Exploring the deep with diving and hyperbaric medicine

Recognising ANZCA’s research successes
An update on what our fellows have achieved

Managing exams in a pandemic
How ANZCA dealt with COVID-19 disruptions
Are You Improving Outcomes with SpHb?

Six studies across four continents have found that noninvasive and continuous hemoglobin (SpHb) monitoring can help improve outcomes.1-6

Clinical decisions regarding red blood cell transfusions should be based on the clinician’s judgment considering among other factors: patient condition, continuous SpHb monitoring, and laboratory diagnostic tests using blood samples. SpHb monitoring is not intended to replace laboratory blood testing. Blood samples should be analyzed by laboratory instruments prior to clinical decision making.

CAUTION: Federal (USA) law restricts this device to sale by or on the order of a physician. See instructions for use for full prescribing information including indications, contraindications, warnings, and precautions.

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Visit www.masimo.com/sphb

Our research

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Contents
Time to cast off 2020 and look ahead to the future

Beyond COVID
Outsider our working lives in hospitals, the COVID restrictions gave us a glimpse of a slowed-down, clearer world, as a consequence of much-reduced traffic noise and lower fossil fuel emissions. Everywhere, people reported similar observations during the lockdowns (fullfil):
• Birds came down from the trees, and showed no fear of humans.
• Neighbours looked after each other, without breaching their “bubbles”.
• Clear days were amazingly clear.
• Strangers out for walks greeted each other, as did their dogs, usually from at least two metres away.
• People relearned the value of face-to-face contact.
• Spirits lifted or sank on the basis of daily changes in COVID case numbers.
• Online shopping became a necessity, rather than an option.
• Takeaway food became a much-anticipated event.
• People re-learned the value of face-to-face contact.
• Working from home merged with living at the office.

2021
The possibility that the pandemic will be over by late next year allows us to resume thinking about interrupted projects, such as:
• The diploma of clinical perioperative medicine.
• Dual training for those who want to be both intensivists and anaesthetists.
• A Te Reo Māori name for the college.
• A “re-imagined” ANZCA Annual Scientific Meeting.

Thanks
Nothing is ever a complete disaster. Even COVID has taught us lessons and prompted innovations that will outlast the pandemic. It is now nine months since ANZCA’s Melbourne staff last worked at the St Kilda Road office. Since the arrival of Zoom, no one has had to endure the frustrations of an audio-visual teleconference. Thanks to great efforts by our dedicated staff, the college has continued to serve its members and perform its functions almost seamlessly.
I thank you all – staff, officers and volunteers of ANZCA, for continuing to work under such extraordinary conditions.

Professor Kate Leslie
appointed president of AMC

A former ANZCA President, Professor Kate Leslie, AO FAHMS is the new president of the Australian Medical Council (AMC).

Professor Leslie, ANZCA president from 2010-2012, was elected president and chair of the board of directors of the AMC at the council’s annual general meeting in November 2020.

An internationally renowned anaesthesia researcher, and foundation member and past chair of the ANZCA Clinical Trials Network, Professor Leslie is a specialist anaesthetist and head of research in the Department of Anaesthesia and Pain Management at the Royal Melbourne Hospital. She was appointed to the AMC Council in 2011 and was elected as a director in 2013.

She was a member (2011-2018) and chair (2015-2019) of the AMC Specialty Accreditation Committee, and was deputy president (2018-20). She is also a former chair of the Council of Presidents of Medical Colleges.

The AMC is the independent national standards body for medical education and training for Australia. It accredits primary medical programs, intern training, accreditation bodies and specialist medical colleges, and assesses international medical graduates. ANZCA is accredited by the AMC to provide vocational training and continuing professional development programs, and to assess specialist international medical graduates.

Professor Leslie acknowledged the expertise she gained with AMC accreditation while on ANZCA Council, especially as chair of the Specialist International Medical Graduate Committee, as being vital to her role at the AMC.

She said she was looking forward to working with the AMC as it reflects on lessons learned from COVID-19 in 2020.

“In the next two years our challenge will be to recover from the COVID-19 pandemic and embed some of the fantastic innovations that have arisen from it. The AMC shares these challenges with universities, colleges and health services.”

Professor Leslie has received many accolades and honours during her career, including the ANZCA Orton Medal, the Australian Medical Association Warran in Medicine Award and fellowship of the Australian Academy of Health and Medical Research. She was appointed an Officer in the Order of Australia in 2016 and was the first anaesthetist to be honoured with a Doctor of Medical Science (Honoris Causa) by the University of Melbourne in 2017.

Free ANZCA Doctors’ Support Program

How to make an appointment:
To speak with a counsellor over the phone or make an appointment to see a consultant for a face-to-face session:
• Telephone: 1300 666 367 in Australia or 08 666 366 367 in New Zealand.
• Email: support@convergient.com.au.
• Identify yourself as an ANZCA fellow, trainee or SIMG for a faster response.
• Appointments are available from 8am to 5pm Monday-Friday (excluding public holidays).
• 24/7 emergency telephone counselling is available.

HELP IS ALSO AVAILABLE VIA ARE

Doctors’ Health Advisory Service:

NSW and ACT
02 9497 6552
NT and SA
08 8366 0250
Queensland
07 3835 4352
Tasmania and Victoria
03 9495 6011
WA
08 9321 3098
New Zealand
0800 471 2654
LifeLine
13 11 14
beyondblue
1300 222 463
Reflections on a unique year for the college community

The international partnerships ANZCA fosters and actively participates in have been extremely beneficial in sharing learnings, alternate approaches and exploring what has or hasn’t worked when trying out new methodologies – there is no rule book on the workarounds required to respond to COVID.

Despite the majority of our staff having to work from home for extended periods during 2020 there has been a lot of activity and project delivery. Highlights include:

- Launching the new ANZCA FPM website with regular updates and changes based on the valuable feedback we have received.
- Re-imagining how we stage and offer events such as our 2021 ANZCA Annual Scientific Meeting in Melbourne with ENGAGE hubs across Australia and New Zealand (www.anzca.edu.au/events/courses/events/majorevents/2021-anna-asm) and our ongoing provision of continuing medical education (CME).
- Redesigning exams and viva formats to ensure the integrity of the ANZCA Training Program is maintained.
- Embracing Zoom as an online meeting and webinar platform that has allowed the important work of the college to continue.
- Progressing work on our perioperative medicine qualification with the development of a perioperative care framework and learning modules.
- Heightened media interest in anaesthesia and research projects because of the significant and important role played by our fellows and trainees in the pandemic response.
- A renewed focus on our safety and quality measures and principles and recognition of the expertise of many of our fellows on infection control guidelines and personal protective equipment.

We will continue to see a range of strategic projects being progressed in 2021 as we are able to redirect our efforts and staff resources away from the demands of our COVID-19 response.

I would like to sincerely thank fellows, trainees, SIMGs and staff for the support, advice, commitment and patience this year as the college responded to the implications and effects of COVID on so many college activities.

Here’s to 2021 welcoming some form of a return to a “new norm”.

I would like to wish everyone associated with the college a happy and safe festive period and best wishes for 2021.

Nigel Fidgeon
ANZCA Chief Executive Officer

AS 2020 DRAWS to a close, there’s no doubt to any of us that this has been a year like no other. The devastating impact that COVID-19 brought to so many people across the world has been unprecedented. Likewise, the effect on the college has been significant. It has not only affected the personal and professional lives of many of our fellows, trainees and specialist international medical graduates (SIMGs), but also our staff who have had to adjust to new ways of working.

Travel restrictions have bit hard and we have all had to come to terms with the rollout of virtual platforms across our professional and personal worlds to maintain contact with colleagues, friends and family. The use of Zoom across the college has been a huge benefit although it can never replace the face-to-face discussions and collegiality that is fundamental to our college as a specialist medical college.

The pandemic has demonstrated though has been our ability to be agile and respond to the many challenges this has created. It has forced us to develop alternative approaches to a vast array of college activities so our role as a specialist medical college continues. It hasn’t been easy.

As Australia and New Zealand emerge from the cloud of COVID a new approach will need to be established so life can return to some sense of normality. This will continue to be a work in progress for ANZCA well into 2021 when our St Kilda Road office re-opens so we can welcome back staff, trainees and fellows.

We were made for you
ANZCA'S NATIONAL ANAESTHESIA Day (NAAD) and fellows’ expert comment on COVID-19 infections, chronic pain and ANZCA research were the highlights of the college’s recent media coverage in Australia and New Zealand.

The #NAAD20 #AlwaysReady “Matter of fact I’ve got it now” video created by the department of anaesthesia’s provisional fellows at the Royal Brisbane and Women’s Hospital featured on Nine News Brisbane’s evening news on 15 October ahead of National Anaesthesia Day on 16 October. The “exclusive” broadcast of the video attracted more than 200,000 viewers (see pages 16-17).

ANZCA President Dr Vanessa Beavis was interviewed by New Zealand media on 16 November following a coroner’s ruling about the death of Northland NZ anaesthetist Dr Richard Hardin in 2017. Dr Beavis told stuff.co.nz that while there is no robust data on psychological distress among anaesthetists, it is an issue ANZCA has been aware of for more than two decades, establishing groups and resources to aid awareness and access to support.

In Adelaide, fellow Professor Guy Ludbrook was interviewed in an 11-minute segment by ABC Radio Adelaide’s afternoon host Sonya Feldhoff on 11 November about an advanced recovery care trial jointly funded by the ANZCA Research Foundation and the subject of an ANZCA media release “Golden hours after surgery the key to new model of patient care.” The program reached an audience of 50,000 people in Adelaide and regional SA ABC stations in Broken Hill, the Eyre Peninsula and Port Lincoln, ABC North and West SA (Bert Pite), ABC Riverland SA (Renmark) and ABC South East SA (Warrnambool).

The findings of another research study led by ANZCA’s Safety and Quality Committee Chair Professor David Story into COVID-19 screening of hospital patients were published in an article in The Sydney Morning Herald on 21 October. The Saturday Paper on 19 October explaining why opioid management is so important for patients.

In Bendigo, Victoria, FPM fellow Dr Kim Hattinng was featured in an article in the Bendigo Advertiser on 15 October explaining why opositined management is so important for patients.

Carolyn Jones
Media Manager, ANZCA

Melbourne fellow Associate Professor Aliya Dennis was interviewed by ABC online for a 14 October article that examined Australian healthcare workers’ responses to the pandemic and the consequences of COVID-19 in their hospitals. She told the ABC that it was more difficult to provide patient-centred and personalised care during a pandemic. The article reached an audience of nearly 400,000 people. Associate Professor Aliya Dennis was also interviewed for an article published in The Saturday Paper on 19 September about healthcare worker COVID-19 infections.

Adelaide anaesthetists Dr Christine Nuttle and Dr Gilberto Arenas featured in a Nine News Adelaide segment on 8 October about how a revolutionary new pain block treatment is being used at the Royal Adelaide Hospital to help people recover from broken ribs more effectively and safely.

FPM Dean Associate Professor Mick Vagg was a guest on ABC Radio National’s evening program Nightlife on 19 October. Professor Vagg took questions from listeners on chronic pain, opioids and pain medicine during the 50-minute segment which reached an audience of 325,000 people.

In New Zealand, FPM NZ National Committee Chair Dr Timu Armit was interviewed by Radio New Zealand about the lack of specialist pain medicine physicians in New Zealand for a radio broadcast and online article on 19 September about healthcare worker COVID-19 infections.

It is anticipated learning objectives for modules 1, 2 and 4 will be finalised by the end of the year with the potential for more detailed learning outcomes for module 3 completed following physician involvement.

Module 1 – Perioperative impact of major disease
Focus on:
- Cosmetic disease.
- Preoperative assessment.
-Leader and manager.

Module 2 – Planning for surgery
Focus on:
- Patient factors.
- Surgical and anaesthetic factors.
- Risk stratification.
- Perioperative management plans.
- Communicator.
- Collaborator.
- Health advocate.

Module 3 – Optimisation
Module 4 – Intraoperative impacts on outcomes

Framework
Significant progress has been made by the Perioperative Care Working Group on finalising the perioperative care framework. Underpinning the framework is a series of principles, recommendations, resources and references.

The framework outlines the patient’s journey from first visiting their GP to eventually returning to the GP’s care following surgery for a follow-up consultation.

This framework is being designed to be interactive and will soon be on the ANZCA website, including links through to the more detailed recommendations, resources and references sections.

Dr Sean McManus
Chair, Perioperative Steering Committee

Since the Spring 2020 edition of the ANZCA Bulletin, ANZCA and FPM fellows have featured in:
- 12 print reports.
- 10 radio reports.
- 30 online reports.
- 2 TV reports.
Your summer “to do” list for the ANZCA ASM
Brought to you by the Melbourne Regional Organising Committee

☐ Visit the ASM website – the program is available now!

☐ Save the date – registration opens mid-January.

☐ If you are a prospective author or researcher submit your abstract now – call for abstracts closes 24 January.

☐ Learn the lyrics to Paul Kelly’s song Leaps and Bounds.

Virtual ANZCA ASM
27 April – 4 May 2021
#ASM21MEL
asm.anzca.edu.au
Australian health budget contains few surprises

**Australia**

**2020 Budget**

Treasurer Josh Frydenberg delivered the 2020-21 federal budget on 6 October. Traditionally handed down in May, like many things in 2020, the budget was deferred until later in the year due to COVID-19.

Despite the obvious significant impact of the pandemic on the health system and the Australian economy more broadly, the health portfolio budget contained few surprises and many of the new initiatives flagged had been previously announced. Overall health portfolio spending over the forward estimates will increase from $115.5 billion in 2020-21 to $121.8 billion in 2023-24, which equates to about $2.1 billion or 1.8 per cent per annum. Some relevant highlights include:

**Medicines and medical devices**
- $7.7 million over the next three years to establish a unique device identification (UDI) system for medical devices designed to protect patient safety and allow for a quick response to any safety issues with implanted devices.
- An additional $1.7 million over the next three years towards ongoing funding for the administration of the medicinal cannabis research, cultivation and manufacture regulation scheme.
- $33.3 billion to supplement the National Medical Stockpile, including masks and other personal protective equipment (PPE), pharmaceuticals, medical supplies and equipment and $9.2 million to increase onshore mask manufacturing capability.

**Telehealth**
- Extension of telehealth services for a further six months while the long term design is developed in conjunction with medical groups and the community.

**Hospitals**
- The 2020-25 National Health Reform Agreement provides public hospitals across the country with $133.6 billion in funding over five years – an increase of $33.6 billion compared with the previous five years.

**Aboriginal and Torres Strait Islander health**
- An additional $90 million over three years for community controlled health organisations, with three year funding agreements and annual indexing, under the Indigenous Australians’ Health Program.
- An additional $3.3 billion to enable the Indigenous Australians’ Health Program to expand Aboriginal and Torres Strait Islander primary health care services by investing in regions of high need or high population growth, or where there are service gaps.

**Rural health**
- $5.5 million “Stronger Rural Health Strategy” to give doctors more opportunities to train and practise in rural and remote Australia and give nurses and allied health professionals a greater role in the delivery of multidisciplinary, teams-based primary care.
- $503.3 million from 2020-21 to 2023-24 for infrastructure to strengthen and develop a critical element of the rural training pipeline, the Rural Health Multidisciplinary Training Program.
- $125 million from 2020-21 to 2024-25 for the Rural, Regional and Remote Clinical Trial Enabling Infrastructure Program (funded under the Medical Research Future Fund) to improve the access of Australians in rural, remote and regional areas to innovative clinical trials.

**Private health insurance**
- $17.1 million from 2020-21 to 2023-24 to enhance the Medical Cost Finder (out-of-pocket costs) website and support specialists to use the tool and update fee information.

**New Zealand**

New Zealand’s new parliament turns red

Labour celebrated a landslide victory in the 17 October New Zealand general election winning 50 per cent of the vote once specials were counted. The new government was sworn in on 6 November with the most representative cabinet ever seen in New Zealand.

The numbers are a reversal of the 2017 results, when Labour polled 36.9 per cent, National had 44.4 per cent of the vote and New Zealand First leader Winston Peters became the kingmaker.
The conversation news site ran political commentary on the mixed-member proportional representation (MMP) era. Jack Vowles, Professor of Political Science at Victoria University of Wellington, said the historic MMP result could be put down to one thing: COVID-19. "Labour and Ardern made the right calls. Comparative analysis of COVID responses internationally show it's not just a matter of what you do, it's a matter of whether you do it soon enough. Labour did that and have been rewarded electorally."

With a record 1.9 million people casting an early vote, Bronwyn Hayward, Professor of Politics, University of Canterbury commented that this was always going to be an election with a difference with younger voters enrolling in historic numbers. A generation's hopes and aspirations now hang in the balance. With this in mind the new Labour government will have two overarching priorities: to drive our economic recovery from COVID-19, and to continue on our health response to keep New Zealanders safe from the virus. In health the new politicians in charge are Chris Hipkins as the Minister for COVID-19 Response. This is a new role that will give the minister responsibility for all aspects of our ongoing response, including the running of managed isolation facilities, border defences as well as the health response including testing and contact tracing systems and managing any resurgence of the virus. Experienced former Justice Minister Andrew Little is the new Minister of Health, driving overdue reforms of the system. He is to be supported by Peeni Henare and Dr Ayesha Verrall (Infectious disease specialist) who will focus on Māori health and public health respectively. There were also two referenda held during the New Zealand election. The End of Life Choice Act will come into force on 7 November 2021 after receiving 65.1 per cent of the vote. A total of 50.7 per cent of votes cast were against the proposed Cannabis Legislation and Control Bill.

In response to the proposed widespread cuts the government has now provided the CDHB with a $180 million bailout addressing the deficit for the coming year. Although this has staved off any impending cuts, the CDHB's annual plan for 2021-22 is already under development and it isn't known how the DHB will handle the future funding of pain services. On 14 October the FPM New Zealand National Committee Chair, Tamsin Atman, met with the Minister of Health's Chief Allied Health Professionals Officer, Dr Martin Chadwick. The discussion about pain services was as a whole indicated growing the specialist workforce, reducing inequity, protecting the specialist scope of practice and developing a National Pain Strategy. The Ministry of Health has invited FPM for a follow up discussion on these points as the Bulletin goes to print. With requests in progress to meet with the new minister of health for advocacy of pain medicine in New Zealand it will continue to argue for support for delivery of services in the CDHB and across all district health boards.

The college continues to advocate on behalf of members through representation on steering committees and working groups with numerous government departments, agencies and non-government organisations. During the year ANZCA's Policy and Communications staff participated in more than 100 meetings with government and non-government stakeholders across Australia and New Zealand including:

- Australian Department of Health (Postgraduate Training Section, Health Workforce Reform Branch, Medicare).
- New Zealand Ministry of Health (Maratiri Hauora).
- Therapeutic Goods Administration.
- Pharmac (Te Pūtaha Whaingaroa).
- Interplast Australia and New Zealand.
- Te Ohu Rata o Aotearoa.
- Medical Council of New Zealand-Te Kaumārura Rata o Aotearoa.

In 2020 the college also made more than 50 written submissions in response to a range of policy initiatives and inquiries. Some examples of the range of topics include:

- Medicare Benefits Schedule specialist services for possible expansion to phone or telehealth (Department of Health).
- Core performance standards for responsible authorisation (Therapeutic Goods Administration).
- Consultation on the draft ethical framework for resource allocation in times of scarcity (Ministry of Health Ministry of Health).
- Review on the safety of low dose cannabidiol (Therapeutic Goods Administration).
- Proposed accreditation standards for providers of vocational training programmes for vocationally-registered doctors in New Zealand (Medical Council of New Zealand-Te Kaumārura Rata o Aotearoa).
- Consultations on clinical practice of pain medicine in New Zealand (New Zealand South Wales Health).
- National strategic action plan for pain management.

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**Ray Hader Award 2020**

Sydney fellow Dr Christopher Sparks is the recipient of the 2020 Ray Hader Award for Pastoral Care.

Dr Christopher Sparks

A VISITING MEDICAL officer (VMO) anaesthetist at Royal North Shore Hospital since 1996, Dr Sparks has been recognised for his commitment and passion to teaching, training, mentoring, and welfare support of anaesthetists in Sydney and the Pacific region.

Trainees and consultants who have worked and been mentored by Dr Sparks in Sydney say they owe an enormous debt to him for his support and encouragement of training and welfare of anaesthetists. He has been described as the "go to" person for anaesthetists in Sydney, Vanuatu, Fiji and the Solomon Islands.

His selfless commitment to teaching and mentoring, which is valued by consultants and registrars, has often led to him volunteering to help, speaking at workshops on weekends, early mornings and on his days off. More importantly, he encourages registrars to talk openly with others if they are struggling with any aspect of their clinical work or training.

Dr Sparks’ mentorship extends internationally to the Pacific region where he has supported and encouraged training and welfare of anaesthesia trainees since 1988 in Fiji, the Solomon Islands and Vanuatu.

Dr Sparks spent two years in the Solomon Islands in 1991 and 1992, teaching and training Dr Kaeni Agiomea, a young doctor who had been directed into anaesthesia by the Solomon Islands Ministry of Health. Dr Agiomea was to become only the country’s second anaesthetist.

According to Tasmanian fellow Dr Haydn Perditi, a former director of Royal Hobart Hospital’s Department of Anaesthesia who has worked alongside Dr Sparks in the Pacific region, Dr Sparks has maintained his support for Dr Agiomea, encouraging him to undertake a number of training years in New Zealand and making repeated short visits to Honiara to undertake further training.

Dr Agiomea was later diagnosed with a life-threatening malignancy that required him to travel to Sydney for extended treatment. Dr Sparks was the key support person for Dr Agiomea in Sydney, helping with accommodation and weekly visits over what was a very difficult time.

“Kaeni Agiomea is now the senior anaesthetist for the Solomon Islands and has in turn been responsible for the training of seven Solomon Islands anaesthetists over the years. Chris’s mentoring and influence through his professional and personal relationship with Kaeni has seen this Pacific Island country become completely self-sufficient in anaesthesia providers in the space of twenty years,” Dr Perditi said.

“Chris has made an enormous contribution to anaesthesia development in the Pacific through his support of individuals and organisations and through his gentle leadership and vision. He has helped promote the idea of overseas anaesthesia work as an important role for Australian anaesthetist professionals.”

Dr Sparks has spent many years teaching and mentoring young Australian anaesthetists on a week-long course designed to prepare anaesthetists from high-income countries to work and teach in lower middle income and low income low resource settings. Now known as the Real World Anaesthesia Course, it has inspired generation of young anaesthetists to undertake the work that he himself had embarked on a decade before.

“Compiled with the assistance of provisional fellow Dr Nihin Vitharana, Children’s Hospital, Westmead, and fellow Dr Haydn Perditi.”

Dr Christopher Sparks

About the Ray Hader Award

Dr Ray Hader was a Victorian ANZCA trainee. He died in 1997 of an accidental drug overdose after a long struggle with drug addiction. To mark the 10th year anniversary of his death, a friend, Dr Brandon Caro, established an award for trainees that promotes a compassionate approach to the welfare of anaesthetists, other colleagues, patients and the community.

In 2012, Dr Caro agreed to continue his support in sponsoring the award and to change in the scope of the award to also recognise the pastoral care elements of trainee supervision. The winner receives $A2000 to be used for training or educational purposes and a certificate to acknowledge the award.

In 2014 the criteria for the award was changed to allow any accredited trainee or ANZCA fellow who has made a significant contribution to the welfare of one or more ANZCA trainees in the area of pastoral care, to be eligible for nomination.

