesia incident reporting system. Data are entered voluntarily, deidentified, and protected by qualified privilege coverage. Since its foundation in 2009, more than 10,000 incidents have been reported, and an overview of these was presented at the recent Combined Scientific Congress (CSC) in Wellington (October 2022). In addition, data are continuously cleansed and analysed, making webAIRS one of the largest accessible incident reporting systems in healthcare worldwide.

Exciting analyses are in progress, including the review of perioperative cardiac arrest data, oesophageal intubation, paediatric regional anaesthesia, and more.

Twenty-six journal articles have been published which include an overview of the first and second 4000 webAIRS reports, aspiration cases, analysis of difficult and failed intubation, corneal abrasion, and medication errors. Additionally, the webAIRS publication group provides regular updates on interesting incidents to the ANZCA, Australian Society of Anaesthetists (ASA), and New Zealand Society of Anaesthetists (NZSA) magazines.

There are also presentations at the annual meetings of the ANZCA, ASA, and NZSA. A summary was presented at the recent CSC in Wellington in a 90-minute webAIRS session. Following an overview of the first 10,000 reports, the detailed results of an analysis of the medication errors were presented, and the advisory notices to anaesthetists (ANAs – previously known as alerts) were described. ANAs are a recent addition to the webAIRS website. The presentations are available for delegates who registered for the meeting on the virtual CSC 2022 meeting website.

It was noted in the presentation of the medication data that medication errors are not a new problem with a summary of medication errors reported to the Australian Incident Monitoring Study (AIMS) published in 1993. This analysis reported 144 reports of the wrong drug being given among the 2000 incidents reported at that time. Since then, there has been an article published in *Australasian Anaesthesia* (the Blue Book) in 2013, a case report in the *ASA Monitor* published by the American Society of Anesthesiologists and 130 incidents involving a wrong drug among the 462 medication incidents reported to webAIRS from 2009 to 2017.

Clearly, the current methods from preventing medication errors are failing and have been unsuccessful since at least 1993. Stronger methods were discussed during the presentation which included all steps from manufacture, the hospital pharmacy, storage in the operating theatre, the anaesthesia trolley and careful cross checking before administration. While many incidents involved latent factors such as similar ampoules and similar syringes there were also many incidents involving human factors.

The third presentation explained the new ANAs feature. ANAs are similar to the advisory notices issued in the airline industry to pilots and other interested parties. Cognisant of concern regarding inappropriate access, ANAs allow anaesthetists to report incidents to a peer group so that lessons might quickly be learnt by Australasian colleagues without the concern of a privacy breach, personal approbation or adverse public comment.

Embedded in the normal webAIRS reporting system is a mechanism whereby the reporter can recommend promulgation as an ANA. The basic format is of self-reporting with the invitation to include reflection and suggestions for future avoidance or mitigation strategies. Each entry is filtered at ANZTADC executive level to ensure complete anonymity for any party involved in the incident and then submitted for comment by a peer panel before release.

Feedback is by way of panel comment through the password-protected environment of the webAIRS member website or by direct application. This ensures complete anonymity for the reporter who is in the position of then accessing the completed entry without declaring identity. Although in its relative infancy, the take-up of this method of protected peer-to-peer incident reporting is significant, and it is expected to increase over time.

Why are incident reporting and analysis important for patient safety? In its 2020 released guidelines on incident reporting in healthcare, the World Health Organization states that the ultimate aim of investing adverse events is to reduce the risk of harm and their occurrence. WebAIRS is working to achieve this by continuously managing the database, analysing incidents, and reporting findings back to the anaesthesia community via peer-reviewed journals, conference attendances, magazine articles, alerts, and workshops.

Every anaesthetist in Australia who is either a member of ANZCA, ASA, or NZSA can support quality and safety by reporting incidents that occurred in their practice. These incidents may involve allergic reactions, documentation errors, cardiovascular problems, respiratory problems, and more. Any harm category may be included, including hazards and near misses, even if the patient was not affected by the incident, as every unsafe condition has the potential to cause a major event.

If, as a reader of this article and a webAIRS user you would like to send any feedback or suggestions regarding the website, please contact ANZTADC via anztadc@anzca.edu.au.

If you are not already a registered user, then please register to start contributing to patient safety by visiting the webAIRS registration page at: www.anztadc.net/RegisterAccount.aspx.

ANZTADC Case Report Writing Group

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How we celebrated #NAD22

Above: The ANZCA 2022 National Anaesthesia day poster

Above: The te Reo Māori translations of the #NAD22 fact sheets.

Left: Screenshot from the #NAD22 video "Anaesthesia and children."

Nearly 80 National Anaesthesia Day champions in Australia and New Zealand celebrated ANZCA's event on Monday 17 October this year in public and private hospitals, anaesthesia practices and hospital communications departments.

This year's theme "Anaesthesia and children: Caring for your kids" was a natural follow on from the 2022 theme "Anaesthesia and having a baby". With the co-operation of the Society for Paediatric Anaesthesia in New Zealand and Australia, ANZCA developed a suite of web-based promotional materials including a patient information animated video, four factsheets in English and te Reo Māori and a poster in English and te Reo Māori which many of you used and shared as part of your celebration of the day.

Despite many hospitals still experiencing COVID-19 resourcing pressures many fellows, trainees and specialist international medical graduates (SIMGs) embraced the day with social media posts, cake extravaganzas and colourful displays.

Nominated champions included fellows, trainees and specialist international medical graduates from sites in Australia and New Zealand including Perth Children's Hospital, Queensland Children's Hospital, the Women's and Children's Hospital (Adelaide), St Vincent's (Melbourne), Coffs Harbour Hospital, Royal Prince Alfred, Dunedin Hospital, Tamworth Hospital, and Southland Hospital, Invercargill. Many hospitals shared their photos with us on Twitter and Instagram. The ANZCA Clinical Trials Network celebrated with a cake and the Geoffrey Kaye Museum of Anaesthetic History tweeted an image of the first equipment used to intubate children with diphtheria.

Child-friendly decorations were popular – the Women's and Children's Hospital in Adelaide had coloured paints and canvases for kids who were encouraged to make a mess, others were given hands-on lessons in intubating mannequins.

Our promotion included media coverage in Australia and New Zealand in the lead-up to the day. Two media releases were distributed and ANZCA President Dr Chris Cokis was a guest on ABC Radio Perth's "Ask an expert" segment. The 30-minute segment included calls from listeners asking about anaesthesia and sending in questions via text. Dr Cokis also pre-recorded audio "grabs" for distribution to dozens of metropolitan, regional and rural radio station newsrooms with a media release.

The Courier Mail in Brisbane interviewed paediatric anaesthetist Dr Paul Lee-Archer about his child recovery score trial (the focus of one our NAD media releases) and featured a photo and interview with one of Dr Lee-Archer's young patients and his mother. The article was syndicated to nine other News Limited titles across Australia including the *Daily Telegraph* in Sydney, the *Herald Sun* in Melbourne, the *Gold Coast Bulletin*, the *Hobart Mercury* and the *Cairns Post* reaching more than 500,000 readers.

In New Zealand, paediatric anaesthetist Dr Dean Frear from Starship Children's Hospital in Auckland appeared on RNZ Nights with Karyn Hay to discuss NAD in a nine-minute segment and NZ online news Rotorua Now posted an article "Anaesthesia campaign to ease children's fears" with a link to the video.

Carolyn Jones
Media Manager, ANZCA

SOCIAL MEDIA

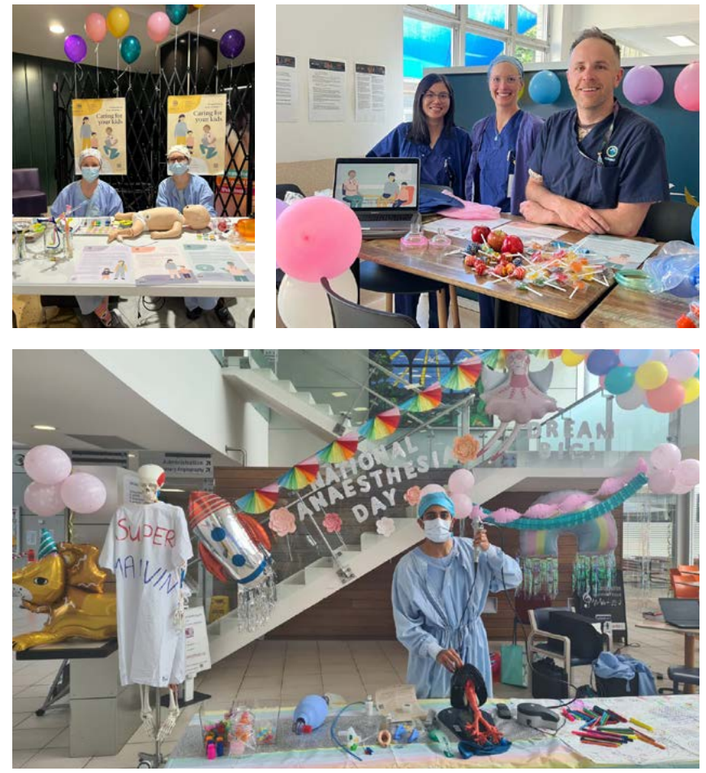
The NAD 2022 hashtag #NAD22 has received more than two million impressions and 336 tweets from nearly 150 participants.

Our anaesthesia and children video has had more than 700 views on YouTube, reached over 900 accounts on Instagram, and over 700 people on Facebook.

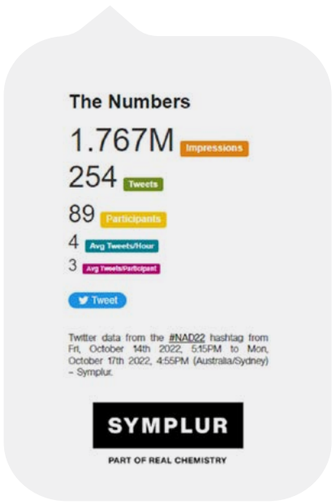
A video created by fellows from the Royal Children's Hospital titled "Your baby, our baby" (their rendition of Cold Chisel's "My Baby") has been highly praised, receiving more than 5100 impressions and 279 engagements on Twitter. It's also reached more than 4400 people and had more than 1050 engagements on Facebook.

Many hospitals got involved and shared their photos with us on Twitter and Instagram. The Royal Prince Alfred Hospital held a theatre bake-off competition, the Mid North Coast Local Health District at Coffs Harbour Hospital had an incredible display with colourful balloons, streamers and creative characters and plenty of hospitals displayed our special NAD posters, fact sheets and new patient information video.

Quite a few people used elements from our NAD social media toolkit including the custom GIFs on Twitter and the Instagram stickers.



Scenes from hospital #NAD22 celebrations clockwise from top left: Royal Prince Alfred; Wangaratta; Coffs Harbour; Perth Children's; Toowoomba; Wellington.



Grant focuses on First Nations people

Darwin anaesthetist Dr Edith Waugh is a recipient of an ANZCA 2022 Health Equity Projects Fund grant. Her research project focuses on patient valued perioperative outcomes for the First Nations people of the Northern Territory and is being conducted with the Menzies School of Health Research. Here, she and Menzies co-authors Mark Mayo and Associate Professor Marita Hefler explain more about the project.

Imagine you live in a remote Northern Territory community of only a few hundred people. Far from the cafés and buzz of Australian cities and towns, facilities are limited to a community store, health clinic, school, arts centre and local council. Although English is not your first language, you do speak it with outsiders, including most healthcare staff.

Among community members however, most conversations happen in one of the Aboriginal languages that have survived colonisation. Culture and kin relationships and obligations dictate the rhythm of life.

"... I was catching fish and turtle for dinner when the clinic bus arrived to pick me up ... the driver pointed to the clipboard note saying I had a plane to catch to fly to the "big smoke" for a medical appointment ..."

You are attending to your daily activities when the community clinic bus unexpectedly arrives to take you to a hospital appointment in the distant "big smoke" city. Because you trust the clinic and the driver, and you have been treated well at the hospital before, you agree to travel hundreds of kilometres away from your home.

You travel alone and have no time to pack a bag with your regular medications, phone charger or your ATM card. The bus takes you to the airstrip where you board the eight-seater plane chartered to support essential services to the community.

On arrival to the preadmission clinic at the hospital, you are told you will have an operation tomorrow. Much has happened behind the scenes between the hospital, patient travel service and local clinic to get you to the hospital. While you vaguely recall discussing the operation with the surgeon last wet season, your understanding of what will happen is limited.

The English-speaking healthcare staff at the clinic and hospital believe they have fully explained the procedure to you and have your informed consent. The outpatient department receptionist, preadmission clinic nurse, anaesthetist and surgical registrar – none of whom you have met before and none of whom speak your language – provide you with a long list of instructions in English, using medical terminology you don't fully understand which turns into "white noise". There are no interpreters at any of the discussions to ensure you are given information in your language – a common experience in this part of Australia, although efforts are under way to change this[1].

You know these people have good intentions, but what is important to you and your family when having an operation?

To answer this question, the 2022 ANZCA Health Equity Projects Fund is supporting a research project titled: "What is valued by remote Aboriginal patients living in the Northern Territory during their perioperative journey?" This exploratory qualitative project seeks to bridge the knowledge gap between First Nations peoples' values of health and wellbeing and the westernised healthcare system in the perioperative setting.

First Nations peoples in Australia are less likely than non-Indigenous people to have medical or surgical procedures while in hospital (64 per cent versus 81 per cent)[2], and while researchers have explored access barriers to surgery[3] and the reasons behind high self-discharge incidence prior to treatment completion[4], there has been no consultation or collaboration with First Nations consumers to explore what outcomes they value in the perioperative journey.

From left: Co-authors Mr Mark Mayo, Dr Edith Waugh, FANZCA and Associate Professor Marita Hefler.

One study of postoperative pain experiences in Central Australian Aboriginal women highlighted the significant gap in understanding culturally appropriate methods of expressing pain and how western medically trained staff assess and record this pain[5]. In international perioperative literature, patient experiences are limited to reflections on communication and sense of security, and there has been little examination of broader cultural considerations[6].

First Nations peoples' trust in the health system is limited due to colonisation, persistent institutional racism, and dynamics where power is held by the doctor who is assumed to know best. The medicine toolbox has trained clinicians to manage and evaluate patient health with western tools and outcome frameworks. Addressing health equity requires consideration of cultural values and developing ways for the health system to work in collaboration with marginalised groups. Perioperative care of patients with complex medical conditions by busy multidisciplinary teams is incomplete and insufficient when it does not match patients' needs and values. The priorities of First Nations peoples must be central in perioperative care management.

The research will be co-designed with First Nations co-researchers and guided by consumer reference groups. The Participatory Research Action methodology, which empowers voices to be heard and translated into action, will use focus groups and interviews moderated by First Nations mentors with lived experience of surgery and health service engagement. An experienced qualitative research team, including First Nations researchers and community engagement officers, will oversee and collaborate in data collection, analysis and interpretation. Healthcare staff working in the NT, where the majority of clinicians are non-Indigenous, want to improve the care they provide to the more than 50 per cent of patients who identify as First Nations[7]. Our colleagues' research taking a similar approach in other domains has shown improvements in patients' experiences[8], increased skills and satisfaction of healthcare staff, and likely reduced costs associated with re-admission[9].

We are seeking to understand which factors are important when contemplating surgical intervention options. For example, what is the role of appropriate kinship support and healing on-country? Who is culturally and spiritually

responsible for making these decisions where autonomy and decision making are seen through a collective rather than individual lens? How should discussions with patients happen in the time-poor westernised health care system where direct questioning is the norm rather than cultural yarning to establish rapport and trust through oral story telling? Furthermore, how is the discussion about the balance of westernised medicolegal "benefit versus risk" concept with First Nations people pitched when the concept of risk is poorly defined in some First Nations communities? While recognising First Nations peoples' cultural and spiritual values are diverse, this project strives to commence the discussion about benefits of sharing knowledge of health and wellbeing in the context of perioperative journeys.

ANZCA's support strengthens the team to ensure the cultural values outlined in the National Health and Medical Research Council guidelines for ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities are followed. This project will provide a process for the gathering of new knowledge and a foundation structure for future perioperative research projects with First Nations Peoples in Australia.

Dr Edith Waugh
FANZCA and PhD scholar, Royal Darwin Hospital

Mr Mark Mayo
Senior researcher and deputy Director of Indigenous Leadership
and Engagement, Menzies School of Health Research

Associate Professor Marita Hefler
Principal research fellow and specialist qualitative researcher, Menzies School of Health Research

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Health Equity Projects Fund

The ANZCA Health Equity Projects Fund supports college activities in global development and Indigenous health.

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

2023 RECIPIENTS

Dr Arihia Waaka, Rotorua
Composing a karakia for families to use, preop

Develop a surgery-specific karakia (incantation) for use by ANZCA fellows and trainees. This karakia will then be able to be used by patients and their families before surgery, thereby affording them another layer of safety, and be a positive affirmation for them as well in this time of uncertainty. ANZCA will have the right to distribute the karakia as it sees fit (for example, on posters in theatre waiting rooms, on the website, in information booklets for families), with credit to the composer.

Dr Hannah Bennett, Townsville
Indigenous EQUIP Pain Management Group Program

Revise the current EQUIP pain education module and adapt this for the local Indigenous community to provide culturally safe and appropriate pain education. This would be located at the local primary health care centre in a community space with staff travelling to the community to deliver the program with local health professionals. The session would run as a "one-off" with the aim to continue a regular program depending on the quality review process. Local health practitioners and health workers will also be able to attend.

Dr Carolyn Deng, Auckland
Understanding Māori perspectives of anaesthesia preadmission clinic at Te Toka Tumai, Aotearoa New Zealand

This project aims to assess the perceptions of Māori patients and whānau (family) attending anaesthetic preadmission clinic. The main focus of the survey is to understand how accessible and culturally safe the preadmission clinic is for Māori patients and whānau, using a whānau-centred approach.

Above: Anaesthetists and trainees from Colonial War Memorial Hospital, Suva

Dr Adam Mossenson, Perth
Implementation of VAST in Pune, India, including curriculum integration of the VAST Foundation Year

Deliver three Vital Anaesthesia Simulation Training (VAST) courses to new post-graduate students to build facilitator capacity to implement the VAST Foundation Year program. VAST was founded in 2017 to overcome barriers limiting widespread application of simulation-based education in resource-limited environments. Using multidisciplinary, immersive, low-cost simulation training, the course addresses anaesthesia and resuscitation for obstetrics, paediatrics, and trauma, as well as safe general surgery and pre- and postoperative care, with an underlining focus on nontechnical skills.

Dr Nilru Vitharana, Sydney
Pacific Paediatric Anaesthesia In-situ Teams Course (Pacific PAINTS)

Deliver the Pacific Paediatric Anaesthesia In-situ Teams Course (Pacific PAINTS) – a half-day course that covers the principles of resuscitation and management of the critically unwell child and common anaesthesia emergencies in a simulated environment, in Suva, Labasa and Lautoka.

Dr Mark Trembath, Brisbane
Pacific Islands anaphylaxis box and education project

This project will provide anaphylaxis emergency response boxes for participating hospitals in the Pacific Islands. The emergency boxes will include laminated copies of the adult and paediatric cognitive aids, background guidelines and patient paperwork as per Australian and New Zealand Anaesthetic Allergy Group (ANZAAG) recommendations. On receiving the box each participating department will receive an online training session to support its implementation and safe use. The hospital lead will also be provided with training resources to support ongoing departmental training.

Dr Justin Skowno, Sydney
Morbidity and Mortality in Mongolian paediatric anaesthesia practice – building a quality improvement system for the specialty

A study to collect mortality and morbidity related information in paediatric anaesthesia and surgery, with the goal of improving safety and quality in hospital policy level in particular fields. In parallel with this specific study focus, this group aims to develop an ongoing quality improvement project in Mongolian paediatric anaesthesia.

Be connected

ANZCA ASM 2023 5-9 May, Sydney

"It's our great privilege to invite you to 'Be connected' in Sydney for the 2023 ANZCA Annual Scientific Meeting #ASM23SYD. After the many challenges of the COVID-19 pandemic, we're excited to present an in-person meeting that is a celebration of science, excellence in patient care, collaboration and human connection."

Dr Shanel Cameron and Dr Tanya Selak,
ASM Co-convenors

#ASM23SYD
asm.anzca.edu.au

Register now and 'Be connected'!

