ANZCA
FPM

Bulletin

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

SPRING 2025

On the road with the FPM dean

ANZCA Clinical Trials Network

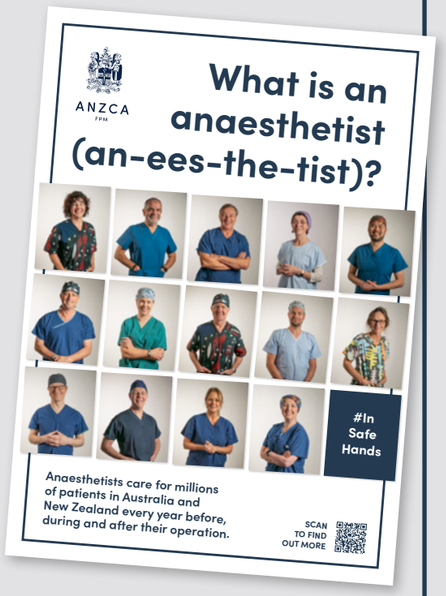
Patients the lifeblood of CTN

Gastric ultrasound

An important skill to have

ANZCA
FPM

Get ready for National Anaesthesia Day!



16 October 2025

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

We've created resources including posters that can be on display all year round, as well as video interviews with college leaders across Australia and New Zealand.

Join in the fun by using the hashtag #InSafeHands.

Visit our website for more information or email communications@anzca.edu.au.

It's not too late to get involved!

ON THE COVER

FPM Dean Dr Dilip Kapur with Port Lincoln Aboriginal Health Service practitioners Natasha Johncock and Maryanne Clements. Photo: Robert Lang

ANZCA Bulletin
The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and specialist pain medicine physicians. ANZCA and FPM comprise about 8900 fellows and 1950 trainees. mainly in Australia and New Zealand. It serves the community by upholding the highest standards of patient safety.

Medical editor: Dr Kate McCrossin
Editor: Clea Hincks
Feature writer: Carolyn Jones
Designer: Michelle Nightingale
Production team:
Liane Reynolds, Siobhan Spence and Greer Sutherland
Advertising manager:
Vivienne Forbes

We encourage the submission of letters, news and feature stories. Please contact *Bulletin* editor Clea Hincks at chincks@anzca.edu.au if you would like to contribute. Letters should be no more than 300 words and must contain your full name, address and telephone number. They may be edited for clarity and length. To advertise please contact communications@anzca.edu.au.

ISSN: 1038-0981 (print)
2206-5423 (online).

ANZCA may promote articles that appear in the *Bulletin* in other forums such as the ANZCA website and ANZCA social media platforms.

Contact us
ANZCA, 630 St Kilda Road, Melbourne
Victoria 3004, Australia
+61 3 9510 6299
communications@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine
+61 3 8517 5337
fpm@anzca.edu.au

FSC
www.fsc.org
MIX
Paper from responsible sources
FSC® C010983

The ANZCA Bulletin has been printed on FSC® certified paper using vegetable-based inks by Southern Impact under ISO14001 environmental certification. It is fully recyclable.

In this edition

ANZCA Education: A hotbed of Venn diagrams

"Education: The path from cocky ignorance to miserable uncertainty."
– Mark Twain

"I'm not stressed, I'm just in 'exam mode.'"
– Me and many others

Education has two of the "big five" ANZCA activities: Training and continuing professional development (CPD). The others being professional documents, safety and quality, and government relations. As always these should be seen as Venn diagrams rather than silos.

Cocky ignorance is where we believe we know a lot, but our knowledge is actually superficial leading to overconfidence. The Dunning-Kruger effect is a close cousin. While there is the certainty of known knowns, miserable uncertainty refers to the anxiety of knowing how much is unknown – both known unknowns and unknown unknowns (thanks Donald Rumsfeld!)