Ray Hader Award 2020

**Top anaesthesia journal appoints ANZCA fellows as assistant editors**

ANZCA fellows Dr Maryann Turner and Dr Lachlan Miles have been appointed assistant editors of Anaesthesia Reports, the independent case report journal of the Association of Anaesthetists of Great Britain and Ireland.

Dr Turner is a paediatric anaesthetist at The Children’s Hospital at Westmead. Her international fellowship experience includes clinical roles at London’s Great Ormond Street Hospital, Auckland’s Starship Children’s Hospital, and Queensland Children’s Hospital. She has been admitted as a lawyer to the Supreme Court of NSW and has a Masters in Health and Medical Law from the University of Melbourne. She is the ANZCA New Fellow Councillor.

Dr Miles is a staff specialist in anaesthesia at Austin Health, an honorary senior fellow at Peter MacCallum Cancer Centre and an honorary senior fellow of the Centre for Integrated Critical Care at the University of Melbourne. His sub-speciality practice involves cardiothoracic anaesthesia, liver transplant anaesthesia and peripartum medicine. He is a PhD candidate at the University of Melbourne, and is examining the identification and management of iron deficiency in the perioperative setting. Dr Miles is also the scientific convener of the 2021 ANZCA Australian Scientific Meeting.

The Association of Anaesthetists launched the case report journal in January last year and it is now Published listed. The assistant editor role involves reviewing submitted manuscripts and multimedia items and editing them in preparation for publication.

Dr Turner said she was delighted to have been appointed to the role. The journal covers all aspects of clinical care including perioperative medicine and pain medicine and also includes reports on clinical or educational techniques, equipment and strategies.

“Being an assistant editor provides a valuable opportunity to learn from the diverse and novel reports submitted by the international anaesthetic community, as well as from the extensive editorial expertise of other anaesthetists on the team” she said.

Dr Miles said the journal highlights the important role that case reports still have in anaesthesia and perioperative medicine.

“While clinicians rightly place a lot of weight on higher levels of evidence to guide their practice, case reports still have an important role in educating us about rare or previously unknown phenomena. As the COVID-19 pandemic has shown, early notification through a case report allows rapid adaptation of practice before higher levels of evidence catch up,” he said.

Dr Maryann Turner and Dr Lachlan Miles

College bursaries

Did you know each year ANZCA offers a number of bursaries to trainees who are experiencing financial hardship?

Eligible trainees can receive up to a 50 per cent reduction in their annual training fees. All applicants will also receive an extension to the annual training fees due date.

Applications for 2021 will open in mid-November.

Please note: Applicants must be registered as a trainee with ANZCA.

Applications close 31 January 2021.

For further information, please contact the ANZCA Training and Assessments team via email at training@anzca.edu.au or call +61 3 9510 6299.
NATIONAL ANAESTHESIA DAY 2020

Anaesthetists: Always ready

National Anaesthesia Day 2020

NATIONAL ANAESTHESIA DAY, ANZCA’s annual celebration of the specialty on 16 October, took on a very different form this year because of COVID-19. With many hospitals in Australia and New Zealand restricted in terms of the events and displays they could stage, we launched a digital #NAD20 event featuring fellows, trainees and specialist international medical graduates. Rather than just calling on champions to spearhead local celebrations at their hospitals or anaesthesia practices we called on you to submit short video “selfies” explaining why you’re #AlwaysReady — a recognition of your response to the pandemic in your hospitals and practices. Our aim: To harness the increased interest in anaesthesia and build further on the profile of anaesthetists as frontline specialists in the response to the pandemic.

Our plan was to compile these into a #NAD20 “show reel” compilation that we would post on our website, our social media platforms of Twitter, Facebook and our new Instagram feed to highlight the breadth of the specialty including cardiac, paediatrics and obstetric anaesthesia. ANZCA councillor Dr Tanya Selak (@GongGasGirl) was the “go to” for many of our submissions with her informative “how to” guide for those still getting used to the idea of instant #NAD20 fame while ANZCA’s committed Twitter army also helped spread the word.

Your response was heartening and more than 50 fellows, trainees and SIMGs contributed 35 videos which are now available on the college’s YouTube channel. Not wanting to miss out ANZCA President Dr Vanessa Beavis, Vice-President Dr Chris Cokis and 11 college councillors also submitted their own videos.

As we were unable to send out posters and flyers we took NAD online on our website. A digital poster was created featuring many of your faces that was available for download and print from our website for display.

In the lead-up and on 16 October, 91 Twitter participants tweeted 225 times using #NAD20. Twitter had a temporary global outage on the day but things were back on track by midday. On Facebook our NAD compilation video post reached 17,409 people and had 2384 engagements. The RBWH video reached 21,462 people and had 4672 engagements. We launched our new Instagram platform to coincide with NAD and it did well, with the RBWH video reaching 579 people with 46 likes.

Carolyn Jones
Media Manager, ANZCA

We received some outstanding joint video efforts including those from the provisional fellows at Royal Brisbane and Women’s Hospital (RBWH) who adapted the iconic Australian Victoria Bitter commercial tune and the Royal Melbourne Hospital’s anaesthesia department who still managed to submit despite Melbourne’s level 4 COVID-19 restrictions and hospital coronavirus cases.

The RBWH “Matter of fact I’ve got it now” video made the Channel Nine evening news on the eve of National Anaesthesia Day reaching an audience of nearly 236,000 people. The video was made with the approval of celebrated Australian composer Bruce Rowland who owns the copyright to the song. Mr Rowland waived the fee when provisional fellow Dr Joel Thomas contacted him seeking permission to adapt the tune for the NAD video.

Some hospitals continued to organise foyer displays or other NAD activities including Goldburn Valley Health, St Vincent’s Hospital in Melbourne, Fiona Stanley Hospital in Perth, Tamworth Hospital and Sunshine Coast University Hospital which highlighted #NAD20 on their giant outdoor electronic screen.

To see all our #NAD20 #AlwaysReady videos go to the ANZCA YouTube channel

Tamworth Hospital theatre nurse Robbie Hill with her NAD display on 16 October.
COVID-19 continues to dominate

Running exams in a pandemic

Making exams work in 2020 was an incredibly complex process involving countless hours of meetings and hard work by examiners, college leaders and staff, not to mention our trainees of course, who managed to get through their exams in this very stressful, uncertain time. ANZCA’s Chair of Examinations, Dr Michael Jones explains.

WHEN SOUTH AUSTRALIAN Premier Steven Marshall announced on 19 November that his state was moving into hard lockdown from midnight – the day before the 2020 final vivas – hearts sank collectively around ANZCA. And a sense of deja vu settled in; COVID-19 had struck again.

This was a huge blow after the many, many hours of meticulous preparation to run both face-to-face and online final vivas for 178 candidates across Australia and New Zealand. Rather than the usual single Sydney venue, these exams had been booked to be held over two days at eight sites.

It brought back memories of the 17 August announcement the day before the primary written exams that Auckland was going into lockdown. Back then, after a number of late-evening calls, the Auckland candidates sat the exam in their hospital, just like their Victorian counterparts, who were in the midst of a worrying second wave of the pandemic that limited movement around the state.

As with Auckland, the SA Premier’s decision to lock his state down set in motion a flurry of activity. The college – through Immediate Past President Dr Rod Mitchell and Dr Robert O’Brien, ANZCA’s Executive Director, Education and Research – tried hard to get an exemption to allow the candidates to sit the exam together as planned, but SA’s chief health officer wouldn’t budge. So we swung into plan B – to get the six affected candidates to Sydney, whose borders remained open to SA (“for now”).

Dr O’Brien was able to ascertain that the candidates were allowed to leave SA and, after speaking to officials at Sydney Airport Disaster Control, that the candidates could enter NSW.

Flights and accommodation were booked for the six with the college covering costs, and we then set about rewriting the examiners’ rosters to incorporate the additional candidates.

Just as we were starting to believe this plan might just work, an area health service raised safety concerns about their consultants examining the SA candidates. Another burst of phone calls and this problem was finally resolved at 7.30pm on Thursday night as the candidates were preparing to fly out the next morning.

This is just a small taste of what it has been like to deliver exams in 2020. The fire alarm going off at ANZCA House in Melbourne during the primary vivas in November, teething issues with new technology in Hobart where we were doing combined face-to-face and online vivas, and an Auckland hotel cancelling our exam booking to become a quarantine hotel were also issues we dealt with.

But somehow we have managed to examine 329 primary exam candidates and 204 final exam candidates (183 trainees and 21 specialist international medical graduates).
Our new-look vivas

Normally held at one venue, this year the vivas were held in several. Some venues held face-to-face viva, some online, only while others had both.

The pandemic sets in

It was way back in March that then-ANZCA President Rod Mitchell and Final Examination Sub-Committee Chair, Sharon Tivey, cancelled the medical viva that were to be have held later that month with the 2020.1 final written exams. This decision was based on the worsening COVID-19 situation and the risks to “patients”, the knowledge that hospitals had other things to worry about, not to mention the personal and professional impact of the pandemic on trainees and examiners.

The college established an Examination Contingency Planning Group (ECPG), chaired by a past president, Dr Lindy Roberts, now ANZCA Director of Professional Affairs (Education), who also led the development of helpful web-based information for candidates whose training was being disrupted by the pandemic. Other members of the ECPG, which met at least weekly for the first two months, were Dr Tivey and her deputy Dr Fiona Johnson, Dr Emma Giles, Chair of the Primary Examination Sub-Committee and her deputy Dr Julia Coldrey as well as Dr Kat Gough, Co-Chair of the ANZCA Trainee Committee, Dr O’Brien, Ms Helen Maxwell-Wright, one of a college consumer representative, among others.

At their first meeting, the ECPG determined that under no circumstances should standards lapse so that the integrity of the exams could be called into question and our community representative was particularly insistent – in other words, no one was to get a “leave pass”.

At this stage, any thoughts of holding exams using Zoom or other videoconferencing was deemed too risky, and well justified after seeing some of the exams disasters that occurred in Australia and overseas due to technical issues.

The ECPG also sought the views of trainees, sending out a survey in late April to gauge the appetite for exams. The response showed an overwhelming desire by both final and primary candidates to complete the 2020 exams.

Another incentive to go ahead was the issue of workforce progression. The Australian Medical Council expressed great concern that “blocking the pipeline” would have repercussions through to 2027 and strongly encouraged colleges to run exams.

May vivas cancelled, written on

With 2020.1 primary and final vivas approaching in late May and the pandemic showing no signs of easing, ANZCA Council made the decision to postpone until later in the year. The college had already made the decision to cancel the 2020 ANZCA Annual Scientific Meeting in Perth and ANZCA staff were working from home. Melbourne staff are still working remotely, making their management of the exams all the more remarkable.

All the while we tried to keep trainees, fellows and SIMGs as informed as possible through email updates from the president and others, as well as through web-based news and information.

On 8 August a new-look ANZCA Council with Vanessa Beavis as president held an extraordinary meeting via Zoom to discuss how to approach the exams for the remainder of the year. Victoria was as well and truly in the midst of the pandemic’s second wave by then and in level 3 and 4 lockdown. After hours of debate, council decided the remainder of the primary and final written exams – the second or 2020.2 sittings – would go ahead as planned. The Victorian candidates would sit their written exams in their hospitals across the state while candidates throughout the rest of Australia and New Zealand would sit at the usual major city venues. Other than the Auckland hiccups, the 2020.2 primary and final written exams were ahead without major problems.

A number of other decisions were made at that extraordinary council meeting, including recognising training time for trainees whose progression had been interrupted by exam delays, not penalising those who withdrew from exams and allowing additional exam attempts for those who withdrew or failed.

New-look vivas

With the written exams completed in August, attention turned to the viva.

Acknowledging the ever-moving goalposts, the EPCG came up with three options for how the viva might go ahead. ANZCA Council eventually settled on holding them in Australia and New Zealand rather than the usual single venue in Melbourne for the primary exams and in Sydney for the final exams.

The primary vivas were scheduled to be held in five venues across Australia and New Zealand over eight weeks, with the 20.1 and 20.2 candidates examined together. Perspectives and sitters at viva stations were a sign of the COVID-safe times.

The final viva for the 2020.1 candidates were scheduled to be held over just two days in five time zones at eight different locations, although of course this became seven locations in four time zones when the SA candidates were forced to join the NSW cohort.

While it is possible to hold the primary vivas on more than one date, this is not possible for the final vivas. Closely aligning with the written component, the final vivas are designed to be held concurrently and to cover different parts of the curriculum.

Despite our best efforts, it was logistically not possible for the 2020.2 final candidates to sit with the 20.1 candidates in the primary vivo or even early in 2021 to allow unsuccessful candidates to join the 2021.1 cohort.

Vivas for the 2020.2 candidates will be held in May 2021, and these candidates have been given the option to withdraw based on information provided to them about their written results, and join the 2021.1 cohort.

Online solution for vivas

When the exams are held in a single venue over two days, there are plenty of examiners to make them run smoothly.

Pre-COVID, examiners would fly interstate to bolster numbers and to remove potential perceived bias in examiners examining candidates known to them. With the pandemic still limiting travel, it became clear that a reliable online solution was needed so that candidates could sit their viva either face-to-face, online or both. The solution needed to enable drawings to be shared and discussed. The technology also needed to be reliable with glitches undetectable, crashes disastrous.

Eventually the college settled on Zoom to help deliver online viva exams and began the lengthy process of making this method as foolproof as possible.

The system was installed on 32 new laptops, originally purchased as part of an IT upgrade for staff, and we set about testing and retesting the computers in a lab and onsite, then organised training for candidates, trainees and registrars.

With vdeo vivos on 6 and 8 December in Perth (16 candidates), Tasmania (three), NSW (one), SA (one) and Gippsland (one), the viva are now over for 2020.

We got there

To our primary and final exam sub-committees led by Emma Giles and Sharon Tivey respectively, and of course our examiners who have given up five to 10 days of their time, this has been a remarkable achievement by volunteers who have examined our trainees under the shadow of COVID-19. Literally thousands of hours on Zoom and in phone calls have gone into making these exams happen.

Enormous credit must also go to Robert O’Brien and his team, the ANZCA IT team and the staff in our Australian regions and New Zealand. It’s worth remembering that most staff were doing all this while working from home.

And finally, to the candidates. As many of us know only too well, sitting specialist exams is one of the most stressful experiences in life. To do it during a once-in-a-lifetime pandemic is truly a remarkable feat.

As many of us know only too well, sitting specialist exams is one of the most stressful experiences in life. To do it during a once-in-a-lifetime pandemic is truly a remarkable feat.

“We are immensely proud of you all.

Dr Michael Jones
Chair of Examinations
NZ fellow plays key role in Cook Islands response

 Auckland anaesthetist Dr Ted Hughes recently returned from Rarotonga in the Cook Islands where he was involved in that country’s COVID-19 response planning. Here he explains how the pandemic has been managed there.

MY MUM IS from Atiu, near Rarotonga in the Cook Islands. Since 2008 I’ve visited Rarotonga Hospital many times to work with the New Zealand Society of Anaesthetists (NZSA) to set up intensive care units (ICUs) and services and develop the hospital’s anaesthesia practice.

Last year I made five visits — twice taking critically-injured patients back to New Zealand — and joined a hospital faculty on a five-day World Health Organization disaster course. My family connections helped embed me there. Mum’s brother was head anaesthetist at Rarotonga Hospital, another brother is a former deputy prime minister while the past two health ministers and the Secretary of Health are relatives. All Cook Islanders are NZ citizens.

In mid-January I could see COVID-19 was coming. In my role as a voluntary advisor to the Te Marae Ora Cook Islands Ministry of Health (TMO) I was involved in discussions with them about the risks of the coronavirus and I was asked to help, arriving there in early March. Last year I had helped broker a memorandum of understanding (MOU) between the TMO and North Shore Hospital in Auckland. The MOU enabled the hospital to provide assistance to the Cook Islands — including in emergencies — so I was deployed to Rarotonga at the request of the Cook Islands Prime Minister Henry Puna.

My plan was to set up a rapid pipeline for supplies from New Zealand similar to the one I had organised to transport personal protective equipment during the Samoa tsunami in 2009 but COVID-19 required a different approach. The pandemic meant we had to enforce rapid changes similar to those that could only be activated on a war footing.

I became part of a small tight management group that planned the pandemic response for the Cook Islands and became the go-to man for many different projects. Anaesthesia training is really useful in an emergency – anaesthetists move across all specialties and all organ systems in all patients so we have an overview some other specialties lack.

Because of my previous work I helped convince “doubting Thomas” politicians and heads of ministries that drastic action was needed. We decided to choose where to fight COVID-19 by focusing on Rarotonga which has optimal staffing and facilities. We shut off all movements to the other 14 Pa Enua islands after first advising all older, high-risk Cook Islanders to leave Rarotonga and move to the Pa Enua. We also moved all older nurses and doctors there. The TMO coronavirus advice led to schools shutting two weeks before New Zealand. Border closures to the US, Europe and other countries were also introduced, the prime minister started weekly rational “fireside chats” that were broadcast on television and we began to prepare the TMO to face the pandemic.

There are about 10,000 residents in Rarotonga. Our main challenge was how to reconfigure a health system to be safe and effective in a pandemic. Keeping the coronavirus out of the hospital is essential as there is no back-up if staff get infected.

We reconfigured the hospital-based TMO into a “puna model” of community care to prevent the spread of the coronavirus. Historically Rarotonga has had 10 villages or “puna” which in modern times are clustered around the ring roads around the island. The puna form tightly knit groups of families. Each puna is united by historical, cultural and religious ties and work and are all shared by neighbours — often for many generations. By putting a clinic in each puna with a nurse and healthcare worker we accomplished several goals. Residents find this model familiar and comforting and it is cheaper to run than a full hospital model.

We were well prepared for COVID-19 cases using the puna model. If a case was diagnosed, local puna members would quarantine and provide food and water to quarantined families. As part of our planning I ordered 100 oxygen concentrators and 350 pulse oximeters, and advised on the purchase of 900,000 masks, 100,000 N95 masks and respirator masks for key frontline staff. Each order consumed hours of time — days in the case of the concentrators. Auckland anaesthetic technician Nick Webster was invaluable during his two-month deployment to Rarotonga as he taught the local staff how to use and doff their personal protective equipment.

I played a key role in the COVID-19-driven infrastructure upgrade. The hospital has about 80 beds so we set up a 30-bed COVID ward in an isolated wing with its own ventilation. We developed two air-conditioned negative-pressure rooms of four and six beds with high flow oxygen supplies. A local builder, formerly an asbestos remover in Sydney, built the negative pressure set-ups in two weeks each for a cost-effective $20,000. I was involved in the new oxygen concentrator and gas pipeline commissioning — which built on earlier work I had done installing air, suction and oxygen supplies and the first oxygen concentrator there. I also developed a plan for aeromedical transfer by organising the conversion of a SAAF340 into a flying ambulance able to carry up to 20 patients with oxygen supplies.

In two months I had one day off.

NZ anaesthetist Dr Ted Hughes with anaesthetic technician Nick Webster.

“The pandemic meant we had to enforce rapid changes similar to those that could only be activated on a war footing.”

In mid-April Prime Minister Puna declared the country COVID-free and my transfer back to New Zealand began. But we had a huge problem with 350 stranded Cook Islanders scattered across New Zealand to be transported to a quarantine hotel with nurses, doctors and security staff. This group then had to be flown home on special charter flights and then placed in hotel quarantine in Rarotonga. Each day of my two-week isolation started with a Zoom meeting with Mr Puna and his cabinet.

I returned to my work in Auckland in June but Mr Puna asked if I could return to Rarotonga to help with COVID-19 preparations in early September. I spent another two months there including doing some acute ICU work.

A lot of my work involved surgical referrals for cancers that are untreatable in Rarotonga. We have had problems due to the border closures and the reduction of NZ flights from 30 a week to one a week. Before the pandemic most Cook Islands patients with chronic complex medical or surgical conditions just hopped on a flight to Auckland and saw their GP who then referred them to a New Zealand hospital. They were treated quickly and efficiently.

In Rarotonga visiting NZ surgical teams funded by the NZ Ministry of Foreign Affairs and Trade would also see assess and treat patients. Since the pandemic it has been 15 months since any visiting surgical or medical teams have been to Rarotonga. The result has been dozens of patients moving in and out of the hospital here with cancer related problems that are untreatable in Rarotonga. What I have been able to do is convince surgical services in New Zealand to accept these patients so they can be assessed and treated there.

I found myself working six or seven days a week including four nights in a row sleeping in the ICU catering for a dying patient. My monitored isolation time in New Zealand was filled with reviewing the acute COVID-19 treatment plan for the Cook Islands and regular Zoom meetings with Rarotonga Hospital.

My background in anaesthesia, intensive care and pain medicine has been very useful in Rarotonga. In the longer term I hope to encourage staff at Auckland’s North Shore Hospital to visit Rarotonga Hospital when the pandemic ends to get a feel for working in the Pacific and to contribute to teaching local anaesthesia, surgical and trauma services.

Dr Ted Hughes is a member of ANZCA’s Indigenous Health Committee.
The view from Gibraltar

With Europe now experiencing a second deadly wave of COVID-19, Australian anaesthesia trainee Dr Arghya Gupta reflects on his experience working in the health service of the tiny territory of Gibraltar.

The Chief Minister of Gibraltar declared a state of emergency on 16 March, a day after Spain’s declaration. There were just three cases in all of Gibraltar. All retailers were closed indefinitely (except pharmacies and supermarkets), and people were only allowed to leave their house for exercise. If you were over 70, you could only leave for an allotted hour between 1 am and 12 pm every morning. The border with Spain was closed and open only to essential workers from Spain who contributed nearly half of Gibraltar’s hospital workforce.

The anaesthesia department where I worked included a team of eight European-trained consultants and six registrars at various levels of training. Based on the UK system, we would rotate between ICU and anaesthesia duties in normal times, but the onset of COVID-19 meant we were all appointed full time intensivists.

A “prepare for the worst, hope for the best” scenario saw elective surgery lists cancelled and a single operation theatre open for emergencies and caesareans. Every patient on admission to hospital (regardless of symptoms) was swabbed and put into a high risk-low risk ward based on their condition. The ICU was transitioned from a three-ventilator, 10-bed setup to a 20-ventilator, 30-bed setup with the use of transport ventilators, donated ventilators and unused anaesthetic machines.

About 100 people were infected in Gibraltar over the first month. Lockdown measures were then eased (excepting, at the beach was allowed during the summer) and elective lists resumed. All emergency surgery patients received a rapid COVID-19 swab while all elective patients were made to isolate at home for 10 days prior to their operation and then undergo a drive-through swab 24 hours before surgery.

The supply of staff personal protective equipment (PPE) included 60 elastomeric face masks with P100 filters and a discussion with the manufacturer about appropriate donning and doffing technique, as well as reprinting of labels to ensure no staff member would be unprotected. Hospital staff were also required to undergo swabs each weekend and not affected by symptoms so asymptomatic carriers could be detected. In early June, all 1200 employees of Gibraltar’s health system underwent an immunoglobulins blood test with results showing about 2 per cent of staff had serum antibodies present. The measures taken in Gibraltar resulted in very few cases of COVID-19 during my time there and no deaths. The border with Spain was opened in mid-June and I was able to travel around southern Europe in a very different world before returning to Australia.

While the second wave in Europe now causing an exponential rise in cases, Gibraltar has recorded nearly 800 cases. It is still yet to reach its peak, and no one has died from it.

While the resources and population of Gibraltar may have allowed for a rapid and successful strategy to be implemented, some of the clinical techniques could be applied in Australia and New Zealand. Asking for all elective cases to voluntarily isolate before surgery could limit infection and not affect elective surgery lists and theatre needs. Elastomeric masks with appropriate distribution could significantly decrease stress on PPE resources. Regular staff swabbing could detect asymptomatic cases and protect other staff members and vulnerable patients.