What to expect:

Expect a bumper program, with something for everyone: workshops, small group discussions, the scientific program, social functions and optional activities. Can't make it to Sydney? No worries, there are great virtual delegate experiences too! Be sure to check out the website and the inclusions available as an in-person or virtual attendee.

Be connected:

As the year draws to a close and we make plans to 'Be connected' make sure you:

- Visit the website to make your plan for the week of the ASM! (something for everyone! Science, social, connection....)
- Request your leave, book your flights and accommodation...
- If you are a prospective author or researcher, submit your abstract (submissions close 15 January, 2023)
- Register for the ASM (early bird closes 3 March, 2023)

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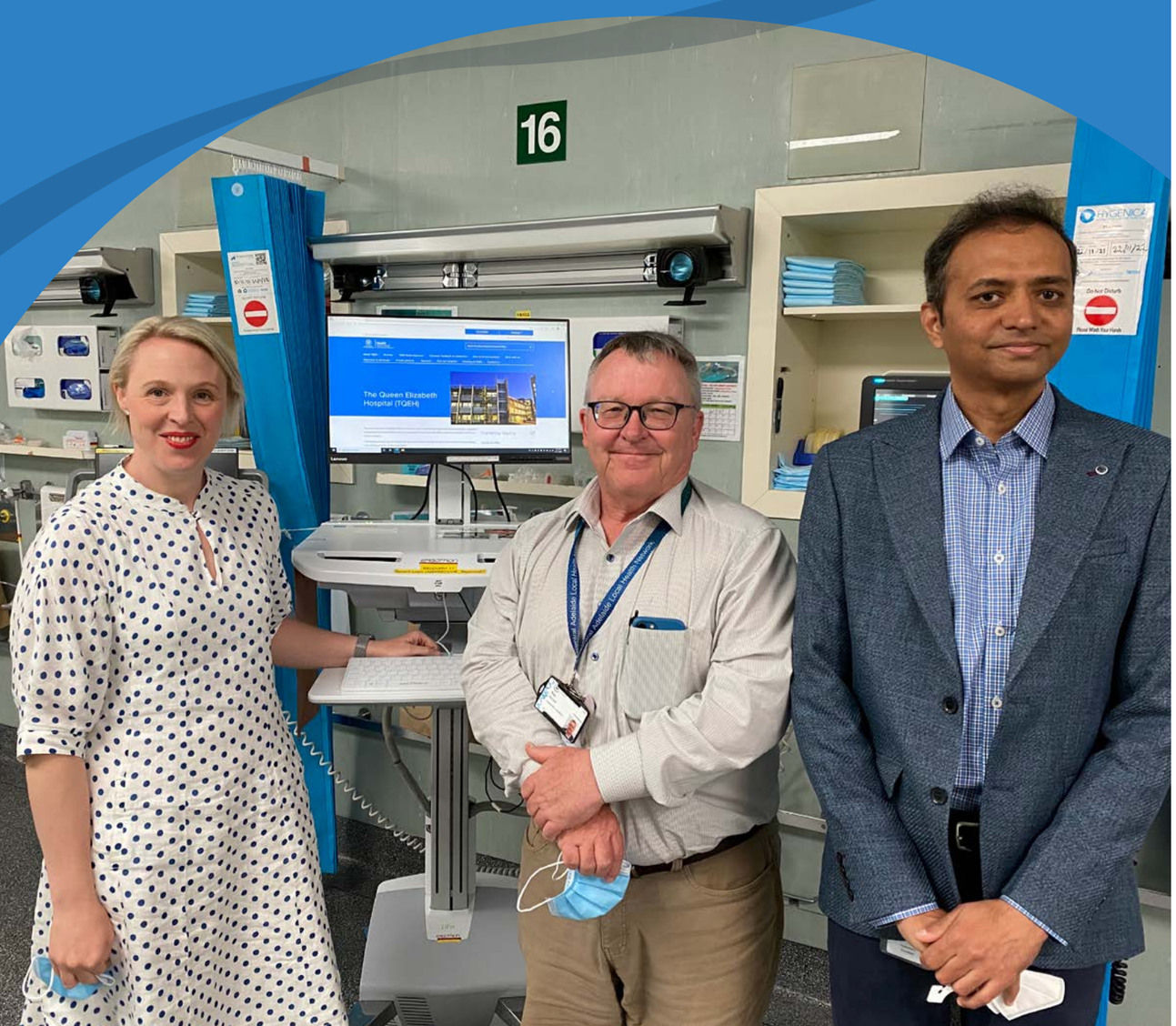
ANZCA FPM

Research



Research grants for 2023

It was very pleasing to see the high number of applications received to be considered for grant funding in 2023, despite the continued pressure of COVID-19 on clinical workloads and its impact on research projects.

With a roll-over amount of funds from the deferred 2020 grant round, the ANZCA Research Committee has awarded funding of almost $A2 million through the ANZCA Foundation for 2023 research grants: the Lennard Travers Professorship, the Academic Enhancement Grant, 20 new project grants, 10 second year project grants, one novice investigator grant, the Patrons Emerging Investigator Grant, the Skantha Vallipuram ANZCA Research Scholarship, and an allocation for Clinical Trial Network pilot grants.

Thirty-five investigators and teams will be supported in 2023. Their important research will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong, and are a vital part of ANZCA's continuous advancement of safe, high-quality evidence-based patient care in anaesthesia, intensive care, perioperative medicine and pain medicine, through high quality medical research, and translation and implementation in clinical practice.

In 2023, we are pleased to be funding a new project to support research in postoperative outcomes in geographically isolated and culturally diverse populations in the Northern Territory, and providing second year funding for a study identifying facilitators of and barriers to engagement with Māori patients in the perioperative setting. We are striving to encourage applications to support research in our Aboriginal, Torres Strait Islander and Māori populations.

The foundation is very appreciative of the generosity of all of its donors and supporters, especially the regular giving of our patrons, and those who provide named research awards, bequests, and major grants: Mrs Ann Cole, Mrs Indi Mackay, the late Dr Robin Smallwood, the late Dr John Boyd Craig, the estates of the late Dr Nerida Dilworth AM, Dr Elaine Lillian Kluver, Dr Peter Lowe, Mrs Asoka Vallipuram, The Medibank Better Health Foundation, and Auckland's North Shore Hospital and Waitemata District Health Board.

Professor David A Scott
Chair, Research Committee

Mr Rob Packer
General Manager, ANZCA Foundation

LENNARD TRAVERS PROFESSORSHIP

ANZCA congratulates Professor André van Zundert on being awarded the quadrennial Lennard Travers Professorship for 2023. This is a prestigious award which provides support for a fellow of the college to work in an area of their choosing towards the advancement of knowledge in a nominated area of anaesthesia in Australia, New Zealand, Hong Kong, Malaysia and Singapore. The tenure of the professorship is one year and Professor van Zundert will hold the courtesy title "Lennard Travers Professor of Anaesthesia".

Discovering anaesthesia recovery treatments (DART): A super-resolution microscopy approach to uncovering reversal agents

Although general anaesthetics (GA) have been in use since 1846 and hundreds of millions of people every year worldwide undergo surgery, we still lack a full explanation of the mechanism of action of most agents used in general anaesthesia. This knowledge gap has hindered our capacity to address some aspects of general anaesthesia that remain problematic, in particular recovery from deep anaesthesia, especially in elderly patients. Considering the shift to older demographics and the increased reliance on general anaesthesia for most surgeries, there is a clear need to better understand why recovery can sometimes be difficult or unduly prolonged, and whether designer drugs can help with this process. This lack of a capacity to counteract the anaesthesia process has serious secondary consequences, such as increased length of hospital stay, and more postoperative complications, including postoperative cognitive decline.

The aim of this study is to investigate whether two propofol analogues are effective in reversing the effects of propofol on syntaxin1A mobility at the synapse when provisioned in combination with clinically relevant concentrations of propofol. This work will be done in fly brains and mammalian cell cultures in the laboratory of Professor Bruno van Swinderen at the Queensland Brain Institute.

The study will provide a platform for screening and testing candidate reversal agents for general anaesthesia, based on our growing understanding of a relevant presynaptic process that is targeted alongside the better-understood post-synaptic receptor targets. This platform will help establish novel approaches to reversing GA, based on a better understanding of the underlying molecular processes.

Professor André van Zundert, Royal Brisbane and Women's Hospital, Queensland; Associate investigator, Professor Bruno van Swinderen, Queensland Brain Institute.

$A69,687

The Elaine Lillian Kluver ANZCA Research Award winners from left, Dr Sarah Flint, Dr Tim Semple and Dr Venkatesan Thiruvenkatarajan.

Harry Daly Research Award

The environmental footprint of packed red blood cells: A life cycle assessment from donation to disposal

A sustainable healthcare system is achieved by delivering high quality care and improved public health without exhausting natural resources or causing ecological damage. Like all sectors of the economy, the healthcare sector in Australia and New Zealand needs to move to a more sustainable model by actively reducing its environmental impact and carbon emissions. Subsequently, there are a multitude of processes and clinical pathways in healthcare that require environmental assessment.

The investigators will conduct a Life Cycle Assessment (LCA) (cradle to grave) to determine the environmental footprint of a producing a unit of Packed Red Blood Cells (PRBC). The study is purely observational, with no changes to patient activity.

The scope of the LCA will include all significant material and energy inputs from the time of blood donation to the administration of blood to a patient. Inputs will include raw material production, manufacturing, packaging, transport, use, and end-of-life (clinical waste, landfill, and recycling). The production of a unit of RBC will be subdivided into donor travel, donation, separation/fractionation, transportation, storage, laboratory testing, and delivery to the patient.

This study will provide valuable information regarding the environmental impact of PRBCs. Understanding the environmental footprint of PRBCs will provide further motivation to improve the appropriate use of blood products and reduce any associated waste. Further, this study will provide a detailed analysis of both the location and extent of environmental impacts, such as greenhouse gas, particulate matter emissions, and water use, meaning any mitigation strategies can be focused on those processes that have the highest environmental burden.

Professor Bernd Froessler, Lyell McEwin Hospital, South Australia; Associate Professor Forbes McGain, Western Health, Melbourne; Dr Owen Tomasek, Northeast Health, Wangaratta, Victoria. Technical lead: Dr Scott McAlister, University of Melbourne, University of Sydney.

$A45,610

The Russell Cole Memorial ANZCA Research Award

PAIN in survivors of intensive care units (PAIN-ICU) study: A multicentre, prospective, observational cohort study

Pain is ubiquitous in critically ill patients with more than 50 per cent of intensive care unit (ICU) survivors recalling moderate to severe pain during their ICU admission. The incidence of moderate to severe pain at rest for both medical and surgical ICU patients is 51 per cent. Treatment of acute pain within the ICU can lead to improved outcomes and decreased length of ICU intervention, while inadequate analgesia can lead to chronic physical and psychological morbidity.

Improvements in the management of critically ill patients have resulted in improved survival. However, these survivors are at an increased risk of cognitive, psychiatric, and physical disability, including chronic post-ICU pain (CPIP). The incidence of CPIP ranges from 17.7 to 74 per cent. Such diverse estimates are explained by different cohorts, study locations, definitions of CPIP, timeframes of evaluation and study design. There is also disparity about and focus on potentially modifiable causal factors.

This research project aims to determine the incidence of chronic pain in patients six months after being discharged from intensive care. The outcomes of this study will determine potential modifiable causal factors for CPIP that will enable targeted therapeutic interventions and hence, clinical trials that could potentially reduce the incidence of chronic pain in ICU survivors. Even a modest reduction in the incidence of chronic pain would have profound effects in the long-term outcomes of patients with a reduction in the burden to the individuals and the community.

Dr Ben Moran, Gosford Hospital, NSW; Professor John Myburgh, The George Institute of Global Health, NSW; Professor David A Scott, St Vincent's Hospital, Melbourne; Associate Professor Elizabeth Holliday, Hunter Medical Research Institute, NSW.

$A70,000

John Boyd Craig Research Award

Nebulised fentanyl for labour pain – a pharmacokinetic and feasibility study

In Australia 78 per cent of labouring women use some form of medication for pain relief. Inhaled nitrous oxide is one of the widely available, used by 53 per cent of women. However, the widespread use of nitrous oxide is currently being reconsidered due to environmental concerns.

Anaesthetists are already deeply involved in obstetric analgesia, providing epidural and remifentanil analgesia. This study presents an opportunity to use our expertise and collaborations to provide preliminary data evaluating nebulised fentanyl as a needle-free and inhaled form of analgesia. Having formulated an evidence-based repeated dosing strategy, further studies will be required to evaluate the full regimen in labouring women. Nebulised fentanyl presents an opportunity to reduce or even eliminate the use of nitrous oxide for this purpose, consistent with the ANZCA Position Statement on Environmental Sustainability PS64(G).

Ultimately, we would like to compare nebulised fentanyl with the existing inhaled nitrous oxide to determine if the two techniques provide equivalent analgesia without causing significant neonatal or maternal side effects. Patient and midwife experiences will also be evaluated. This preliminary research will lead to dosing recommendations and larger clinical evaluations, aiming to provide an additional needle-free, widely available and environmentally friendly option for pain relief during labour.

Associate Professor Victoria Eley, Dr Christoph Lehner, Associate Professor Tim Donovan, Associate Professor Jayesh Dhanani, Royal Brisbane and Women's Hospital, Queensland; Dr Elizabeth Martin, Mater Health, Queensland; Dr Nigel Lee, Professor Jason Roberts, University of Queensland.

$A63,483

Robin Smallwood Bequest

Neurocognitive trajectory in adolescents recovering from major spinal surgery for idiopathic scoliosis

Neurocognitive changes have been studied extensively in the elderly where evidence suggests the possibility of persistent cognitive dysfunction after surgery. The incidence, time course, etiology, and relevance of this possibility in pediatric populations are incompletely understood. While there has been extensive study into the neurotoxic effects of anaesthesia in early childhood, there has been little research into the impact of surgery and anaesthesia in older children.

This study will include children between 10 to 16 years of age scheduled for major spinal surgery for idiopathic scoliosis, in otherwise healthy children. The trajectory of the child's neurocognitive function will be assessed at regular intervals using well validated psychometric testing. The study will also explore the incidence of post-anaesthesia delirium as in adults, delirium has been linked to cognitive decline.

The findings from this study should have an immediate impact on information for parents as well as being an example for similar studies for other surgeries. If decline is documented, the study will also provide data to understand aetiology, potential risk groups and possible targets for future interventions.

Professor Andrew Davidson, Associate Professor Christopher Brasher, Royal Children's Hospital, Melbourne; Dr Suze Bruins, Perth Children's Hospital, Perth; Associate Professor Aaron Buckland, Melbourne Orthopaedic Group, Melbourne; Dr Louise Crowe, Murdoch Children's Research Institute, Melbourne; Associate Professor Justin Skowno, The Children's Hospital at Westmead, NSW; Professor Laszlo Vutskits, University Hospitals of Geneva, Switzerland.

$A50,074

The Elaine Lillian Kluver ANZCA Research Award

Implementation of an opioid weaning program prior to TKR: Feasibility and effect on postoperative outcomes

Total knee replacement (TKR) surgery in Australia has increased from 123 to 242/100,000 population from 2013-2016, with a projected rise of 276 per cent by 2030. Recommendations for medical management of knee osteoarthritis suggest short courses of non-steroidal anti-inflammatory drugs and corticosteroid injections, with strong recommendations against opioid use. A significant increase in opioid prescription for non-cancer related pain has occurred in recent years; one in two Australian patients are prescribed opioids in the year prior to TKR.

A preoperative opioid-free period for up to three months has been associated with reductions in adverse effects, however robust prospective studies exploring the feasibility of opioid weaning before TKR, and its clinical impact are lacking.

The aims of this study are to assess the feasibility of an opioid weaning pathway in patients waiting for TKR, and to assess the impact of preoperative opioid weaning on preoperative pain as well as short-term and long-term postoperative outcome measures. If opioid weaning is feasible, it will be implemented as standard care across our health network. Patients and the community will benefit by an improvement in their pain, quality of life and reduction in opioid burden. It will guide clinicians to assess the economic impact on healthcare by reducing the risk of post-surgery adverse outcomes. Supporting patients and their GPs to wean from opioids prior to TKR may both improve pain and functional outcomes and provide a good return on investment.

Associate Professor Venkatesan Thiruvenkatarajan, Dr Sarah Flint, Dr Tim Semple, Queen Elizabeth Hospital, South Australia; Professor Pamela Macintyre, Royal Adelaide Hospital, South Australia.

$A59,800

Skantha Vallipuram ANZCA Research Scholarship

High flow nasal oxygen to prevent desaturation for labouring women using remifentanil PCA (HOPE-for-REMI study)

This randomised controlled trial is investigating the feasibility and safety of high flow humidified nasal oxygen (HFNO) in labouring women using remifentanil for patient-controlled analgesia (PCA). Opioid PCA is commonly used as pain relief for women who have contraindications to epidural analgesia such as thrombocytopaenia or who desire a non-invasive form of labour pain relief such as women undergoing vaginal birth for fetal death in utero. In our hospital, we use the opioid fentanyl, however, evidence suggests that remifentanil provides superior pain relief.

The major side effect of remifentanil PCA is maternal hypoxaemia from opioid-induced ventilatory impairment. HFNO can provide accurately titratable inspired fraction of oxygen, dynamic continuous positive airway pressure and apnoeic oxygenation. This trial is a first step towards investigating whether the addition of HFNO to remifentanil PCA is a safer option for this therapy and determine feasibility of a larger trial. If HFNO can reduce oxygen desaturation in pregnant women receiving remifentanil PCA, this could have significant application for obstetric centres worldwide, affect a shift in clinical practice and raise awareness regarding the needs of the vulnerable subpopulation of labouring women giving birth to stillborn babies.

This trial forms a component of Dr Tan's PhD at the University of Melbourne with the research to be undertaken at The Royal Women's Hospital.

Dr Patrick Tan, Royal Women's Hospital, Melbourne.

$A14,203

Patricia Mackay Memorial ANZCA Research Award

Research into older patients' anaesthesia and surgery outcome numbers (REASON) in the Northern Territory: A feasibility trial

Perioperative medicine research has highlighted the association of patient, surgical, and healthcare system factors with postoperative outcomes. Yet, there has been no exploration of postoperative outcomes in the geographically and culturally diverse population such as in the Northern Territory, where the more challenging access to surgical care results in later presentations and more advanced illness. In the Northern Territory 40 per cent of the population lives remote and 30 per cent identify as First Nations peoples with an estimated five-year shorter life span and 80 per cent higher burden of disease, especially in those living remote and/or identifying as First Nations peoples.

The primary aim of this project, Outback REASON NT, is to establish whether research examining postoperative outcomes in a geographically isolated and culturally diverse population, such as that of the Northern Territory, is feasible. Further, the project will determine the appropriate tools and processes to measure postoperative outcomes for the geographically and culturally diverse population of the Northern Territory. The findings of this study will guide informed decision making for a future definitive study on postoperative outcomes in this population. The new knowledge will contribute to designing equitable perioperative models of care suitable to greater diversity of people in Australia and globally.

This project forms part of Dr Waugh's PhD program with the research to be undertaken at the Royal Darwin Hospital.

Dr Edith Waugh, Royal Darwin Hospital, Northern Territory.

$A90,000

ACADEMIC ENHANCEMENT GRANT

Collaboration, mechanisms and modulation: Improving perioperative brain health

This grant will guide best clinical practice in Australia, revolutionise our understanding of the mechanisms through which acute illness and surgery alter the cognitive trajectory, and lead international efforts in trials on the prevention of delirium. It will significantly expand the breadth of Professor Sanders research program and accelerate the depth of accumulated knowledge for the field. The timing of this work is critical as: biospecimens and imaging data are ready for analysis; there is a significant knowledge gap in these areas of research; my mechanistic evidence suggests novel preventative measures for delirium that can be implemented rapidly and cost-effectively; and in Australia, we can optimise best clinical practice for preventing delirium.

This program of research encompasses three projects: Translate delirium research into national standards and a collaborative research network; determine whether cumulative hospitalisations lead to chronic inflammation and neurodegeneration that mediate long-term cognitive decline using UK biobank data and conduct new trials informed by discovery, research collaboration and new networks.

Professor Robert Sanders, The University of Sydney, NSW.