The Australian Government's 2021-2031 National Medical Workforce Strategy has important implications for education at ANZCA. Of interest, this strategy has clearly survived change of government federally and in several states; so is here to stay.

Within the New Zealand Health Workforce Plan there isn't a clear medical workforce strategy except: more doctors and increased scope of practice (magic phrase) for nursing and allied health.

Despite outstanding patient outcomes by world standards, governments want to apply their new magic word "streamlining" to specialist medical education. The latest is an inquiry into streamlining (read: shortening) training (strategic priority three). I am reminded of Chesterton's Fence principle: don't pull down a fence until you know why it was built. That is, making good decisions requires understanding past decisions. So don't shorten training until you know why it is five years. If we consider the increasing complexity of patients, their comorbidity and management both surgical and medical, along with new procedures and technologies, I think we will struggle to cram in all the required technical and non-technical skills and knowledge into five years, let alone fewer, given that government wants a Day-1 FANZCA to be a generalist who can confidently work in regional

Reference: The Australian Government's Department of Health "National Medical Workforce Strategy 2021–2031".

hospitals (priorities two, four and five).

We currently have about 2000 anaesthesia trainees across both countries, about 400 per year of training. We have made headway in reminding government (priority one) that their funding of posts, rather than our accreditation of hospitals, is the major limiting step in expanding training. Through regional and national committees we have been approaching governments about increasing training places, particularly to address the "choke points" of specialist study units (SSUs in ANZCA-speak), notably cardiac and paediatric anaesthesia. We have been challenged by government to justify these SSUs. Subspecialty anaesthesia for cardiac surgery and for many children under two years of age increasingly requires added post-FANZCA training. How much and what type of experience is required for FANZCA training? This is an ongoing discussion.

There is no doubt that exams are anxiety-provoking, largely due to the uncertainty about what we think we know and what the examiners will ask. As many know I personally failed the primary exam twice but later became a primary examiner. These experiences, including being a novice examiner, re-activated my longstanding and occasionally recurring nightmare that I haven't studied for my year 12 maths exam. Despite all this, I am a firm believer that our exams are the least-worst approach to test knowledge in a consistent way from Darwin to Dunedin, that is as unbiased and evidence informed as possible. As I often say to candidates either during trial vivas or my (excellent!) acid-base talks: The examiners want to help trainees demonstrate their knowledge, not trick them. ANZCA has pressure from several directions to increase workplace-based assessments. These have some role but implementability is variable and place added demands on both trainees and assessors, particularly supervisors of training.

I'd be fibbing if I said I joyously fill in CPD data. For doctors everywhere CPD is important, often interesting to undertake, but at times tedious to report. For all CPD homes, requirements are largely dictated by our overseeing bodies: the Australian Medical Council and Medical Board of Australia, and the Medical Council of New Zealand. As with many regulatory demands ANZCA is learning to be increasingly flexible while also having lines in the sand with CPD. We are also more prepared to push back on regulatory demands. I have directly asked the medical board if they would consider returning to a three-year cycle which I think would suit fellows and the college. ANZCA continues to improve CPD and is always happy to consider suggestions. However, ANZCA is not unique in needing fellows to do their bit.

We repeatedly say to governments, and others, that our priorities are high-quality patient care and workforce wellbeing. How ANZCA leads in education is vital for both.

Professor Dave Story
ANZCA President

ANZCA Council approves new strategic plan

At the September ANZCA Council meeting in Wellington, it was pleasing to see unanimous support for our new 2026-2028 strategic plan which will underpin all that the college does over the next three years.

With the purpose of ensuring patients, the public, our members and staff have confidence in the work of the college and importantly for patients, their end-to-end care, the new strategic plan sets out four goals for us to be:

- **A trusted college** that works seamlessly through continued investment in our platforms so that we're digitally enabled, operationally excellent and easy to engage with.
- **A vibrant college,** providing a professional home where specialists choose to belong, contribute and lead throughout their careers.
- A college that pursues **elevated standards,** delivering education, research, and safety and quality advice that transforms practice and creates opportunities for trainees and fellows.
- An organisation with a focus on **improved patient outcomes** and an authoritative voice that shapes health policy and drives system change for better care, both in our regions and internationally.