My time overseas was intended to be used as a learning experience in anaesthesia practice in an international context. While I could not have foreseen the pandemic, the impact of COVID-19 on clinical practice in Gibraltar enabled me to apply some of what I had learnt to my clinical practice here in Australia.

Dr Arghya Gupta is an advanced trainee in anaesthesia practice in an international context. While I could not have foreseen the pandemic, the impact of COVID-19 on clinical practice in Gibraltar enabled me to apply some of what I had learnt to my clinical practice here in Australia.
Library notes on the pandemic

ANZCA Library Manager John Prentice explains how he learnt to quickly adapt to the challenges of running an essential college resource from his kitchen table.

It was during a week-long cycling trip to Tasmania in mid-February that I first realised that the coronavirus wasn't going away and that if I wasn't careful I might find myself trapped in Tasmania if the borders were to suddenly close. Fortunately, that didn't happen, but just four short weeks later I remember finding a bag of rice during another cycling weekend away and being more than happy to carry it halfway across Victoria to store alongside my dwindling toilet paper supplies. Little did I know then that I would soon be carrying around library books on my bike as well.

Just two days after my weekend scrounging trip, we were in lockdown working from home, discovering the joys of Zoom. For the library, it also meant discovering ways of continuing to circulate our print book collection.

With trainees accounting for more than 90 per cent of all library loans, it was critical that this service be kept up and running. This resulted in a modified service whereby I was one of the few staff allowed on site, as I lived nearby.

With an active library collection being composed of literally thousands of items, and with early studies showing that the virus could persist on the surface of books for up to three to four days, infection control became a major concern. We had to ensure each returning book underwent its own strict COVID-related sanitisation and period of isolation before recirculating.

“A few weeks after the lockdown began, one of our fellows asked us to locate as much information as we could on COVID healthcare infection rates. I spent hours tracking down and pouring over national and international data sites. Few offered the data granularity required, however the Italian data proved both comprehensive — and alarming. I became acutely aware that the lack of any substantive community transmission of the virus within Australia at that point was mostly just pure luck. This was to be borne out in subsequent weeks.

An informal co-operative of health librarians quickly formed, many of whom were on the “frontline” in hospitals. A dizzying amount of information was soon circulating in a determined effort to keep colleagues abreast of the latest news, advice, guidelines, articles and search strategies.

At this time, the library began work on a standing COVID-19 news item that quickly evolved into a fully-fledged library guide using a lot of the suggestions and ideas that were coming through the VPN. Cue hasty fix by ANZCA’s information technology team.

Preparing COVID-safe ANZCA library staff for package

The guide eventually discovered that the reason they were passing through the VPN was because our web browsers weren’t passing through the VPN. Cue hasty fix by ANZCA’s information technology team.

At its peak the COVID clinical guide was getting more than 1000 hits per day, and turnaround time became a major challenge — with a 30-minute delay meaning that sometimes 20 people didn’t see the latest PPE advice. The flood of information was often so overwhelming and the workload so intense that the rest of Australia’s national lockdown is little more than a sleepless blur in my memory.

I joined the college’s expert working group and the library’s nascent COVID library guide quickly evolved into the hub of the college’s clinical response. I spent five to six months sifting through hundreds of incoming emails and articles for inclusion in the guide.

I spent an inordinate amount of time googling terms and reading background documents to get more up-to-speed. PPE, AGPs, PCR, SARS2, nCOV, COVID-19 all became a sort of library. What was interesting was how much of this terminology quickly entered the public vernacular as well, although often without any contextual understanding. I remember once taking a perverse pleasure in explaining to a friend via Facebook how many different ways he could potentially contaminate his facemask before stepping foot outside his front door in the morning.

Working off my tiny kitchen table, I began to discover a number of small but time-consuming limitations managing some of our services. Two of our e-journals are onsite use only, as they can’t be passed through our authentication system. Even with the college’s virtual private network (VPN), library staff were unable to access these titles, which resulted in many of my early library visits spent downloading articles. It was eventually discovered that the reason they were inaccessible was because our web browsers weren’t passing through the VPN. Cue hasty fix by ANZCA’s information technology team.

We had to ensure each returning book underwent its own strict COVID-related sanitisation and period of isolation before recirculating.

I managed one cycling trip between the national and the subsequent Victorian lockdowns. During the last stage of the trip, my tyre was spliced and I resorted to masking tape to fix the resultant hole. The tyre burst just as I reached civilization. As metaphors go, it’s an apt one, as one week later Victoria was back in lockdown.

If the first lockdown passed in a blur, the second lockdown became a mind-numbing marathon. Luckily I was still heading into the college a few days a week to post out books. However, even that became a challenge: bedecked in mask and gloves and coated in sanitiser, I discovered that the gloves had a wonderful habit of getting caught in the Express Post bags as I sealed them up. I’m still at it, for it rather resembled a Mr Bean episode, with me flapping about the office with a bag of books stuck to my hand.

One benefit of living so close to work, was that my manager and I were able to have walking “meetings” around Albert Park Lake. Our restricted one hour of exercise would be spent dodging maskless joggers, avoiding the breeding swans, discussing the latest COVID news and speculating about the US election. I’m still undecided as to which was the most dangerous, although I must admit I’d never be able to look at a Jogger again without thinking “great big running AGP.”

As the second lockdown finally wound down, I realised that I’d finally had enough. With little human contact over the preceding seven months, I began rotating library visits with the other library staff — much to their delight — packed my bags and moved out of the city.

The sense of freedom I felt was intoxicating. As metaphors go, it’s an apt one, as one week later Victoria was back in lockdown. The rest of Australia’s national lockdown is little more than a sleepless blur in my memory.

And so here I sit in my new home-based office, looking up details on viral shedding while I listen to the birds outside and the possum in the roof. Apparently, the latter isn’t moving out till next week.

Nearly a year after coronavirus, things are finally starting to look up on the vaccine front, with both Pfizer and Moderna announcing successful vaccine trials in the last week. And believe it or not, you probably have Dolly Parton to partially thank for the latter. Strange times indeed.

Historical note: This article was written in the immediate aftermath of the second Victorian COVID lockdown (July-October 2020).
After the Whakaari/White Island volcano erupted at 2.11pm on Monday, 9 December 2019, more than 30 victims were taken to Whakatane Hospital with at least 27 suffering major burns ranging from 30 per cent to more than 90 per cent of their bodies. Out of the 47 tourists and guides caught in the eruption, 16 died either on the island or shortly after. Remarkably, only five more died during the coming weeks (and one more recently) making the final death toll 22.

Much of the credit for the survival of the others is given both to the first aid provided on the island and the boat that, along with helicopters, rescued survivors, and to the initial treatment provided at Whakatane Hospital, which has about 80 beds, three operating theatres, an acute care unit and a 17-bay emergency department (ED). Despite the overwhelming number of patients with horrendous injuries from the hydrothermal eruption and a horizontal explosion blasting scalding hot ash and acid compounds deep into the victims’ skin, hospital staff managed to do “the impossible”. This is what it was like to be there, as told by some of the hospital’s six anaesthesia senior medical officers (SMOs).

**ANAESTHETIST DR FRANK DEUTSCH**, rostered for a 24-hour on-call shift, was called to ED about 3pm and told the island had erupted. Despite not knowing what to expect, he arranged for theatre staff to finish their procedures and stand by, and asked colleagues at home to do the same.

“I also helped advise ED on preparation – medications, pain relief, cannulas, fluids, intubation equipment – whatever I thought we might need. Every minute was used to get ready. Hospital staff from the wards and elsewhere came to help. We started sorting teams so people knew who they would be working with.

“Then the first patient came through the door. And then the next one came, and the next one; one after another, after another.

“I was at resuscitation bay 1 ready to intubate if needed. A young guy was brought in. I remember the sulphur smell. He was completely white, covered in ash. His eyes were white. I could see he was in pain but with skin coming off, I could not put the cannula where I normally would.”

Eventually it went in a foot. It was the same for monitoring – everything was burnt, making it impossible to do normal electrocardiogram or blood pressure readings. For most patients, central lines were put in the groin, the area that had been most protected by clothing. “Then we could give pain relief, fluids and antibiotics. Nothing was normal. It was incredibly challenging.”

Dr Deutsch worked until 10am the next day, remaining on call for the rest of the hospital, and waiting to see the last burns patient transferred. “Then I went home, and I cried, and cried and cried,” he said.

While distressing memories linger, Dr Deutsch takes comfort knowing that: “We could not have done anything more. And what we did seems almost impossible. Every single patient had been treated well.”

Then lead anaesthetist at Whakatane Hospital, Dr Lutz Sauer, was finishing up in dire when he was called to ED and learned about the eruption. “I thought: ‘Oh, we might have a couple with broken bones, maybe a burnt arm; probably one patient might need to be transferred.’ Then the first patient arrived covered in ash, grey as anything, and realised a very serious situation was unfolding.

“And then they were bringing patients in, and bringing patients in, and bringing patients in... As soon as we intubated one patient, there was another. Each anaesthesia SMO was covering multiple ED bays but all somehow worked smoothly.

“We just went into auto mode and did our jobs. We didn’t think about the time, or when we could eat or go home.”

As patients were stabilised, a fleet of rescue helicopters and fixed wing aircraft transferred them to the New Zealand National Burns Centre at Middlemore Hospital in Auckland, and the regional burns units at Waikato Hospital in Hamilton, Hutt Hospital near Wellington, and Christchurch Hospital.
“We just went into auto mode and did our job. We didn’t think about the time, or when we could eat or go home.”

Once the first patients had been transferred, we saw that others who had not initially needed intubation were deteriorating and, over the course of the evening, most of them needed to be on a ventilator,” Dr Sauer said.

An eight-time visitor to Whakaari White Island who never felt unsafe there, Dr Sauer says the eruption was an eye-opener. “I probably try to appreciate each day more now as I realise that could have been me or my loved ones, it could all be over in a minute. It was a life-changing event for all involved.”

Anaesthetist and intensivist Dr Owen Callender divides his working time between Whakatane and Tauranga Hospital, a one-hour drive apart. He was in Tauranga when he received the request to stand by. He headed for Whakatane and into a scene of frantic activity.

There were countless critically unwell patients with a relatively small group of senior ED and anaesthesia clinicians overseeing their care, helped by many other allied health staff and local GPs.

Dr Callender assisted with some of the ED patients, then went through to the acute care unit, wards and theatres (which were all being used) to place central lines, and help with intubations, analgesia and fluid management.

“There were multiple patients requiring multiple procedures. Usually in Whakatane, even one critically unwell emergency admission will take clinicians off the wards and affect the hospital flow. That evening, I think we handled about 30,” he said.

“I was struck by the immense scale of the suffering we were witnessing. As part of the resuscitation team, I couldn’t take as much time as I normally would to comfort and reassure patients, to explain what we were doing and what was going to happen. We just had to do our job... supporting each other with the occasional hug and pep talk. It was like nothing I have been through before.”

By 2am the flurry was over, with all but one of the victims transferred. Staff were too stunned for any type of group debriefing. However the the district health board held debriefing sessions later and has provided access to psychiatrists and psychologists for counselling. For Dr Callender, informal chats with colleagues have been helpful, with time being a big support.

“It affects different people differently. That kind of trauma is powerful. I am glad we are in such a supportive environment.”

These three Whakatane anaesthetists all praised the “amazing teamwork” as all manner of hospital staff (theatre staff, cleaners, kitchen staff, nurses, therapists, volunteers and more) pitched in, often working well outside their area of expertise. “That was one of the best things. You could rely on anyone to help. Everyone was there doing the best they could,” Dr Sauer said.

The community also sprang into action, keeping staff supplied with pizzas, other food and drink.

NZ National Burns Centre (NBN) anaesthetist Dr Matt Taylor was on call when the first patients arrived at Middlemore. He believes that initial treatment at Whakatane (along with the rescue work) is responsible for an exceptional number of survivors, saying the usual survival rate for people caught in a volcanic eruption is 0.5 per cent. In this instance, the survival rate was over 50 per cent – “something that, I believe, has never happened before” – and amazing given that no one in New Zealand, and few elsewhere, had any experience in dealing with volcanic eruption victims.

“Perhaps the most amazing thing is how well these people tolerated the trauma,” Dr Taylor says. “I think what the Whakatane staff achieved was spectacularly impressive. For me, it was extending an area in which I was already specialising. That was not the case for them. What they did was pretty bloody heroic.”

Dr Stapelberg also acknowledges the personal trauma involved. “Seeing and treating burns victims can be incredibly traumatic. It is hard to comprehend the personal trauma for those confronted by 30 such cases at once. They did an amazing job.”

Most of those caught in the eruption were Australian and within 72 hours, 13 patients were repatriated to Australian hospitals, taking the strain of the New Zealand hospital system. Clinicians there have also praised the quality of that initial care, Dr Stapelberg says. Other Whakatane Hospital anaesthetists working that night were Dr Denise White, Dr Wolf Kremer, Dr Nicolas Haus and Dr Heike Hundemer, who was also the hospital’s medical leader. A few days after the eruption Dr Hundemer told media that while staff had held mass casualty training exercises, what they were faced with after the eruption was “beyond comprehension.” Dr Hundemer said she had never seen so many critically injured patients coming into an emergency department in such a short space of time. Normally there would be about six nurses and two doctors in the Whakatane ED but that evening there were about 100 staff, and they used every resource and bed space to care for the victims.

Dr Pierre Botha, head of anaesthesia for the Bay of Plenty District Health Board at the time, covering both Taunana and Whakatane Hospitals, was working in private practice when he heard about the eruption. He checked with his Whakatane staff during the evening to see whether additional help was required and visited the next day.

“It was surprising to find how calm people were, and they were talking about how incredibly well everyone had worked together,” That Friday, at the regular monthly departmental meeting, Dr Botha invited the Whakatane anaesthetists, who joined by video, to share their experiences.

Susan Ewart
Communications Manager NZ ANZCA (2010 – 2017)

“They did exceptionally well. The victims who did die had unsurvivable injuries. It is a miracle anyone survived.”

Dr Stapelberg also acknowledges the personal trauma involved. “Seeing and treating burns victims can be incredibly traumatic. It is hard to comprehend the personal trauma for those confronted by 30 such cases at once. They did an amazing job.”

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Diving into the deep end with ANZCA

Houston and Hobart may seem worlds apart but for Dr Alicia Tucker, now completing ANZCA’s Diploma of Advanced Diving and Hyperbaric Medicine (Dip Adv DHM), they actually have a lot in common.

Dr Tucker is an emergency physician who has spent the past 12 months completing her diploma as a fellow in the Royal Hobart Hospital’s Department of Diving and Hyperbaric Medicine. Having completed a month-long sabbatical in space medicine with the NASA Johnson Space Centre in Houston the year before, she was keen to explore how she could apply what she had learnt in the US to her subspecialty in Tasmania.

Now, as a staff specialist in the new $12 million Hobart hyperbaric unit, the diploma candidate hopes to be able to combine her training in diving and hyperbaric medicine with her knowledge of space medicine to enhance our understanding of physiology and future space exploration.

The Hobart facility is one of only a small number of units in the world that can simulate high altitude environments. The unit’s dual capability gives it an edge over other hyperbaric treatment centres as it can both pressurise (hyperbaric) and depressurise (hypobaric).

The hypobaric chamber will enable space researchers to develop and test “intermediate atmospheres” so astronauts or space tourists can live and work safely without compromising their health. The unit’s three interlocking hyperbaric chambers will allow doctors to test the impacts of extreme low-pressure environments on humans. It can not only pressurise to simulate undersea depths of 50 metres but can depressurise to simulate an altitude of 45,000 feet (13.71km). (The altitude chamber is human rated to 45,000 feet but has the capability to be used experimentally for research up to 100,000 feet.)

Hyperbaric oxygen treatment is a well-established treatment for decompression illness that affects divers after they have been exposed to pressure while underwater. The hyperbaric chamber is also used to treat medical conditions such as diabetic problem wounds, tissue injury following radiation treatment for cancer and soft tissue infections such as necrotising fasciitis.

“As clinicians we have to be aware of how our bodies respond to unusual environments and what can go wrong.”

Hyperbaric medicine is fascinating because your body is being challenged by these unusual environments. As clinicians we have to be aware of how our bodies respond to those environments and what can go wrong,” Dr Tucker, an aviation medical examiner for Australia’s Civil Aviation Authority and a rescue diver with the Professional Association of Diving Instructors, explained.
Dr Emma Wilson realised that there really was a natural marriage between Smart (the co-director of the facility in Hobart) and I as well as current medical registration and declaration of fitness to practice (dive and hyperbaric medicine training program and a Certificate in Diving and Hyperbaric Medicine in 2018. (The diploma replaced the former ANZCA Certificate in Diving and Hyperbaric Medicine in 2018. Award of the diploma requires completion of the training and a few of the consultants there had talked about diving and hyperbaric medicine, I could see there was an opportunity to participate in meaningful aerospace research out of Hobart alongside diving and hyperbaric medicine.

“In my private practice, I regularly do aviation medicals for pilots and air traffic controllers. We know that the space flight environment and microgravity has the potential to lead to long-term exposure to radiation and we know it can affect your balance because of the research and testing that has been done on astronauts,” she said.

“But what we don’t know is how space flight will affect normal people with underlying health conditions. We assess people for fitness to fly and for fitness to dive and one of the things that滕 now hoping to be able to contribute is fitness for space flight. Could Hobart be a place where you go for your altitude experience to get some pre-flight conditioning before travel? There’s a lot of exciting potential here.”

After her stint in Houston Dr Tucker began exploring diving and hyperbaric medicine opportunities and sought out Tasmanian emergency physician Dr Juan Carlos Ascencio-Lane who was the first candidate to complete the exam and be awarded the Dip Adv DHM in 2018. (The diploma replaced the former ANZCA Certificate in Diving and Hyperbaric Medicine in 2018. Award of the diploma requires completion of the diving and hyperbaric medicine training program and a specialist qualification acceptable to ANZCA Council, as well as current medical registration and declaration of fitness to practice.)

“That then led to a conversation with Professor David Smart (the co-director of the facility in Hobart) and I realised that there really was a natural marriage between hyperbaric diving medicine and space medicine. I could see there was an opportunity to participate in meaningful aerospace research out of Hobart alongside diving and hyperbaric medicine.

“In terms of my experience with the fellowship program I have had exceptional support. My portfolio was quite robust and I sat the advanced diploma exam mid-year and was successful,” Dr Tucker said.

“To have gone through the exam process makes me feel that I have earned my standing even though I’ve only had a two-year affiliation with the area. It’s definitely something I would encourage as a subspeciality for an anaesthetic, intensive care physician or emergency physician.”

“With diving and hyperbaric medicine you need someone to put up their hands and embrace it. Before I trained as an emergency physician I started out as a surgical registrar. As a surgical registrar I had a lot to do with plastic surgery and burns so in a way I’ve come full circle as I’m now working alongside the surgical specialties I was working with back then.”

“By doing the advanced diploma I’m not only part of the Australasian College for Emergency Medicine (ACEM) but also ANZCA. In Tasmania we’re unusual in that the majority of our hyperbaric physicians have emergency backgrounds. There are a least eight of us in Tasmania – one has a background in anaesthesia and intensive care, one is an anesthetist, one is a GP anesthetist, and the rest of us are emergency physicians.”

Like Dr Tucker who first started scuba diving 15 years ago, Dr Emma Wilson is also a convert to the underwater world.

“A provisional ANZCA fellow at Geelong Hospital, Dr Wilson will move to Hobart in early 2021 to undertake a 12-month fellowship position at the Hobart Hyperbaric unit under the supervision of Professor Smart.

She has taken an unusual path to hyperbarics. After growing up in Washington State in the US as a keen skier and winter enthusiast, a move to Australia for medical school soon led to adapting to the Australian tropics, and later a job as an anaesthesia registrar on the Northern Queensland rotation. However, it wasn’t until a trip to the Gill Islands in Indonesia with her brother that Dr Wilson was introduced to scuba diving and she hasn’t looked back. Diving trips to Central America, Asia and the outer reef in Australia soon followed, with her enthusiasm buoyed by keen northern Queensland colleagues and diving conferences.

“It had been in Townsville doing my anaesthesia training and a few of the consultants there had talked about diving and hyperbaric medicine, so I then started looking into it a bit more,” she explained.

“At that time I didn’t see a role for anaesthetists in hyperbarics. After my stint in Townsville doing my anaesthesia training and a few of the consultants there had talked about diving and hyperbaric medicine, so I then started looking into it a bit more,” she explained.

“It then applied for the fellowship through David and then the diploma through ANZCA. Anaesthetists are generally interested in pharmacology and physiology and seeing how that then translates to the real world. Diving and hyperbaric medicine is another area you can specialise into while still practicing anaesthesia, so I’m hoping to ultimately be able to practice a mix of both.”

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Professor David Smart has been medical co-director of Royal Hobart Hospital’s Department of Diving and Hyperbaric Medicine since 1996. As the immediate past president of the South Pacific Underwater Medicine Society (SPUMS) he’s excited by the research opportunities that are now possible in diving and hyperbaric medicine.

“The chamber facility here in Hobart has at least a 50-year life and there are things the chamber will be used for in the future that I can’t even imagine. We’re glowing the field to the best of our ability and part of this involves fostering the next generation of diving and hyperbaric medicine specialists coming through. There are numerous of overlaps with acute medical specialties such as anaesthesia and ICU.”

The unit recently participated in the HOLLT (hyperbaric oxygen lower limb trauma) randomised controlled trial which examined how hyperbaric oxygen can help reduce swelling, reduce infection and help tissue healing for compound fractures of the lower leg.

“When I first started as an intern in the 1980s there weren’t too many medical treatments taking place, in those days we were mostly treating divers and people with carbon monoxide poisoning but none of the wound care issues or radiation injuries had been discovered at that point,” Professor Smart explained.

“The field has really benefited from people who are working in it, understand the physiology of the field and who then apply it to specific disease states.”

Professor Smart says Specialist Training Program (STP) funding from the Australian Department of Health has been invaluable for the unit’s clinical skill training and retaining staff.

“The funding means we can have a fellow such as Dr Tucker each year. Having a fellow in the department really stimulates everyone’s knowledge base. You’re learning in the field and that flows on to our technical staff and our nursing staff and creates a higher level of operation. The other aspect is that STP also funds the supervisor of training position. We wouldn’t have the program we have in Hobart without that funding as the baseline hospital funding we receive is just enough to do the clinical cover.”

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The unit’s move to the hospital’s new 10-storey building was delayed earlier this year due to COVID-19. (The installation of 100 new ICU monitors in the new building had to be postponed after the federal government initially consigned them for the national stockpile.)

But Professor Smart says it was worth the wait: “Our floor area has tripled and it has meant that we’ve had no problems with being COVID-safe. The medical treatment compartment of the main chamber has a floor space of 24 square metres which means we can have five patients at a time with a four square metre distancing rule, supervised by one specialist nurse. In addition we have an emergency treatment lock which is 12 square metres and allows up to two staff providing care to an acute patient. Each of the treatment compartments is adjacent to an entry lock of 12 square metres area.

“Our core business is as a clinical service for diving emergencies and to treat patients with conditions that respond to hyperbaric oxygen treatment. We also provide support to the diving industry and others in Tasmania who would need that routine treatment for occupational health and safety.”

“We have a busy diving unit here especially with recreational divers and during the scallop season. Scallop divers have been coming to us as emergencies with the bends and ruptured lungs. We have a helipad on the roof of the building so when they arrive we can assess them really quickly and then they go straight into the chamber for decompression. The first treatment takes about five hours and then it might be another two to three days before they can be discharged.”