$A100,000

NOVICE INVESTIGATOR GRANT

The relationship between hunger and gastric volumes assessed by ultrasound in patients with an acute abdomen

Aspiration is the leading contributor of anaesthetic-related morbidity and mortality, of which inaccurate risk assessment is often the root cause. Fasting patients to ensure they have an empty stomach prior to general anaesthesia is a mainstay of anaesthetic management. Emergency surgery represents a significant risk factor, with up to 56 per cent having a "full" stomach on ultrasound assessment. This is particularly relevant in patients with acute intra-abdominal pathology, who can have delayed gastric emptying with large stomach volumes.

The aim of this study is to define the relationship between hunger and fasting as assessed by gastric ultrasound in patients with acute intra-abdominal pathology. The investigators hypothesise that hunger is a reliable indicator of an empty stomach, and the study aims to validate the use of these symptoms to guide anaesthetic management. Gastric ultrasound is a point-of-care assessment tool to that can be used to quantify aspiration risk in patients undergoing general anaesthesia. It is non-invasive, fast and easy to perform procedure which has been well validated.

The project will allow anaesthetists to make better decisions when managing patients, potentially reducing the risk of aspiration and improving the safety of anaesthesia. If a strong association between hunger and an empty stomach on ultrasound is found, this then validates the use of hunger as an indication of fasting. This approach will have great utility in low-resource settings where ultrasound may not be available.

Dr Fraser Morton, Dr Michael Busser, Royal Brisbane and Women's Hospital, Queensland.

$A17,808

PATRONS EMERGING INVESTIGATOR GRANT

CHIPMUNK – Chocolate-based innovative formulation of prednisolone – making unpalatable steroids nice for kids

Asthma is a leading cause of disease among children aged five to 14 years, with higher prevalence of asthma found in younger children, Indigenous children and children with disability. Oral prednisolone is the most common steroid prescribed for managing asthma flare-ups in Australia.

However, prednisolone medicines for children have intolerable taste, with children often refusing to take them or spitting them out when compelled to do so. This leads to poor medication compliance, treatment failure and potential consecutive increased risk for perioperative complications.

This project aims to overcome the low acceptance of current prednisolone products by developing a novel palatable and chewable prednisolone tablet using our patented chewable chocolate-based delivery system (CDS) that meets pharmaceutical standards of quality and storage stability. A more palatable prednisolone will help improve medication compliance and reduce the trauma experienced by caregivers and children alike when the children are forced to take bitter medications. By improving treatment compliance, patients' respiratory function and symptoms can be better optimised prior to surgery leading to less perioperative complications as well as better treatment adherence and outcomes in the acute setting. A further outcome will be the continued upskilling of the research team allowing development of other novel more child-friendly medications which are clinically important for which currently paediatric formulation are lacking and/or are unpalatable.

Dr Chloe Heath, University of Western Australia and Telethon Kids Institute; Professor Lee Yong Lim, Associate Professor Connie Locher, University of Western Australia.

$A70,000

PROJECT GRANTS

The relationship of hepcidin to patient outcomes after cardiac surgery – a sub-study of TRICS IV

The aim of this project is to understand the role of hepcidin in relation to patient outcomes after cardiac surgery. Hepcidin is a key regulator of iron homeostasis. Iron dysregulation has been implicated in the majority of cases of anaemia in the context of cardiac surgery. Nevertheless, determining the various causes of anaemia, particularly prolonged postoperative anaemia (at 30 days postoperatively) and studying its impact on postoperative outcomes has rarely been performed. Small studies have suggested that hepcidin levels may be associated with patient outcomes; however, these studies have not always accounted for the contribution that more complex analysis of iron stores, presence of anaemia or transfusion history may have on patient outcomes. Performing this sub-study in the context of a major international transfusion trial that is appropriately funded enables a cost-effective opportunity to examine this complex area with the potential to develop insights into novel blood conservation therapies.

The impact of this research on transfusion medicine is significant, as it has the potential to provide new insights into blood conservation strategies. Potential avenues from this research include deriving new methods to avoid preoperative and postoperative anaemia; and supporting the development of novel therapeutic agents.

Dr Raymond Hu, Austin Health, Melbourne; Professor David A Scott, St Vincent's Hospital, Melbourne; Professor James Isbister, University of Sydney Medical School, NSW; Professor Alistair Royse, Royal Melbourne Hospital, Victoria.

$A70,000

Developing a competency-based facilitation evaluation tool supporting healthcare simulation in resource-limited settings

Surgical and anaesthetic care are integral components of universal healthcare, but the shortage of skilled anaesthesia providers in low-resource settings (LRS) hinders delivery of life-saving procedures. Educational interventions can increase the capacity and quality of surgical and anaesthesia care in this setting. Simulation-based education (SBE) is a highly effective educational tool that replicates the clinical environment without harm to patients, and is an emerging movement in LRS.

In addition to baseline facilitation skills, simulation educators in LRS also require the ability to navigate inter-cultural interactions, work flexibly within resource limitations and resolve language and communication barriers. This research will develop a bespoke tool to support simulation facilitator training in LRS. This begins with an exploration of existing simulation facilitation assessment tools to determine their relevance in LRS. Subsequent work will be to design and implement a new tool for peer-feedback, self-reflection and mentorship of simulation educators working in LRS. The tool will be integrated into the Vital Anaesthesia Simulation Training (VAST) Facilitator Pathway. VAST is a not-for-profit company focused on overcoming barriers to SBE in any context. To date, VAST's facilitator training has been delivered in eight countries, to multi-disciplinary participants from 31 countries.

SBE in LRS is increasing. A contextually relevant tool for simulation facilitator training has potential both to strengthen VAST's facilitator training and to have value for the global simulation community. This research is a component of Dr Mossenson's PhD program.

Dr Adam Mossenson, SJOG Midland, Curtin University, Western Australia and Dalhousie University, Nova Scotia, Canada; Dr Patricia Livingston, Dalhousie University, Nova Scotia, Canada; Dr Janie Brown, Curtin University, Western Australia.

$A83,139

Dexamethasone and Albumin in Major Abdominal surGEry to Protect the Endothelial Glycocalyx (DAMAGE protection trial)

Stress during surgery can result in damage to the microcirculation that impacts adversely on kidney, heart, liver, lungs, gut and brain function. This study aims to determine if giving albumin and dexamethasone immediately prior to and during surgery can reduce the stress/inflammatory response from surgery. The investigators will evaluate the effects of the dexamethasone and albumin in patients undergoing major liver, pancreatic and colorectal resections within 24 hours of surgery using one of the main biomarkers of endothelial damage, heparin sulfate. Heparin sulfate is a measurable, validated surrogate biomarker shedding/breakdown of the endothelial glycocalyx. Supporting translational and mechanistic animal studies using electron microscopy to directly evaluate the impact of these interventions on endothelial glycocalyx of the major organs will also be undertaken, together with a health economic evaluation of dexamethasone and albumin.

The results of this pilot trial may lead to a larger multicentre, multinational NHMRC or MRFF funded trial. This in turn will inform anaesthetists, with a higher degree of precision, whether postoperative complications and long-term outcomes are improved after major abdominal surgery when dexamethasone and albumin are administered.

Professor Laurence Weinberg, Austin Hospital, Melbourne.

$A70,000

Evaluating hypotension using limited echocardiography and microcirculation imaging in postoperative patients

Postoperative hypotension is common, life-threatening and poorly understood. It is associated with an increased risk of perioperative myocardial infarction, stroke, acute kidney injury and mortality. The physiological basis of postoperative hypotension after non-cardiac surgery has not been extensively investigated. As the Australian surgical population ages and acquires risk factors for postoperative hypotension, there is an urgent need to identify the common causes of postoperative hypotension so that appropriate treatments can be delivered.

This project uses point of care cardiac ultrasound and side-stream dark-field microscopy, which images the capillary circulation under the oral mucosa to identify the major physiological disturbance driving hypotension. Both techniques have been extensively used in intensive care, but few studies have used them after major non-cardiac surgery.

This project aims to illuminate the common physiological basis for postoperative hypotension and define the relative contribution of vasodilation compared to other causes of hypotension in patients having major vascular surgery. The investigators hypothesise that a majority of patients who are hypotensive postoperatively will have evidence of vasodilation. Fully understanding the causative mechanisms behind the syndrome of postoperative hypotension will allow perioperative clinicians to design appropriate treatment plans to reduce morbidity and mortality after major surgery.

This project forms part of Dr Douglas' PhD program at the University of Melbourne with the research to be undertaken at the Royal Melbourne Hospital.

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

$A83,685

Between-centre differences in overall patient outcomes and in trial treatment effects in multicentre perioperative trials (BALLISTIC study)

Large randomised controlled trials (RCTs) are generally conducted across multiple centres. However, patient outcomes may be expected to differ between participating centres. Variability in patient outcomes between participating centres may impair the integrity and reliability of multicentre trial findings. Many clinicians believe that between-centre differences in multicentre RCTs represent a level of "background noise" that will reduce the chance of finding a statistically significant treatment effect.

The investigators will use data from several large multicentre RCTs conducted by the ANZCA Clinical Trials Network. Data collected in each trial will be used, to see if adjusting for trial centre ranking affects the primary findings of each trial. We will also combine key data (length of hospital stay and mortality rates) from all the trials and using this pooled data to look for any evidence of correlation between the ranking of trial centres by the incidence of perioperative complications overall, and their ranking by the trial treatment effect on that incidence. We will also conduct further analysis to see if these relationships are stronger for more complex or difficult trial interventions.

This extensive analysis will provide compelling evidence on the reliability of large multicentre trials to answer important clinical questions in anaesthesia and perioperative medicine, with equally important implications for research in other fields of medicine.

Professor Philip Peyton, Austin Health, Melbourne; Ms Vanessa Pac Soo, Centre for Epidemiology and Biostatistics, Melbourne.

$A17,250

Pharmacogenomic guided perioperative therapy to improve the quality of recovery after surgery: A feasibility study

More than 2.7 million operations are performed per year in Australia. Approximately one in 20 perioperative medication administrations include a medication error or an adverse drug event and more than 30 per cent suffer from significant postoperative complications which can lead to patient dissatisfaction, increased hospital stay, delayed return to work and ultimately increased patient and societal costs.

Pharmacogenomics is the study of how genetic variations affect individual drug responses, and it is an exciting emerging area which has the potential to personalise medicine, with improved patient safety, recovery and comfort after surgery. This is supported by a recent study where the use of pharmacogenomic data to guide medications for postoperative pain relief following major abdominal surgery halved opioid requirements, improved pain control and reduced pain-related side effects.

This study aims to determine if it will be possible to perform a future larger prospective trial to investigate whether pharmacogenomic testing and tailoring a patient's anaesthetic to their individual genetic profile can improve the quality of their recovery from anaesthetic, improve postoperative pain management and decrease adverse drug reactions.

Dr Michelle Gerstman was awarded an ANZCA scholarship to support her higher degree research program. This feasibility study is part of this program and has received MRFF funding.

Dr Michelle Gerstman, Professor Bernhard Riedel, Peter MacCallum Cancer Centre & University of Melbourne, Melbourne; Professor Andrew Somogyi, University of Adelaide, South Australia; Professor Carl Kirkpatrick, Monash University, Melbourne; Professor Colin Royse, University of Melbourne.

$A20,000 scholarship

COMET: Changes in oscillation mechanics, FOT and lung recruitment in paediatric laparoscopic appendectomy

Laparoscopy is the preferred surgical approach in certain abdominal procedures as it provides several advantages compared to open surgery, including minimal surgical incision, shorter hospital stays, less pain after the operation, and earlier mobilisation. However, gas insufflation into the abdomen increases abdominal pressure with consequent changes in respiratory mechanics and derecruitment of lung volume. Patients undergoing laparoscopic surgery are normally anaesthetised, muscle relaxed, intubated and mechanically ventilated. Intraoperative lung-protective ventilation has been recommended to reduce postoperative pulmonary complications. One of the guiding principles of lung-protective ventilation is to recruit the lung and to use the lowest level of positive-end expiratory pressure (PEEP) that keeps the lung open. However, adequate tools are lacking in the operating theatre for monitoring lung volume recruitment and guiding the anaesthetist in the selection and adjustment of the optimal PEEP level for each individual patient. The forced oscillation technique (FOT) is a non-invasive method for the assessment of lung mechanics, which has been successfully applied in ventilated patients.

This study will evaluate whether this novel approach of continuous monitoring of respiratory mechanics is feasible in children undergoing laparoscopic appendectomy. The results will help paediatric anaesthetists to formulate new evidence-based ventilation guidelines and policies to optimise and personalise the ventilation strategy in children undergoing laparoscopic surgery. This novel, custom-made device for the anaesthesia setting has the potential to be highly valuable in clinical practice in the future, particularly when caring for children with complex co-morbidities and/or surgery affecting the cardio-respiratory system, for example neonates with diaphragmatic hernias or gastroschisis.

Professor Britta Regli-von Ungern Sternberg, Dr Michael Collin, Dr Mon Ohn, Perth Children's Hospital, Western Australia.

$A70,000

Prehabilitation needs of patients with breast cancer: A qualitative study

Prehabilitation is a holistic suite of interventions to prepare patients for surgery. There is now strong evidence that after cancer diagnosis, but before surgery, lifestyle changes such as exercise, improved nutrition, and smoking cessation, can have a positive impact on patient's response to surgical cancer treatment. However, there is little understanding about what New Zealand patients with breast cancer, and in particular Māori patients need in terms of their wellbeing in the time between cancer diagnosis and surgery and how this compares to the understanding of prehabilitation that healthcare providers have.

This study aims to bridge this gap with the aim of improving understanding and ultimately knowing what support and care to give to breast cancer patients.

The results will form the basis of new patient co-designed prehabilitation programme in breast cancer in New Zealand. The project has a prespecified focus on Māori patients who continue to have the worst outcomes in breast cancer. Identification of patients' needs will have important impacts on future research and cancer pathway planning. It is hoped to achieve greater clinical translation and ultimately improve outcomes in breast cancer patients and that the processes underpinning this study and its findings will inform research approaches to other underrepresented groups of interest to ANZCA researchers, such as the Aboriginal and Torres Strait Islander populations.

Dr Marta Seretny, Professor Simon Mitchell, both at University of Auckland New Zealand & Auckland City Hospital. Co-investigators; Dr Hanna Van Waart, Professor Jenny Weller, Mrs Elizabeth Kanivatoa, University of Auckland New Zealand.

$A60,222

Early endotheliopathy and coagulopathy in major trauma patients: Pilot study

The management of major haemorrhage and shock has evolved significantly over recent years, and will continue to do so. Addressing acute traumatic coagulopathy (ATC) and endotheliopathy of trauma (EoT) is central to this, starting on-scene. In order to understand these processes and eventually test interventions directed at them in the pre-hospital environment we must firstly have a system for measuring them and, in turn, establish some background statistics for this patient population.

MedSTAR is the pre-hospital and medical retrieval arm of the South Australian Ambulance Service. Its scope includes the treatment of critically injured patients on-scene before transfer to a trauma centre. It is therefore well-placed to investigate the pathological processes that take place soon after a traumatic event, as well as to effect early interventions aimed at improving mortality and morbidity in trauma patients.

This pilot study entails the collection of venous blood samples from pre-hospital trauma patients, at the earliest opportunity, and pairing them with samples taken on arrival in the emergency department. Its aims are to establish a system for investigating the pathology of early trauma and to estimate population characteristics that can be used to plan further studies, including use of novel interventions.

Dr Paul Lambert, Adelaide Anaesthetic Services, Dr Daniel Ellis, Royal Adelaide Hospital, and both at MedSTAR, Rescue, Retrieval and Aviation Services, Adelaide, South Australia.

$A9000

High flow humidified nasal oxygen versus face mask oxygen for preoxygenation of pregnant women with high body mass index – a prospective randomised controlled crossover study (HINOP3)

Maternal morbidity and mortality from airway complications during general anaesthesia for pregnant people having caesarean section remains a significant issue globally. Large databases demonstrate approximately 10 times that of the non-pregnant population. It is likely that a better preoxygenation technique may lead to a reduction in maternal morbidity and mortality from airway complications. High flow humidified nasal oxygen (HFNO) is a new technique that has been studied by the investigators in two previous trials in pregnant people: Firstly, "High flow humidified nasal preoxygenation in pregnant women" (HINOP1) which showed that HFNO was feasible and acceptable in 60 per cent of the cohort. Followed by "High flow humidified nasal oxygen versus face mask oxygen for preoxygenation of pregnant people" (HINOP2) which showed that pregnant people achieved better oxygen levels with the new high flow nasal oxygen.

The third proposed study, HINOP3 will focus on the specific group of high-risk pregnant people – those with a high body mass index (BMI) as these people are at particularly high risk of airway complications during general anaesthesia for caesarean section.

It is hoped that this study will successfully demonstrate the advantages of high flow humidified nasal oxygen in pregnant people with high body mass. This could then pave the way for widespread international use of this technique in pregnant people, and an extension of its application for apnoeic oxygenation, the desired result of which would be improving the safety of tracheal intubation in pregnant people with high body mass who are at high risk of oxygen desaturation.

Professor Alicia Dennis, Dr Patrick Tan, The Royal Women's Hospital, Melbourne.

$A83,985

Long term follow up study of chronic post-surgical pain in the ROCKet Trial

The ROCKet (Reduction Of Chronic Post-surgical Pain with Ketamine) trial is a definitive, large, multicentre, double-blind, placebo-controlled, randomised trial of the effect of perioperative intravenous ketamine on the incidence and severity of chronic postsurgical pain (CPSP), measured at three months and 12 months following abdominal, thoracic or major orthopaedic surgery. The trial is also measuring the treatment effects of ketamine on chronic pain severity and character, associated psychological wellbeing and quality of life, and healthcare utilisation costs.

While International Classification of Diseases (ICD) now define CPSP is pain persisting for at least three months postoperatively, the longer term trajectory of CPSP is of most importance, as it represents the vast bulk of the burden of disease on quality of life for patients and associated healthcare costs.

We will conduct a four-to-five-year follow up of all surviving patients who reported CPSP at 12 months in the ROCKet Trial using the same measurement tools, but also including Medicare data and Pharmaceutical Benefits Scheme (PBS) expenditure to estimate healthcare costs.

Irrespective of the primary finding of the ROCKet Trial, this high-quality data will assess the true chronicity of CPSP and quantitate its overall human and economic costs, to better inform future risk management and promote investment and innovation in primary prevention and treatment of chronic pain.

Professor Philip Peyton, Dr Ilonka Meyer, Dr Esther Dube, Austin Health, Melbourne; Associate Professor Malcolm Hogg, Royal Melbourne Hospital, Melbourne.

$A70,000

Pulmonary artery catheterisation in cardiac surgery (PUMA Pilot): A multicentre, randomised, pilot and feasibility clinical trial

The PUMA Pilot will establish the feasibility of conducting a large, multicentre, and definitive randomised trial of pulmonary artery catheter use in low-risk cardiac surgery (PUMA II). This world-first trial will address a hotly debated and highly editorialised topic in cardiac anaesthesia and could lead to a shift away from an area of potentially low-value care.

While pulmonary artery catheters can provide unique data on cardiovascular physiology that can be used to guide therapeutic decision-making in the perioperative period, they may also have unintended consequences. Some studies have suggested that their use could trigger more intense and potentially unnecessary therapies, leading to increased rates of complications and longer stays in the intensive care unit by up to 35 per cent. Despite this, their use remains pervasive with particular uncertainty regarding their role in low-risk cases.

Pulmonary artery catheters have never been rigorously evaluated in a randomised controlled trial, and clinical practice guidelines have relied on low-quality evidence. Accordingly, there is an urgent and unmet need to define the possible risks and benefits of this frequently used monitoring device.

The PUMA Pilot is an interdisciplinary collaboration involving cardiac anaesthetists, surgeons, intensivists, statisticians, health economists, and consumers. It will be conducted across two sites in 2023 and will enrol adults undergoing low risk coronary artery bypass or aortic valve replacement surgery.

Dr Luke Perry, Professor Alistair Royse, Professor Reny Segal, Dr Marco Larobina, Royal Melbourne Hospital; Professor Rinaldo Bellomo, Austin Hospital, Melbourne; Professor Julian Smith, Dr Luke O'Halloran, Monash Medical Centre, Melbourne; Dr Alistair McLean, University of Melbourne.