The development of the strategic plan, now available on the ANZCA website, anzca.edu.au/stratplan, has been a rigorous and detailed process.

Guided by Workwell Consulting's Andrew Hollo, an expert in getting diverse interests to reach a strategically aligned position, there was strong input from our operational leadership teams as well as ANZCA Council and the FPM Board.

The process began with an environmental assessment/scan and took into account government/regulator drivers and the reality of global workforce pressures.

Importantly it was informed by the results of last year's fellowship survey, the top five priorities being:

1. Training for fellowship.
2. Safety and quality.
3. Professional documents, guidelines and statements.
4. Continuing professional development.
5. Representations and submissions to government.

As has been outlined in previous messages, medical colleges continue to face many challenges from governments in Australia and New Zealand who increasingly expect system-wide efficiency, mainly around workforce. The extent of ongoing reform, increasing regulatory requirements and pressure on workforce remains foremost in college activity in responding to these relentless pressures.

Our relationship with government seems to be improving.

Australia's health minister Mark Butler attended an in-person meeting of the Council of Presidents of Medical Colleges (CPMC) at ANZCA House in August.

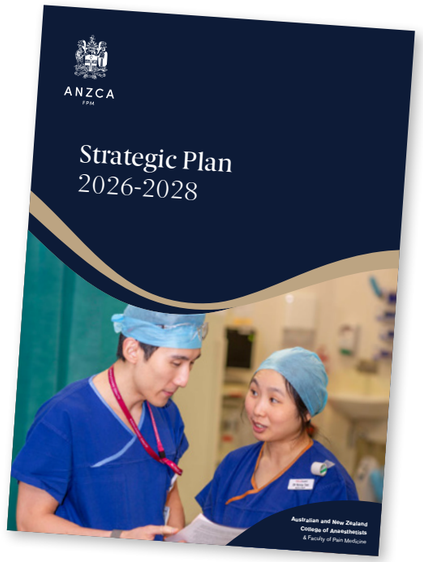
On an extremely busy day for the minister, ANZCA President Professor Dave Story and CPMC Chair Associate Professor Sanjay Jeganathan had valuable one-on-one time with the minister over a quickly arranged breakfast prior to CPMC.

Professor Story is on the executive of CPMC and spoke on their behalf at a meeting of the Medical Board of Australia. He was able to highlight some of the major issues colleges are having with the healthcare reform agenda around proposed changes to accreditation and scope of practice, as well as freezing colleges out of the specialist international medical graduate (SIMG) expedited pathway process, theoretically aimed at getting more doctors into rural areas in Australia.

It is no secret that maldistribution of the workforce is a key, ongoing problem.

One of the ways ANZCA is responding to this in Australia is to develop rural training pathways. We've had constructive conversations with senior health bureaucrats in several jurisdictions, and it's pleasing to see that we're making headway.

Following meetings with Queensland Health, they agreed to fund an additional four advanced trainee positions and we agreed to work with SA Health on workforce needs and gaps across the state in an in-person meeting with SA Health Minister, Chris Picton.



The Victorian Regional Training Network (VRTN) will increase the number of anaesthesia registrar positions, add a pain medicine trainee in Ballarat, and was successful with other funding bids including skills workshops, training meetings and accommodation support for trainees.

In September the college planned to meet with NSW Health and the Health Education and Training Institute (HETI) on possible options to try to streamline NSW anaesthesia rotational scheme selection.

New Zealand National Committee Chair Dr Rachel Dempsey is building on the work of Dr Graham Roper to address workforce issues there.

If we can continue to build our relationships with government, our strategic plan will be that much more effective.