Professor Smart says the longer-term vision for the centre is to be able to operate as a multi-environment facility that can combine medical delivery of care with cutting-edge research and formal training programs for altitude simulations.

Anaesthetist Dr Lia Freestone, chair of ANZCA’s Tasmanian Regional Committee and the Royal Hobart Hospital’s Anaesthetics – Education and Training Clinical Lead said the success of the unit in attracting specialists with anaesthesia, emergency and ICU backgrounds was testament to the leadership of Professor Smart and his team.

“It is one of only six hyperbaric units in the world with a dual capability and which also has the potential to be used for aerospace research. The opportunities it provides for clinical practice and for those interested in pursuing research in diving and hyperbaric medicine are very impressive.”

Carolyn Jones
Media Manager, ANZCA

Hyperbaric oxygen treatment is an important treatment for decompression illness and is often used in the commercial and recreational diving industries. It is increasingly used to treat other conditions, including tissue injury from radiation treatment for cancer, diabetic wounds and other serious tissue infections.

It helps wounds heal by:
- Stimulating collagen production as a framework for new cells to grow.
- Reducing swelling to allow greater blood flow to the wound.
- Using high oxygen levels to help white blood cells kill bacteria.
- Encouraging new growth in blood vessels.

Hyperbaric chambers are used for aerospace, or altitude research and training to simulate the effects of high altitude on the body, with potential application to high altitude, space and extreme medicine research and testing, and airline defence training.

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Futile treatment and decision-making

IN MANY OF our recent morbidity and mortality meetings, the term “futility” and “futile surgery” has been over represented. The term futile has both an ethical and medical definition.

Medically it can be defined according to the American Medical Association as a treatment or clinical intervention that is not likely to result in benefit to the patient or produce the expected outcome. Ethically it is not as easy to define. For a decision to be ethical and just, it should meet three criteria (Husted and Husted 1991):

1. It should be appropriate to the situation at hand.
2. It accomplishes the goal without causing undue harm.
3. The outcome is foreseeable by the agent or agents who have made the determination.

In more simple terms, there should be a clear relationship between the decision, its action and outcome that can be explained in a rational manner to others by the person or people making those decisions.

After observing these terms on an intellectual and rational basis, the following questions remain. Taking it as a given that we all have our patient’s best interest at heart, there seems to be a lack of consensus in how we process the concept of futile treatment.

What we define as futile treatment at times seems to be different between anaesthetists as a group and other medical and surgical specialties. This difference can also be seen within the anaesthetic cohort itself. Acknowledging that although we are in the same specialty and may have common values and personality traits, we all are individuals and thus think and feel differently. The difference lies at a deeper level. Namely, how we see our role within the medical process in both psychological and philosophical terms.

Pragmatically, futile and utility go hand in hand – that is, what we are not seen as futile has utility. How do we measure utility as anaesthetists? As anaesthetists we have some inherent factors which have a profound effect on our job utility. This includes being seen as facilitators rather than primary clinicians. After all, patients are booked for surgery, not an anaesthetic – even though one is not often medically possible without the other. Another seems to be the unwritten but well understood hierarchal structure that exists between both sides of the proverbial blood brain barrier. This perceived or actual power differential may go unacknowledged or even unacknowledged by both the surgeon and the anaesthetist. It is often coupled with a lack of understanding of the intricacies of the operative process and how we see the process itself.

Consider the bertiens action of crossing the road. It is a process that can be relatively simple and in fact is done daily and safely and without much thought. However, if not done with due vigilance and care, it can result in severe injury and even death.

Philosophically, how we see ourselves in the process falls into four categories. The first is the unguarded crossing. This crossing is inherently known to be dangerous. However, we justify it by saying that those who choose to cross here, know the risks, but cross anyway. Psychologically this correlates with nihilism or perhaps even fatalism. We do our best but what happens, happens. After all the outcome is out of our control. It was meant to be. This mindset also represents the path of least resistance.

The second category is the zebra crossing. It is sacrosanct. Everyone knows the rules. It’s safe to cross even with oncoming cars. We all know that they will stop, as pedestrians always have the right of way. Psychologically this equates to optimism or perhaps to the more cynical as naivety. We all did our best and therefore the outcome was the best for the patient. This mindset also represents a diminishing or perhaps even an absorption of individual responsibility.

The third philosophical viewpoint is the guarded crossing. There is a warning sign that says “children crossing”. We inherently understand that these crossings are voluntary. They are usually ignorant of the road rules, combined with drivers that are unpredictable and potentially distracted. We have only the authority that our stop signs and high visibility vests give us. Most of all we are self-empowered by personal responsibility. We blow our whistles and hold our signs, and believe, or hopefully possibly only hope that the cars will stop. Psychologically this represents paralysis for if anything happens, we take full responsibility. It’s our fault. They never end in our care. This mindset can at times lead to an overbuddering of personal responsibility even for variables that to the impartial observer are clearly out of our control.

The fourth and final perspective is that of the traffic policeman. We have a civic and legal duty to keep the crossings safe. We are aware of the risks, are well trained and most of all experienced. Psychologically this would be the closest match to authoritarianism.

If things go wrong, in most cases, we try and learn from the planning and execution. Knowing it was well planned and that we were able to do our best. We aim not to repeat mistakes in the future. In my practice I wish I could say that I feel like the traffic policeman. In reality I am often left feeling like the lollipop man who guides vulnerable school children while being surrounded by impatient and impatient drivers.

I would be interested if any of my colleagues relate to these philosophical and theological viewpoint.

Where, if anywhere on this continuum do you sit? Where do your patients cross the road? Do you sit? Where do your patients cross and more importantly where would you ideally like them or your loved ones to go, to get to the other side of the road?

Dr Jonathan Kapul, FANZCA
Specialist Anaesthetist,
The UQ Emergency Elizabeth II Jubilee Hospital, Brisbane

The development of a new ANZCA professional document P167 guideline on end-of-life care for patients scheduled for surgery or intervention procedures is currently being undertaken. This will be a multidisciplinary document co-chaired with The Royal Australian College of Surgeons (RACS), Royal Australasian College of Physicians (RACP), Australian College of Rural and Remote Medicine (ACRRM), College of Intensive Care Medicine of Australia and New Zealand (CICM), Australian College of Emergency Medicine (ACEM), Palliative Care, and ANZCA.

Anaesthesia-related deaths — example case from SCiDUA’s 2018 Special Report

The New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCiDUA) has been reviewing deaths associated with anaesthesia and sedation since 1960. Example cases from the 2018 Special Report are being reproduced in the ANZCA Bulletin in an effort to enhance reporting back to the medical community.

Example case two – orthopaedic surgery

A 70-year-old female presented for a femoral nail after a fall.

Background history:
Severe chronic obstructive pulmonary disease with a recent exacerbation and moderate pulmonary hypertension, mitral valve replacement and arterial fibrillation.

Given her poor premed condition, discussion with the family ensued, deciding she was not for resuscitation in the event of a cardiac arrest.

Anaesthetic details:
A fascia iliac block was performed under Ketamine sedation (10mg + 10mg). The patient was then turned lateral for a spinal block with 1.5ml Heavy Marcain and Fentanyl 25mcg. She was then transferred to the operating table and positioned.

The patient developed profound bradycardia and hypotension. She was resistant to Atropine, Metaraminol and Ephedrine and then suffered a cardiac arrest. Given her advanced care directive no CPR was initiated.

Learning points:
• High-risk patients having high-risk surgery feature predominately in SCiDUA reports.
• It is essential to appreciate the magnitude and severity of the patient’s co-morbidities (especially cardiovascular) prior to undertaking anaesthesia.
• This will guide not just the type of anaesthetic given but also the level of monitoring required for the procedure. While having an arterial line in this patient might not have altered the outcome, perhaps having one would have led to earlier recognition of a deteriorating patient.

Source:
Assessment and documentation incidents reported to webAIRS

ANZTADC reached an important milestone in May 2020 with 8000 reports submitted. Among the first 8000 reports, 4.7 per cent were categorised by the reporter as involving assessment or documentation. A breakdown is shown in the table below.

<table>
<thead>
<tr>
<th>Assessment and Documentation</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Assessment (inadequate/incorrect)</td>
<td>27.0%</td>
</tr>
<tr>
<td>Risk Assessment (inadequate/incorrect)</td>
<td>15.3%</td>
</tr>
<tr>
<td>Documentation (missing, illegible or delay in availability)</td>
<td>10.3%</td>
</tr>
<tr>
<td>Incorrect Patient</td>
<td>1.1%</td>
</tr>
<tr>
<td>Operation list changed</td>
<td>0.7%</td>
</tr>
<tr>
<td>Operating List Incorrect</td>
<td>1.0%</td>
</tr>
<tr>
<td>Tests performed inadequate</td>
<td>3.2%</td>
</tr>
<tr>
<td>Test results not available</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other or no subcategory specified</td>
<td>40.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Interim results of the subcategories of the cardiovascular reports among the first 8000 reports shown as a percentage. Please note that the figures above are approximate and might change slightly because of data cleansing during the detailed analysis that will be performed by ANZTADC before final publication.

This advertisement is for medical professionals only and has been removed for this edition.
What would you do?

Dr Peter Roesler explains ANZCA's professional documents using practical examples. In this edition, he addresses standards.

Standard? What standard?

Scenario:

You have just commenced a new position as a locum in a regional hospital. On your first day you enter theatre to find that the machine has been checked, tray set out along with airway equipment and so on. However, you notice that an airway apparatus is required for your preferred technique of total intravenous anaesthesia for the scheduled procedures and patients listed. You discuss your plan with your assistant at which point you are curtly informed: “That is not how we do things here. It's not standard practice in this hospital”.

What would you do?

Many will be familiar with the story of Goldilocks. The contemporary version of this story is that one fine day during lockdown, Goldilocks felt her temporary accommodation at the Quarant-Inn to go for a walk in the forest, whereupon she was apprehended and taken to the Three-Bears Inn. There she was offered a choice of three beds. She promptly tested them all until she found the one that was just right. She promptly tested them all until she found the one that was just right for her. Ever wondered on what she based her decisions?

The lesson from this story is that if you have standards you know what you are looking for, and consequently, know when they have been satisfied.

In the theatre scenario above, it is interesting to ponder the reasons behind the assistant's response. Most facilities, either intentionally or inadvertently, develop their own local "culture" from which any deviation is met with suspicion and concern or fear. The desire to maintain a status quo is fulfilled by standardising what that go into making a product are known and fixed. Therefore, starting with fixed ingredients and applying a set standardised process the quality of any product will be predictable and consistent, the result. Genetic differences and epigenetic influences are unknown for any given individual.

It has been said that there is only 1 per cent difference between the generic makeup of humans compared with warthogs, but that 1 per cent clearly makes a huge difference (come to think of it I vaguely recall my early childhood days when I was once referred to in porcine terms).

Given the multiplicity of genotypic and phenotypic variations, development of processes to extract the same outcome in individuals is problematic. In what is being said, there are aspects that lend themselves to standardisation with demonstrable improvements in outcomes.

Nonetheless, standardisation as applied to anaesthesia needs to ensure a degree of built-in flexibility to allow for deviations in patients and outcomes. What outcomes can then be compared to a benchmark. The establishment of standards against which outcomes/performance can be compared is essential. From correspondence received at the college it is evident that there is some confusion when it comes to understanding what a standard is and what purpose it serves.

A standard defines a level of quality or achievement against which activities or behaviours can be measured. Standards serve as benchmarks, which can then be used to evaluate outcomes of processes or the processes themselves. It is important to appreciate that standards have no legal status and no requirement for compliance. However, a standard may be cited in legislation.

Standards may define a minimum level below which an activity/outcome is regarded as unacceptable. Minimum standards are designed to address issues of safety. Some standards are set to identify a range of acceptable performance, which are related to quality (control). Finally, there are standards identifying levels of excellence, which are regarded as aspirational. These aim to drive quality improvement.

Standards may be articulated in various ways including:

- Statement of defined outcome – such as demonstration of cultural safety when engaging with the community.
- Statement of specifications or process – for example, for continuing professional development, activities are to be documented.
- Quality statement – for example the National Safety and Quality Health Service Standard on medication safety states that the aim of the standard is to ensure that "... clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicines use".

There are many examples of standards that have been set by standard setting organisations including the Australian Council on Healthcare Standards (ACHS), Standards Australia (SA), and National Health and Medical Research Council (NHMRC). Some colleges have also set standards including the Faculty of Pain Medicine, the Royal College of Anaesthetists, and the Royal Australian and New Zealand College of Radiologists.

ANZCA's professional documents do not explicitly state standards in the true sense of standards, although they are implied within the documents. It is important to appreciate that the college's guidelines and position statements are not, of themselves, standards.

The implication of standards and their application to clinical and professional performance in anaesthesia, perioperative medicine, and pain medicine are paramount, as standards are what we are judged against and what drives both safety and quality. We are all standard bearers for our craft when it comes to our commitment to excellence in caring for our patients.

Reference

1 Standards Australia (2019) Standardisation Guide 003 p4

The ANZCA and FPM professional documents are available via the ANZCA website.

Recent updates

- Review of PS49 Guideline on the Health of Specialists, Specialist International Medical Graduate and Trainees has commenced. The first document development group (DDG) meeting was held in October 2020 to consider the purpose and scope of the guideline as well as the development of an accompanying background paper.
- Work has commenced on the development of a new professional document P167 Professional development of a lifetime for patients scheduled for surgery. This will be a multidisciplinary document co-ordinated by RACS, RACP, ACCRM, ACRA, ACGM, Palliative Care, and ANZCA. The DDG is responsible for its development met in October 2020 to discuss the professional document development process as well as the broad principles that should be included.
- Feedback received during the pilot phase is informing the final versions of PS26 Guideline on consent for anaesthesia or sedation, P566 Guideline on the role of the anaesthetist in commissioning medical gas pipelines and PS141 Guideline for the safe management and use of medications in anaesthesia.
- Document development groups have been approved for the review of PS41 Guideline on acute pain management and PS45 Statement on patients’ rights to pain management and associated responsibilities.

- An expert group has been established to develop a guideline on breastfeeding after anaesthesia/surgery. The document will be incorporated as an appendix to an existing professional document.

In pilot

- PS55 Position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations (until May 2021).
- PS56 Guideline on equipment for a difficult airway during anaesthesia (until May 2021).

Recent releases

- PS43 Guideline on fatigue risk management in anaesthesia practice.
- PS66 Guideline on the anaesthesia record.
- PS29 Guideline for the provision of anaesthesia care to children.

Feedback is welcomed during the pilot phase for all professional documents. All comments and queries regarding professional documents can be sent to profdocs@anzca.edu.au.
Each year, the college supports new research studies in anaesthesia, pain and perioperative medicine through the ANZCA Research Committee and the ANZCA Research Foundation.

THE OUTCOMES OF ANZCA-supported research help to advance scientific understanding and the evidence base available to guide decisions made in clinical practice by ANZCA fellows and other perioperative specialists, supporting continuous improvement in clinical practice and outcomes experienced by patients.

This contribution is important in a range of ways. Examples include reducing perioperative adverse events, mortality and morbidity, improving patient-centered outcomes, identifying high potential novel therapies, beneficial repurposing of existing medicines, and empowering advancements in professional practice.

To review the benefits of the investments in research made by ANZCA, and ANZCA Research Foundation donors, the ANZCA Research Committee and the foundation track the outcomes of all funded studies through the formal progress and final reports required from each grant recipient (principal investigators).

These reports address how the original problems or questions targeted by funded studies have been answered, what results were delivered against the aims or “outcomes” identified in the grant application and protocol, and what direct or indirect implications these might have for translation to clinical practice, further scientific or clinical investigation, or both.

ANZCA-supported research has been extensively recognised internationally, frequently published in world-leading peer-reviewed medical journals, and widely reported at international conferences, contributing to global advancement in the specialties over almost three decades. The exploratory studies funded by ANZCA through the foundation fill gaps in and build upon medical understandings, and in many cases provide important pilot data that eventually lead to large multicentre clinical trials through the ANZCA Clinical Trials Network, providing gold-standard evidence for wide-reaching changes in clinical practice.

I am very pleased to be able to provide this report which summarises some of the more recent contributions made by ANZCA-funded research studies conducted by teams of anaesthesiologists and pain medicine physicians, supported by enthusiastic research coordinators, touching on findings and implications for the benefit of future patients and healthcare overall. Further outcomes will be reported in the future.

Professor David A Scott
Chair, ANZCA Research Committee
Obese pregnant women are at a higher risk of surgical site infection than non-obese pregnant women. At the time of our study, the Australian Therapeutic Guidelines did not recommend weight-based dose adjustment of the standard 2 gms of cefazolin administered prior to caesarean section.

Our research team identified that there was inadequate pharmacokinetic data available to be sure that current dosing regimens achieved therapeutic cefazolin levels in the tissue of obese pregnant women. In 2017, we were awarded an ANZCA Project Grant to describe the plasma and interstitial fluid pharmacokinetics of cefazolin in obese women undergoing elective caesarean section. We aimed to use dosing simulations to predict optimal dosing regimens.

We studied women with a body mass index \( \times 35 \) kg.m\(^{-2} \) and scheduled for elective caesarean delivery at term. Our results suggested that a repeat dose of cefazolin should be administered if the wound is not closed by two hours after the initial dose was given. This indicates that even the updated Therapeutic Guidelines (2018) recommendations are inadequate for obese pregnant women. Our results need to be confirmed in a large, fully powered study, evaluating the outcome of surgical site infection. Our study was published in Anaesthesia and Analgesia in July 2020.

This publication represents the work of a multidisciplinary collaboration, including the departments of Anaesthesia and Perioperative Medicine and Obstetrics and Gynaecology of the Royal Brisbane and Women’s Hospital, together with laboratory and pharmacokinetic experts from the University of Queensland Centre for Clinical Research.

Reference

When engaged in visually demanding tasks or when the visual display of the pulse oximeter is obscured in the operating room, anaesthetists must rely on its auditory display to monitor patient SpO2 parameters with the enhanced display more accurately than when using the standard display. This improvement in performance outcomes and patient safety is supported by the hypothesis that anaesthetists will be more accurate at identifying SpO2 parameters when using the enhanced compared to when using the standard auditory display, while performing other tasks, and in the presence of background noise.

Studies and reported that the studies to date favour improved overall survival when patients receive propofol-based TIVA, largely weighted by studies in patients having major surgical resection. Therefore, an international, multi-centre, prospective randomised control trial is urgently needed to definitively investigate the impact of anaesthetic technique on cancer-free survival and overall survival. This two-year feasibility study, funded by ANZCA, recruited 146 patients across Peter MacCallum Cancer Centre, The Alfred hospital, The Royal Melbourne Hospital and internationally at the University of Texas MD Anderson Cancer Centre (USA) and proved the viability of recruiting for and delivering on a definitive multicentre trial. The study has been published in the international journal Anaesthesia (2020) and forms an integral component of Dr Dubowitz’s PhD work. The ANZCA funding for the feasibility study played a critical role in securing $4.9 million in National Health and Medical Research Council funding to conduct a definitive study. The Volatile Anaesthesia and Perioperative Orchestration (VAPOR-C) project grant: $70,000 per year; year two $68,875.

More than 60 per cent of patients with cancer require surgery and more than 80 per cent require anaesthesia as part of their care. Several preclinical and retrospective clinical studies have suggested that physiological perturbation in the perioperative period may impact cancer recurrence likely due to surgery initiating an inflammatory and immunosuppressive stress response in patients. Anaesthetic agents also have immunomodulatory effects that may be cancer-promoting by activating proangiogenic and anti-apoptotic pathways within tumours or undiagnosed micro-metastatic disease.

Volatile anaesthesia and perioperative outcomes related to cancer: The VAPOR-C Trial (Feasibility Study)

Professor Bernhard Riedel, Peter MacCallum Cancer Centre and The University of Melbourne, Dr Julia Dubowitz, Dr Jonathan Hillier and Associate Professor Erica Sloan, Monash University, Melbourne. January 2018 – December 2019 Project grant: year one $70,000; year two $68,875.

Understanding the impact of anaesthetic technique and neural-inflammatory signalling on cancer recurrence and metastasis

Surgery is essential for treatment of most solid tumours, with more than 60 per cent of cancer patients requiring surgical resection. A further 20 per cent will be anaesthetised for diagnosis, supportive care or other cancer therapy, exposing up to 80 per cent to anaesthetic agents. Alarmingly, recent clinical analyses suggest that type of anaesthetic agent may have long-term effects on cancer outcomes. These retrospective studies found that resection under volatile anaesthesia was associated with reduced overall survival compared to total intravenous anaesthesia (TIVA) with propofol. This concern, as well as the benefit of anaesthesia during cancer surgery, are crucial in understanding the impact of anaesthetic technique on cancer outcomes.

The study did not find support for the differences between volatile anaesthesia and TIVA that have been suggested by retrospective analyses and patient databases. It is plausible that the preclinical models of breast cancer used might not be sufficiently sensitive. Breast cancer was the chosen target because clinical evaluation had found an effect in this cancer type, and the selected models were gold standard for surgical research.

However, other tumour types may be more suited to detection of an effect of anaesthetic agent on cancer outcomes after surgery, and future research may consider looking at colorectal cancer as a surrogate for this. There is an urgent need for an international, multi-centre, prospective randomised control trial. The study did not find support for the differences between volatile anaesthesia and TIVA that have been suggested by retrospective analyses and patient databases. It is plausible that the preclinical models of breast cancer used might not be sufficiently sensitive. Breast cancer was the chosen target because clinical evaluation had found an effect in this cancer type, and the selected models were gold standard for surgical research.

Identifying strategies to improve outcomes after surgery will have significant global economic and social impact. Furthermore, this can be achieved by choice of anaesthetic agent. It can be done for relatively little cost. While many of the new oncological therapies are costed in thousands of dollars per patient, a change in anaesthetic agent is costed in single dollar figures per patient. Therefore, it remains important to definitively identify if anaesthetic agents impact outcome with a large prospective randomised clinical study. This underpins the importance of the ongoing international multicentre VAPOR-C prospective clinical study.
Does MRGPRX2 activation produce life-threatening anaphylaxis during 
anæsthesia, and can it be predicted and avoided?

Associate Professor Paul Soeding, Dr Jeremy 
McComish, The Royal Melbourne Hospital, Melbourne; Dr Graham 
Mackay, Department of Pharmacology and 
Therapeutics, The University of Melbourne.

January 2018 – October 2019
Project grant: $69,211

In most individuals, muscle relaxant drugs used to 
facilitate effective anaesthesia, such as rocuronium, 
are effective and safe. However, in rare cases they can 
produce a severe life-threatening allergic-like drug 
reaction which can cause circulation failure during 
surgery and have potentially fatal consequences.

This severe reaction has similarities to an anaphylactic 
allergic response, in which the body generates the 
IgE antibody that interacts with the allergic substance 
to stimulate the immune system’s mast cells, which 
then release chemicals such as histamine to produce 
the severe symptoms of anaphylaxis. While this IgE 
mechanism is important to some drug allergy it does 
not explain all cases. Despite discovery of a new mast 
cell receptor mechanism called MRGPRX2 whereby 
certain drugs such as rocuronium can directly activate 
mast cells, we still do not know why only some people 
are affected, and whether by understanding this new 
mechanism we could identify individuals likely to suffer 
these devastating reactions.

This project aimed to answer these questions, and 
in so doing provide a more individualised and safer 
approach to the use of muscle relaxant drugs during 
surgery.