$A69,981

Preserving brain health in older adults: Does light general anaesthesia reduce postoperative delirium and cognitive decline? The Balanced-2 randomised controlled trial

Delirium is a common, serious surgical complication in older adults. One in four adults will experience delirium after major surgery which can cause confusion, reduced awareness of the environment and difficulty maintaining attention. Delirium is distressing to patients, carers and family and is associated with prolonged hospital stay, poor outcomes after surgery and deterioration in physical and mental function.

The causes of postoperative delirium are complex. However, there is evidence to suggest that titrating general anaesthesia drugs to avoid overly deep anaesthesia may be a simple and effective way to reduce postoperative delirium. An electroencephalogram (EEG) measures the electrical activity of the brain and provides anaesthesiologists with information on how deeply anaesthetised a patient is and allows titration of general anaesthesia drugs during surgery. Using electroencephalography, this study will compare light and deep general anaesthesia to see if this could reduce delirium and later problems with brain function after surgery. In Australia, every patient affected by delirium costs an additional $A60,000 through direct healthcare needs, financial losses, and loss of wellbeing. If found to be effective, this simple intervention could help to preserve the brain health of many older adults undergoing surgery and save the health system millions of dollars.

Dr Carolyn Deng, Dr Doug Campbell, Professor Tim Short, Auckland City Hospital, New Zealand; Professor Kate Leslie, Royal Melbourne Hospital, Victoria.

$A70,000

Mechanistic observational study of Anaemia and inflammation in cardiac surgery (the MOSAICS study)

Postoperative anaemia has been identified as being strongly and independently associated with worse outcomes after major surgery. Until recently, available treatments were limited to allogeneic red blood cell transfusion and intravenous iron. However, recent work has revealed mechanistic targets which may improve restorative erythropoeisis in the setting of anaemia. However, it is not known whether some or all these mechanisms drive postoperative anaemia.

The MOSAICS study will follow adult patients for three months following elective cardiac surgery, during which time multiple blood samples will be collected that will form the basis of a mechanistic biobank. Firstly, samples will be analysed for haemoglobin concentration, reticulocyte count, reticulocyte haemoglobin concentration and hepcidin, with subsequent biomarkers to follow depending on these primary results. Our aim is to determine the mechanistic underpinnings of postoperative anaemia, and for how long these responses last for after major surgery.

Once the primary study and analysis of the biobank is complete, MOSAICS will provide important insights to the still unknown mechanisms that drive postoperative anaemia, and in turn direct which interventions might be tested in future clinical trials targeting specific steps in postoperative, restorative erythropoeisis.

Associate Professor Lachlan Miles, Dr Timothy Makar, Austin Health, Melbourne; Dr Anastazia Keegan, King Edward Memorial Hospital, Western Australia.

$A69,970

Grant review process

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

Much effort goes into ensuring that the process is as fair and rigorous as possible. It starts each year with ANZCA Research Committee members considering the grant applications and determining the three reviewers for each grant who are selected for their relevant expertise.

One reviewer is the "spokesperson" and a member of the research committee, while the other two are usually from outside the committee. These reviewers include expert researchers from anaesthesia or pain medicine as well as other specialties if needed. The reviewer comments are sent back to the researcher applicant for response, and the spokesperson then collates the information (including the reviewer scores, comments, and applicant's responses) into a synopsis with an overall score.

Each grant is then discussed by the whole committee during a day-long face-to-face meeting, with their final scores determined by the averages of ballot scores (out of seven) from each committee member, provided in secret to minimise bias.

Conflicts of interest are declared and recorded, and members of the committee are excluded from consideration of any grants for which they have a conflict. The presence of Mr Andrew Brookes, our new community representative and his long experience in ethics committees, medical research grants and corporate governance adds an extra safeguard in this regard.

Finally, funding is allocated to the grants considered "fundable" in descending order of the final averaged committee member scores, within the limits of the funds available. Inevitably, in any competitive process some applicants are unsuccessful. As with most grant programs, detailed feedback is not provided to applicants after the committee has finalised its grant decisions, except to novice investigators. However, detailed feedback on grant applications is formally provided during the review process through reviewers' comments to applicants, which reflect most or all of the factors that will influence committee decisions.

Most of the senior members of the committee have themselves experienced many unsuccessful grant applications to ANZCA and other granting agencies such as NHMRC and HRC and recognise the disappointment felt when a submission is unsuccessful. However, even an unsuccessful application forms part of the development of grant writing skills for future success for the applicant, and perhaps it is this persistent pursuit of continual improvement that most characterises all ANZCA grant applicants. The committee recognises the very significant time and effort involved in writing research grants, extends its thanks and encouragement to all applicants, and strongly encourages all fellows and trainees considering applications to apply for the 2024 grants round which opened on 1 December 2022.

Every year committee members, reviewers and ANZCA staff put a great deal of work into the maintenance and continuous improvement of our high-quality research grant process. For committee members and reviewers, this is often in their own time. We would like to express our very sincere thanks to all of them, and to the ANZCA Council and CEO of ANZCA for their ongoing commitment to research – as a vital contribution to continuous improvement in quality, safety and patient outcomes.

Finally, I would particularly like to thank Professor David Story and Professor Jennifer Weller who are stepping down as members after 12 years on the committee at the end of 2022. In particular to David who has been deputy chair of the committee for the past six years; I am extremely grateful for his counsel and support. Jenny was a key driver for the establishment of our Professional Practice Research Network which also has increased our activity in qualitative research methodology. Both David and Jenny have given substantial time to the committee and their contributions have improved our processes and are greatly appreciated.

This will also be my last report as chair of the ANZCA Research Committee. I wish to congratulate Professor Britta Regli-von Ungern Sternberg who has been formally approved by council as the new committee chair to commence in January 2023. I will remain on the committee until the end of 2023, to provide support and mentorship for the incoming chair. I am extremely proud to have been chair of the committee for the past six years and to see the important work the college has continued to support to provide safe and high-quality patient care in anaesthesia, pain medicine and perioperative medicine.

Professor David A Scott
Chair, ANZCA Research Committee

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Research grants for 2024

ANZCA AND ANZCA FOUNDATION GRANTS PROGRAM

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

Grants available for 2024:

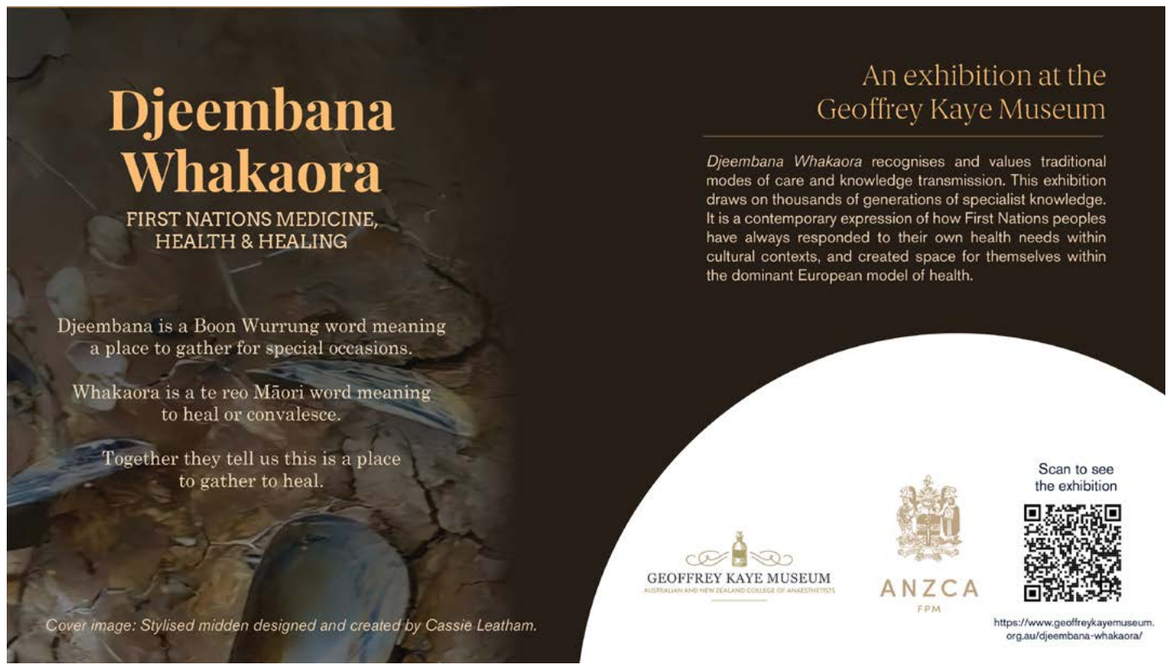
- **Academic Enhancement Grant**
- **Project grants including scholarship**
- **Professional Practice Research Grants**
  These grants are to support high quality research to provide evidence for effective, efficient, safe, and equitable professional practices in anaesthesia, perioperative and pain medicine for patients, organisations and staff and include the areas of education, simulation, and strategies for translating and implementing evidence into clinical practice.
- **Novice Investigator grants**
  Early applications from novice investigators are invited for mentoring during the application process. Further details available on the website.
- **Skantha Vallipuram ANZCA Research Scholarship**
  This scholarship has been established by the family of Dr Vallipuram, FANZCA, FFPMANZCA to support a fellow or trainee enrolled in a higher research degree and assist in establishing their research career.
- **Environment and Sustainability Research Grant**
  This grant is the initiative of a group of anaesthetists and the foundation to encourage and support research exploring the environmental impact of anaesthesia and related products and activities.
- **ANZCA Patrons Emerging Investigators Grant**
  A dedicated grant to support emerging researchers transitioning from the novice investigator grant level. The grant is named in honour of the foundation patrons who are high-level donors to research.

Full details of the ANZCA grants program and each of the grant categories with the relevant application forms and guides for applicants are available on the college website. **The closing date for all grant applications is 5pm AEST 3 April 2023.**

Further information contact:

Ms Susan Collins
Research and Administration Co-ordinator
ANZCA Foundation

research@anzca.edu.au



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ANZCA Foundation year in review

GRANTS

It has been another strong year thanks to our generous donors. About $A1.5 million was granted for 25 new research projects in 2023 (from 54 applications), increasing to just over $A1.97 million including second year funding for 10 2022 projects.

Grants continued to leverage further funding and multi-centre clinical trials led through the ANZCA Clinical Trials Network (CTN), generating publications, evidence, and impact on clinical practice worldwide.

Four global development and three Indigenous health projects received foundation funding totalling $A102,000, after assessment by the ANZCA global development and Indigenous health committees.

DIVERSITY AND SUPPORT

The foundation and research committee are committed to improving diversity of grant recipients especially among newer investigators and across states and regions. Several support resources are available to assist applicants – an online research hub, research support tool kit, professional practice research guide, research repository (AIRR), scholarships, novice mentoring and grants, an emerging investigators' grant, and two new professional practice research grants.

All application forms now include a section for applicants to outline personal circumstances that may have limited opportunity to develop their track records. This is particularly important to ensure fair consideration of life factors such as pregnancy, childbirth and childcare, to increase access to and equity of opportunity within the peer-review process.

NEW AWARDS AND GRANTS TO ENCOURAGE NEW INVESTIGATORS

The new donor-funded Patricia Mackay Memorial ANZCA Research Award, Patrons Emerging Investigator Grant, and Skantha Vallipuram Research Scholarship were all launched across 2021-2022, to encourage more, and a wider spread of, successful applicants.

ENVIRONMENT AND SUSTAINABILITY GRANT

While this new grant did not attract a successful application, it has been increased from $A15,000 up to $A25,000 for 2024. This, along with increased promotion and now allowing unsuccessful applications to also be considered for project grants, should lead to the first award of this grant in 2024 in this important research space.

This additional funding commitment relies on fundraising income, so if you'd like to help, please consider donating to support the grant in 2024.

The foundation and recipients are very grateful to all the generous donors who have made the new awards possible: Mrs Indi Mackay, Mrs Asoka Vallipuram, Dr Brenton Sanderson, Dr Amardeep Singh, and the foundation's generous patrons.

PERTH FORUM AND DINNER

On 15 October, the first foundation forum and dinner was held at the Royal Perth Yacht Club in WA to discuss the need to reduce perioperative complications as a national health priority.

More than 110 guests attended including ANZCA President Dr Chris Cokis, ANZCA and FPM fellows, other perioperative medicine specialists, senior hospital and healthcare leaders, and others interested in healthcare, patient outcomes, and high-quality research.

ANZCA Vice-President Professor David Story, past president and ANZCA Research Committee Chair Professor David A Scott, Professor Britta Regli-Von Ungern Sternberg (Perth Children's Hospital), Professor Tomas Corcoran (Royal Perth Hospital), and Associate Professor Lis Evered (Weill Cornell Medicine, New York) shared examples of world-leading ANZCA-sponsored research and multi-centre clinical trials, highlighting anaesthetist and pain specialist researchers' strong track record of influencing improved clinical practice.

Their strong message was that with more funding and collaboration, ANZCA fellow-led research is ideally positioned to further contribute to driving down complications.

The foundation thanks all table sponsors and donors, particularly St John of God Healthcare, and Associate Professor John Rigg, for his outstanding support which made this event possible.

NEW FOUNDATION PATRONS

The foundation welcomes its newest Life Patron, Dr Lahiru Amaratunge, and Dr Stanley Tay, our newest Governor Patron, joining Professor Barry Baker, Mrs Ann Cole, Dr John Craig, Dr Peter Lowe, Mrs Indi Mackay and Mrs Rosalind Smallwood in having donated or pledged $100,000 or more to the foundation's work. Dr Tay and Dr Amaratunge are redirecting income from their successful YouTube channel "ABCs of Anaesthesia" and "The Anaesthesia Collective" website to support their patronage.

MAKING A DIFFERENCE WITH YOUR SUBSCRIPTION

If you have not yet subscribed for 2023, it's a good time to add a donation as an easy way to support anaesthetist and pain medicine clinicians' research and education to advance knowledge and clinical practice in the specialties and perioperative medicine.

Most of this work is only possible because our foundation grants cover the basic costs of their studies and projects, with no remuneration for investigators or educators.

Please consider donating, or becoming a patron. To the many donors and patrons who have already donated – especially our long-term supporters – thank you!

BEQUESTS CAN SUSTAIN OUR WORK

Leaving a gift in your will helps protect the foundation's future support for innovation led by anaesthetists and pain medicine physicians. To discuss options in confidence, please contact me.

Wishing you all a safe happy and healthy festive season.

Rob Packer
General Manager, ANZCA Foundation
rpacker@anzca.edu.au
+61 3 (0)409 481 295

To donate, search "GiftOptions – ANZCA" in your browser or contact Leah Wolf, Fundraising Administration Officer, lwolf@anzca.edu.au.

For information on the research grants program contact Susan Collins, Research and Administration Co-ordinator, scollins@anzca.edu.au.

Above: ANZCA Vice President Professor David Story speaking at the foundation forum in Perth in October.

Thank you to all foundation donors

The ANZCA Foundation is very grateful to all of its patrons, bequestors, and other generous donors for assisting the vital work of fellows and trainees in research, global development, and Aboriginal, Māori, and Torres Strait Islander health.

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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.

Converge International

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A brighter outlook for the ANZCA Clinical Trials Network

As we look back on 2022, we can feel proud of our achievements. We've revised our terms of reference for the executive for greater transparency, diversity and sustainability.

We are also pleased to have appointed four new members to the ANZCA Clinical Trials Network Executive: Associate Professor Stefan Dieleman, Associate Professor Lis Evered, Dr Jennifer Reilly and Dr Doug Campbell. These leaders will connect with the wider CTN community and bring diversity, craft group expertise and vibrancy to the executive.

We thank our outgoing members for their enormous contribution in building the network: Professor Paul Myles, Professor David Story, Professor Matthew Chan and Professor Tim Short.

In 2022 we were also pleased to return to a hugely successful face-to-face workshop in Brisbane with great speakers and lively constructive discussion.

Despite another challenging year for us with a downturn in clinical trial recruitment, 2023 promises to have a brighter outlook with many new trials getting under way including CALIPSO, TRIGS, LOLIPOP and TRICS-IV. Our office will continue to run educational sessions throughout the year to provide educational and mentoring opportunities to our members.

The executive will focus on new initiatives from its strategic plan including developing strategies to build capacity in new hospital centres across Australia and New Zealand in particular regional centres and improve access for culturally and linguistically diverse populations to participate in our clinical trials. We also aim to develop tools and frameworks to support effective consumer engagement throughout the lifecycle of our trials, and we also aim to develop strategies and career structures to support junior trialists.

The 2023 CTN Strategic Research Workshop will be held in Coogee, NSW from 3- 6 August with an emphasis on new trial development and latest methodology to improve the efficiency and cost-effectiveness of running trials. Several social events throughout the weekend are being planned to enhance networking opportunities among delegates. The meeting will be open for registration and abstract submissions in early 2023.

We thank all our members for their commitment to the CTN in 2022. We look forward to working with you in 2023.

Venue hire

Looking for event or meeting spaces in Melbourne? ANZCA House offers a wide selection of corporate function and meeting rooms; tailored catering packages; and onsite technical support.

ANZCA fellows, trainees, and special international medical graduates enjoy special discounts and tailored event packages.

A UNIQUE VENUE

Located in Melbourne's St Kilda Road precinct on the southern fringes of the CBD, ANZCA House is a unique venue. Set among landscaped gardens, the college includes an elegant, heritage listed 19th century Italianate villa with stained glass windows and chandeliers, and a modern office building with a six-storey, light-filled atrium; state-of-the-art auditorium and boardroom; and six smaller meeting rooms.

SETUP AND SUPPORT

All of our event and meeting spaces offer high-speed internet; integrated Zoom and teleconferencing technology; and touch-screen displays. From custom room configurations to catering, our onsite facilities and tech support staff are on hand to help.

Take a virtual tour and find out more, including catering options at our website – www.anzca.edu.au/about-us/venue-hire.

ANZCA's Environmental Sustainability Network turns one

The ANZCA Environmental Sustainability Network (ANZCA ESN) was established in 2021 to advocate, collaborate and promote initiatives and projects related to environmental sustainability within anaesthesia, perioperative and pain medicine. It aims to position ANZCA as a proactive leader and advocate in environmental sustainability. Its executive subcommittee now reports to the ANZCA Professional Affairs Executive Committee. Since its launch it has attracted more than 200 members including nurses, allied health providers and other stakeholders.

The ANZCA ESN has been quite busy over the past 12 months. Since their first meeting in November 2021, the ESN executive have hit the ground running with activities that will support greater awareness of environmental sustainability in our practice:

- The first webinar, "N_2O or not?", in March co-chaired by ANZCA trainees Dr Beth Hall and Dr Maggie Keys and featuring international speaker Alifia Chakera, founder of the Nitrous Oxide Project, and fellows Dr Rob Burrell and Dr Matthew Jenks.
- A second webinar, "The pointy end: Greening sharps and drug waste", in November chaired by ESN executive members Dr Archie Shrivathsa and Dr Raj Pachchigar and featuring fellows Dr Marty Minehan and Dr Taryn Naggs, and ANZCA trainee Dr Daniel Brooks Reid.
- A joint conference, "Adapting the changing world" with the Mackay Anaesthetic Community in Airlie Beach in June, featuring speakers including Associate Professor Kerstin Wyssusek, Dr Cath Hellier and Renee McBrien presenting on sustainability activities around Queensland, and Dr Lachlan McIver from Medicins San Frontieres speaking about the impact of climate change on developing nations.
- Working with the Continuing Professional Development (CPD) Committee to consider sustainability audit tools that could be used by CPD participants.
- Evaluation of consumer information that addresses the environmental impact of anaesthesia.

As part of its activities, the ESN executive have supported other projects:

- Dr Scott Ma represents ANZCA on the Royal Australasian College of Physicians Climate and Health Multi-College Advisory Committee.
- Dr Archie Shrivathsa represented ANZCA on the Australian Medical Association /Doctors for the Environment Australia webinar "Climate change and sustainability: Leadership and action from Australian doctors" held in August (https://www.ama.com.au/climate-webinar) and the Better, Healthier Futures – Health Leaders Roundtable in September.
- The ESN executive supported the CODA plan of action on greenhouse gas emissions in anaesthesiology (https://codachange.org/anaesthetic-gases-info/).

The ESN already has a large agenda for 2023, including:

- Planning for a virtual forum for people to share ideas.
- Hosting a concurrent session at the ANZCA Annual Scientific Meeting in Sydney featuring Dr Kate Charlesworth, Associate Professor Justin Skowno, Associate Professor Kerstin Wyssusek and Dr George Zhong.
- A working group will look at producing a resource to assist in improving sharps and pharmaceutical waste management.
- Completing work towards audit tools to assist clinicians in auditing sustainable practices.
- Sharing consumer information about sustainability in anaesthesia.

