Collaboration in the time of COVID

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These are different and difficult times. Throughout 2020 and 2021, we have been planning for the 50th celebration conference for ASUM. It should have been a time for us to meet collegially, share knowledge and practical tips, and discuss our latest research findings with our colleagues. Fortunately, we have adapted to online learning and we have learned to communicate in a virtual way. Never before has collegiality been more important. We can increase our knowledge from webinars, reading journals online and attending virtual conferences. But the thing many of us miss the most about conference attendance is meeting old colleagues; forging new professional relationships; and building multi-centre research collaborations. As a professional society, ASUM is well positioned to support its members and offers us a place to grow the ultrasound community. In this issue of AJUM, we include three papers that discuss ultrasound practice across institutions.

Firstly, Manivel et al.[1] present the results of a survey that invited emergency department staff across Australia and New Zealand to self-evaluate their preparedness to cope with the COVID-19 pandemic. They found a general lack of preparedness and in particular challenges with infection control. It is likely that patients will continue to arrive at hospitals with both symptomatic and asymptomatic COVID-19 for the foreseeable future as both countries grapple with outbreaks of the delta variant and the desire to allow citizens to move around and between cities, states and countries. The emergency department staff may be the first they encounter, so having adequate preparation at that stage is critical.

Next, Bennett et al.[2] report on their second workforce survey of surgeon-performed ultrasound use amongst registered members of the Breast Surgeons of Australia and New Zealand Society (BreastSurgANZ). They conclude that 'an ultrasound training curriculum as part of the BreastSurgANZ postfellowship training programme is a necessary imperative'. Interestingly, their respondents were divided as to whether this training should be offered by the BreastSurgANZ (52%) or through a certificate of clinician-performed ultrasound (CCPU) programme (31%), but 22% of their respondents reported completing a CCPU programme versus just 10% in 2010 when their initial survey was undertaken. At the same time, breast ultrasound training is increasingly being offered to advanced trainees. Although this survey primarily informs the future provision of surgeon-led ultrasound, there are important parallels with other specialities. Increasingly, medical colleges are requiring trainees to learn bedside ultrasound. The landscape for teaching clinician-performed ultrasound has changed enormously and will continue to do so. Maintaining standards, providing appropriate training and developing supportive collegial relationships are important steps for the entire ultrasound profession.

Lastly, Paoletti et al.[3] conducted a survey about reporting practices in third-trimester ultrasound, including the choice of reference charts and approaches to reporting, and found inconsistencies that have the potential to misdiagnose abnormal fetal growth. They have called for Australian and New Zealand collaboration to develop evidence-based charts that can be widely applied, and this was mirrored by one-third of their respondents using the free text part of the survey to comment upon the need for national standardisation of reference charts used in third-trimester ultrasound and standardised reporting. Given this is a major component of ultrasound practice across Australasia, with its diverse ethnic make-up, this is important to get right.

Collaboration is something that comes naturally to many of us in clinical practice and in research, but less so when it comes to departmental protocols and decisions about which guidelines to use. Some of this is undoubtedly historical and reflects personal preference or training, but a patient-centred approach would ideally lead to the same conclusion reached by different providers. For example, if patients cross a state boundary and have to change providers, it must be alarming if the new provider comes to a different conclusion, based on different charts for determining normality. This is also true when the full ultrasound report is not available and a simple description is included in the patient's letter such as 'the heart is enlarged' without reference to the numeric value of the patient or the reference value used. If we all applied the same reference values, this would make transfer of care much easier. In times, such as these, when we are necessarily restricted to our own geographical location, it is easy for our own practice patterns to be deeply embedded without scrutiny. But let's not lose our collaborative spirit and use this time to undertake research to empower our Australasian ultrasound practice.

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