The results showed that changes in the MRGPRX2 gene 
sequence are not strongly predictive of individuals’ 
responses to muscle relaxants. However, in one severe 
anaphylaxis patient, a gene change was identified that 
the team intends to analyse further for contribution to 
increased MRGPRX2 activity.

It was also shown that having more MRGPRX2 is not 
the cause of sensitivity to muscle relaxants, and that 
individuals sensitive to muscle relaxants are not likely 
to have a blood factor that makes their mast cells more 
active.

This research has provided important new insight into 
the causes of muscle relaxant drug sensitivity. Within 
the limitations of a relatively small patient group, it 
indicated that a change in the MRGPRX2 gene sequence 
or having more MRGPRX2 is not the major causal 
factor. Although a genetic test would therefore not seem 
ruled out in predicting susceptible patients, these results 
have provided new information on natural changes 
in MRGPRX2 that can be expanded upon in future research.

Our analysis of the way different muscle relaxants 
activate mast cells has identified pathways within the 
mast cell that we can further examine. Changes in these 
pathways, rather than MRGPRX2 itself, might be the 
cause of patient sensitivity to muscle relaxants.

Support for this project has generated a bank of 
biological samples that will be a very useful resource for 
much further research. Simple and definitive answers 
to the questions asked were not identified during this 
project. This likely suggests that a number of factors are 
important which will vary from patient to patient. The 
patient samples we have obtained and the knowledge 
gained during the project has helped direct our future 
project aims with the ultimate goal to make anaesthesia, 
and in particular the use of muscle relaxants, safer for all.

This novel project provides evidence to inform a gap 
within basic scientific knowledge, and the results 
support the study hypothesis that adverse outcomes 
may be reduced by using RSI instead of ABB, due 
to improved immune competence following RSI.

The safety of ABB has continuously improved, but 
significant risks remain. A considerable body of research 
confirmed the association between intraoperative 
ABB and an increased risk of poorer postoperative 
patient outcomes, including cancer recurrence and 
bacterial infections. ABB is associated with a 29 per cent 
increased risk of major infection. Transfusion related 
immune modulation or suppression (TRIM) describes 
this delayed immune suppressive response following 
ABB.

These potentially devastating effects may be avoided 
by using intraoperative cell salvage. Although the 
exact mechanism of TRIM is still unknown, laboratory 
research suggests it may result from transfusion of 
foreign proteins within donated blood. Transfusing 
autologous patient blood may therefore be a solution, 
and this study aimed to confirm that use of RSI instead 
of ABB will reduce immune modulation in surgical 
patients.

The specific objectives were to assess in vitro immune 
response following RSI compared to ABB, and to 
reduce TRIM associated risks such as infection and 
tumour recurrence by using RSI instead of ABB.

The study provided evidence of a different immune 
profile and improved immune competence following 
RSI compared to ABB. Despite the clinical evidence that 
transfusion is associated with immune modulation, 
the precise mechanism’s remain largely undefined.

TRIM is likely multi-facortal, and the adverse outcomes 
identified may be a consequence of other confounding 
factors such as complex surgery and or patient 
comorbidities. The definition and importance of TRIM 
are subject of ongoing debate; therefore the in vitro 
evidence from this study is valuable to link the immune 
consequences seen in clinical studies to an ability 
to assess these outcomes in vivo.

This study also provided a model of in vitro testing that 
complements the assessment of changes to specific 
immunocyte subsets and overall leukocyte function.

The assessment of immune competence through the 
study of intraacellular cytokine production and co-
stimulatory and adhesion molecules expressed on 
endritic cells and monocytes, and the modulation of 
the overall leukocyte response, may predict adverse 
outcomes – particularly infection-related outcomes – 
following transfusion. The research team proposes that 
immune modulation, reduced by RSI, is important in 
determining patient outcomes following transfusion 
amongst numerous surgical specialties in Australia and 
internationally.

Considering more than 800,000 red blood cell units are 
transfused in Australia annually, the benefits of RSI 
as an alternative to ABB, to improve immune competence 
during surgery, may be substantial.

Reference
1Michelle Roets, David John Sturgess, Mehalik Prabodeni 
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Alexis Jacqueline Pierre, John Paul Tung Robert Lewis Powell 
Flower, Melinda Margaret Dean. Intraoperative Cell Salvage 
as an Alternative to Allogeneic (Donated) Blood Transfusion: 
A Prospective Observational Evaluation of the Immune 
Response Profile. Cell Transplantation 2020, 29: 1–15. DOI: 
10.1177/0963689720966265

The authors wish to acknowledge the work of the 
intraoperative cell salvage group and the department of 
anæsthesia research nurses at the RBWH in this study 
and the Australian Red Cross Lifeblood for their support.
Can free nicotine replacement therapy (NRT) increase smoking cessation before scheduled surgery? A randomised trial

Dr Ashley Webb, Peninsula Health.

January 2017 – September 2019

Project grant: $70,000

Smoking causes a range of respiratory and vascular diseases and significantly increases complications during and after surgery, including more risk of death, wound infection and breathing complications. Tobacco cessation is important for improving health before surgery, and significantly lowers respiratory and wound complication risks after quitting for four or more weeks. Statements and guidelines from many anaesthesia organisations recommend healthcare providers advise smokers of the benefits of preoperative quitting, and offer some form of quitting assistance.

Despite this, there is considerable variation in health services’ delivery of preoperative tobacco help. The majority of smokers in many health services do not receive all three major components of tobacco-brief intervention: asking about tobacco use, advice to quit, and arranging or offering quit assistance such as tobacco quit-lines or stop-smoking medication. The offer of assistance is the most frequently omitted, yet data show that it is the component most associated with increasing rates of subsequent unplanned quit attempts.

Nicotine replacement therapy (NRT), an effective and safe nicotine addiction treatment, could be offered to smokers when placed on the effective surgical wait-list, potentially using wait-list time to improve preoperative health. Further, upcoming surgery is a ‘reachable moment’ where behaviour change is more likely, so a systematic offer of quit help at that time may be particularly effective in triggering preoperative quitting.

This pilot study assessed the feasibility and effectiveness of an offer of free mailed NRT patches to nicotine-dependent smokers at patient surgical wait-list placement, to determine if four-week cessation support would result in more people using stop-smoking medication before surgery and that those using medication were far more likely to quit before surgery.

Approximately 30 per cent of the offer group received and used NRT who would not otherwise have done so, resulting in a 3.2 per cent increase in sustained cessation before surgery. This pilot study was not large enough to show if this improvement was statistically significant, and more research is needed. Based on the data, offering NRT patches to 31 nicotine dependent smokers would produce an episode of clinically important quitting that is, more than four weeks before surgery, enough to reduce wound infection risk that would not otherwise occur. The modest program cost involved contact calls and, for the 99 per cent who accepted the offer, A$5 for NRT and postage.

Based on the data, a future study involving around 1500 smokers was needed. With additional funding from the Heart Foundation, this larger study incorporating a more powerful intervention of NRT patches, fast-acting NRT product to manage cravings and automatic “Quitline” via e-referral recently concluded. The outcomes of this appear much stronger than the automatic “Quitline” via e-referral recently concluded. The modest program cost involved contact calls and, for the 99 per cent who accepted the offer, A$5 for NRT and postage.

The offer stimulated more quit attempts before surgery, particularly among heavier, more nicotine dependent smokers, with many more in the intervention group either quitting or making serious attempts. As expected, offers led to significantly more people using stop-smoking medication before surgery and those actually using medication were much more likely to quit before surgery.

Opioids are commonly used for postoperative analgesia, but as opioid prescriptions have increased, so too have international concerns about diversion, overdose, dependence and unintentional poisoning. Oxycodone-related deaths in Australia, both unintentional (the majority) and otherwise, have increased along with prescription levels. Therefore, control of excess-opioid supply to the community, whilst meeting post-surgical analgesia requirements, is an important harm reduction technique.

The contribution to the community opioid pool by opioids prescribed at hospital discharge following surgery in Australia was unknown. This study aimed to beter describe Australian practice, and was specifically designed to inform the situation regarding different patient populations across four Melbourne hospitals (The Royal Melbourne, The Royal Women’s, Peter MacCallum Cancer Centre and The Western Hospital – Footscray campus). This local knowledge of opioid medication prescribing and patient management of these medications in our community is important to guide practice improvements relevant to Australia.

Our study found that 60 per cent of the surgical patients were prescribed opioids on discharge from hospital after surgery. Immediate release oxycodone was by far the most commonly prescribed discharge opioid medication. Of those that were prescribed opioids on hospital discharge, for 90 per cent of patients the quantity supplied was excessive to analgesia requirements by report of ceasing opioid therapy with left over opioid medications at follow up. At follow up 27 per cent were still taking opioids, and 25 per cent reported requiring further prescription opioid supply after hospital discharge.

These findings provided useful information on current prescription opioid use handling after surgery in Australia. The findings have been published in the medical literature. More broadly, presentation and publication of this work allows other clinicians in anaesthesia and pain medicine to develop a local perspective on opioid prescribing and management after surgery to inform their practice.

The outcomes allowed our research group to design and pilot a post-surgery opioid stewardship intervention bundle. With further ANZCA grant funding support, the impact of this intervention bundle is being assessed in a separate post-intervention study. We hope that our work in this four-week period patient care by better targeted opioid prescribing after surgery.

The role of intestinal microbes in sepsis

Dr Megan Allen, Dr Charles Kim, The Royal Melbourne Hospital, Melbourne; Dr Tim Hucker, Peter MacCallum Hospital, Melbourne.

January 2017 – September 2019

Project grant: $34,459

Sepsis is a life-threatening condition, characterised by the presence of harmful microbes or their toxic products in the blood. These lead to systemic inflammation and are associated with disruption of the intestinal epithelium, the single-cell layer separating our gut luminal microbes from the bloodstream.

In this study, Dr Chan and his team of basic science researchers conducted work in animal experiments to understand the role of resident gut microbes in sepsis. The intestinal epithelium compartmentalises the sterile bloodstream and the contaminated gut lumen, and accumulating evidence suggests that this barrier is impaired in sepsis, aggravating systemic inflammation.

Previous studies reported that cathelicidin is differentially expressed in various tissues in sepsis. However, its role to sepsis-induced intestinal barrier disruption has not been investigated. This study aimed to investigate the role of murine cathelicidin-related antimicrobial peptide (mCRAMP), a rodent antimicrobial peptide analogous to human cathelicidin LL-37, in maintaining gut barrier function in sepsis, and to explore the relationship between misoprostol (prostaglandin E1 analogue) and cathelicidin production in a celiprolol and puncure (CUP) mice model.

Misoprostol was administered to induce intestinal expression of cathelicidin. Mice pre-treated with misoprostol had decreased seven-day mortality and significantly less sepsis deaths compared to controls.

Using transgenic models, the research team discovered that cathelicidin plays a protective role in preventing translocation of bacteria in sepsis, and that cathelicidin preserves intestinal barrier function in polymicrobial sepsis by preventing exaggerated inflammatory response.

The team has also demonstrated that the therapeutic efficacy of misoprostol has provided additional protective effect in sepsis. These findings provide new insights on the use of the non-antibiotic drug misoprostol, in preserving the gut barrier function to reduce the morbidity and mortality of sepsis.
Predicting disability-free survival after surgery in the elderly

Dr Mark Shulman, Professor Paul Mylne, Ms Sophie Wallace, Alfred Hospital and Monash University.

January 2017 – present

Project grant: $209,541 over three years

This study seeks to address concerningly high six- and 12-month postoperative mortality and morbidity among elderly patients with existing co-morbidities. Although not yet complete, it has now delivered a registry database of elderly surgery patients to allow the identification of risk factors for poor long-term recovery, to support better patient and clinician decisions about having surgery and assist with better level of care planning before and after surgery. The database is able to capture data relating to disability, comorbidities, surgery and anaesthesia, blood test results, in-hospital complications and mortality. The project is notable for having already changed practice at The Alfred, gaining hospital approval to include the World Health Organization Disability Assessment Schedule (WHODAS) for direct entry as routine clinical data into the electronic medical record, and to be used in the preoperative surgical checklist for this cohort. The study builds upon previous research from this group that demonstrated postoperative disability and confirmed the operational definitions of WHODAS for patient outcomes measurement.

The group’s previous research also found that 13 per cent of patients, or almost one in seven, had a new postoperative disability persisting 12 months after surgery, experiencing poorer healthy than they were preoperatively. Only 70 per cent of patients aged 70 or older were alive and without clinically significant disability six months after surgery, compared to 83 per cent for patients aged under 70. However, the sample size of the initial validation study was too small to characterise the postoperative predictors or epidemiology of postoperative disability; one of the aims of this subsequent study.

In this study of surgery patients aged 70 or more the team’s aims were to develop a large prospective patient registry to create a validated scoring system to predict postoperative disability-free survival, to characterise the epidemiology of postoperative disability and confirm the operational definitions of WHODAS for this cohort, and to examine the health economic consequences of disability-free survival. Recruitment is continuing towards a target of 500 cases of patients reporting significant disability at six-months postoperative follow-up, to provide adequate power for analysis.

Reference

1 The Rovenstine Lecture, 2015

Evaluating a national quality improvement initiative: multidisciplinary operating room team simulation for safer surgery

Professor Jenny Weller, University of Auckland.

January 2017 – April 2020

Douglas Joseph Professorship: $70,000

The global burden of disease due to unsafe medical care is significant and unacceptably, and communication errors are estimated to contribute to 43 per cent of surgical errors. (Lavendhomme, Zinner, Studdert, and Brennan, 2003). Operating room team-based simulation has the potential to improve the safety of patients undergoing surgery. This evaluation of New Zealand’s national “NetworkZ” intervention aims to provide evidence to support sustainable implementation of simulation-based training and safety interventions, and will be relevant to other acute care settings. Its findings are expected to be of national and international significance.

A stepped national rollout of the NetworkZ project, the first simulation-based team training and patient safety intervention funded for implementation across New Zealand, is providing new knowledge and understanding in three areas: implementation processes for quality improvement initiatives such as NetworkZ; teamwork and communication process change measurement; and the use of large-databases for patient outcomes measurement.

The NetworkZ program may improve aspects of clinical practice, but the likelihood that it continues to be funded and generate patient safety outcomes depends on providing good evidence of its benefits. The results of the evaluation will help to inform decision makers and funders about the value of investing in NetworkZ and other simulation-based programs.

Several simulation team training programs have been piloted, but few if any have been sustained. This study will improve understanding of factors influencing implementation and sustainability, to support the sustainability of NetworkZ, and provide recommendations for programs.

This ANZCA grant was supplemented with funding from the New Zealand Accident Compensation Corporation through the first two years of the five-year NetworkZ evaluation program, with outcomes to be assessed in 2021 on completion of NetworkZ course rollout to all 20 district health boards in New Zealand. To date, program uptake tracking and qualitative assessment of implementation and long term sustainability factors have been assessed. This grant has also enabled quantitative data collection for Cohorts 1 and 2 of the NetworkZ rollout.

The work complements existing patient safety research on implementation of the World Health Organization Surgical Safety Checklist, enhancing understandings of enablers and barriers and the impact of the checklist on teamwork. Several simulation team training programs have been piloted, but few if any have been sustained. This study will improve understanding of factors influencing implementation and sustainability, to support the sustainability of NetworkZ, and provide recommendations for programs.

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The effect of dexmedetomidine given as a premedication or intraoperatively on post-hospitalisation behaviour change in children: A randomised controlled trial

Dr Paul Lee-Archer, Queensland Children’s Hospital and the Paediatric Critical Care Research Group, Centre for Children’s Health Research, University of Queensland. January 2017 – October 2020

Project grant: $28,792

Various studies have reported that postoperative negative behaviours occur in more than 50 per cent of children undergoing general anaesthetic, including sleep and eating disorders, defiance of authority, nightmares, murriness and temper tantrums. The effects are usually short-lived (two to four weeks), however in five to 10 per cent of children, they can last up to 12 months. The exact cause of these behaviour changes is unknown, but may be related to the stressful experience of hospital, anaesthetic drugs, surgical stress, inflammation and pain.

These behaviours represent a significant problem, and may have long-term effects on the child’s future compliance with medical therapy. It has been suggested that distress surrounding medical procedures in children leads to an increase in pain and anxiety surrounding medical events as adults. If the six million children undergoing general anaesthesia every year in the US (including 1.5 million preschool children) are indicative, this issue may have significant public health implications in terms of adverse effects on the future health of children, and the additional burdens on parents and families.

The risk factors for developing negative behaviours include underlying anxiety in the child or parent, a previous bad hospital experience, emergence delirium and pre-school age. A recent meta-analysis of alpha-2 agonists (including dexmedetomidine) found that they effectively reduce the incidence of emergence delirium, but none of the studies looked at longer term outcomes, such as negative behaviours after discharge from hospital. Dexmedetomidine is a drug that is a promising therapy for the prevention of behaviour changes. It reduces anxiety, pain and inflammation and may protect the brain from other insults. This study aimed to discover whether dexmedetomidine could also reduce the incidence of negative behaviour change in children after day case surgery and anaesthetic, whether dexmedetomidine should be given as a premedication or whether the same effect could be produced with an intraoperative dose, and to examine the concurrent validity of the Post Hospitalisation Behaviour Questionnaire for Ambulatory Surgery (PHBQ-AS).

The investigators measured the incidence of behaviour changes for one month after surgery using the validated (PHBQ-AS) and Strength and Difficulties (QoT) tools, in 249 two- to seven-year-old children having day-case surgery who were otherwise fit and well. Children were randomised into three groups, with researchers, parents and children blinded to group allocation. Group 1 children were pre-medicated with a nasal spray of dexmedetomidine, reducing anxiety before having their anaesthetic. Group 2 were given a dose of intravenous dexmedetomidine during the surgery, and (top up) 3 were given a placebo. Baseline anxiety levels of the parent and the anxiety of the child were recorded during induction of anaesthesia using the validated tools.

The study outcomes demonstrated very little difference in the incidence of behaviour change on day three and day 14 postoperatively between the groups, but by day 28, the children who had received intravenous dexmedetomidine demonstrated significantly less negative behaviours. The children who received dexmedetomidine had less pain and less emergence delirium, but also stayed slightly longer in the recovery unit after surgery. There was no difference in adverse events between the groups.

The researchers found that in healthy preschoo-age children having day-case surgery there is little benefit in adding or premedication or postoperatively. However, in children who have received previous bad hospital experience, these patients may benefit from a premedication or postoperative dose. This study has important implications for the future of anaesthesia in children.

Dr Paul Lee-Archer
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Centre for Children’s Health Research
University of Queensland
Anzac Bulletin
Volume 105, Number 2
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Do bolus intravenous fluids cause lung injury: Role of TRPV4 channels

Dr Thomas Painter, Royal Adelaide Hospital, Professor Paul Myles, The Alfred hospital and Monash University, Professor Andrew Bersten, Dr Shalalah Bhari, Flinders Medical Centre, Associate Professor Dani Dixon, Flinders University, South Australia.

January 2017 – October 2019

Project grant: $65,869

Resuscitation with intravenous fluid boluses is a common intervention for critically ill patients dehydrated due to illness, or after surgery. However, recent evidence has associated liberal fluids with worsening oxygenation, possibly increasing patient mortality, especially in children with severe infection. Acute Respiratory Distress Syndrome (ARDS) remains a common problem in intensive care units, with a 30 per cent worldwide mortality rate, largely due to the absence of treatment other than supportive care. Identifying the mechanism by which liberal intravenous fluid doses may contribute to ARDS would provide clinicians with evidence for a conservative approach when administering intravenous fluid, and a potential target for therapeutic intervention which would allow fluids to be administered more safely when necessary.

The research team aimed to examine health outcomes and blood of hospital patients to further investigate this hypothesis and the mechanism by which such effects may occur.

The project was a sub-study of the NHMRC-funded “Restrictive versus Liberal Fluid Therapy in Major Abdominal Surgery” (RELIEF) multicentre clinical trial, supported by the ANZCA Research Foundation and endorsed by the ANZCA Clinical Trials Network. The study sought to measure a series of biomarkers to assess whether evidence of lung blood vessel injury was greater in patients in the liberal or restrictive arms, and investigate the effects of each fluid regime on factors on the blood markers of lung injury.

The results of the study found no difference in biomarker levels between the liberal and restrictive arms of the RELIEF study, meaning there was no difference in injury to lung blood vessels between the arms. However, it showed that receiving more fluid in total leads to more injury of blood vessels generally within the body. The outcome is important, because it indicates that the harm signal from the RELIEF study showing that restricting fluids during abdominal surgery leads to more kidney complications and wound infections, is likely to be related not to blood vessel injury, but to some other mechanism, requiring an alternative explanation for its results. Further, the association between a liberal fluid regimen in patients undergoing major abdominal surgery and blood vessel injury generally is an important consideration in the liberal administration intravenous fluid.

Novice investigator grants

A major goal of the college and the foundation is to encourage and foster novice investigators. The ANZCA Research Foundation therefore invites ANZCA Novice Investigator Grant applicants to make early applications for the mentoring scheme, which is available during the application process. Applications for mentoring support must be received by 14 January each year.

A mentor, who is an experienced investigator, will be appointed by the Research Committee. The mentor will assess the application and provide prompt feedback. The applicant must then resubmit his or her application to the college by the usual deadline on 1 April. Late applications for either deadline will not be accepted. All mentoring provided to the applicant will be confidential, and not available to the committee.

For the purposes of this process, a Novice Investigator (Grant application is for a novice investigator who: 1) may have been awarded previous grant funding as a principle investigator provided no single grant has exceeded $10,000; 2) has not published more than five research papers in the five years prior to the year of application; 3) does not have an experienced investigator as a co-investigator on the proposed grant.

Below are some of the important outcomes from recently-completed novice investigator grants.

Comparison of ultrasound guided trans-muscular quadratus lumborum (TQL) block catheter to surgically placed pre-peritoneal catheter (PPC) for postoperative analgesia in abdominal surgery – a prospective randomised study

Associate Professor Vasanth Rao Kadam, The Central Adelaide local health network (CALHN).

January 2016 – April 2019

Novice Investigator Grant: $14,199

Both continuous local anaesthetic infusion through pre-peritoneal catheter (PPC) and trans-muscular quadratus lumborum (TQL) block have been described for postoperative analgesia after abdominal surgery. This study compared the efficacy of continuous TQL block versus PPC for post-operative analgesia after laparotomy.

The principal investigator and research team hypothesised that ultrasound-guided TQL block would provide superior analgesia, as reflected by the improved Verbal Numerical Rating Score (VNRS) for pain on movement and reduced opioid requirement in comparison with surgically guided continuous pre-peritoneal block.

Eighty-two patients between 18 and 85 years of age undergoing elective surgery were randomised to receive either PPC or TQL block. In the PPC, group, after 20mls bolus of 0.375 per cent ropivacaine infiltration at subcutaneous, sub-fascial and pre-peritoneal plane catheters were placed bilaterally. In the TQL group, under ultrasound guidance, an 18-gauge Tuohy’s needle was passed through T9 muscle to reach its anterior peritoneal plane and catheters were placed bilaterally. Both groups received an infusion of 0.2 per cent ropivacaine at 5ml/h continued up to 48 hours along with a multimodal regime including regular paracetamol and patient controlled analgesia with fentanyl. The primary end point was post-operative pain score on the VNRS (VNRS, 0-10) on coughing. Other outcomes measured were VNRS at rest, fentanyl usage until 48 hours, satisfaction scores and costs.

The outcomes showed there was no difference in VNRS at cough (p=0.24). In the TQL group there was a reduction in VNRS at rest (p=0.036) and satisfaction scores on days 1 and 30 (p=0.004, p=0.006). Nonetheless, fentanyl usage was similar. The TQL technique incurred $A574.64 per procedure more than the PPC.