If you would like to join the ANZCA ESN, register at https://www.anzca.edu.au/news/fellowship-news/join-the-environmental-sustainability-network-(esn

Dr Scott Ma
Chair, ANZCA ESN Executive

FUNDING BOOST FOR ENVIRONMENT AND SUSTAINABILITY GRANT

The Environment and Sustainability Research Grant (ESG) is the initiative of a group of anaesthetists designed to encourage and support research activity evaluating the environmental impact of current anaesthesia, pain medicine and perioperative practice. It also assesses how the implementation of environmentally sustainable options may affect patient outcomes and costs.

Thanks to our generous donors, the 2023 grant will offer increased funding of up to $A25,000 – a significant boost to the $A15,000 provided when the grant was first offered in 2022.

The 2023 grant round is now open for applications.

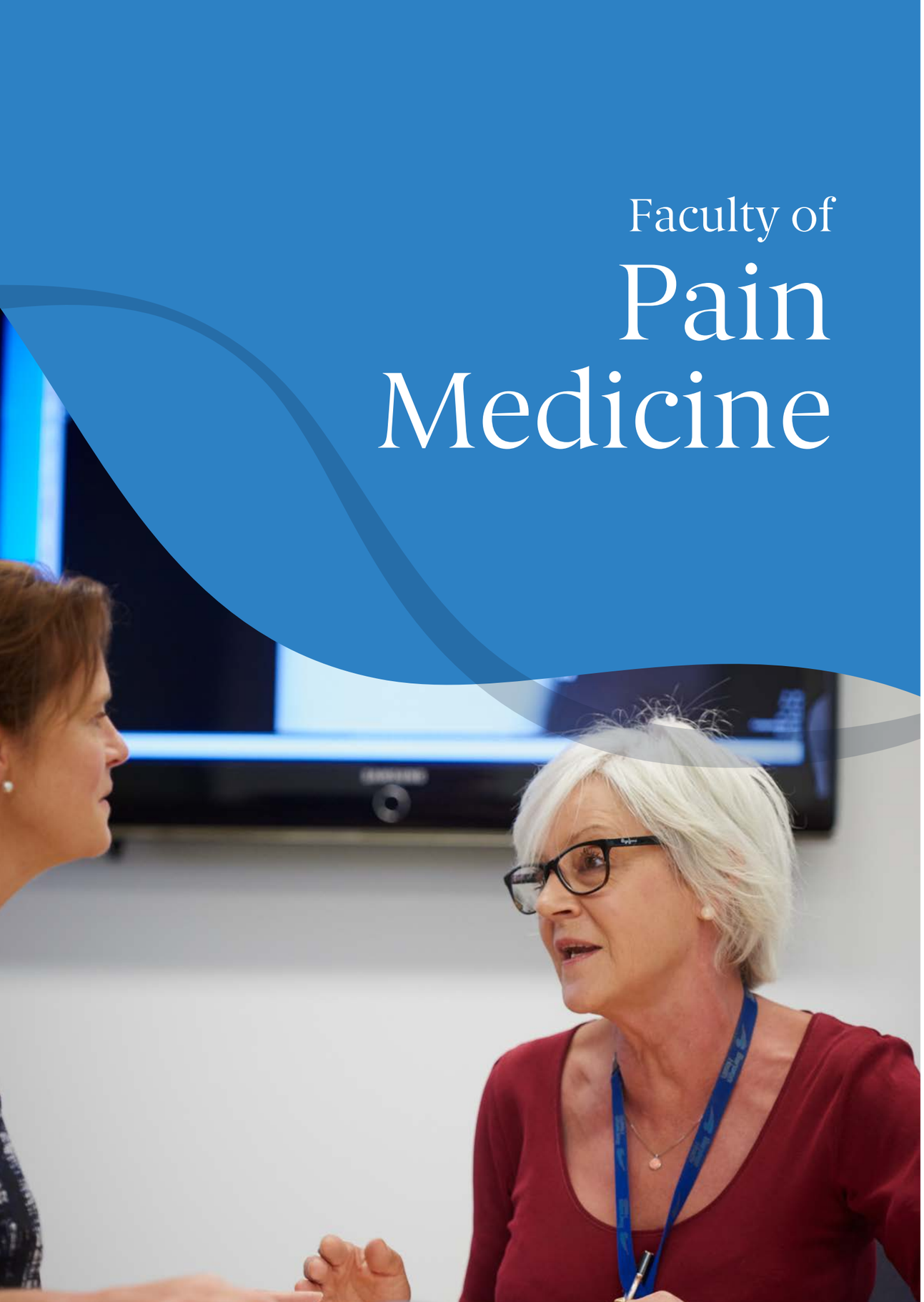
Applications that do not secure an ESG will also now have a second chance to be funded, by being considered in the ANZCA Project Grant category, increasing the chances of success.

Chief investigator A (first named investigator) must be a fellow or registered trainee of the college. To find out more or to apply for a grant please visit the website.

If you are interested in donating to the ANZCA Research Foundation's Environment and Sustainability Grant please visit the donations webpage and select Environment and Sustainability Grant under donation options.

Faculty of

Pain Medicine



A heartfelt thanks to faculty anchor Milton Cohen

"In my view Milton was the unseen keel at the birth of the faculty while as dean he was very much the tillerman. He transcended to become the wind that blew the faculty forward as it grew and gained speed."

During the July FPM Board meeting Milton Cohen announced that he would be standing down as the FPM Director of Professional Affairs (DPA). Milton was a board member at the faculty's first board meeting in February 1998 and this was to be his last, 24 years later.

For this edition of the *ANZCA Bulletin* I have asked past FPM deans to make a few comments about Milton, starting with Meredith Craigie's Robert Orton Medal address and ending with his old friend David Jones.

Leigh Atkinson refers to Milton as the unseen keel and Brendan Moore sees him as the tillerman. In my view Milton was the unseen keel at the birth of the faculty while as dean he was very much the tillerman. He transcended to become the wind that blew the faculty forward as it grew and gained speed.

Milton has always encouraged and supported me as I have worked my way through the various committees and working groups, only to leave as I became dean – there might be something in that!

After joining the board my first experience of Milton's notorious linguistic precision was when I worked with him and Frank New on writing the specialist international medical graduate regulations for the faculty. A line-by-line discussion on sentence construction and meaning sounds like a treatment for insomnia but with Milton it became an intellectual joust. I enjoyed it so much I put my hand up to work with Milton again when the training and accreditation regulations needed re-writing.

As a faculty we are indebted to Milton for our current and previous training program, in particular our curriculum which defines our profession and is the cornerstone of training.

It is easy as a fellow to never look at the curriculum, but I would highly recommend that you do as it is a systematic construction of the component parts of the knowledge required to be a specialist pain medicine physician. Everything else in the training and assessment process comes from the curriculum, and not only did Milton construct ours in 2014 he reviewed and renewed it again between 2019-2021. Those that follow have a high bar to attain but have been left with a launchpad from which to achieve it.

Of the many contributions Milton has made to the faculty, becoming the first DPA and using the role to raise the profile of the faculty outside ANZCA is possibly the least known about. Fellows are not always aware that government organisations from Australia and New Zealand are frequently seeking submissions and opinions – from Medicare Benefits Schedule changes to Therapeutic Goods Administration regulations. For the past 14 years those requests have gone to Milton to construct a position statement that the dean and board of the day were comfortable to stand behind.

In New Zealand Milton took the Sapere report and worked his magic on it with the result that it helped generate government interest in pain medicine in a way that had never happened before.

I am sure we will continue to meet Milton at future faculty meetings and I would encourage younger fellows to stop and talk to him.

If there is one constant about Milton it is that his wisdom is something he is always happy to share.

As the current dean I would like to thank Milton for the time, effort and passion he has given in making our faculty a leader in pain medicine.

Dr Kieran Davis
FPM Dean

Professor Milton Cohen AM

Past FPM deans reflect on Professor Milton Cohen's contribution to the faculty after 25 years.

ASSOCIATE PROFESSOR MEREDITH CRAIGIE
DEAN 10 (2018-2020)

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

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

Milton was a foundation board member and third dean of the faculty from 2004 to 2006. He has served the faculty in many roles including as the chair of the education committee that developed the foundation curriculum in 1998 establishing the faculty as a world leader in pain medicine. Milton has been the director of professional affairs since 2010 and chairs the faculty's Learning and Development Committee. He remains active in many other organisations including the International Association for the Study of Pain (IASP), and as an adviser to federal and state governments. Milton has taught extensively, published more than 100 articles in peer reviewed journals and more than 30 book chapters and is a senior editor for the journal *Pain Medicine*. He is recognised for his incisive analysis and wise counsel.

Taken from Dr Craigie's Robert Orton Medal address in 2020.

ASSOCIATE PROFESSOR BRENDAN MOORE
DEAN 7 (2012-2014)

From the very beginning, the concept of a Faculty of Pain Medicine was the work of a small group of inspired visionaries recognising the diverse and complex nature of a patient's experience of pain. Twenty-five years ago Milton was one of this small group who sought to formalise an approach based on the co-operation of medical specialists and allied health professionals with diverse backgrounds and skills. This aspiration was both revolutionary and overwhelmingly ambitious.

The Faculty of Pain Medicine of ANZCA is now a world leading institution and recognised internationally for groundbreaking leadership in the specialty, its training curriculum and standards of care, as well as for political and community advocacy.

Milton Cohen has been the steadfast tillerman and guardian of the cause throughout.

Any institution can only exist in the strength and completeness of the documentation of the policies and processes that define it. The enormity of this task is almost indescribable.

Over the course of 25 years, Milton has extended to the faculty a gift of exceptional language craftmanship combined with a dogged determination and attention to detail that has built the very foundations of our faculty. Every word of every sentence of every policy, position statement, exam and curriculum has had the benefit of Milton's attention and exceptional skills.

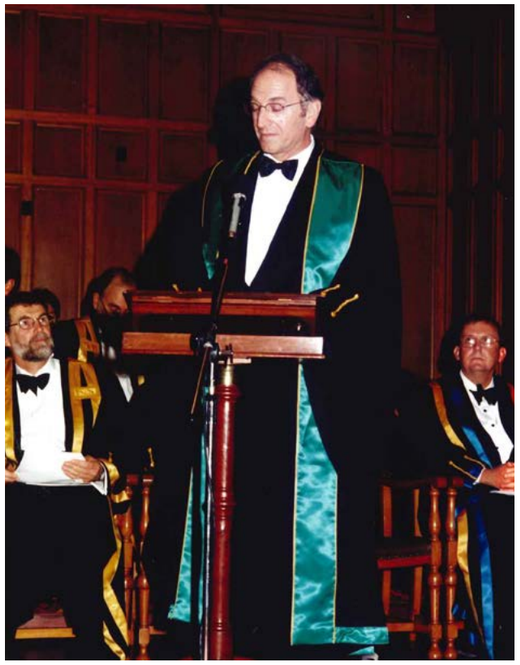
Milton's legacy will endure through a thriving and ever-expanding Faculty of Pain Medicine, and the realisation of a vision for a more comprehensive understanding and treatment of pain.

On behalf of our college and faculty, and more personally, as a former dean, thank you Milton for 25 years of leadership, mentorship, and friendship.

ASSOCIATE PROFESSOR MICK VAGG
DEAN 11 (2020-2022)

It is possible that there will never be the opportunity for another individual to contribute as much as Milton to the life of the faculty. He has been involved at a leadership level from the pre-history of the faculty to its latest curriculum revision. It has been an extraordinary achievement. I wish him very well in his retirement, and hope he feels deep satisfaction that the enterprise he was fundamental to creating and nurturing will thrive as it enters adulthood!

Opposite page: Top, from left, Professor Cohen AM was a foundation board member and the third dean of the faculty from 2004 to 2006; Professor Roger Goucke AM with Professor Cohen AM at the 2006 ASM; Professor Cohen AM speaking at the 1999 ASM.



DR DAVID JONES
DEAN 6 (2010-2012)

I think a most apt description of how Milton's sharp mind works is summarised by Lewis Carroll's character Humpty Dumpty in *Through the Looking Glass:* "When I use a word ... it means just what I choose it to mean – neither more nor less."

Milton has excelled in seeking and using precision language both for professional writings on his passion of pain, and in the administrative sphere during our time collaborating on revising faculty administrative instructions and some professional documents. Clarity of meaning on the one hand, but also questioning terminology which was often circuitous, for example, "How can you name a disease the same as its principal symptom?" or where terminology use implied disproved causations. It will not have passed by those well versed in the latest ICD-11 classification of chronic pain that Milton had a prominent involvement in the IASP groups that worked on it.

As a rheumatologist specialising in pain medicine, pain and the musculoskeletal system are frequent targets for Milton's sharp critique on clarifying taxonomy surrounding the remaining "murky waters" of "chronic primary musculoskeletal pain"[1]. In one presentation to a faculty meeting earlier this century he addressed a vexed problem with the AMA tables for impairment rating, and rightly asked how can one measure the immeasurable? He concluded with a precise mathematical solution:

$$\text{Degree of disability} = \sqrt{(\text{M-I-L Birthday} \pm \text{UR Mood on the day})}$$

While the above formulaic solution might seem unsympathetic, underlying the quest for precision language in our specialty, Milton always exhibited a compassion and generosity towards others, with a strong sense of social justice. Widely read on many areas of life philosophy, partaking in a range of water-sport interests and a passion for interesting tourism Milton has had tremendous support from Pam in all these ventures.

Milton, we have gained so much from your wisdom, enthusiasm and generosity. May your retired life continue to reward you and hopefully we can share many more of the deep discussions about our various passions.

ASSOCIATE PROFESSOR LEIGH ATKINSON AO
DEAN 2 (2002-2004)

When the history of the Faculty of Pain Medicine is written, the contributions of Professor Milton Cohen will be a highlight.

As the representative of the Royal Australasian College of Physicians he became the third dean, following an anaesthetist and a surgeon, highlighting Professor Michael Cousins' determination to weld together a multidisciplinary medical group to identify the need for all specialties to be sensitive to improved management of the burden of persistent pain in our patients.

Over the years as board member, dean and director of professional affairs, Milton has been the unseen keel that has balanced and provided a consistent direction for the faculty as we established standards, training requirements and published guidelines for pain medicine.

As a busy rheumatologist and Sydney physician he has provided an alternative perspective to ANZCA, defining the individual nature of our faculty and the need to encourage all trainees in general practice and specialties to recognise the need for appropriate management of pain patients.

I join with all FPM fellows to sincerely thank Professor Cohen and his family for the remarkable support he has provided to our fellows and I wish him all the best for the future.

Reference

1. Cohen ML. Clarifying "chronic primary musculoskeletal pain"? The waters remain murky. Pain Rep. 2022 Sep-Oct; 7(5): e1021. Published online 2022 Aug 9. doi: 10.1097/PR9.0000000000001021

New ePortfolio to support pain medicine training

From the commencement of the 2023 hospital employment year, recording pain medicine training experiences and requirements will move from paper forms to a web-based ePortfolio. The ePortfolio is being introduced as part of the college-wide Lifelong Learning Project.

In addition, an exam management system will be implemented to support the 2023 FPM fellowship examination. The learning management system (currently Networks) is being replaced in the first quarter of 2023 and changes have been made to the continuing professional development system to align with the changes to the Medical Board of Australia standard. An ePortfolio for specialist international medical graduates will be introduced later in 2023.

WHAT TO EXPECT FROM THE NEW TRAINING EPORTFOLIO

The implementation of the pain medicine training ePortfolio follows the successful implementation of the ePortfolio for the FPM Procedures Endorsement Program in July 2022. The ePortfolio is an off the shelf product from a UK-based company that is used by several medical colleges and universities both here and in the UK. The exams management system is another product of this company which allows seamless integration of data between the two systems.

From February 2023 regular in-training assessments, workplace-based feedback and applications for flexible learning will all be completed within the new ePortfolio. Each trainee will have a dashboard displaying their progress through the training program and reports on different aspects of training. Supervisors of training and practice development stage supervisors will have customised dashboards that identify tasks to be done, provide access to the dashboards of the trainees that they are the nominated supervisor for, and access to reports for each of their trainees.

REVISED WORKPLACE-BASED FEEDBACK

Ahead of building the new ePortfolio and as part of the assessment review, the Learning and Development Committee have reviewed each of the tools during 2022 for refinement and to ensure they reflect the current curriculum. The opportunity was taken to adjust the name of these forms from "workplace-based progressive feedback" to the simpler "workplace-based feedback". In the pain medicine training program, they aren't called the usual workplace-based assessments as we want these interactions to be focused on providing feedback and identifying opportunities for development and resources to support this development.

All FPM fellows and placement supervisors will be able to complete workplace-based feedback on pain medicine trainees in the new ePortfolio. The trainee will start the process and identify who will be providing feedback. The fellow/placement supervisor can then either complete the assessment on the same device as the trainee and confirm the process later or complete the feedback tool from their own device. The ePortfolio is mobile responsive and has an offline mode if you are working in an area with poor internet.

The multisource feedback survey can be completed electronically by the individuals invited by the trainee. The trainee starts by self-evaluating their performance before identifying those they wish to seek feedback from. Once the responders have submitted their feedback the nominated supervisor can view the consolidated results who can review and finesse ahead of the feedback meeting between the supervisor and trainee.

As part of the assessment review, it has been decided that trainees no longer need to complete the Better Pain Management program. The Centralised Trainee Tutorial program ensures that new trainees have early access to educational content replacing the need to undertake the Better Pain Management program.

TRACKING PROGRESS

A key benefit of moving to an ePortfolio is that trainees and their nominated supervisor will easily be able to see how the trainee is tracking against requirements of the program. This visibility will enable the trainee and their nominated supervisor to identify gaps in exposure to type of cases and have a discussion to consider what resources are available to support the trainee meet their learning goals.

The trainee dashboard shows progress and is complemented by a suite of reports that can be viewed in system or exported to excel for analysis or PDF as a record. We anticipate the dashboard and reports will be altered over time once we have feedback from trainees and supervisors on functionality and data that would enhance their experience using the system.

INTEGRATION ACROSS SYSTEMS

Early in 2023 we will be looking to integrate data from the new ePortfolio with the ANZCA/FPM CPD portfolio for registered participants who undertake assessments that accrue CPD credits. We will let fellows know once this is in place.

SUPPORT AS WE IMPLEMENT THE NEW EPORTFOLIO

Orientation sessions will be arranged for supervisors and trainees ahead of the launch of the ePortfolio. Several sessions will be run over Zoom to allow trainees and supervisors to attend at a time that suits them. Drop-in sessions to address queries as they arise will be available for several weeks following the ePortfolio introduction.

Trainees commencing in 2023 will receive training in the new ePortfolio at the Orientation to Pain Medicine Training Course on 25-26 February.

EXAMS MANAGEMENT SYSTEM

FPM examiners will have use of a web-based exam management system for the 2023 fellowship examination. Examiners will be able to draft, review and approve questions and marking guides for both the written and oral sections online. Pending further testing, it is anticipated that the written section of the 2023 fellowship examination will be delivered online in test centres replacing the handwritten delivery. Trainees will be advised how the written exam will be delivered in early in 2023.

Implementation of systems to support the delivery of the pain medicine training program has been a priority of the faculty for many years. We will be seeking feedback during 2023 to identify improvements to both systems. If you have difficulty with either system, please contact our team for advice.

Become an accredited procedural supervisor

We encourage fellows looking to become an accredited procedural supervisor in 2023 to start the application process which includes endorsement through the Practice Assessment Pathway. For further information please see the website or contact the faculty office.

New fellows

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

- Dr Ho Yin Chan, FHKCA (Anaesthesiology), FFPMANZCA (Hong Kong).
- Dr K M Mominul Hassan, FRACGP, FFPMANZCA (NSW).
- Dr Jeffrey Tze Fung Ip, FHKCA (Anaesthesiology), FFPMANZCA (Hong Kong).
- Dr Adeline Xin Yu Leong, MMed (Sing), FFPMANZCA (Singapore).
- Dr Hassan Zahoor, FACEM, FFPMANZCA (WA).

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

- Dr Bradley Lewinsohn, FRCA, FFPMANZCA (Vic).
- Dr Shankar Ramaswamy, FRCA, FFPMANZCA (Vic).

