

25 February 2026

The Hon. Mary-Anne Thomas MP
Minister for Health
Email: mary-anne.thomas@parliament.vic.gov.au

Dear Minister Thomas,

Your statement yesterday on the conduct of a Victorian gynaecologist highlights the distress experienced by many women who may have received inadequate or inappropriate treatment for the management of pelvic pain and endometriosis.

The [Faculty of Pain Medicine](#) of the Australian and New Zealand College of Anaesthetists is the peak body responsible for the education and training of specialist pain medicine physicians, as well as the maintenance of professional standards within the specialty of pain medicine.

The matters you address in your statement are deeply concerning to our fellowship, as allegations relating to patient safety, professional conduct, and potentially inappropriate clinical practice are currently being addressed through statutory regulatory channels.

Women living with persistent pelvic pain are a particularly vulnerable cohort. Many have experienced years of dismissal, delayed diagnosis and fragmented care. Any suggestion that patients may have been exploited or mistreated in this context risks further harm to a group who are already underserved.

Last year, the Faculty of Pain Medicine produced a detailed position statement, [PS15\(PM\): Statement on the Clinical Approach to Persistent Pelvic Pain, Including Endometriosis-Associated Pain](#) (February 2025). The paper was written by a highly regarded group of specialist pain medicine physicians, most of whom are also senior clinicians in the speciality of gynaecology. The document was supported and endorsed by multiple professional and consumer groups, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).

This position statement emphasises that persistent pelvic pain should be approached as a complex persistent pain condition requiring multidimensional, whole-of-person care rather than focusing on a narrow, end-organ pathology model, noting the inevitable emphasis on the surgical removal of lesions that the latter model might promote.

Our statement on pelvic pain and endometriosis (*PS15*) highlights several key risks of a reductionist, lesion-focused paradigm, including delay in provision of symptom-directed care, exposure to low-value or repeated procedures, inequitable funding models and invalidation of the experience of pain suffered by many women.

The statement also notes that surgical treatment of lesions has not been shown to correlate reliably with improved pain and disability outcomes and that, in some circumstances, ill-advised or repeated surgery may worsen outcomes.

The faculty understands that Safer Care Victoria is developing standardised guidance for the diagnosis of endometriosis. We would welcome the opportunity for our statement to inform

that work. In particular, the faculty considers that *our* statement could reinforce the importance of early education and symptom-directed care, prioritisation of multidisciplinary care over single modality treatment, as well as highlighting problems with low-value or repeated invasive interventions and validating women's reported pain, irrespective of lesion status.

The faculty has also commenced constructive engagement with the Victorian Health Department following the recent publication of its report, *Bridging the Gender Pain Gap*. We have already met with the project team and have proposed further collaborative work aimed at embedding contemporary pain science, equitable access to multidisciplinary services and culturally safe pain education into future policy and service design.

Despite the tragic circumstances you reference in your statement, this has perhaps highlighted an important opportunity to align system reform with current evidence from pain medicine.

Your call for urgent meetings with medical colleges to ensure doctors feel confident about speaking up resonates strongly with our own recent work on professionalism. Articles circulated to our fellowship have emphasised that professionalism rests on competence, integrity and the avoidance of low-value or harmful care. Professional integrity further requires that we resist both financial and cultural pressures that might normalise ineffective or exploitative interventions, particularly in areas such as pain medicine where patients are understandably desperate for relief.

If public confidence is to be maintained, it is essential that clinicians are supported to practice in accordance with evidence, to question entrenched but low-value practice, and to speak openly where care falls short of accepted standards. The faculty stands ready to contribute constructively to this dialogue.

I would welcome the opportunity to meet with you or your department to discuss how the faculty's position and ongoing work may assist in strengthening standards of pelvic pain care in Victoria and throughout Australia.

Yours sincerely,



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