While the TQL group achieved reduced pain scores at rest, there was no difference at cough. The positioning time required for TQL is more than PPC, potentially affecting theatre time per patient.

The results showed that the two techniques were comparable in terms of pain scores during cough, and rescue opioid requirement. Though rest pain scores were significantly less for the TQL group, cough pain scores may be more important during the postoperative period. Considering the invasiveness and expertise required for the TQL block, the PPC technique may be a cost effective viable alternative for postoperative pain management after abdominal surgery.

This study was accepted as an e-poster and oral presentation at the ANZCA AVM 2019 meeting in Kuala Lumpur and also published in Anaesthesia 2019, 74, 1381–1388.
The efficacy of an anaesthetic record in transferring information across hospital settings

Due to the very low identification of relevant information in the anaesthetic record, a comparison between sections (history, medications, and interventions) could not be conducted. For the same reason, a comparison between participant demographics (years of service, years at the institution, profession and background) could not be conducted, nor could the ability to target specific interventions be commented upon, aside from a global need to highlight the availability and importance of information contained within the anaesthetic record.

The investigators concluded that their results show that a disturbingly high percentage of perioperative staff are either not accessing, or not able to interpret, relevant information contained within the anaesthetic record. The customised format and nomenclature used within the anaesthetic record may both play a role in its utilisation by staff across the perioperative journey. As a component of a contemporaneous record, documenting details and important aspects of a patient’s care and progress, the anaesthetic record’s utility is not limited to the intraoperative period nor to anaesthetic personnel alone.

This study objectively demonstrates a limitation in the accessibility or utility of the anaesthetic record which may carry significant clinical consequences and merits further investigation.

A tailored electronic anaesthetic information management system would allow for local engagement in addressing how information is captured and documented within the anaesthetic record. The lack of overall understanding and appreciation of the importance the anaesthetic record can play outside of direct intraoperative care can often result in the adoption of a digital anaesthetic record being one of the last components to transition in a hospital’s record keeping system. The lack of overall understanding regarding the importance of the anaesthetic record also plays into the common adoption of systems without adequate consultation or consideration of anaesthetic workflows, quality assurance, and clinical decision support functions.

Influence of anaesthetic choice on prospective outcomes after creation of arteriovenous fistula (POCAF)

End stage kidney disease (ESKD) represents a considerable health burden in Australia and New Zealand. The incidence of patients requiring treatment is projected to increase with our ageing population, and around half of all patients diagnosed with ESKD will require vascular access for renal replacement therapy by haemodialysis.

Regional anaesthesia for creation of an arteriovenous fistula (AVF) may be beneficial in patients with ESKD by avoiding hypotension and providing optimal surgical conditions through superior vasoconstriction and vasodilation. This may be important in preserving AVF function, however regional anaesthesia may be associated with an increased risk of peripheral neural dysfunction.

To date, only small retrospective studies have investigated the impact of anaesthesia on medium-term postoperative outcomes after AVF. This pilot multicentre prospective observational study investigated regional versus general anaesthesia for initial AVF patients, using outcomes at six weeks as the clinically important time frame during which a decision to reintervene or abandon the fistula is typically made.

The primary aims were to assess the feasibility of a data management system to enter and store data at participating hospitals, and to determine the recruitment rate of eligible patients at each hospital. The secondary aims were to establish the incidence of arteriovenous fistula failure (six-week primary patency rates) and peripheral neural symptoms; and to determine the magnitude and direction of benefit of anaesthesia technique on outcomes.

Eight sites were activated, with 168 completed eligible patients over two years, and a recruitment rate of between two to 27 patients per year across the sites. The data collection tool was completed appropriately in over 90 per cent of cases.

Against its secondary aims, the investigators found six-week primary patency rates of 84 per cent, peripheral neural symptoms in 7 per cent, and confirmed that a biaxial plexus block was associated with improvement in AVF primary patency rate of 89 percent (95 per cent CI 0.83-0.89 per cent) versus 75 percent (95 per cent CI 0.65-0.85 per cent) with a p-value of 0.033.
The number of total hip replacements (THR) performed each year is projected to increase from 1.8 million in 2015 to 2.8 million in 2040, yet there is no agreement on the ideal pain relief for this frequently performed operation. Local infiltration analgesia (LIA)—injection of high volume, dilute local anaesthetic into the area around the hip joint—is widely used, being simple to perform and associated with few side effects. However, evidence for its efficacy in providing good pain relief is unconvincing.

Most prior trials had been in the setting of a lateral or posterior surgical approach to THR. While an anterior approach in which muscles are separated rather than cut and reattached is increasingly being used for its potential advantages in postoperative pain, only one trial had investigated the effect of LIA in anterior THR, finding no difference in pain scores four hours after surgery. However, that study did not fully consider other important measures of recovery, and had a small number of participants.

This study was therefore conducted to determine whether LIA would improve patient-reported quality of recovery (including pain, independence and physical comfort) one day after anterior THR. The hypothesis was that LIA with 0.2 per cent ropivacaine when compared with injection of placebo (0.9 per cent saline) would improve quality of patient recovery on postoperative day 1 (POD 1), as measured by the patient-reported outcome measure (PROM) Hip-166.

160 patients having an anterior THR were randomly assigned to LIA or saline placebo, and the intention-to-treat analysis included 152 patients. All other care, including the anaesthetic technique, was standardised. The study found that LIA was no better than placebo at improving quality of recovery one day after surgery. There was no difference in opioid consumption or mobilisation one day after surgery, duration of hospital stay, or pain score after 3 months, between patients randomised to receive LIA with 2.5 mL/kg of 0.2 per cent ropivacaine, compared with 0.9 per cent saline as placebo.

Therefore, we have strong evidence that LIA should no longer be used as an analgesic technique for anterior THR. This will reduce the potential for unnecessary complications and healthcare costs of a commonly performed operation.

This trial was completed and was published ahead of print on June 3, 2019 in Anaesthesia & Analgesia under the title: “Impact of local infiltration analgesia on the quality of recovery after anterior total hip arthroplasty: a randomised, triple-blind, placebo-controlled trial”.

Does the addition of LIA to a multimodal systemic analgesic regimen improve recovery after anterior THR?
Global development

The first grant from the foundation’s “Global Safer Surgery Fund” (GSSF), generously donated by Dr Genevieve Goulding, was made in 2019 to the African Surgical Outcomes-2 (ASOS-2) Trial Maternal Mortality Sub-study, through the University of Cape Town and the African Perioperative Outcomes Research Group.

This mixed-methods sub-study aimed to describe factors contributing to caesarean delivery-related maternal mortality in Africa, which is 50 times higher than in high-income countries. It was conducted within the context of ASOS-2, an international African, multicentre randomised trial with a primary outcome of in-hospital mortality.

The completed sub-study will provide vital information for planning future interventions aiming to improve outcomes after caesarean delivery, helping meet this significant health need across the African continent. There is an option to donate to the GSSF on the foundation’s donation page on the ANZCA website.

Contacting the foundation

To donate online, search “GIII Options – ANZCA” in your browser. For general queries on supporting the foundation:
- Rob Packer, General Manager, ANZCA Research Foundation, +61 409 481 295, rpacker@anzca.edu.au.
- Anna Smeele, Fundraising Administration Officer, asmeele@anzca.edu.au.

Donations with subscriptions

Adding a tax-effective donation to your subscription is one of the easiest ways to support the work supported by your foundation. General gifts can be added to subscription payments, however to direct your donation to a specific program please select an option on the donation page of the ANZCA website (search “Gift Options – ANZCA” in your browser).

Thank you again for your kind support! Whether as a patron, through donations with your annual subscription payment, or other gifts, you are making a significant difference.

Thank you again for your support.

ANZCA Research Foundation team

Reference
The Long-term Outcomes of Lidocaine Infusions for persistent PostOperative Pain in patients undergoing breast cancer surgery (LOLIPOP) Trial

In a landmark achievement, a team led by Deputy Chair of the ANZCA Clinical Trials Network, Professor Tomas Corcoran, secured a $2.4 million grant from the Medical Research Future Fund to perform the LOLIPOP trial. The five year LOLIPOP trial is a large (n=4400) pragmatic, multicentre, randomised, stratified, controlled, superiority trial evaluating the effect of lidocaine infusions in the intra- and postoperative periods on the incidence of moderate or severe chronic post-surgical pain (CPSP) at one year in patients undergoing elective breast cancer surgery. Secondary outcomes will include analgesic efficacy (pain scores), psychological and quality of life outcomes, the influence of pharmacogenomic profile on efficacy, and cost-effectiveness.

Women undergoing breast surgery and cancer treatment are a high risk group for development of chronic post-surgical pain (CPSP), where it is estimated that nearly half of breast cancer surgery patients may develop this outcome. A systematic review and meta-analysis by the study team observed a 71 per cent reduction of the odds of CPSP (odds ratio [OR], 0.29; 95% CI, 0.18 to 0.48) with a number-needed-to-treat (NNT) of approximately 5 for lidocaine infusions—a finding that remained consistent in a planned sub-group analysis limited to breast surgery. The primary purpose of a meta-analysis where there is insufficient evidence is in hypothesis generation and to identify subgroups. Hence, this very substantial reduction in the odds of CPSP must be tested in a properly conducted large trial. The team has compered and is preparing the LOLIPOP pilot trial. This trial enrolled 150 patients and examined feasibility and safety outcomes in addition to pharmacokinetic data, in preparation for the large international trial.

In our recent survey of ANZCA fellows, 52 per cent of respondents reported the incorporation of perioperative lidocaine into their practice, with the remaining 48 per cent having no perceived barriers to lidocaine use. These findings, in addition to the results of the meta-analysis, confirm that there is equipoise regarding lidocaine as a perioperative intervention. This trial will inform clinical practise globally.

Study hypothesis: The administration of a lidocaine infusion intraoperatively and up to 24 hours postoperatively reduces the incidence of moderate or severe CPSP following breast cancer surgery compared to placebo.

Professor Tomas Corcoran
ANZCA Clinical Trials Network Deputy Chair
Please email Tomas.corcoran@health.wa.gov.au if you are interested in being involved, with your contact details and any questions.

Trainee research networks

New South Wales

FOR THOSE of you that have not yet heard of us, we are “Anaesthesia Trainee Research and Audit Intrarnees NSW” also know as A-TRAIN. We are the relatively newly developed Trainee Research Network (TRN) for NSW. Our principal aim is to facilitate collaborative research and quality improvement activities across our state. We recognise that while many trainees have an interest in this area, barriers such as rotational training, examination preparation and interest in general make participation challenging. This is where we believe that we can help!

Since our inception in mid-2019, we have been developing our inaugural project. Like many others, we have faced a COVID induced productivity hit. However, we are now regaining momentum and ready to roll into 2021 with our inaugural project, “QUIT Talking” ready for release.

By developing and coordinating this, A-TRAIN will assist you in each stage of the project and alleviate the common barriers to research participation.

QUIT Talking is a simple survey-based project designed to assess and optimise the way in which anaesthetists and anaesthetic trainees talk to patients about smoking and smoking cessation. With the perioperative period being a recognised teachable moment, and given that smoking is the leading preventable comorbidity, this could have real health benefits for your patient population. While the patients of your region may benefit, you will also benefit! We expect that this project will enable you to complete your scholarly role audit, work with a friend, learn the principles of quality assurance and potentially contribute to a peer reviewed publication. Better yet, A-TRAIN have already developed the project protocol, and the survey, and can help guide you in obtaining the appropriate ethical or quality assurance approval to participate. It really is very simple to be involved.

We have an enormous pool of talented and motivated anaesthesia trainees across our state. Working together, we have the ability to make a positive difference to our hospital services and your personal and professional development.

If you would like to know more about the project, we would be very happy to talk to you. Please send an email to talk to you. Please send an email to Quit.talking@health.nsw.gov.au.

Dr Nathan Hewitt
Provisional Fellow in Anaesthesia, The Royal North Shore Hospital
Member of the A-TRAIN Team

If you are interested in joining our trainee research network in Victoria then please get in touch through our website at ausatnetwork.wordpress.com.
DEAN’S MESSAGE

Diversity of fellowship helps lift community profile

As well as training specialists, FPM needs to set standards in areas related to clinical pain medicine. Our Choosing Wisely recommendations, as well as our professional documents, are the public-facing aspect of this work. The recent decision by the FPM Board to fast track the development of plain language versions of our position statements to enable them to be used more widely in public advocacy is a reflection of this. Our Procedures Endorsement Program over time will become influential in setting and maintaining standards for those in our fellowship who perform them, and may also attract interest from other craft groups who perform these procedures. We will continue to be meticulous in applying the expectations of the Australian Medical Council and Medical Council of New Zealand to ensure that our stewardship of the specialty is never questioned.

The most extraordinary asset of the faculty is its fellowship. Within our ranks we have a diversity of skills, experience and opinions which means that over the years we have been able to deliver thought leadership with an impact that far exceeds our numbers. As this year draws to a close, I encourage all of our fellows and trainees to reflect on the contribution they are making to our community.

As with many organisations where much of the work is done pro bono, there is an ever present risk that the heavy lifting will be done by an irreplaceable few rather than the sustainable many. In my military days, when an officer was posted to a new unit, they were routinely assigned secondary duties in addition to their main job. Secondary duties included looking after garden areas of the base, property of the officers’ mess, deciding when to replace sporting equipment, and dozens of similar seemingly menial tasks. The wisdom of this practice is that it builds community and promotes a sense of service and interdependence. Fellowship of our faculty is just the entry point to the kaleidoscope of relationships that exist in the pain management community. The more diverse our interactions, the stronger our community and the more satisfying our achievements.

For me, the most resonant lesson of 2020 has been about the importance of cultivating all our relationships, be they recreational, work or family. As our social worlds shrank during lockdown, the quality of those relationships became paramount and this lesson should not be forgotten.

As our social worlds shrank during lockdown, the quality of those relationships became paramount and this lesson should not be forgotten.

I wish all of our fellows and trainees a restful and enjoyable holiday season. I very much look forward to renewing so many relationships in person. I would like to thank our faculty staff for their extraordinary contributions in these very demanding circumstances and recognise the level of professionalism that they bring to all their interactions with fellows and trainees.

Whatever 2021 may hold for us, I am confident that the pain medicine community will be as innovative, resilient and compassionate as it has always been.

Associate Professor Michael Vagg
Dean, Faculty of Pain Medicine

WHERE TO START with summing up 2020?

There seems little that has not been said or written already about the impact of the pandemic, so I will not add to that noise. What I would really like to focus on is the opportunities we have over the next couple of years. As a specialty, we are uniquely placed to lead a critical effort at tackling the silent pandemic of persistent pain, which continues to be the largest cause of disability in adults of working age in both Australia and New Zealand.

Those who need us most may know very little about what we do and what we stand for.

Only FPM can train more specialist pain medicine physicians (SPMPs). We have a responsibility not just to grow our own workforce of doctors, but to use our leadership position in the health bureaucracy to help our colleagues in nursing and allied health professions grow their specialist workforce in pain as well. The strategic leadership of the faculty in this area has been recognised by the federal government in awarding us the grant to produce the National Health Practitioner Education Strategy, but there is arguably more that we could do to raise the profile of SPMPs within our own profession as well as in the public consciousness.

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Faculty of Pain Medicine

“Within our ranks we have a diversity of skills, experience and opinions which means that over the years we have been able to deliver thought leadership with an impact that far exceeds our numbers.”
PAIN IS RECOGNISED as one of the leading causes of disability and the greatest source of patient distress globally, with the number of people living with chronic pain increasing year on year1. Best practice in chronic pain management encompasses care by an inter- and multi-disciplinary team using a somatic and biobehavioural approach. Despite the need for skilled health practitioners to address the growing burden of chronic pain, we know that pain management content continues to be lacking in health professional education at all levels worldwide. This has resulted in limited translation of pain research and clinical evidence into practice.

In 2018, Australia was one of the first countries in the world to develop a National Pain Strategy, with the National Strategic Action Plan for Pain Management following in 2019. This year, the Department of Health awarded grants for projects to achieve the goals of the plan. In March, the Faculty won a $A500,000 grant for a project to “develop an overarching education strategy to promote evidence-based pain management education across a broad range of health practitioner disciplines, through undergraduate, postgraduate and continuing education”. The project supports goal three of the action plan, which aims to “ensure health practitioners are well-informed and skilled in pain management”, with its aim to “support goal three of the action plan, which aims to “ensure health practitioners are well-informed and skilled in pain management”.

Producing a national pain management education strategy for Australian health practitioners puts the faculty in a world-leading position once again. We have a unique opportunity to define the future of pain management education in Australia by creating a nationally consistent and comprehensive set of principles and goals to inform its development and implementation across a broad range of health practitioner disciplines. We are also aware that colleagues across the globe have been watching the implementation of Australia’s National Pain Strategy.

Implementation of the education strategy will no doubt be affected by the COVID pandemic, not least because of already-emerging reports of COVID survivors experiencing chronic pain. An economic perspective, many of our implementation recommendations will require further funding and with a tighter fiscal environment as a result of the recession, such funding may have to come from sources outside of government. However, the COVID-recession also provides an opportunity to really highlight the benefits and cost savings which ultimately come from sources outside of government. The Learning and Development Committee has continued the review of the curriculum in 2020 with a focus on designing the curriculum to support the development of a strategy framework, which will be tested and further refined through a series of stakeholder consultation forums in 2021. Planning for these forums is well under way – with COVID-restrictions permitting, we aim to use both face to face and virtual forums.

Associate Professor Meredith Craigie
Clinical Lead – Pain Management Health Practitioner Education Strategy

References


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

• Dr Eliza Besani
  FANZCA, FFPMANZCA (NSW)

• Dr Surabhi Gupta
  DNB Anaesthesiology, FFPMANZCA (ACT)

• Dr Jigna Hapani
  FANZCA, FFPMANZCA (Vic)

• Dr Brian Hua
  FANZCA, FFPMANZCA (WA)

• Dr Ksenia Katyk
  FRANZCOG, FFPMANZCA (NSW)

We also congratulate the following doctor on her admission to FPM fellowship through completion of the pain medicine SIMG process:

• Dr Louise Lynch
  FRCA, FFPMANZCA (New Zealand).

New fellows

Updates to the FPM curriculum

The Learning and Development Committee has supported the review of the curriculum in 2020 with respect to the relevance, redundancy and assessability of learning outcomes. Following the review of sections one, two and parts of essential topic area 3.1 in 2019, the following essential topic areas were reviewed in 2020:

• 3.1: Mechanisms in the biomedical dimension of pain
• 3.3: Spatial pain
• 3.4: Problematic substance use
• 3.9: Chronic widespread pain

An updated version of the curriculum has been placed on the website. During 2021 the curriculum revision will continue in addition a review of the online support resources for trainees.

In July the FPM Board made the decision to retire the election to fellowship pathway (By-law 3.2). Further to this decision, the Board have agreed to incorporate a transition period until 30 June 2021. The board will consider applications for election to fellowship from eligible individuals during this transition period.

Committed to supporting safer opioid prescribing and decision-making

We need you! Start the conversation in your workplace and engage your colleagues with the Better Pain Management free online education program.

Designed by specialist clinicians, the program comprises six e-learning modules that will assist your healthcare team to better manage all types and levels of pain for those in their care.

Course modules include:

• Making an effective pain diagnosis: A whole person approach.
• The impact of management of psychological pain factors.
• A whole person approach to chronic pain.
• Opioids in pain management.
• The pharmacology of pain medicine.
• High-dose, problematic opioid use.

To enroll, simply scan this QR code, email fpm@betterpainmanagement.com.au or call +61 3 9093 4930.

This Better Pain Management e-learning course is free for Australian residents.

FPM Wins Department of Health Grant

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Save the date
The 2021 Combined Spring Meeting of the Faculty of Pain Medicine and the Hong Kong College of Anaesthesiologists

Moving with pain
15-17 October 2021
Millennium hotel
Queenstown, New Zealand

#painCSM21

Registrations opening in January!
We will celebrate the evolving art which is pain medicine and the nexus between overlapping specialties. We will aim to showcase different concepts in pain and what we can learn from other specialties who approach their patients in a similar, holistic manner.

For more information on the program and when to register, please visit the website.

MDA National’s priority will always be to support our Members in the moments that matter.

Our unwavering care and support was demonstrated during the on-set of COVID-19. We provided the advice and guidance our Members urgently needed to navigate the evolving uncertainties, so they could keep on delivering safe patient care.

We are committed to being by the side of our Members by offering:

- In-house medico-legal support and expertise – on call to help with any queries that may arise
- One case manager until your matter is resolved
- 80% premium discount in your first year of private practice, with ongoing discounts for up to four years in private practice
- Support in Practice expertise and tailored risk management services
- Complimentary education and resources designed for your specialty

As a specialist Anaesthetist, if you join MDA National from 1 January 2021, you are eligible to receive a 15% discount on your Membership and Professional Indemnity until 30 June 2022*

Request a quote

*This offer is only open to eligible Anaesthetists, being those who satisfy the eligibility criteria. This offer applies over two policy periods - the first policy period being 1 January 2021 to 30 June 2021 and the second policy period being 1 July 2021 to 30 June 2022. The availability of this offer is subject to change. The offer may be withdrawn at any time and without notice. The insurance policies are subject to the terms and conditions and all exclusions and limitations that are applicable to the policies. This offer is not available to existing members. Financial products are underwritten by MDA National Insurance Pty Ltd (ABN 38 000 026 875) at level 10, 8-10 Market Street, North Ryde, NSW 2113 and the availability and contents of the MDA National, Medical Indemnity Plan are subject to the terms and conditions specified in the MDA National, Medical Indemnity Plan. Product Disclosure Statements (PDS) and Product Information Statements (PIS) (if applicable) relating to the MDA National, Medical Indemnity Plan and this offer are available at www.mdnational.com.au or by contacting us on 1800 011 255.
CONTINUING PROFESSIONAL DEVELOPMENT

2020 CPD timeline and road to 2021

THis YEAR HAS brought about many changes to the way in which participants maintain their continuing professional development (CPD). From cancelled conferences to new emergency response activities, our usual quality improvement excelled to meet the demands of the pandemic’s restrictions.

This timeline was developed for CPD participants to reflect, re-group and refresh on 2020 college operations and consider plans for 2021.

January – new update for 2020

We started the year with four updates to the CPD program including:

• Amendment to the cultural competency activity, relocating to the practice evaluation (PE) category at two credits per hour. This activity has been damaged more than 500 times in participants’ CPD portfolios during 2020.
• New emergency response (ER) activity on cardiac arrest for special pain medicine physicians (SPMP).
• New CPD plan question regarding activities supporting health and wellbeing.
• New PE activity for examiners.

February – submissions to MBA/MCNZ

In February, we provided our submission to the Medical Board of Australia’s (MBA) public consultation on the draft revised Registration standards: Continuing professional development. Our response provided consideration for allowing our program to continue with weighted credits as opposed to purely moving to a time based approach. The MBA will finalize the registration standard in 2021 and submit to the ministerial council for approval.

Discussions began regarding the Medical Council of New Zealand’s (MCNZ) official strengthened recertification requirements for vocationally registered doctors in New Zealand, with the college expected to work towards new requirements with implementation by 1 July 2022.

March – pandemic announced

The World Health Organization (WHO) confirms COVID-19 as a pandemic. College staff including the CPD team start working from home in response to the announcement. CPD participants are affected by added demands in the workplace and their CPD impacted by cancelled events, including our annual scientific meeting (ASM) and travel restrictions.