Celebrating the wins of the Gender Equity Sub-Committee

The Gender Equity Sub-Committee (GESC) launched in 2019, and 2022 marks the end of its inaugural action plan. We would like to take the opportunity to reflect on the group's achievements and thank them for working to make our college and workplaces more equitable, inclusive, and safe places for all genders to pursue careers in anaesthesia and pain medicine.

KEY OUTCOMES

- Released the unconscious bias on interview panels toolkit.
- Collation of gender metrics across ANZCA and FPM to identify gaps in gender representation among fellows, trainees, specialist international medical graduates, supervisors of training and all college committees.
- Released a gender equity self-assessment quiz.
- Introduced the "ANZCA Panel Pledge" to encourage gender equity representation among speakers at events.
- Annual hosting of STEMM breakfast at the ANZCA Annual Scientific Meeting to promote women in leadership.
- Gender neutral and inclusive language used throughout college communications and at events.
- Updated college style guide and events procedures to promote diversity of fellows in photographs.
- Established a speaker bureau to promote equitable gender mix at events.
- Updated the professional documents regulation and style guide with contemporary, gender-neutral language.
- Established the gender equity and unconscious bias library guide.
- Hosted a "Women and Medicine" symposium at the Geoffrey Kaye Museum of Anaesthetic History in 2019, featuring the historical challenges women faced entering the field of medicine.
- Led "Women in leadership: Achieving an equal future in a COVID-19 world" social media campaign in 2021.
- Presented "Leadership in 2022: Challenge Accepted!" webinar attended by more than 100 fellows.
- Launched International Women's Day campaign including five short videos to celebrate women anaesthetists, reflect on gender challenges in the medical community, and explore the theme of bias in 2022.
- Released third iteration of a seminal gender research survey examining the impact of gender on the professional lives of Australian and New Zealand based fellows.

Stay tuned for the next action plan which will be released in early 2023, with a strong focus on providing gender equity support to targeted college stakeholder groups while broadening our inclusion and diversity footprint.

Dr Bridget Effeney
Gender Equity Sub-Committee Chair (outgoing)

Dr Claire Stewart
Gender Equity Sub-Committee Chair (incoming)

Ms Jan Sharrock
Executive Director Fellowship Affairs

MESSAGE FROM INCOMING GESC CHAIR

It is with great enthusiasm that I take on the role of Gender Equity Sub-Committee (GESC) Chair.

Dr Bridget Effeney developed the gender equity group from inception to an established ANZCA sub-committee. She has ensured the GESC is driving change within the college on behalf of all fellows.

The Unconscious Bias Toolkit is a brilliant initiative, disseminated to Part 2 examiners and interview committees Australia-wide. The college is progressive in its panel pledge and careful documentation of college metrics to ensure we know whether equity is being achieved at college events.

The gender equity survey is a timely research project that examines a broader scope of equity issues affecting all fellows. I look forward to Bridget's ongoing leadership and mentorship as we expand inclusion and diversity in the organisation. Many thanks on behalf of the committee to Bridget for all her time and effort.

Dr Claire Stewart

ANZCA
FPM

Listen to the Blue Book on the go!

We've recorded 10 chapters of the 2021 edition of Australasian Anaesthesia (commonly referred to as the Blue Book) so you can listen on the go.

You can stream these on our ANZCA SoundCloud page and listen via Spotify, Apple Podcasts and Google Podcasts.

Listening to these audio recordings can be claimed under the ANZCA and FPM CPD Program's knowledge and skills "learning sessions" activity.

Thank you to Dr Peter Cook FANZCA from The Tweed Hospital for voicing the audio recordings.

ANZCA
FPM

Steuart Henderson Award

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

All fellows of ANZCA and FPM are eligible for the award.

For nomination information including eligibility criteria visit the ANZCA website.

Nominations close 15 February 2023.

Training & Education

The ANZCA Educators Program has been revised and updated

The ANZCA Educators Program (AEP) is a practical course designed to equip participants with the knowledge and skills to be competent clinical teachers. It is open to ANZCA fellows, specialist international medical graduates, provisional fellows and trainees (basic trainees onwards), and to FPM fellows and trainees. Led by the ANZCA Educators Sub-Committee, with extensive input from AEP Facilitators and external experts, a review of the AEP has been completed resulting in a redesigned course.

Learning outcomes for the revised course are based on the progression indicators in tier one (knowing and doing) of the recently-launched ANZCA Educator Competency Framework. This is the foundational level of competency, applicable to all ANZCA and FPM fellows in their role as clinical teachers. Other highlights include:

- Five core modules over 1.5 days to complete the course (previously eight modules over 2.5 days).
- A new course handbook that also functions as an enduring reference for participants.
- Maintaining alignment with scholar role activities to enable trainees to gain credits in towards the "teach a skill" and "facilitate a group discussion/running a tutorial" activities.

Dates and venues for 2023 are being finalised with both in-person and online courses on offer. Some courses include additional modules to cater to different groups. The learning outcomes for the revised AEP are described in the accompanying table.

Visit the AEP page on the ANZCA website for information on 2023 courses. If you are interested in becoming an AEP facilitator, email us at aep@anzca.edu.au.

Dr Nav Sidhu FANZCA
Chair of the ANZCA Educators Sub-Committee and Lead AEP Facilitator (NZ); Staff Specialist, Department of Anaesthesia and Perioperative Medicine, North Shore Hospital, Auckland, NZ

Module/section	Learning outcomes
Underpinning content (interweaved throughout modules)	Establish positive working relationships and communicate effectively with learners. Promote a culture that emphasises equity and social justice, and is free from discrimination, bullying, and harassment. Recognise the influence of unconscious bias on teaching, learning, and assessment. Recognise the influence and importance of role-modelling in educator role.
Module 1: Planning Effective Teaching and Learning (PETL)	Describe the principles of adult learning relevant to medical education. Create a supportive and psychologically safe educational environment. Outline an approach to performing a needs assessment. Write a SMART learning objective. Develop a teaching plan for a teaching and learning session.
Module 2: Facilitating Learning In Clinical Settings 1 (FLICS1)	Identify specific characteristics of teaching and learning in the clinical setting. Evaluate the use of deliberate teaching tools in the clinical setting. Plan a session to facilitate learning of a practical skill. Demonstrate key concepts to facilitate learning of a practical skill. Adapt teaching and learning approaches to a variety of clinical settings.
Module 3: Facilitating Learning In Clinical Settings 2 (FLICS2)	Describe models for feedback conversations. Conduct an effective feedback conversation. Outline the factors required to provide effective clinical supervision. Articulate appropriate levels of supervision for various clinical scenarios.
Module 4: Teaching In Non-Clinical Settings (TINCS)	Evaluate the utility of different non-clinical settings to facilitate teaching and learning. Outline approaches for facilitating a small-group discussion. Incorporate techniques to promote interactive teaching and learning in small groups. Outline approaches for managing the "different" participant behaviours that can impact on learning.
Module 5: Assessment and Evaluation in Medical Education (AEME)	Describe the key concepts in assessment. Describe different assessment instruments and their role in facilitating learning, with a focus on WBAs. Outline methods to evaluate a teaching encounter. Outline approaches to seek feedback and reflect on own teaching practice.
Additional concepts in medical education (included in handbook)	Recognise the importance of professionalism, leadership, and teamwork in medical education. Recognise the basic principles of coaching, mentoring, and professional development. Demonstrate awareness of fair and equitable selection processes for learners Identify and support learners experiencing difficulty. Recognise different approaches to producing new knowledge in medical education research, including quantitative and qualitative approaches. Describe the principles of critical appraisal and peer-review. Identify the standards set by statutory and other regulatory bodies in provision and quality assurance of medical education.

Left: ANZCA educator facilitators at the face-to-face facilitator workshop in June 2022

Successful candidates

Primary fellowship examination

2022.2 Exam

A total of 162 candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory

Si yu Xian

New South Wales

Ankit Ahluwalia
Bardia Aryaie
Khalil Ayoub Bazzi
Brian Koon Kiu Chan
Philip Choi
Matthew Jonathan Chua
Gregory John Collins
Elinor Jeanne Cripps
Jillian Ann De Coster
Rachel Dilawari
Matthew Sean Doherty
Philippa Dossetor
Jared William Bowdern Ellsmore
Noah James Freelander
Lachlan James Gan
Jonathan James Daniel Gayed
Nicole Maree Glavan
Hakeem Shing Kam Ha
Adam Osman Joghee
Andrew Lee
Andrew Lin Luo
Luke Daniel McCarthy
Lachlan Hunter McLennan
Jonathon Oliver Murtagh
Rahul Nair
Alexander Zi Ying Peng
Salm Ramzani
Victoria Sadick
Julian Klaus Smyth
Peter James Stark
Krishan Subhaharan
Terence Brendan Chee Lun Sue
Patrick Anthony Tully
Clare Ann Dymoke White
Samuel Allan Williams
Matthew Le-Gend Wong
William Yao Lin Yip

Northern Territory

Krushna Bharatkumar Patel
Daniel Benjamin Patti

Queensland

Adeel Aftab
Annica Bester
Jessica Lee Byrnes
Alek Rodney Calleja
Lindon Shane Collins
Faraaz Richard de Belder
Kate Nicole Engelke
Samuel Jonathan Ayre Fell
Joseph Juan Goicoechea
Jadon David Hart
Harrison Fung Yi Pung
Jaa-Kwee
Lillian King
Jessica Arna Lewkowicz
Justin Er Wenn Lim
William Jesse Radford Lindores
Kate Roseanna McCall
Stephanie Margot Mulligan
Peter Petrus
Kristoffer Graeme John Phare
Mayank Nikhar Arun Raniga
Jesse Jae Renouf
Robert Kyle Thomson
Tim Tran
Matthew Robert Walker
David Marc Weinberg
Marissa Lee Woodburn
Scott James Wyvill

South Australia

Matthew James Bolt
Cassandra Louise Driscoll
Matthew Douglas Fischer
Nanthanan Jeyakumaran
Bradley Andrew Mereine
Sharmini Michelle Punitham
Michael Andrew Rooke
Richard William Sexton
Jessica Mary Walker
Yadanar Zaw

Tasmania

Helen Ann Harkness Browne
Trent Maxwell Carr
Bi Wen Lau
Georgia Ellen Mohler
Natasha Christine Nilsen
Nicholas James Reeve

Victoria

Alastair John Anderson
Jordan Bade-Boon
Anna Mary Bakogianis
Tristan Peter Boonstra
Daniel Robert Bronsema
Kerry Karwai Chen
Yu-Jen Chen
William Nelson Clearfield
Rebecca Karen Cogan
Luka Simun Cosic
Amranthir Singh Dhillon
Stefan Dodic
Christie Farag
Joel Ashwin Fernandez
Andrew Kirk Fordyce
Joel Francis Greaney
Adam Guilfoyle
Lidia Antonious Guirguis
Divya Iyer
Ahmed Kadhmawi
Tejas Kumar
Ade Rizki Kurniawan
Emma Louise Lawson
Kissane
Wen-Shen Lee
Jayson Woei-Liang Leow
Zheng Jie Lim
Joel Ryan Loth
Victor Solka Pasternacki
Harry James Pearce
Alexandra Lia Ricci
Catherine May Rickard
Ashleigh Kate Rohde
Yannick Leon Roosje
Cameron Mitchell Rosengarten
Charlotte Anne Russo
Amelia Catherine Adeney Steel
Rose Anna Stewart
Angela Temple
Jeigh Merill Tiu
Kelsey Elyse Caitlyn Turner
John Peter Webster
Tracey Wong

Western Australia

Ahmed Samy Batanony
Lauren Christina Foster
Julia Madelaine Inman
Sarah Shu Min Liew
Han Lu
Latifa Mah
Vibhushan Manohar Manchanda
Marie Ellen Timlin
Ariane Elyse Tioke
Alex Patrick Wright

NEW ZEALAND

Edward Peter Andree Wiltens
Jonathan Brian Lightley Blake
Megan Audrey Briscoe
Fraser Benjamin Paul Capill
Yinman Chan
Claudia Margaret Crawford
Samantha Laurel Ellis
Simon David Foster
Steven Joseph Greenblatt
Sarah Katherine Fay Holman
Irina Elizabeth Horvat
Edward William Hughes
Reagan Lee Stanley Humphrey
Marije Jansen
Shona Seu-Yu Jian
Kieran Anthony Jongerius
Christopher John Logan
Hamish Keith Louis
Kyriakos Philippos Matsis
Kimberley Amelia Noah
Bhanuka Yasas Jayatilaka Rathnayaka Mudiyanselage
Marisa Anna Schubert
Alexandra Ruth Skerten
Nicole Amy Toy
Sione Inoke Faivakimoana Tukia
Hannah Elizabeth Widjaja
Nicole Yuen Ern Wong

RENTON PRIZE

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

John Peter Webster, Victoria

MERIT CERTIFICATES

The court of examiners recommended that merit certificates at this sitting of the primary examination be awarded to:

Jayson Woei Liang Leow, Victoria
Peter Petrus, Queensland
Kyriakos Phillippos Matsis, New Zealand
Luka Simun Cosic, Victoria
Lachlan James Gan, New South Wales

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 30 June 2022 be awarded to:

Alexandra Lauren Carle, WA

"The ANZCA primary exam shared many features of my former road cycling career: a punishing training schedule, a few high stakes moments, and the opportunity to work with extremely talented and highly motivated colleagues. Fortunately, there was less blood and sweat, although a comparable volume of tears (ml/person/year).

My 2014 move from Canberra to Perth was a stroke of luck that has given me the best possible start to my career in anaesthesia. It introduced me to the lovely friends I work, study, and drink wine with. It has given me access to excellent teaching, including the weekly primary exam tutorials at Sir Charles Gairdner Hospital. Most importantly, it is the place where I met my wonderful partner, Toby. Thank you all very much for your help and support.

With the exam behind me, I am looking forward to a study-free summer of hiking, fish and chips, lounging with our greyhound, and helping some of the 2024 candidates towards that post-primary glow."

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2022 be awarded to:

John Peter Webster, Vic

"I grew up in regional south-west Victoria before studying medicine as an undergraduate at Monash University, where I graduated in 2015. I was lucky enough to have an anaesthesia rotation as a final year medical student and knew from this experience that I wanted to be an anaesthetist.

I worked for two years at Eastern Health in Melbourne before travelling to London for an extended working holiday. I worked in the NHS at Imperial College National Trust, gaining great experience working in a different country and health system. I then returned to Eastern Health in 2020, where the anaesthesia department was highly supportive and I began accredited training in 2022.

I'm extremely grateful for all the support I received from my family, friends and colleagues I worked with during my primary exam study. I'm especially thankful to my wife for putting up with me for the last year and look forward to holidaying in Europe together next year to celebrate."

Final fellowship examination

2022.2 Exam

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

AUSTRALIA

Australian Capital Territory

James Marcus McCredie Dando
Liam Daniel Gleeson
Fabio Longordo

New South Wales

Hayden Alicajic
Lucy Ellen Andersen
Dani Martin Bachmann
Mitchell Blake Brooks
Tristam Owen Brown
Charles Peter Haggerston Cartwright
Christina Shan Cheng
Alexandra Constantin
Imogen Annette Coppa
Julian Arie de Jong
Elif Fatma Durur
Chloe Anne Louise Edwards
Kathleen Margaret Fixter
Felicity Annabelle Charlotte Fletcher
Anri Forrest
Sheridan Louise Frisby
Alexander James Garner
James Michael Harrison
William John Ibbotson
Dushyant Iyer
Emily Rose Kettle
Melissa Xiao-Ming Kuo
Jason Lau
Kevin Kun-Han Lin
Daniel Moi
Eliza Hannah Jean Patterson
Erica Lee Sanderson
Gene Stokel Slockee
Patrick Chee Kong Teo
Simon Trevor Thomas
Jireh Tsun
Nile Nesem Ulgen
Jason John Verden
Jing Wang
Annabel Whitaker
Julia Victoria Whitby
Hoi Sang Wong
Sarah Hui Xin Wong

Queensland

Graham Wesley Coupland
Jasmin Ellenberger
Leah Andrea Hatton
Rosie Herrmann
Thomas Joseph Holmes
Nathan Robert James
William Johnson
Tyson Byrne Kevin Jones
Amanda Jane Marshall
Catherine Elizabeth Mason
Chloe Louise McKenna
Alexander Charles O'Donnell
Nicholas David Pawula
James Domenic Rigano
Davina Christel Louise Seidel
Casey Luke Steele
Zi Ping Tong
Raphael Weidenfeld

South Australia

Hayley Marie Adams
Ryan Christopher Breslin
Andrew Thomas James Chong
Timothy David Hall
Gregory David Leverett
Daniel Hoang Minh Ly
Emma Jane Panigas
Timothy James Wonders
Misha Yadav
Kevin Wei Yu

Tasmania

Sneha Ann Ancheri
Hayden Paul de Mouncey

Victoria

Grace Andrews
Edward William Bender
James Mark Hulls
Gemma Anne Johnston
Anthony Leonard Kavanagh
Qizhan Sherman Lee
Siak Khui Lee
John Chang-Chuan Leou
Christopher William MacGregor
Thomas Lloyd Smith
Ashley Gordon St John
Alexander James O'Mullane Stevens

Western Australia

Robert James Brogan
Rohit Daswani Daswani
Louise Elizabeth Dawson
Sharon Eow
Joel Michael Krause
Jingjing Luo
Ross McNaught
Paul Jason Schaper
Hannah Lucy Wray

NEW ZEALAND

Rose Cameron
Abhishek Charukonda
Leanne Rebecca Connolly
Emily Jayne Craven
Philip M. Dabrowski
Richard Alan Hamilton
Alice Louise Hickey
Hannah Elizabeth Janssens
Lucy Kate Johnstone
Jad Jurji
Jae Hyun Lee
Harriette Rose Helen Mulcaster
Mary Newmarch
Elizabeth Ann Robinson
Phillip David Tarrant
Adam George Tiley
Elizabeth Mary Turner
Daniel Wansong
Christine Frances Wood

SIMG EXAMINATION

Seven candidates successfully completed the specialist international medical graduate examination:

Juliana Caicedo Salazar, NSW
Mathilde Lunoee, NT
Afrida Gergessm, Qld
Fernando Arduini, WA
Anuradha Ragunathan, WA
Rujuta Shah, WA
Eniko Egyed, NZ

CECIL GRAY PRIZE

The Cecil Gray Prize for the 2022.2 final examination was awarded to:

Alexander James Garner, NSW

MERIT CERTIFICATES

Merit certificates were awarded to:

Joel Michael Krause, WA
Alexander Charles O'Donnell, Qld

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2022 be awarded to:

Alexander James Garner, NSW

"After getting into medical school, I brushed aside my maths teacher's suggestion to train as an anaesthetist. I studied at the University of Western Sydney with a mix of high school friends and new friends.

It wasn't until my third year, after my first term in anaesthesia, that I decided it was exactly what I wanted to do. I spent my prevocational years at Liverpool Hospital, and in my senior resident medical officer year I rotated to Bathurst Base Hospital for my anaesthesia term. I was fortunate enough to return the following year for more anaesthesia time, before starting scheme training at Royal Prince Alfred Hospital in Sydney in 2019.

Through thick and thin, and through both the primary and final examination, I have had my wonderful fiancée by my side. I have been blessed to be with someone who truly understands the highs and lows of anaesthesia training and exams. With the exam now out of the way, we are looking forward to our wedding next year!"

No Cecil Gray Prize was awarded for the half year ended 30 June 2022.

Library news

RAPM IS BACK! NEW LIBRARY JOURNALS FOR 2023

The ANZCA Library is delighted to announce that a number of new and returning online journals will be added to our existing stable of more than 900 health and medical titles beginning January 2023.

Regional Anaesthesia & Pain Medicine (RAPM)

The library has just commenced a new online subscription to RAPM – available now! Coverage includes intraoperative regional techniques, perioperative pain, chronic pain, obstetric anesthesia, paediatric anesthesia, outcome studies, and complications. Users can access any issue/article from Volume 1, 1976 onwards. Access via BrowZine.

Neuromodulation: Technology at the Neural Interface

This oft-requested title is finally available via the ANZCA Library. Neuromodulation covers an ever-expanding field including pain, headache, movement disorders, spasticity, paralysis, psychiatric disorders, epilepsy, sensory deprivation, gastric dysfunction, obesity and incontinence. Available from January.