April – new COVID-19 ER activity

To support members the CPD committee and team developed:

• New COVID-19 airway management ER standard/ activity. This has been extremely well received with more than 3000 fellows claiming participation in their CPD portfolios.
• New webpage “COVID-19 – Information for CPD participants” including a list of key resources and frequently asked questions (FAQ).
  This webpage has so far had more than 3500 page views.

May – adjusting to the new normal

College operations continue with finalising the 2017-2019 triennium, with more than 5000 participants, resulting in 99.9 per cent successful completions. Furthermore, our annual (2019) verification of CPD activities with 450 participants (7 per cent of fellows) also resulted in a high success rate of 99.5 per cent. This continues to be seen as an amazing achievement and highlights the dedication our members have to their professional development.

June – audit ethical consideration

A statement on ethical consideration is included in the CPD handbook, appendix 10 Clinical audit guidelines reflecting the importance of ethical considerations for quality improvement. This aligns with frameworks for the scholarly role activity audit and ensures that everyone respects the rights of patients and their data during quality improvement activities.

July – library and CPD webinar

The college conducted for webinar “Staying current: Library and CPD” based on the workshop originally designed for the 2020 ASM. Bridging off enquiries it was remodelled to give special attention to online resources in consideration of the COVID-19 pandemic. Members can log into Networks to access a recording of the webinar or directly at networks.anzca.edu.au/d2l/home/7635.

August – no 2020 verification

The college agreed not to undertake the 2020 verification (audit) of CPD activities process. This decision acknowledged the challenges in accessing evidence to support completion of CPD activities in new areas brought on by the COVID-19 pandemic. Annual and triennial CPD requirements remain the same; rather no evidence of CPD activities will be verified scheduled by the college for this year. Support continued to focus on members meeting their CPD requirements and sharing available resources. Full details were made available on the website news item – www.anzca.edu.au/news/cpd-news/no-2020-cpd-verification-update.

September – supporting 2018-2020 triennium

Tailored support emails started being sent to the 2018-2020 triennium participants confirming their submission date remained unchanged for 31 December 2020. These emails provide clarification on outstanding CPD requirements and resources on how to meet them.

Participants are encouraged to connect with the CPD team at cpd@anzca.edu.au for additional support.

October – flexibility with ER hands-on objectives

The college agreed to accept virtual and online education sessions (workshops/courses) as an alternative delivery method. This is specifically for the hands-on learning objectives under the ‘Cardiopulmonary Critical Care’ (C3), Cardiac arrest, and Cardiac arrest SFMP ER standards. Education sessions may be recognised for up to 12 months (up to 30 September 2023). Full details were made available on the website news item – www.anzca.edu.au/news/cpd-news/updates-to-cpd-emergency-response-standards.

November – PE unmasked webinar

This second webinar with CPD Committee Chair Dr Debra Devonshire unmasked and demystified the PE resources available and offered practical advice on completing PE activities. Members can log into Networks to access the recording “Practice evaluation unmasked: CPD and library webinar” or directly at networks.anzca.edu.au/d2l/home/7635.

December – preparing for 2021

From 2021, participants will no longer be able to add or confirm any new activities in your CPD portfolio until your CPD plan has been fully completed. Taking a small amount of time to plan CPD for the next three years will assist in ensuring that activities undertaken are meaningful and relevant to members needs. Participants can amend their CPD plan at any time during the triennium. This measure is to avoid the common occurrence encountered when CPD plans are overlooked, and stopping some members from transitioning into our new triennium.

In addition, from next year participants will also notice a change in their annual CPD statements of participation and certificate of compliance. This is to align with the college’s rebranding and all details on statements and certificates will remain the same.

What is 2021 CPD looking like?

Learnings for 2020 will support the 2021-2023 CPD review project group. This review aligns with the program’s cyclic schedule (every five years) and aims to accommodate new regulatory requirements from the MCNZ strengthened recertification requirements for implementation by 1 July 2022 and MBA professional performance framework and revised CPD registration standard (implementation date not yet confirmed).

2018-2020 end-of-triennium update

THE ANZCA AND FPM CPD Program is approaching its final submission date for the 2018-2020 triennium. With just under 1800 participants the submission date remains unchanged at 31 December 2020. As advised in August, the college will not be conducting its annual verification (audit) this year and CPD evidence will not be requested for 2020 activities. The CPD team are sending regular reminder emails to help with ensuring our participants successfully complete their CPD requirements and gain access to their certificate of compliance.

We hope these targeted emails are helpful with outlining any outstanding activities. If you have any questions or concerns about the end of your triennium, or feel you should not be receiving these reminders, please contact the CPD team at cpd@anzca.edu.au.
Support at hand for culture shock

Self matters

This edition’s column addresses the critical topic of supporting our colleagues who join our specialties through the specialist international medical graduate (SIMG) pathway. They are important contributors to the medical workforce, and our college — an inspiring example is our president Dr Vanessa Beavis.

My thanks to Dr Scott Ma and Associate Professor Jill Benson for illuminating the challenges SIMGs face and highlighting supports for their wellbeing, experiences and progress through what can be a bewilderingly complex system. More information about ANZCA’s SIMG assessment process for overseas trained specialist anaesthetist (anaesthesiologist) and specialist pain medicine physicians is at www.anzca.edu.au/education-training/certification-of-overseas-qualifications.

Ideas for future topics and contributors are welcomed to lroberts@anzca.edu.au.

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

Specialist international medical graduates: Supporting the culture shock

Specialist international medical graduates (SIMGs) are substantial contributors to the medical workforce, particularly in areas of community need in both Australia and New Zealand. In Australia, it has been estimated that almost four in 10 of the medical workforce and one half of doctors in rural and remote communities are SIMGs. In New Zealand, approximately four in 10 registered doctors are SIMGs, with greater proportions in rural hospital medicine, psychiatry, and obstetrics and gynaecology.

Doctors migrate with hopes of new opportunities, both professional and personal, but may meet many challenges such as regulation of their ability to practice, cultural differences and expectations, along with social isolation and limited access to healthcare services for themselves and their families. These may be exacerbated by uncertainties such as the COVID-19 pandemic.

Regulatory challenges

Along with navigating the bureaucracy of immigration and employment, SIMGs face processes mandated by the Australian Health Practitioner Regulation Agency (AHPRA), the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ) if they wish to be recognised as a specialist/vocationally-registered doctor. The college’s role in this process is to provide an assessment for comparability against Australian and New Zealand trained anaesthetists or pain medicine physicians. This may require SIMGs to undertake a workplace-based assessment, the SIMM exam and other activities (for example, Effective Management of Anaesthetic Crises (EMAC) to demonstrate comparability). SIMGs also need to negotiate the Australian or New Zealand health system which may have profound differences. Examples include the gatekeeper role of general practitioners (GP), the Pharmaceutical Benefits Scheme, public versus private billing, Accident Compensation Commission funding, a flatter hierarchical structure, and teaching and research expectations.

Socio-cultural challenges

When SIMG is migrate to what to them is a new health system, they must adapt to a different culture and community expectations. This adaptation can be more pronounced for individuals from cultural and linguistically diverse (CALD) groups. Communication for instance extends beyond a command of the English language as information can be “lost in translation” by how words are used (jargon, dialect, slang), and non-verbal signals. They will usually be separated from social networks (family, friends) and find challenges in re-establishing networks in a community that may not meet their cultural, dietary or religious needs. This may be even more pronounced in rural areas, although isolation may also be experienced in large communities.

The need for rapid acculturation to what are sometimes highly emotional and challenging contexts in healthcare may lead to:
- Communication difficulties, potentially experienced by patients and colleagues as lack of empathy
- Perceived loss of professional status due to more equitable workplace relationships
- Reluctance to engage in teaching and learning due to the unfamiliarity of less-didactic, facilitated learning models and concern about attracting negative critics

Supporting SIMGs

Orientation

The 2012 report on the inquiry into Australian registration processes and support for overseas-trained doctors lost in the Labyrinth details strategies to support SIMGs in their orientation to their role, their new work environment and the cultural context in which they are practising. Organisations that welcome SIMGs should establish ways to promote and develop cultural competence, not only for SIMGs caring for patients, but also for staff working with new SIMGs. The college’s PESC Statement on Cultural Competence can be used as a guide to develop these tools.

Peer support

To address the risks of professional isolation and possible changes in professional identity, peer support programs provide a mechanism for SIMGs engagement with others who have navigated the journey before them. As Dr Jerkins and Dr Roberts described in the Spring ANZCA Bulletin, peer support is a way for SIMGs to “bear witness” to the other clinician’s experience, promoting connection and collaboration.

Access to healthcare

Along with being disturbed from social networks, SIMGs may also move away from the healthcare services they have been using for themselves and their families. For some, accessing healthcare for themselves may not have been the norm, and seeking medical or personal help may be considered a sign of failure. In particular, admitting to feelings of anxiety or depression may be considered taboo in the SIMG’s culture of origin. Additionally, doctors may not want to seek help locally, particularly in rural areas, because of the (perceived) risk of confidentiality breaches. Access to telehealth consultations can facilitate improved care in the face of geographic isolation.

Dr Scott Ma
ANZCA Councillor

Associate Professor Jill Benson AM
Director, Health in Human Diversity Unit, Discipline of General Practice, University of Adelaide
General Practitioner, Doctors Health SA
Senior Medical Officer, Migrant Health Service
Medical Director, Kakarrara Wilurarra Health Alliance

Wellbeing resources and emergency contacts

In Australia, the Doctors’ Health Advisory Services provide confidential 24/7 help over the phone or face-to-face. These services are staffed by senior GPs and experienced counsellors trained in doctors’ health. For more information, including how you can access support or learn more about supporting doctors’ health, you can go to the Drskdrs website (drskdrs.com.au)

In New Zealand, there is the 24-hour New Zealand Doctors’ Health Advisory Service Hotline.

ANZCA has confidential and free health and wellbeing resources for SIMGs, fellows, trainees and immediate family members including the 24-hour ANZCA Doctors’ Support Program, go to www.anzca.edu.au/about-us/doctors-health-and-wellbeing.

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

New Zealand: 0800 666 367

Australia: 1300 881 222

Other emergency contacts: Your GP
Lifeline: 13 11 14

References:


Helping anaesthetists to reduce waste

ANZCA Councillor and Chair, Environmental Sustainability Working Group, Dr Scott Ma invited hospital sustainability officers from Australia and New Zealand to share their reflections on how they can assist anaesthetists in promoting sustainable clinical practice in their workplace.

Here, Debbie Wilson, Principal Sustainability Advisor, Health Infrastructure Unit, NZ Ministry of Health explains how anaesthetists can work with their hospital’s sustainability officer to tackle healthcare waste and reduce our carbon footprint.

**AS A SUSTAINABILITY** officer, your work program reaches across all areas. You work with clinicians, administrators, cleaners, allied health professionals, facilities managers and importantly, decision makers governing procurement and supply chain practices. The sustainability officer works across all levels of the health system from policy and strategy down to waste minimisation and recycling interventions and waste audits.

A successful sustainability officer co-leads a sustainability program across a healthcare system and challenges everyday practices when the benefits do not meet the requirements of the quadruple bottom line (people, planet, profit, purpose).

In order to live in a way that conserves precious resources, restores balance, and leaves the planet and environment in a state that supports and sustains life (to live sustainability) we need to change the way we live and work. To achieve a desirable and long-lasting behaviour a deeper shift in attitudes is required. From my experience, and from my research¹, I have learned that people can change their attitudes, which in turn leads to long lasting proven environment behaviour change. I found that one way an attitudinal shift is initiated is by triggering an emotional response. Quite simply, tapping into a person’s emotions gains access into an important connection between thoughts and behaviour. To illustrate, using personal storytelling when you engage with people helps set you on this path to bring more connected to one another and to your surrounding environment. Listening, sharing, and working collaboratively truly does help identify problems, helps find ways to resolve the issues and forms the basis for ongoing work in the world of sustainable healthcare practice.

Working in acute areas such as operating departments or intensive care units is often where you experience the most frustration with the business as usual operating model. This is because these areas use a lot of equipment, a significant volume of consumables, generate up to 30 per cent of the entire waste from a hospital campus and use many specialised pharmaceuticals often with very damaging global warming potential (GWP).

Anaesthetists are amongst the greenest of all when it comes to being active in the emerging field of sustainable healthcare practice. They are at the cutting edge in terms of leading research from capturing the minute details such as life cycle impacts of medical devices and anaesthetic gases, through to the broader and often national focus of carbon footprints of health care systems. In doing so, anaesthetists are shining the light on some very important issues around unsustainable practice and even better, often showing us the way by offering more sustainable alternatives which generate quadruple live benefits.

Sustainability officers and anaesthetists can work very well together. The sustainability officer links anaesthetists to people that may otherwise remain very well together. The sustainability officer links anaesthetists to people that may otherwise remain siloed such as general or non-clinical support services anaesthetists to people that may otherwise remain siloed such as general or non-clinical support services managers, procurement agents, or likeminded sustainability advocates from across the hospital campus.

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**Examples of shared interests and focus areas**

- Waste reduction: recycling, reusable versus single use instrumentation, reusable gowns, third party reprocessing.
- Protocols: questioning practice around linen use, stock levels, office paper use.
- Safer pharmaceutical practice: examining and measuring the environmental impact of clinical decisions around volatile agents and anaesthetic gases, sedatives, and analgesics.
- Work environment: number of air changes, set temperatures, lighting controls and lighting levels.

Sustainability officers have the time to assist in gathering the data required and to write the necessary reports and business cases, making the case for change. This level of support makes it easier for anaesthetists (and others) to work in a more environmentally conductive way.

By working closely with anaesthetists, sustainability officers gain access to teams, departments and a whole range of environmental issues that would otherwise be less accessible. Sustainability officers working in the setting of health need to be accessible and responsive to the dynamic complex adaptive health system to reap the rewards available and to optimise the value of working in a unique and challenging environment with some of the most incredible and highly skilled leaders in the healthcare workforce.


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**Taranaki DHB reduces its anaesthesia-related carbon footprint**

Taranaki District Health Board’s anaesthesia department has been committed to reducing emissions of volatile anaesthetic agents, particularly desflurane since 2017 due to their significant greenhouse effect. Volatile usage is audited on a monthly basis and they have reported a reduction in emissions of 82 tonnes CO2e over the four-year period to date (see figure 1). This is the equivalent of 15 transatlantic flights for each of the 21 anaesthetic consultants per year. This has been achieved following a number of educational interventions to both consultants and registrars and the purchase of improved computerised pump programs and small-bore infusion tubing to facilitate widespread use of total intravenous anaesthesia with propofol.

Figure 1: Greenhouse gas emissions from volatile anaesthetic agents at TDHB CO2e GWP100 (tonnes)

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**Debbie Wilson**

Principal Sustainability Advisor, Health Infrastructure Unit, NZ Ministry of Health

If you have any ideas for future articles, or want to share your story, please email us at enviro-sustainability@anzca.edu.au

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*The Taranaki DHB sustainability team (from left) Dr Michael Buch, Dr Andrew Holder (middle back), Maria Cashmore Sustainability Lead (middle front) and Dr Duncan Brown.*
WA anaesthetists champion green action

IN 2016-17, VICTORIAN public health services generated approximately 0.81 megatones of greenhouse gas emissions from stationary energy. This is about 10 times the carbon footprint from the stationary energy used by all Victorian government offices1.

With the net zero emissions (NZE) target set for 2050, it’s evident that improving the healthcare sector’s performance is a must and some organisations have already started work on achieving the proposed target. Although a power purchase agreement (PPA) to procure clean energy has the potential to offset a significant portion of emissions, it would be insufficient to offset the overall emissions within the health sector. For example, emissions related to procurement, transportation and distribution of goods require a thorough assessment of suppliers and reporting them is optional in Victoria. The reality is very few health services report on them due to lack of resources to deliver such analysis.

Therefore, if we are to achieve the Victorian government’s NZE target, we will require a monumental effort to improve performance and rethink strategies. That’s where the sustainability officer’s role comes in. It will be a requirement for every health service to allocate resources, engage sustainability officers and create sustainability committees. One of the most important elements will be to create multi-disciplinary teams to bridge gaps and align departments towards achieving common sustainable goals. These teams should focus on the effective design of NZE and climate change strategies, setting specific targets to be delivered.

“With the net zero emissions (NZE) target set for 2050, it’s evident that improving the healthcare sector's performance is a must and some organisations have already started work on achieving the proposed target.”

With the support of the sustainability officer, teams will need to embed NZE into their strategic plans and adequately distribute resources between operational improvements, project implementation, data analysis, reporting, and so on. Health services will need to work together to go above and beyond the implementation of the Department of Health and Human Services (DHHS) sustainability guidelines in capital works. In co-operation with DHHS best practice guidelines will be developed to support planning and implementing strategies. Many services continue to achieve great outcomes despite the absence of a sustainability officer. However, engaging a full-time professional would provide further opportunities to capture and report reliable data, improve operational and financial performance and reduce environmental impact. In regional areas services that don’t have a sustainability officer could team up to share the benefits.

Anaesthetists, other specialists and doctors, and hospital staff can contribute to sustainability in health care by:

- Writing to the CEO requesting a sustainability officer and sustainability committee.
- Developing research in an area of expertise in the context of sustainability (for example, waste increase in theatres due to COVID-19, influence of theatre gases on environment).
- Requesting, initiating and supporting the implementation of sustainable practices in the workplace including theatres and wards. Be innovative and take action. Check out www.greenhospitals.net

Carlos Machado Sustainability Co-Ordinator Western Health

Reference

DESPITE THE CHALLENGES

Faced every health service in 2020, it has been a year of progression and to support environmental sustainability in the South Metropolitan Health Service (SMHS) in Western Australia.

Led by anaesthetists, the multidisciplinary “Green Theatres Group” (established in 2013) at Fiona Stanley and Fremantle hospitals has helped to shape the path of this critical area of healthcare.

In 2019 passionate anaesthetists joined a highly engaged senior executive group to form an environmental sustainability steering committee (SMHS). A sustainability framework for SMHS was born out of this, providing a structure to progress at a site-specific level and an expectation that this is now core business within SMHS’s hospitals. SMHS also became a member of the Global Green and Healthy Hospital Network, aligning with international best practice approaches and ensuring the health service regularly joins state, national and international conversations.

Environmental sustainability has been identified as a key priority in the SMHS Strategic Plan, and 2020 has seen our health service fund and employ a dedicated sustainability officer on a permanent basis—the first position of its kind for a public health service provider in WA.

Fellows Dr Adam Crossley and Dr Jennifer Liddell said: “It was clear to us that as clinicians needing to promise patient care, even with our enthusiasm and hard work, we could only progress sustainability initiatives so far. Having executive support to employ a sustainability officer is a huge step forward. It means we can use our knowledge and experience to help others across the service and affect change at a much greater speed.”

Within the first four months of commencing in her post, SMHS Sustainability Officer Adrienne Wehr has already achieved a great deal. There has been a focus on stakeholder engagement at all levels across the health service and with other state government entities.

There has been strong collaboration with hospital facilities management staff and the hospital’s waste management provider to further minimise waste. The establishment of site-specific interest groups at each hospital site within SMHS has harnessed the enthusiasm and commitment of a broad range of staff to improve communication, share knowledge and support the implementation of new initiatives which support the framework.

“There is a real feeling of culture change, with environmental issues moving to the forefront of people’s minds,” said Dr Crossley.

Anaesthetists continue to drive environmental change within operating theatres and support changes in other departments. Notable perioperative achievements have been the removal of 1300 single-use plastic anaesthetic drug trays per month and commencement of syringe and PVC recycling.

Successful uptake and expansion of PVC recycling to all theatres, has seen volumes increase three-fold in recent months. In a landmark decision, the Fiona Stanley Fremantle Hospitals Group (FSFH) anæsthesia department recently voted to remove desflurane from all theatres, which is expected to be achieved in the first quarter of 2021. Desflurane has the worst greenhouse gas impact of all current volatile agents, and does not offer any clinical advantages other than adequately outweigh this. With this decision FSFH anaesthetists are leading the way as a teaching hospital and clearly demonstrating that they recognise the need to take action against climate change. The example set by anaesthetists is being used to encourage clinicians in other specialties.

SMHS Chief Executive Paul Forden said there was a real commitment across the organisation to drive opportunities to reduce its environmental impact.

“As management, our responsibility is to make change at a broader level and ensure we are supporting our staff in their efforts. Employing a sustainability officer has enhanced our ability to provide direction and help build a culture which prioritises the environment.”

SMHS will continue to build a coordinated approach between facilities management, executive and clinical staff to broaden the reach of initiatives, to embed sustainability as core business and to support keen staff with new innovations.

Achieving the goal of employing a sustainability officer will undoubtedly prove to be key to ongoing successes and we believe that establishing this role should be a priority for every health service nationwide.

Dr Adam Crossley FRCA, FANZCA Consultant Anaesthetist, SMHS

Dr Jennifer Liddell FANZCA Consultant Anaesthetist, SMHS

Adrienne Wehr Sustainability Officer, SMHS

Dr Adam Crossley FRCA FANZCA Consultant Anaesthetist, SMHS

Dr Jennifer Liddell FANZCA Consultant Anaesthetist, SMHS

Adrienne Wehr Sustainability Officer, SMHS

Moving towards a net zero emissions target

“With the net zero emissions (NZE) target set for 2050, it’s evident that improving the healthcare sector’s performance is a must and some organisations have already started work on achieving the proposed target.”

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Carlos Machado Sustainability Co-Ordinator Western Health

Reference
Environmental Sustainability Library Guide

A new guide on environmental sustainability is now available via the library. The guide highlights a number of resources, including those created by the college and its environmental sustainability working group.

This includes the environmental sustainability audit tool, ANZCA Council statement on climate change, and the professional document P564 – Statement on environmental sustainability in anaesthesia and pain medicine practice.

The guide also includes relevant articles from clinical journals, articles from the ANZCA Bulletin, apps, e-books, and links to legislation and policy regarding climate change, waste, and clinical waste.

- Access: libguides.anzca.edu.au/enviro

Updated library orientation page

The ANZCA Library offers a wide variety of resources, with access to over 900 e-journals, 12,000 e-books and 5000 print books. In addition, the library subscribes to a number of special medical databases including Ovid Medline, Trip Pro, AccessAnaesthesiology and Therapeutic Guidelines. It also offers document delivery and literature search request services – all free-of-cost to the user.

If you’re not sure where to start, then the Library Orientation page offers a good overview of the available resources and how to access them.

Recommendations for users are based on your member type, status and location, and includes the following sections:

- Resources for all users.
- Anaesthesia trainees.
- Pain medicine trainees.
- DHM trainees and diplomats.
- Supervisors of training and medical educators.
- College fellows and CPD participants.

Who can use the library?

Full library services and resources are available to all active college fellows and trainees; diving and hyperbaric medicine (DHM) trainees and diploma holders; non-fellow continuing professional development (CPD) program participants; specialist international medical graduate (SIMG) members; and retired fellows.

ANZCA | FPM applicants have online-only access to library resources with full access to all services once they are registered as a trainee.

You can access the Orientation Guide via the Library home page, or at: www.anzca.edu.au/library/library-orientation-guide
New titles in the library

**Anesthesia equipment, 3e**

**Emergencies in anaesthesia, 3e**

**Gray's anatomy, 42e**

**Principles of physiology for the anaesthetist, 4e**

**Personalized medicine in anesthesia, pain and perioperative medicine**

**Anesthesia for otolaryngologic surgery**

**Understanding medical education: evidence, theory, and practice, 3e**
Mirror on society – is health even close?

A LEGAL CHALLENGE in the University of Otago Medical School’s admissions scheme has led to a flurry of media attention and commentary over the last couple of months throwing up big discussions about why we need the policy named by Otago as the “Mirror on society”. It has also prompted ANZCA and many other medical colleges, to lend their support to the policy.