Current Anesthesiology Reports

Another oft-requested title. The library finally gains access to CAR as part of its new Springer Journals Medicine Collection subscription. Current Anesthesiology Reports offers expert review articles on significant recent developments in the field. Available from January.

Journal of Clinical Monitoring and Computing

JCMC is a clinical journal publishing papers related to technology in the fields of anaesthesia, intensive care medicine, emergency medicine, and perioperative medicine. Available from January.

Current Pain Headache Reports

CPHR provides in-depth review articles contributed by international experts on the most significant developments in the field. Available from January.

Canadian Journal of Emergency Medicine

CJEM is an essential resource for emergency physicians in rural, urban or academic settings that reflect the growing interest in emergency medicine, both as a medical discipline and an expanding field for research. Available from January.

Many of these titles form part of the library's new Springer Medicine Journals Collection subscription. This vast collection comprises a number of pre-existing titles including *Canadian Journal of Anesthesia, Journal of Anesthesia, Intensive Care Medicine* and *Die Anaesthesiologie (*formerly *Der Anaesthesist)* but also includes more than 800 other health and medical titles including:

- *Abdominal Radiology.*
- *Current Emergency Hospital Medicine Reports.*
- *Current Environmental Health Reports.*
- *Current Trauma Reports.*
- *Health Care Management Science.*
- *Internal Emergency Medicine.*
- *JGIM: Journal of General Internal Medicine.*
- *Journal of Public Health.*
- *Neurocritical Care.*
- *Pediatric Radiology.*
- *Sports Medicine.*

All of these journals will be accessible via BrowZine and our discovery service from January 2023 onwards. Key titles will also be added to our Journals page and relevant library guides. RAPM is available now!

NZ EXAM TEXT UPDATE

Following consultation with members of the NZ training committee, the library has purchased additional print copies of the high-use primary exam texts for use by NZ-based trainees. This includes texts such as *The physics, clinical measurement, and equipment of anaesthetic practice for the FRCA; Pharmacology and physiology for anesthesia; Nunn and Lumb's applied respiratory physiology*; and Dr Podcast scripts for the primary exam for fellowship of the Royal College of Anaesthetists. The texts will be available to borrow from early 2023. For more information on borrowing from the NZ-based collection, see our Borrowing page: https://libguides.anzca.edu.au/borrowing.

CONTACT THE LIBRARY: +61 3 9093 4967 library@anzca.edu.au anzca.edu.au/resources/library

LIBRARY DOCUMENT DELIVERY SERVICE WINS INNOVATION AWARD

ANZCA Library Manager, John Prentice, recently won the 2022 HLA/MedicalDirector Innovation Award for his work on an automated solution created to handle ANZCA Library's nearly 2000 annual document delivery requests.

The system allows ANZCA library staff to automate many of the standard searching, requesting and communication tasks associated with document delivery requests, resulting in a far quicker turnaround of requests for ANZCA users. With the help of the system, request turnaround time fell to under one working day for most of 2022.

The award follows work completed over several years to better integrate document delivery provision into core ANZCA Library systems and services and improve overall turnaround times. This work has allowed the library to provide more than 200 BJA-related requests alone since the loss of full-text access to the journal at the beginning of the 2022.

ANZCA Library users can now generate "one-click" population of requests through the following systems and services:

- BrowZine.
- Library discovery service.
- Read by QxMD.
- Ovid Medline.

In addition to the above, library staff are at work on creating "how to" webinars on the article requesting service. These will shortly be published on the Help and Request an article pages.

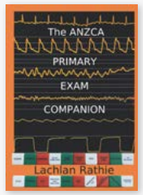
For more information, see our Request an article page.

New books

TRAINING BOOKS

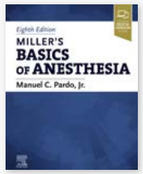
A number of new training-related titles are now available online:

https://libguides.anzca.edu.au/training-hub



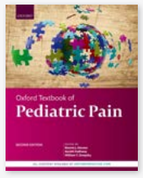
ANZCA primary exam companion, The

Rathie L. Sydney: Independently published, 2022.



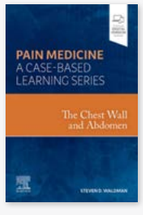
Miller's basics of anesthesia, 8e

Pardo M, ed. Philadelphia, PA: Elsevier, 2023.



Oxford textbook of pediatric pain, 2e

Stevens BJ, Hathway G, Zempsky WT, eds. Oxford: Oxford University Press, 2021.

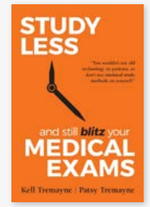


Pain medicine: a case-based learning series. The Chest Wall and Abdomen.

Waldman SD. Philadelphia, PA: Elsevier, 2023.

NEW BOOKS FOR LOAN

Books can be requested via the *ANZCA Library discovery service:* http://www.anzca.edu.au/resources/library/borrowing



Study less and still blitz your medical exams

Tremayne K, Tremayne P, Australia: Kell Tremayne and Patsy Tremayne, 2022.

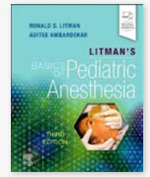
The registrar.

Janakiramanan N, Crows Nest, NSW: Allen & Unwin, 2022.

If you want them to listen, talk their language: communication, motivation and success in business and personal relationships using the process communication model

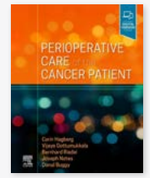
Feuersenger E, Naef A [Waikanae], NZ: Kahler Communications Oceania, 2011.

NEW EBOOKS



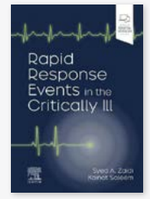
Litman's basics of pediatric anesthesia, 3e

Litman RS, Ambardekar AP, eds. Philadelphia, PA: Elsevier, 2022.



Perioperative care of the cancer patient

Hagberg CA, Gottumukkala VNR, Riedel BJ, Nates JL, Buggy DJ, eds. Philadelphia, PA: Elsevier, 2022.



Rapid response events in the critically ill : a case-based approach to inpatient medical emergencies.

Akhter Zaidi SA, Saleem K, eds. Philadelphia, PA: Elsevier, 2023.

NEW BOOKS

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

The surprising link between autism spectrum disorder and anaesthetists

The traits of people with autism spectrum disorder (ASD) make them perfectly placed to be an anaesthetist – and there's probably more of them working in anaesthesia and pain management than we think.

That's the view of Dr Clare Fisher, who presented on neurodiversity among anaesthesia trainees at November's meeting of ANZCA's New Zealand Education Sub-Committee.

Dr Fisher said while some people joked about anaesthetists being "a bit odd", some of the traits found in neurodiverse trainees were in fact helpful – particularly in the case of ASD.

"ASD traits are perfect for an anaesthetist – they can be diligent, focused, into perfectionism, they want people to be honest, and are often very frank. This is something that's probably out there maybe more than we think it is."

Similarly, much of the day-to-day work of an anaesthetist was well-suited to those with ASD, Dr Fisher said.

"We only deal with one patient at a time, our patient communication is often quite concise, quite task focused and quite direct."

Dr Fisher noted the incidence of ASD within anaesthesia was higher than in other medical specialties – it was highest in GPs, followed by psychiatrists, then anaesthetists.

Trainees with ASD had to deal with an extra layer of pressure in comparison to their colleagues.

"These trainees live under a lot of pressure to fit in with expectations. There's an increased risk of mental health disorders, and increased incidences of anxiety and depression.

"If they've not been diagnosed when they were younger, or not admitted it to a supervisor of training, they will only seek help when it's disrupting their life. The majority of the time they'll just keep trying to fit in."

She said a changed perspective might be needed towards trainees living with ASD.

"Autism spectrum disorder is still thought of as a disorder and we need to fix it, the question is, do we need to be embracing it rather than trying to fix it?

"These are trainees who might need a little bit of extra care because trainee transitions are much more unsettling for them, doing lists with multiple different consultants is also much more stressful.

It could be something that rotational supervisors take into account when they're doing allocations on rotations, it may be something where supervisor trainers or rosterers can allocate these trainees to just a few key consultants to help with their training and try and avoid these unsettling times."

Providing noise-free spaces for trainees could also be helpful.

By contrast, trainees with attention deficit hyperactivity disorder (ADHD) could be viewed as "disorganised" but were also high-functioning.

"It's an inattention disorder but it's actually a dysregulation of attention, so it may not be only inattention, it might be that actually they pay attention to different or inappropriate things."

While trainees with ADHD were great for bringing energy and novel or creative approaches to tasks, and had an abundance of enthusiasm and passion, it was important to not overload them.

"Harness those powers if you can, but be aware, you don't want to cause those people to collapse in a heap because the masking process they've used for so long is actually physically and emotionally exhausting."

Dyslexia was a disorder not just of spelling but of process programming and had broad implications for trainees who might need assistance, Dr Fisher said.

"They might struggle with numbers, names, short-term, long-term memory, the memory process for learning the exam, they need clear instructions. They may also have different ways of doing things – just because it's not your way it may not be wrong."

Dr Fisher said greater consideration needed to be made for those trainees with neurodiverse tendencies.

"As a supervisor of training, if you have a trainee who has a known diagnosis or disability, in the regulations of assessment you have to let the exam committee know 18 weeks out from doing the exam and there may be options to have extra time for sitting exams."

Other resources were also available to support neurodiverse trainees, including online groups on Facebook and Twitter. Also important was the creation of inclusive and safe working environments.

Reon Suddaby
Senior Communications Advisor
New Zealand, ANZCA

ANZCA Council makes history with NZ trip

ANZCA COUNCIL HOLDS FIRST-EVER NEW ZEALAND MEETING

A small piece of ANZCA history was created in September when ANZCA Council journeyed over the Tasman to hold its first-ever meeting in New Zealand.

Fourteen councillors and support staff made the trip to Wellington on 16 and 17 September, with the meeting held in ANZCA's New Zealand office marking the first council meeting outside Melbourne, and the beginning of what is hoped to become a regular annual event.

Among the highlights of the trip was an introduction to Māori language, with an opportunity for those gathered to practice a waiata (song), ahead of the following day's cultural workshop, held at New Zealand's national museum, Te Papa.

Council welcomed New Zealand National Committee Chair Dr Graham Roper, Tasmanian Regional Committee Chair Dr Lia Freestone, WA Regional Committee Chair Dr Marlene Johnson, and ANZCA Trainee Committee Co-Chair Dr Alec Beresford to its internal and open sessions.

The ANZCA Council visited the marae at New Zealand's national museum, Te Papa.

Western Australia

COUNTRY CONFERENCE AT BUNKER BAY

This year's WA ACE Country Conference was convened by SJOG Midland Hospital, and again held at the beautiful Pullman Resort, Bunker Bay.

After the intermittent lock downs of 2021, and virtual ASM, it was wonderful to gather as an anaesthesia community. More than 100 hundred delegates registered, with a diverse mix of specialist and GP anaesthetists from across WA and beyond.

Our opening session, chaired by Midland's Dr Emma Brandon, consisted of three, 20-minute updates into perioperative medicine (Dr Leena Naggapan), obstetric anaesthesia (Professor Mike Pyke), and practice changing highlights from this year's ANZCA ASM (Dr Neil Hauser). These talks were punchy, engaging and certainly got us all reflecting on and discussing our practice.

Dr Duncan Bunning chaired our second session, shifting the focus to digital health and its potential in anaesthetics. Dr Ted Murphy, who kindly joined us from the Royal Adelaide Hospital, described his experience setting up and transitioning to an electronic aesthetic record, and geriatrician and clinical lead of WA's electronic medical record program, Dr Hannah Seymour, gave us examples of how big data could be used to drive quality improvement.

The afternoon saw our Midland consultants deliver a number of well received workshops on major haemorrhage, advanced life support and CICO.

Particularly successful was the kids workshop, despite it being driven inside by inclement weather. Our three-bedroom villa was descended upon by 38 children between the ages of three and 10, who were promptly given official delegate name lanyards, split into six groups, and rotated through Halloween-themed first aid and craft activity stations.

Our Saturday evening function was held at Wise Winery, where a break in the otherwise stormy weather allowed us to appreciate the spectacular views and enjoy a superb acoustic guitar set by local musician Danny Alcorn. The food was great, the company warm, and though I exited early, I believe the dance floor was full until the buses arrived to take everyone home.

On Sunday morning, Midland anaesthetist and pain specialist Dr James Jarman gave us his top 10 acute pain management tips, and Dr Denise Glennon spoke to us of the role of the perioperative geriatrician, and practice tips she has seen make a difference. Our final speaker, Dr Clare Fellingham, presented remotely, which did not detract at all from a hard hitting and fascinating talk about voluntary assisted dying and lessons from its first year being accessible in WA.

We concluded the conference with an interesting and interactive case-based discussion, skilfully facilitated by Dr Paddy Cowie.

As one of the convenors, I was pleased with the conference, am now relieved that it is over, but have been left wondering exactly what value an in-person conference adds to a virtual event.

Clockwise from top: The opening address; Delegates enjoying an evening at Wise Winery; the children's workshop.

In his lessons from the ASM, Neil Hauser made the comment that both to be environmentally responsible, and after seeing the audience reached, flexibility offered and favourable reception of this year's format, future conferences should probably all have a virtual component. I second this notion.

That said, being present at such an event, over a weekend, does deliver more. It's something human, and it's subtle. Conversations at breakfast, sharing a joke in the coffee line during the break, seeing talented and knowledgeable colleagues being partners, parents and going for a swim with their kids. It can be messy, but mostly, it builds trust, authentic connection, and a sense of community. And I think we need that at least as much as the CPD points and polished presentations.

See you in Broome for the next WA ACE Country Conference, 9-11 June 2023! (Charlie's, the stage is yours!).

WA TRAINEE LEARNER'S MANUAL

Dr Fionn O'Laoire, Co-Chair WA Trainee Committee, has co-ordinated an update to the WA Trainee Learner's Manual available on the ASA website. This informative guide is aimed at those rotating between the training sites around WA. The WA Trainee Committee will look to update this document annually and welcomes feedback.

EXAMS

Congratulations to all those who passed their primary exams in Melbourne in October 2022, and those who passed their final exams in Brisbane in November 2022. WA candidates did very well in the 2022.2 exams:

- Eleven of the 12 candidates who sat the 2022.2 primary written exam in Perth, passed the exam.
- Nine of the 10 candidates who sat the 2022.2 final written exam in Perth, passed the exam.

New South Wales

SUPERVISORS OF TRAINING MEETING

A supervisors of training meeting for NSW and ACT was held on October 14 at Northside Conference Centre, Crows Nest. Along with updates from ANZCA, a range of topics were presented including part time training, centralised recruitment and resilience training experience. With 70 supervisors of training attending, in person and remotely, there was considerable discussion, and a great opportunity to meet and support each other.

ANZCA EDUCATORS PROGRAM

The recent ANZCA Educators Program meeting was held face-to-face in October. The facilitators were Dr Kate Chatten and Maurice Hennessey with 20 participants attending in person".

SAVE THE DATES!

NSW ACE Spring Meeting Coffs Harbour – Saturday 11 and Sunday 12 November 2023

NSW ACE Anatomy Workshop Sydney – Saturday 25 November 2023

From top: Dr Sally Wharton (EO NSW), Dr James Nielsen (Deputy EO NSW) and Dr Jo Walsh (Deputy EO NSW) at the supervisors of training meeting; Dr Kate Chatten and Maurice Hennessey with 20 participants at the ANZCA Educators Program meeting.

Victoria

PRIMARY EXAM REFRESHER COURSE

More than 80 trainees filled the auditorium to participate in the primary exam refresher course from 14-25 November.

During the 14-day intensive training program, Dr Adam Skinner, course convenor, brought together more than 20 leading clinicians and researchers in Victoria to build trainees knowledge around many topics including cardiovascular physiology, opioids, equipment, safety electrical hazards, and physiology of ageing.

FPM MEETING FOR TRAINEES

With FPM fellowship exams on the horizon, FPM trainees across Australia and abroad were invited to participate in a hybrid CME meeting on 9 November.

Victoria's leading FPM specialists, Dr Guy Buchanan, Dr Catherine Algie and Dr Louise Brennan, shared their insights on topical health issues facing pain physicians in post-pandemic times.

Topics such as pain intervention "What I wish I had known when I first started out", pain post COVID-19, and pelvic pain, as well as new and emerging clinical research were unpacked, inducing lively discussions throughout the evening.

UPCOMING EVENTS IN 2023

Final Refresher Course – Monday 13 to Friday 17 February

Final Anatomy Course – Monday 20 February

Introduction to Anaesthesia Course – Friday 3 March

Primary Refresher Course – Monday 15 to Friday 26 May

Queensland

2023 QUEENSLAND COURSE DATES

Introduction to anaesthesia training program
11 February 2023

Primary lecture program, series 1
18 February to 17 June 2023

Primary practice viva
18 and 27 April 2023

Primary practice viva (virtual)
24 April and 10 May 2023

Primary viva weekend course
22-23 April 2023

Primary exam refresher course
5-9 June 2023

Final exam refresher course
27 February to 3 March 202

Final practice viva
26 April and 11 May 2023

Final practice viva (virtual)
23 May 2023

Final viva tips and techniques
19 April 2023

Primary lecture program, series 2
8 July to 18 November 2023

Primary practice viva
13 and 19 September 2023

Primary practice viva (virtual)
21 September and 3 October 2023

Primary viva weekend course
30 September to 1 October 2023

Primary exam refresher course
27 November to 1 December 2023

Final exam refresher course
17-21 July 2023

Final practice viva
27 September and 17 October 2023

Final practice viva (virtual)
1 November 2023

Final viva tips and techniques
20 September 2023

For further information email qldcourses@anzca.edu.au.

Australian Capital Territory

ART OF ANAESTHESIA

The regional committees of ANZCA and the ASA recently held the Art of Anaesthesia meeting at Hotel Realm, Canberra. After a two-year hiatus, we were thrilled to host a fantastic meeting, with the face-to-face meeting selling out. Given the popularity, we were able to support a live-stream option as well. It was great to see so many of our local and interstate colleagues catching up, mingling and sharing ideas.

Convenor Dr Bibhuti Thakur and co-convenor Dr Adam Eslick put together a great program, made up of national thought leaders and local experts. The Saturday program covered big, diverse topics including onco-anaesthesia, inflammation, neuroscience, environment and health economics, with clinical updates in interventional radiology, gender affirmation surgery and neuromonitoring (amazingly presented in Dr Seuss rhyme!). Sunday saw a series of workshops, including major haemorrhage, transthoracic echo and an in-situ anaphylaxis workshop.

Looking forward to 2023, with enhanced capacity for in-person attendance.

From left: Dr Bibhuti Thakur, Dr Jessie Ly, Dr Adam Hastings, Dr Adam Eslick and Dr Julia Hoy; Associate Professor Stefan Dieleman.

South Australia and Northern Territory

ACE CONFERENCE

The SA ACE Conference "Navigating the present, mapping the future" was held at the Sanctuary Adelaide Zoo on Saturday 24 September.

Delegates welcomed ANZCA Immediate Past President Dr Vanessa Beavis and Associate Professor Ross Kerridge who discussed the evolution of perioperative medicine, its development as a healthcare model and its future as an integrated clinical specialty. Dr Peter Waterhouse provided an update on managed care and the implications for delivery of healthcare in Australia.

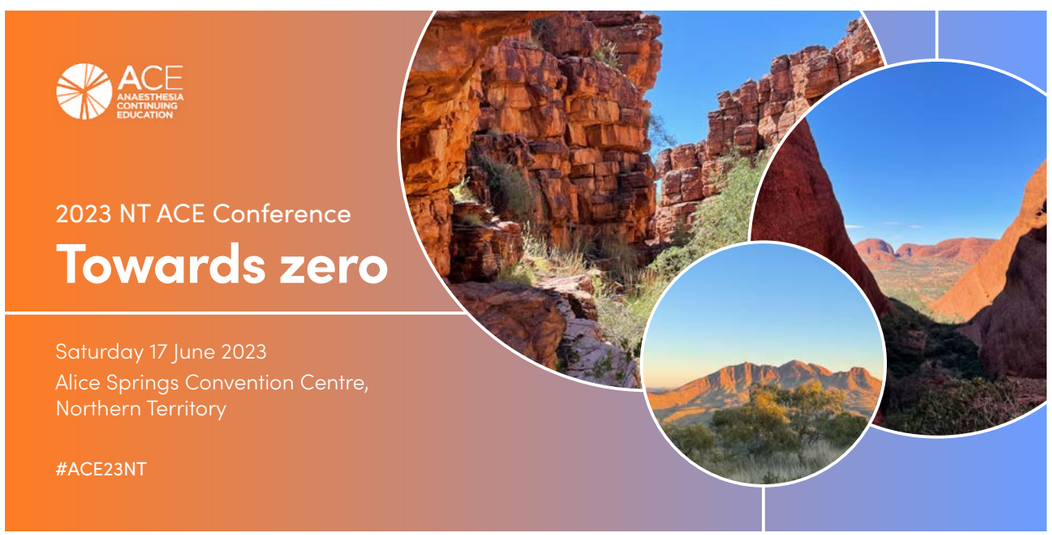
Dr Scott Ma led a team of local speakers who spoke passionately on the work being undertaken to help reduce hospital and anaesthetic waste and improve sustainability. The last session of the day included talks on technology, techniques and devices.