In September 2020, a father, who has name suppression, took the University to court over the Mirror on Society policy, which is designed to boost Māori, Pasifika, refugee and low socioeconomic medical student numbers.

The man filed a civil case against the university after his child, who did not fit a special category, was denied entry to its medical program, despite the student’s results translating into an average of more than 92 per cent.

It’s been reported that for the 2020 intake, 120 of the 202 places available to first year health sciences students went to those entering under special categories. Of those, 79 (39 per cent) were Māori and Pasifika.

But the court case brought up a dispute that murmurs along annually. Despite the challenge being settled out of court with no compensation and no commitment from the university to change the admission process, the university has acknowledged the case highlights the “desirability of increased clarity and transparency” in its admissions process.

It could be argued that the reason we need the policy might be best summed up by the Medical Council of New Zealand chair, Dr Curtis Walker who quotes the latest Medical Workforce Survey (2019) which shows, “…Māori at 3.8 per cent of the workforce just exceeded the 16.5 per cent proportion of the population. And while colleges have been working on ways of capturing those graduates into their specialties, the spectre of a cut in numbers has not been welcomed.

The MCNZ has recently published the Allen & Clarke report Baseline Data Capturer: Cultural Safety, Partnership and Health Equity Initiatives (2020) which clearly established the case for greater investment in cultural safety and health equity training during pre-vocational, vocational training and recertification processes.

Norming culturally safe practice and a commitment to health equity into the health sector will require a three pronged approach:

- A fit for purpose medical education for cultural safety.
- A commitment by medical colleges and regulators to embed these practices in our pre-vocational and vocational training and accreditation processes.
- A growing number of Māori and Pasifika doctors.

ANZCA argues that medical schools and medical colleges are uniquely placed to help grow the numbers of Māori and Pasifika doctors through policies such as the mirror on society policy and other affirmative action practices.

The ongoing debate and the court case have also left medical colleges nervous as the Otago Medical School has been remarkably successful in growing the number of Māori doctors. At times the graduation numbers have exceeded the 16.5 per cent proportion of the population. And while colleges have been working on ways of capturing those graduates into their specialties, the spectre of a cut in numbers has not been welcomed.

The University of Otago has stated the policy named by Otago as the “Mirror on society” was not a “proposal for change”.

The University has since said the number of Māori special entry spaces to 56 students for each of the primary and final trial oral courses but there was a larger cohort of trainees registered due to the first sitting being cancelled, and more hospital sessions needed to be organised to have enough places for everyone.

Many thanks to all the trainees expressing their gratitude to all involved.

Primary refresher course

A course that is traditionally held face to face at the college was another that needed to be held online via Zoom. There was a huge attendance of 129 trainees from across all the states and NZ logged on for sessions each day over the two-week period in November. Presentations were also recorded and are accessible to those that are registered to watch at their leisure which has proven a valuable resource.

Many thanks to all the presenters that delivered their talks in what was already an extremely busy time. All received positive feedback from those who registered.

Reference


Save the dates

Victorian Registrars’ Scientific Meeting – Friday 22 January from 1-6pm

Once again we are offering a prize for best presentation on the day in each of the following two categories: scientific research project or audit research project. To participate please send in an abstract of 250 words in either category, and or register your attendance contact vic@anzca.edu.au.

Final Refresher Course – Monday 8 to Friday 12 February

Scheduled to be held at the college but dependant on restrictions this may move to an online delivery. The program consists of 22 lectures that cover many of the core curriculum topics that are potentially included in the final exam. It is specifically designed to assist candidates in their preparation for both the written and oral examinations. The trainees are also given some updates from library/resources and ANZCA staff members during the program.

Final Anatomy Course – Monday 15 February

There will be four anatomy-based lectures in Lower and upper limb anatomy of the spine and its attachment, head and neck, and anatomy of the heart and lungs. This course complements the Final Refresher Course to assist candidates in their preparation for both the written and oral examinations.

Introduction to Anaesthesia – Friday 26 February

A course for our Victorian introductory trainees and resident medical officers aspiring to be trainees and anaesthetists. Presentations will cover: welfare of anaesthetists, introduction of TIPS/WRAs, curriculum, updates on college resources, Victorian Trainee Committee, ASA, and survival guides – hearing stories from other trainees. A significant part of the course is run by trainees for trainees, and is an opportunity for trainees to network and forge friendships.

Save the date

Melbourne Winter Anaesthetic Meeting – Saturday 31 July and Sunday 1 August

Keeping with tradition, our annual ANZCA/ASA combined CME meeting will be held on the last weekend in July at the Sofitel on Collins, Melbourne. Please contact us via email at melbourne@anzca.edu.au or call +61 3 8317 5513 with any questions.

Save the dates

- NSW Winter Meeting, Hilton 19 June 2021
- NSW Spring Meeting, Laura 20-21 November 2021
- NSW Anatomy Workshop 27 November 2021
ANZCA Bulletin Summer 2020

Flinders Medical Centre Wellbeing Fellows

Dr Jenny Bird and Dr Julia Cox

this we are heading in the right direction.

generated many ideas for us to bring back to our hospital and ANZCA. There is still a long

burnout, medicolegal considerations and suicidal doctors with specialist panel discussions

prominent psychiatrists with a wealth of experience in doctor’s health. Key topics included

Health SA and guest speakers included Dr Maura Kenny and Dr Anne Sved-Williams, two

The workshop was co-ordinated by Dr Roger Sexton, Medical Director of Doctors

to attend a half-day workshop in November.

The Doctors for Doctors (D4D) workshop is an initiative set up by Doctors Health SA. It is

challenge, particularly in high risk specialties such as anaesthesia.

COVID-19 pandemic. Knowing how to recognise and manage wellbeing issues remains a

exhaustion and cynicism in 47.5 per cent of medical professionals and this was before the

Wellbeing remains as important as ever. Beyond Blue’s 2013 survey found emotional

Doctor's Health SA and Northern Territory Rotational Scheme (SANTRATS) trainees during September 2020.

Due to the COVID-19 crisis, an unprecedented number of vacancies and large number of applicants required a plethora of volunteer SA/NT consultants to assist with many rounds of resume and reference checking, scoring, shortlisting and interviews.

Of the 137 applications received, two consultants who were involved in the selection process for the 2021 South Australia and Northern Territory Rotational Scheme (SANTRATS) trainees during September 2020.

The selected SANTRATS trainees will commence in February 2021 and rotate through hospitals in South Australia and Northern Territory as part of the rotational training scheme.

SA FPM Presentation – Real Time Prescription Monitoring

A presentation via Zoom was delivered to the FPM Specialist Pain Medicine Physicians on Real Time Prescription Monitoring (RTPM) on 14 September 2020 by Kevin Montgomerry (RTPM Project Manager and Manager, Drugs of Dependence Unit). It was an opportunity for fellows to gain an understanding of SA’s RTPM system (ScriptCheckSA) which is expected to be released across SA in March 2021, and to provide feedback on the ScriptCheckSA training and education with regard to when prescribers should consider patient referral to specialist pain services.

Viva practice sessions

We would like to thank all the coordinators and volunteers who have generously given their time in training primary and final exam practice viva sessions at the hospitals, private anaesthetic groups and college.

The SA FPM presentation generated many ideas for us to bring back to our hospital and ANZCA. There is still a long way to go to improve the management of doctor’s health but with support programs like this we are heading in the right direction.

For more information on the D4D workshop or for access to some excellent wellbeing resources please visit d4ds.com.au.

Dr Jenny Bird and Dr Julia Cox

ANZCA Provincial Fellows

Finders Medical Centre Wellbeing Fellows

RIACT Course 2021

We’re excited to put together the Readiness for the Initial Assessment of Anaesthetic Competency Training (RIACT) for the incoming ANZCA introductory trainees in 2021, in collaboration with the RPI, SGH and FSH Departments of Anaesthesia. Based on the successful UK model, this hands-on course will cover the basics of skills, competencies and crisis management for novice anaesthetists and will be held over three days in the first six weeks of the training year. We will keep departments updated with dates for the course and further developments.

For further information or if you have questions, please contact Mike Robbins Michael.Robbins@health.wa.gov.au or Archana Shrivathsa Archana.Shrivathsa@health.wa.gov.au.

CME Events in 2021

Planning for our two WA CME events in 2021 is now well under way. The ACE Autumn Scientific Meeting will be held at the University Club, The University of Western Australia (UWA) on Saturday 27 March 2021. The meeting will be convened by Dr Archie Shrivathsa and Dr Charlie Ho, and the program and online registration will be available soon. Also please “save the date” for our annual country conference at Bunker Bay, to be held 22-24 October 2021.

We look forward to seeing you at both events.

Dr Wally Thompson Prize

The Dr Wally Thompson Prize in Anaesthesiology 2020 has been awarded to Vincenzo Figliomeni, congratulations to Vincenzo. The Postgraduate Prize in Pain Medicine 2020 has been awarded to Tessa Clifton, congratulations to Tessa.

SANTRATS interviews

The SA/NT Regional Office would like to thank all SA/NT consultants who were involved in the selection process for the 2021 South Australia and Northern Territory Rotational Scheme (SANTRATS) trainees during September 2020.

Due to the COVID-19 crisis, an unprecedented number of vacancies and large number of applicants required a plethora of volunteer SA/NT consultants to assist with many rounds of resume and reference checking, scoring, shortlisting and interviews.

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SA Burnell-Jose conference

Management of perioperative pain: Opioid-sparing anaesthesia, the Holy Grail?

Saturday 4 September 2021

For further information, please contact sa@anzca.edu.au.

Australian Capital Territory

2021 Scan and Ski Workshop

After the unfortunate postponement of this year’s event, we are excited to announce that the Scan and Ski workshop will take place in Thredbo from Thursday 22 July to Saturday 24 July 2021. The workshop will feature world-renowned ultrasound specialists Dr Ross Peake, Dr Alving Chuan, Associate Professor David M Scott, Dr Peter Helbard, Dr Andrew Lansdown, Dr Brad Lawther, Dr Bojan Bozic and Dr Chris Mitchell. Hands-on ultrasound scanning and instruction will be held during the morning and evening sessions, leaving the middle of each day free for skiing or sightseeing in the beautiful NSW Snowy Mountains. The workshop will cover upper-limb blocks, lower-limb blocks, trunk, and spinal blocks, among other topics. We are also pleased to announce the inclusion of a CICO (can’t intubate can’t oxygenate) workshop into the 2021 program, to be run by Dr Freya Aaskov.

2021 Art of Anaesthesia CME

Save the date for the 2021 Art of Anaesthesia CME – September 11 and 12 at the Hotel Realm, Barton ACT. The working title of next year’s meeting is “The Occasional Anaesthetist” and the focus for much of the lectures will be refreshers in the main anaesthetic disciplines. Pop the date in your diary now and we look forward to seeing you in Canberra next spring.
COVID-19

Tasmania remains COVID-free since control of the outbreak in north-west Tasmania. This is largely due to closed borders, strong public health measures and good initial compliance from the Tasmanian community while cases were still occurring. The Tasmanian Health Services (THS) has taken the opportunity to develop procedures and processes to deal with any future outbreaks but at this stage these have not been tested and healthcare in Tasmania continues essentially as normal including surgical services in all sectors. There remains some inconsistency in the processes and access to PPE in different regions. The Tasmanian Regional Committee (TRC) hopes the measures are adequate and will work with the THS and the anaesthetic community to focus on staff and patient safety, and the best response to COVID-19.

The TRC welcomes the recent announcement from the THS regarding negotiation of a successful tend for external fit testing in southern Tasmania. This is intended to be rolled out soon and will provide staff in high risk areas including anaesthetists with PPE.

The report from the independent inquiry into the NV COVID-19 outbreak has been released. The conclusions and recommendations (including fit testing) are still being worked through and implemented.

Exams and trainees

The dates and formats for final exam viva 2020:1 and primary exam viva 2020.1 and 2021.2 were finalised and completed. There were a mixture of face-to-face exams and video-conference exams. Mock viva examinations were held in both Hobart and Launceston with thanks to all who have volunteered their time to support the trainees at the end of a difficult year.

The TRC welcomes these developments and wishes all exam candidates success.

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UPCOMING EVENTS

We’re excited to announce these upcoming events

INTERACTIVE WEBINAR
Obstetric anaesthesia you won’t learn from a text book
Tuesday 9 February 2021 | 1-2.30pm (AEDT)

ANZCA NZNC Cultural Safety & Leadership Hui
26-28 February 2021
Whangaparaoa Domain, Bay of Islands, New Zealand

To stand together as one, progress our common purpose

2021 ANZAAG Symposium
"Challenging anaphylaxis"
12-14 March 2021
Sydney Clinical Skills and Simulation Centre and ICC Sydney

For further information on the meetings, please contact events@anzca.edu.au.
Dr Alan John McLintic

1958-2020

DR ALAN JOHN (AJ) MCLINTIC died suddenly and unexpectedly of heart disease on 22 September 2020 aged 62. He was a consultant anaesthetist at Middlemore Hospital in Auckland and an honorary senior lecturer at the University of Auckland.

An old friend and colleague Leyla Sanai summed AJ up as “a consultant anaesthetist, academic teacher, medical ethicist, philosopher, talented artist, musician, bon viveur, iron man, marathon runner, swimmer, mountaineer, skier, rugby player, proud Scot, dry wit, sparkling friend, the cleverest person I knew”.

AJ was born of Scottish parents in Dar es-Salaam, Tanzania. His family returned to Scotland when he was a young boy, and he was raised in Dollar, a small town where he and his sister Anne attended the local school, the Dollar Academy. He was a very good scholar and included learning and persisting until the job was done. And the standard was rarely short of excellent.

He started public speaking at university, and this continued through his career. His talks were keenly anticipated and did not disappoint. He would research the subject extensively and then deliver a talk which was as memorable for the delivery, as it was for the content. His dry wit, self-deprecating nature and ability to hold a broad audience meant that the listeners left feeling enriched and entertained. Alan was particularly good at exposing long-held beliefs as myths and explaining how these misconceptions are perpetuated.

One of the joys of his life included attending scientific conferences and sceptics meetings. He would return home raving with ideas which he would enthusiastically share.

AJ stayed loyal to the club contributing enthusiastically and easily earning two of the most prized of club accolades – a great tourist and a ‘coper’.

AJ was extraordinarily talented in many spheres of his life. He embraced whatever he was doing with incredible energy and dedication. He was not driven by the need to impress others or any particular reward. Rather, the pleasure for him was in the journey that included learning and persisting until the job was done. And the standard was rarely short of excellent.

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Alan was a superb and respected clinician, but his most impressive legacy at work was his teaching. He would have had an influence on almost all the anaesthesia registrars training in the Auckland area over the past 25 years, having tutored the part 1 registrars at Middlemore every Thursday morning.

He taught the “gnarliest” subjects: physics, measurement and statistics. What was really impressive was that even after 25 years, he continued to tweak these tutorials, keeping them relevant and interesting. His recent sabbatical was dedicated to writing a textbook which covered this syllabus.

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Alan started painting in the early 2000s, and in more recent years reduced his time at Middlemore Hospital to develop his career as an artist. He painted, among other styles, beautiful oil landscapes, which many of his colleagues and friends have on their walls. In recent years demand for his work increased and it was exhibited and sold in local galleries. No doubt he could have gone on to make this his sole profession, such was his skill.

He started playing the guitar at school and played in a band in his high school and university years. The band stuck together in spite of living on different continents, and the most recent gig was at one of the member’s 60th birthday. AJ would fly back to the UK for these reunions. At home in Auckland he loved playing music with friends. He organised many memorable musical evenings which involved printing songbooks and encouraging everyone to join in, including those of us with lesser musical ability.

Alan was an accomplished endurance multisport athlete, competing in events for many years, including the iconic Coast to Coast twice! and until just months before he died.

His most recent sporting passion was for golf. His unbridled enthusiasm for playing and practicing was infectious and inspired a group of us to play regularly. The golf epitomised his pursuit of excellence, but he played primarily for the fun of it, and for the joy of forging a deeper connection with friends.

Despite his myriad talents, Alan was understated and modest. He could bring humour to the most mundane of topics. He loved relaxing with friends and discussing issues over a beer. He listened intently, and after due consideration he would respond with a worthy and insightful reply.

Dr Craig Birch, FANZCA
Middlemore Hospital, Auckland

“We are so fortunate to have known him as a friend and a colleague. He enriched our lives and made the world we live in a better place.”

Dr Alan McLintic

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Dr Hubert Desmond O’Brien

OBITUARY

1927-2020

Des O’Brien, as he was universally known to his colleagues and friends, was an anaesthetist of great stature. His early publications in the British Medical Journal on fluothane—a new (in 1956) non-flammable, volatile anaesthetic agent—had a profound impact on the practice of anaesthesia. For the first time, the anaesthetist had a liquid agent which was non-combustible, relatively non-toxic and allowed rapid and clear headed recovery. It changed the practice of anaesthesia at the time and enabled significant advances in neurosurgery and much other surgery particularly where diathermy was required. Des also was at the forefront in anaesthesia for cardiac surgery, first at St Vincent’s in Melbourne and later at Prince Henry in Sydney and St George Hospital. He was a fine teacher. He held leadership positions in the Australian Society of Anaesthetists (ASA) and Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He served with the Royal Australian Air Force and rose to the rank of Wing Commander.

Des was born in St Kilda in Melbourne in 1927, the eldest of five children. He entered medicine at Melbourne University in 1945 and graduated MBBS in 1950. He then became a resident medical officer at Launceston General Hospital in Tasmania in 1951 and 1952.

He started his anaesthesia training as a registrar in 1953 at the Royal Women’s Hospital in Melbourne and then went on to work as a registrar at the Royal Melbourne Hospital in 1954-1955. The director of anaesthesia there was Dr Norman James. Norman James was a major figure in Australian anaesthesia, an excellent teacher and a pioneer of high quality anaesthesia. He had worked in England as an anaesthetist through World War II and was a good friend of Professor Sir Robert Macnab, the first professor of anaesthesiology in Oxford at the Nuffield Department of Anaesthetics, the foremost department in England and world famous.

While at Royal Melbourne Hospital Des obtained his diploma of anaesthesiology (DAA) in 1955. He was later awarded his FFAAC(S) in 1955 when the Faculty of Anaesthetists of the Royal Australasian College of Surgeons was established. At the end of his training at Royal Melbourne, prompted by Norman James, he successfully applied to become a Nuffield Dominion Scholar at the Nuffield Department of Anaesthetics, University of Oxford. He travelled to England where he joined the Oxford department from 1956-57. In 1957 he became first assistant to Professor Sir Robert Mcintosh.

This was a game changer. Many of the world’s leading anaesthetists and heads of departments had gained experience and training at the Nuffield Department in Oxford.

In his role as first assistant to Professor Macintosh, Des gained valuable research experience. He, along with Roger Bryce-Smith investigated the new non-flammable liquid fluothane which had been developed by the British company, Imperial Chemical Industries (ICI) in Manchester. They first experimented with it on dogs to learn its behaviour and then used it on themselves to determine effective concentrations and safety. Their paper in 1956, together with parallel work by Michael Johnstone in Manchester changed anaesthesia at the time. Des prospered in Oxford and gained valuable experience in a wide range of anaesthetic areas. He and his wife Esma enjoyed the Oxford experience but it was not always easy. While a Nuffield Dominion Scholarship was prestigious it was not overly generous. The O’Briens had married in Australia in 1954 and arrived in England in 1956 with an infant daughter and soon had a second to care for. They did however enjoy life and made many friends.

Des returned to Australia in 1958 and joined the staff of St Vincent’s Hospital in Melbourne as assistant director of anaesthesia. The director was Dr RalphClark who had himself been trained in Oxford so Des was at home. Des remained at St Vincent’s until 1966. He became a lecturer in anaesthesia at Melbourne University and was also able to practice some private anaesthesia.

At St Vincent’s Des participated in the development of cardiac surgery at the hospital. Des also began a busy private practice during these years and joined the “Albert Street Anaesthetic Group”. He practiced successfully in Melbourne for eight years. However, in 1966 there was a complete change of direction. Des’s wife Esma, originally from Sydney, was desperately homesick so the decision was made to move back to Sydney where they took up residence in Manly and made a new life.

The move was made easier because Des had established a reputation not only in Melbourne but in the Australian anaesthesia community. He had, while in Melbourne, been active in his profession societies. He had become Victorian chairman of the ASA and had joined the state committee of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. He was popular and Sydney anaesthetists were happy to assist his move.

He was invited to join the prestigious General Anaesthetic Services (GAS) group and became a visiting anaesthetist to St Vincent’s Hospital, Sydney and later the Prince Henry and Prince of Wales Hospitals and to St George Hospital. He remained an anaesthetist to the cardiac surgery unit at Prince Henry Hospital from 1966 to 1992. His practice in Sydney soon prospered and he continued until he retired in 1998 – a total of 32 years. As in Melbourne he became heavily involved in teaching and the ASA and was at different times chairman of both the Victorian and NSW sections of the ASA. He was a member of the many working groups of the ASA and in retirement founded the Retired Anaesthetist Group and was its first chairman.

In recognition of his many contributions in 2005 Des O’Brien was awarded the ASA Presidents’ Medal. Sadly, his marriage to Esma did not survive and they separated and divorced in the 1970s. They had five children together, Louise, Christine, Stephen, Arnette and Luke.

In later years Des met and married Victoria Gillesman, whom he met as a theatre nurse at St Vincent’s Private Hospital. They had a long and loving relationship over 37 years and they travelled widely together, often to Oxford but also to Europe, North America and the East. She cared for him to the end when he died peacefully aged 93.

Dr Donald C. Maxwell, FANZCA
Past President Australian Society of Anaesthetists

References

“This early publications in the British Medical Journal on fluothane...had a profound impact on the practice of anaesthesia.”
OBITUARY

Geraldine Hill

Geraldine Hill was born at King George V Hospital in Sydney on 30 August 1945 to Geoffrey and Thelma “Tommy” Hill.

She attended Ravenswood School at Gordon from kindergarten to being a prefect in final year and completing her leaving certificate in 1961.

She entered medical school at Sydney University in 1962 and for her residency years Geraldine chose Perth. After JRMO and SRMO years she returned to Sydney for a year at Royal Alexander Children’s Hospital. After several years away (including travelling from Nepal to Belgium) and with a diploma in child health, Geraldine changed to anaesthetics and did her specialist training at Winchester and Cardiff. After five years in the UK, Geraldine then returned to Sydney where she accepted a staff specialist anaesthetist position at Sydney Children’s Hospital, Randwick where she worked for 29 years until her retirement in 2006.

During her professional life she joined the Nepal Plastic Team of volunteers to operate on patients with cleft lips and palates and for two weeks each year worked under suboptimal circumstances to improve the lives of children overseas.

Outside of medicine, Geraldine had many interests, including reading, embroidery, craft, theatre and travelling.

Geraldine was a dedicated, skilful and caring doctor. Her work involved anaesthetising newborn babies for heart surgery, premature babies and children in critical conditions. She treated the sickest children in the state with unwavering dedication and compassion. She is well remembered for knitting bootees for pre-term babies in intensive care. Her reputation was excellent, she exuded humanity, kindness, gentleness, generosity, respect, humanity, charm, passion and insight.

Geraldine will be greatly missed and will always remain held in high esteem by her friends, colleagues, and the countless patients for whom she has cared.

Dr Roslyn Ridgway and Dr Robert Turner

“Her reputation was excellent, she exuded humanity, kindness, gentleness, generosity, respect, humanity, charm, passion and insight.”

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