The SA/NT CME Committee would like to thank all speakers who donated many hours of their time to present at this meeting.

"UPDATES IN OPIOIDS STEWARDSHIP" HUB

It was an enjoyable evening for SA FPM specialist pain medicine physicians who watched the "Updates in opioid stewardship" webcast at the "hub" dinner meeting at Ayers House, kindly sponsored by CSL Seqirus.

From top: Dr Alex Reid, Dr Vanessa Beavis and Dr Joanne Tan; Conference convenor Dr Nikki Dyson, Dr Dustin de Jonge, Sarah Almeroth, Dr Alyssa Gardner, Dr Scott Ma and Dr Emma Panigas; Winner of the environmental sustainability in anaesthesia and healthcare poster presentation Dr Natasha Stolz with Dr Scott Ma.



Tasmania

TASMANIAN ACE ANNUAL SCIENTIFIC MEETING AND TASMANIAN TRAINEE DAY

Registrations are open; kick off your 2023 CPD year with a trip down south to Tasmania! February is a beautiful time to visit Hobart and MONA FOMA is on the same weekend so get in quick to secure your accommodation before it books out.

Hobart will be hosting the Tasmanian Annual Scientific Meeting (ASM) from 25-26 February 2023. Over two days we'll be "Making connections" through a day of lectures and a day of workshops, exploring the realms of airway management, perioperative medicine, pain management, communication and sustainability.

Our perioperative session will be led by Professor Bernhard Riedel from the Peter MacCallum Cancer Centre and by Dr Liz Crowe, who will connect us with the fascinating topic of futility. Pain expert, Dr Suyin Tan from Nepean Hospital will be guiding us through the connections of analgesia and anaesthesia in a patient's journey. Our scientific session will cover airway and onco-anaesthesia updates from Professor Reny Segal and Professor Bernhard Riedel. Our local speakers will be providing insights into Tasmanian challenges and updates in perioperative medicine, airway management, regional anaesthesia and sustainability.

Make some practical connections in our exciting line up of workshops on Sunday. Join Dr Liz Crowe for a masterclass on communication, a unique opportunity to learn from communication experts in a small group environment. Or update your skills in workshops led by renowned experts in advanced airway, regional anaesthesia, anaphylaxis and cardiac arrest.

The Hotel Grand Chancellor, our new venue, will ensure a spacious, COVID-safe but social environment. Our social function is not to be missed – a cocktail style affair enjoying water views at the renowned Aloft Restaurant.

Our annual Trainee Day, a fantastic opportunity to make and renew junior colleague connections, will precede the meeting on Friday 24 February 2023 at Hadley's Orient Hotel.

Dr Stephanie Cruice and Dr Jana Vitesnikova
Co-convenors, 2023 Tasmanian ASM

TASMANIAN REGIONAL COMMITTEE

The Tasmanian Regional Committee commemorated the dedication and years of broad voluntary contributions as both a member for 16 years including chair to the Tasmanian regional for four years as they farewelled Dr Lia Freestone at a dinner held at Landscape Bar and Grill in Hobart and Stillwater in Launceston at the final dinner meeting for the year on Thursday 24 November 2022.

Mr Nigel Fidgeon, CEO of ANZCA attended to recognise and honour Lia's contribution as well as welcome the new chair from January 2023, Dr Bruce Newman.

The committee also acknowledged the contribution made by previous chairs throughout the period of Lia's contribution to the ANZCA community of fellows and trainees, particularly in Tasmania. This included Dr Richard Waldron, Dr Nico Terblanche and Dr Colin Chilvers.

It was a great evening and wonderful get together for the Tasmanian Regional Committee.

Dr Lia Freestone
Outgoing chair, Tasmanian Regional Committee

CPD IN A DAY

Sixty-one delegates with 11 faculty attended the Tasmanian "CPD in a day" on 5 November. This was a single day workshop-based event, built entirely of ANZCA emergency response activities to meet CPD requirements, including cardiac arrest (ALS) major haemorrhage, can't intubate can't oxygenate and acute severe behavioural disturbance (ASBD).

This was the second time Tasmania has run this type of meeting, with the last one held in 2019. Delegates from around Tasmania and Australia and even as far as New Zealand appreciated the opportunity to concentrate on their CPD requirements on the day.

The meeting convenors Dr Nat Jackson and Dr Harry Laughlin felt that the day went very well and received a lot of positive comments and feedback. They are grateful for all the faculty for their support and involvement, including Dr Stephanie Oak, a consultation-liaison psychiatrist and pain medicine specialist who travelled from NSW to run four ASBD workshops on the day.

Delegates also enjoyed the catering and barista which helped to make the day even better.

A small group joined the social function at Boodle Beasley that night and those who attended found it to be an enjoyable way to get to know other delegates and unwind after a busy day.

Dr Nat Jackson and Dr Harry Laughlin
Co-Convenors, CPD in a day 2022

(Gilbert) Barrie Tait

1934-2021

Rheumatologist Dr Barrie Tait, a foundation fellow of ANZCA's Faculty of Pain Medicine, died aged 87 in Auckland in September 2021.

Barrie made key contributions to both pain medicine and musculoskeletal medicine. Like Woody Allen's character *Zelig*, Barrie was present at many key events in the development of these fields.

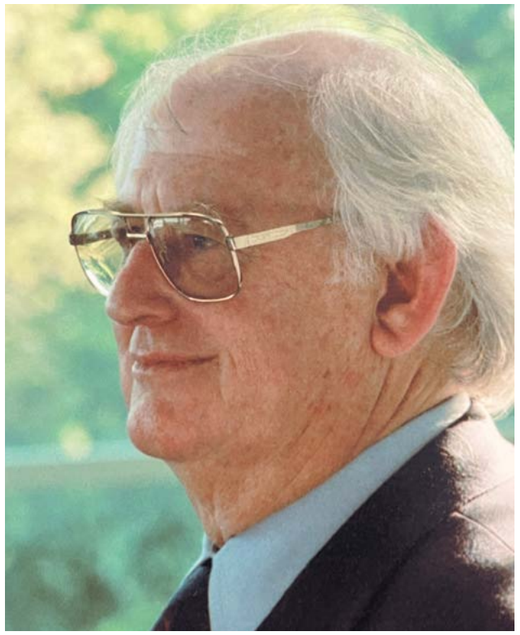
After his house surgeon (intern) year at Auckland in 1960, he spent a decade in the UK. He first sought out, and became registrar to, Dr James Cyriax at St Thomas' Hospital, London, whose *Textbook of Orthopaedic Medicine* Barrie had discovered as a medical student. He then worked in Manchester for JH Kellgren, the UK's first Professor of Rheumatology. With Barrie, Kellgren was one of two co-authors of a 1969 paper in the *Annals of Rheumatic Diseases*. Barrie lectured in rheumatic diseases in Manchester and also spent time at Oxford as a clinical lecturer, and senior registrar in rheumatology, physical medicine and rehabilitation.

On his return to New Zealand he worked first as a rheumatologist at Waikato Hospital, before moving to Auckland as physician-in-charge, departments of physical medicine at Auckland Hospital Board, and then rheumatologist at Auckland Hospital, where he was later clinical director. There, in the early 1970s, he met anaesthetist Dr Bob Boas who was setting up a pain service, based on the interdisciplinary model pioneered by anaesthetist Dr John Bonica at the University of Washington, Seattle. Bob Boas asked Barrie to join the team. Bob and Barrie became foundation members of the International Association for the Study of Pain (IASP) when they were among the 350 invitees to a 1973 meeting in Issaquah, Washington, organised by Dr Bonica. This meeting formed the IASP and launched the journal *Pain*.

In 1977 Barrie moved to Christchurch as a rheumatologist at Christchurch Hospital, and senior lecturer in the department of medicine at the University of Otago. It was here that he made his two major contributions.

He first established a postgraduate diploma in musculoskeletal medicine, a distance teaching diploma aimed at GPs. The academic heads of the departments of surgery, orthopaedic surgery and medicine agreed to form a combined academic department – orthopaedic surgery and musculoskeletal medicine – to house this new diploma, and the associated undergraduate medical teaching. The diploma's first intake of 31 students was in 1989, and by 1995 there were more Australians enrolled (44) than New Zealanders (33).

The combined academic department and diploma continue today. The diploma has expanded to include specific teaching in pain, with – appropriately – a broader spectrum of health care disciplines represented as students and academic staff.



Barrie also set up the clinical arm of this approach – a service for chronic pain patients based at Burwood Hospital in Christchurch. It began seeing patients in February 1988. When, a decade later, Barrie was explaining the history of this service to me, to tutor me as the new clinical director of the Pain Management Centre, he said the service was initially a musculoskeletal medicine service. But he soon realised that the approach should shift from a biomedical to the biopsychosocial approach of an interdisciplinary team model, as pioneered at Seattle, and as modelled by the Auckland Regional Pain Service established two decades earlier by Bob Boas. So Barrie invited Dennis Turk, eminent pain clinical psychologist at the University of Washington, Seattle, to visit Burwood Hospital after the Sixth World Congress of Pain in Adelaide in 1990, to more closely align it with the Seattle model. Sadly, in contrast to the diploma, this service has recently struggled. It is a comfort that Barrie did not witness the attrition of the clinical service in which he invested so much passion.

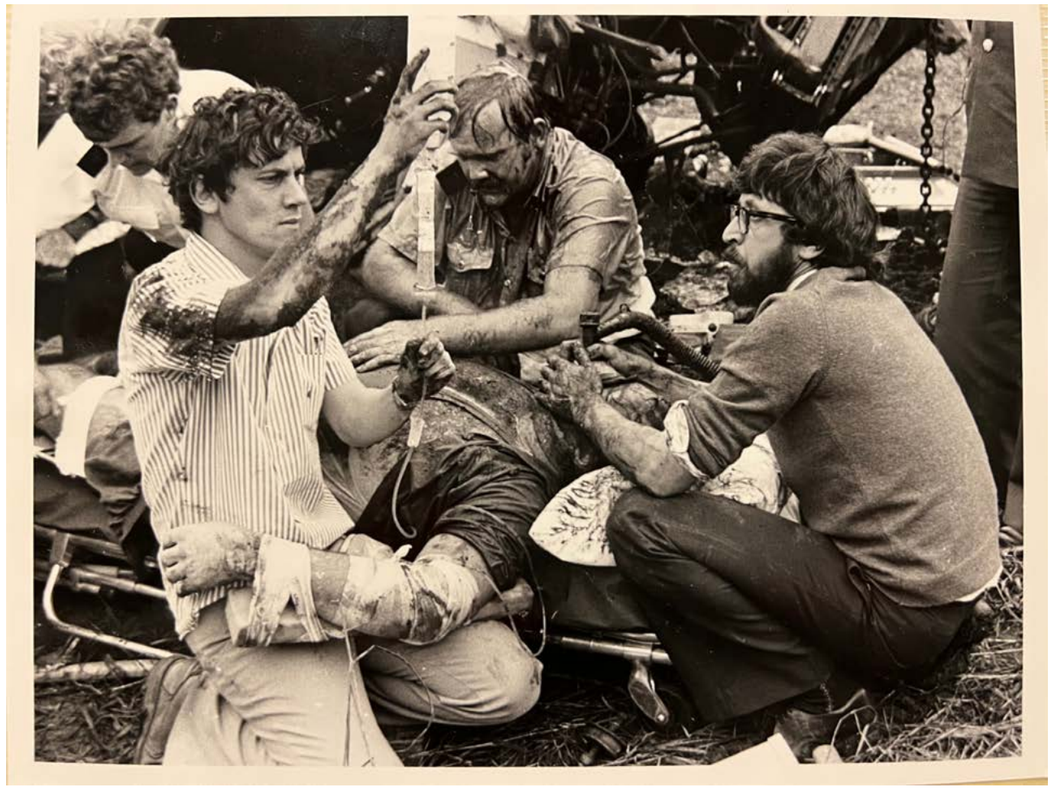
As well as a founding member of IASP, and a foundation fellow of FPMANZCA, Barrie was the foundation president of the Australasian Faculty of Musculoskeletal Medicine (AFMM), and a past president of both the NZ Pain Society and the NZ Association of Musculoskeletal Medicine.

Barrie maintained wide extra-curricular interests, including art history. He was also brave enough to dip his toes into the deep and opaque waters of the philosophy of mind. He is survived by his wife Philippa, and four sons.

Dr John Alchin FAFOEM(RACP), FFPMANZCA
Pain Management Centre, Burwood Hospital, Christchurch (retired); Clinical Senior Lecturer, Department of Orthopaedic Surgery and Musculoskeletal Medicine, University of Otago, Christchurch

Dr Bernard Xavier Kehoe

1953-2022



Dr Bernard Kehoe (in the striped shirt holding the bag of fluid) was part of the retrieval team sent into the field when a truck rolled over on the Toowoomba Range in 1980. Also pictured is Dr Ken McLeod in the glasses holding the airway, who was an anaesthetist in Toowoomba. This photo appeared in the *Toowoomba Chronicle*.

These days, 69 is young. Anyone who was a close friend or colleague of Bernard Xavier Kehoe, would have been deeply saddened by the news of his death in mid-July 2022.

Bernard often signed himself as BXK, and was known variously by these initials or Bern, Bernard, and among his medical colleagues, Bernie "Blocks" Kehoe. He was academically gifted, having been school captain at St Joseph's College, Gregory Terrace in 1970, and topped the year in his senior exams. He graduated from the University of Queensland in 1976 with a Bachelor of Medicine-Bachelor of Surgery. In 1977, he started working at Toowoomba General Hospital with another colleague of ours, who recalls what a lively, energetic and reassuring presence he was. Their first term was "cas" as casualty was affectionately known back then. Now it's "a and e" (accident and emergency.) He would always stay around to help long after his shift finished, with his never-ending font of energy and clinical acumen. He truly cared about his colleagues and his patients.

I first met Bernard when I was doing my fifth year student elective in Warwick in 1978 and he had been rotated from Toowoomba to "the bush." Bernie was a dynamic young doctor working at the local hospital and gaining experience in everything he could especially relishing obstetrics and anaesthetics.

He had already married his life partner Shayne and they had a young toddler Michael, who is now a barrister in Brisbane. I became Michael's babysitter and was also thrown in the deep end on the work front, becoming proficient at sewing up episiotomies and all aspects of anaesthetics, under Bernard's expert tuition. He was inspirational and his enthusiasm was contagious. That was the larger-than-life Bernard. However, there was also the real Bernard underneath all that bravado, the one relaxing and unwinding on the couch to the distinctive strains of George Benson's *Breezin'* and exercising his singing voice on his favourite number *This masquerade*. Fortunately for the world of medicine, it wasn't quite time for him to give up his day job!

The world is a small place, and Bernard travelled it extensively with his family over the years. However, we both ended up working in Toowoomba in the early 80s, where he was a senior registrar in anaesthesia, and I was a resident, then registrar, in anaesthesia.

Bernard continued to be an inspirational, magnetic and entertaining person and teacher. He had a wide range of bow ties. Another colleague who shared a one-in-two on call roster with him, recalls that when the surgeons complained about his brachial plexus blocks, he simply put the ventilator tubing under the pillow, fired up the Bird ventilator and asked the surgeon if that was any better. Invariably it was!

In 1980, a truck rolled over on the then perilous Toowoomba Range. Bernard was part of the retrieval team sent into the field. The driver was trapped underneath his truck. It's an understatement to say that Bernard was quite skinny, and he was the only one capable of wriggling underneath the truck to help extricate the patient. He was also the only one brave enough. Covered with oil, grease and mud, he then established intravenous access and started roadside fluid resuscitation. He made it on to the front page of the *Toowoomba Chronicle* with a defining image. I continued to be Michael's babysitter and also became godmother to his newborn daughter Elizabeth.

Bernard finished his anaesthesia training in 1983 and was awarded the prestigious Cecil Gray Prize.

We dispersed to different areas of the country and the world – Bernard to Southampton in the UK where he gained further experience.

Bernard then returned to Brisbane where he joined Wickham Terrace Anaesthesia from 1986 until 2005, especially enjoying anaesthesia for obstetrics and orthopaedics. He wasn't great at saying no to working idiotic hours. He also didn't want referring surgeons to think that he earned too much so he drove an old 1988 Toyota Corolla until a few months after his fortieth birthday in April 1993. That way he figured that people would keep sending him work. He only ever charged Medicare rebate as he felt uncomfortable about charging a gap. He always wanted to please. Michael often runs into his father's former patients who say that he was very funny and made them feel totally at ease.

Unfortunately, Bernard had also developed serious intercurrent health issues, which plagued him over many years, and which culminated in a diagnosis of Parkinson's disease in 2005. He spoke to me about his utter devastation upon learning of this diagnosis and retired in his early fifties. Bernard and Shayne then left the city, moving from Cooparoo to Currimundi on the Sunshine Coast.

His irrepressible spirit and sense of humour remained undampened. He continued to travel and maintained an encyclopaedic knowledge in many areas including history, music and good wines. He had a canary called Coco and Bantam hens laying eggs in Toowoomba. He graduated to dogs in about 1980, starting with George, then Gracie 1, Gracie 2, Bomber and finally Leo who is still with us. Leo was Bernard's faithful shadow and misses his master.

Bernard remained stoical in the face of his problems, but eventually Lewy bodies took up residence in his brain and the final stages of his illness were rapidly progressive.

Bernard is survived by his wife Shayne, his son Michael, daughter Elizabeth, three grandchildren, and sister-in-law Trish who is a huge support to the family.

He will live forever in our hearts.

Dr Susan Belperio FANZCA
Adelaide

Dr Sandy Zundel Wolf Zalstein

1969-2022

I remember many years ago approaching a senior registrar from intensive care late in the night at The Alfred hospital. I had referred a postoperative patient for possible intensive care admission. As always, these interactions had to be approached with much trepidation as our request for one of our postoperative patients was often mocked or treated with contempt. "Do you really feel that this patient needs intensive care?" I would often hear this question while the registrar or consultant would look at me as if they didn't understand my request.

Instead, I was greeted by a friendly, charismatic person who was unhurried and meticulous in his assessment and took the time to give everyone in the postoperative care unit the time of day, explain his assessment and find a few more minutes in his arduous night shift to have a chat. This was my first memory of Sandy Zalstein. I was delighted after this first meeting to discover that Sandy was in a relationship with a family friend, Nicola, who he went on to marry. Sadly, it is with a sad heart that I now share these recollections because of Sandy's tragic passing.

Sandy was infused with energy and a great restlessness. He was always on the move. After working at The Alfred, Sandy's professional life as an anaesthetist took him to Bendigo, back to Melbourne and then Hobart. His military duties took him further, to Afghanistan, East Timor, and Antarctica. He shared interests in intensive care and trauma management as well as anaesthesia. He loved fast cars, had an envious collection of stylish watches, and enjoyed fine wine and championed the fine whiskies of Tasmania. My wife Nicole and I remember once arriving to a restaurant for dinner with Sandy and Nicola to be greeted with much scurrying and whispering only to be taken to a table where a bottle of Bordeaux was waiting for us, slowly decanting, a symbol of Sandy's great generosity towards his friends. He also showed great generosity to his profession, reflected in his work with the military and his commitment to providing better trauma care for Tasmanians.

Sandy adored his lovely wife Nicola and their much adored children Hanna and Josh, together with adored daughter Carmody. He had a special relationship with Sol, his much older brother, who went out of his way to spoil Sandy to make up for lost time after many years without a sibling. He shared great affection for Sol's family. He will be greatly missed by all his loved ones and his many friends.

Dr Alex Konstantatos
Victoria

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