I'd like to especially thank the many key staff members who are working tirelessly to respond on behalf of the college to the ongoing consultations, workshops, working parties and submissions to ensure the voice of anaesthesia, pain medicine and perioperative medicine is heard and advocated for at the highest level of government.

All of this activity is on top of our business-as-usual and places significant pressure on our teams, but they continue to perform to an exceptional standard.

Nigel Fidgeon
ANZCA Chief Executive Officer

College DPA moves

Past ANZCA president, Dr Vanessa Beavis, has been appointed Executive Director Professional Affairs (EDPA) following the retirement of Dr Leona Wilson from the position.

Dr Beavis will be working in her new role from mid-October for two days a week and one day a week as a Director of Professional Affairs (DPA), Assessor. The new appointment means she has stepped down from her part-time role as DPA, Perioperative Medicine (POM). Dr Nina Civil will take over as DPA Assessor (NZ) and and Dr Jill Van Acker will be the new DPA POM.

ANZCA CEO Nigel Fidgeon thanked Dr Wilson, also a past president of the college, for her significant contribution as EDPA over many years. Dr Wilson will continue as DPA, Specialist International Medical Graduates, for two days a week.

The other DPA positions remain unchanged.


Dr Vanessa Beavis


Dr Nina Civil


Dr Leona Wilson


Dr Jill Van Acker

Letters to the editor

DR PETER ROESSLER RESPONDS TO DR PEDRO DIAZ

I thank Dr Diaz for his interest in reading my letter and for his considered comments, which serve to stimulate discussion with a view to initiating research, promoting education and advancing knowledge.

Dr Diaz's quote that "pressure is a force applied perpendicular to the surface over which that force is distributed" reflects common accepted knowledge stemming from the misunderstanding of the P = F/A relationship. If P is a force, then substituting P for F yields F = F/A, which mathematically has no solution and does not make sense, irrespective of which units of pressure are used. It is akin to saying that in the relationship between velocity and distance, the two are the same because the units contain "metres", which appear on both sides of the relationship v = d/t.

Pressure is a scalar quantity with no direction, whereas force is a vector quantity. Pressure is the *result* of the action of opposing (propulsive and resistive) forces.

Newton's first law (law of inertia):

"An object at rest stays at rest, and an object in motion stays in motion with the same speed and in the same direction unless acted upon by an unbalanced external force."

Newton's second law:

"The acceleration of an object is directly proportional to the net force acting on it and inversely proportional to its mass."

Nowhere is there any mention of pressure in either of these definitions of Force. The force generated by a pump is different from the pressure that is generated as a result of the application of forces.

The observation of fluids/gases moving from high to low pressures accounts for the understandable "interpretation" that pressure is the driver. However, if pressure is the driver, it would be difficult (as I imagine it might have been for Isaac Newton) to explain how pressure can be generated in the absence of the application of applied forces.

Regarding the effect of vasoconstrictors on venoconstriction and preload, the effect of the bolus venous blood squeezed into the circulating blood volume is questionable when blood flow is improved with vasodilatation and tissue requirements are reduced concomitant with the reduction in metabolic rate under anaesthesia. The reduction in afterload (resistance work) with vasodilatation has a greater effect on cardiac work and tissue flow. The non-uniformity of vasoconstrictors is fair comment in which case it needs to be questioned as to the appropriateness of using blood pressure measured at a single site as a surrogate or driver of flow through all tissues.

In response to Dr Diaz's contention that metaraminol has β-adrenergic effects, the only vasoconstrictors that have both α and β effects include epinephrine, norepinephrine and dobutamine, with ephedrine having mild positive inotropy. They come at the cost of increasing heart rate and myocardial oxygen requirement. The combination of tachycardia and increased peripheral resistance should not be taken lightly.

Finally, with reference to intraoperative hypotension (modest or otherwise) there is no standard agreed definition, which may be fortunate as blood pressure, although a useful measure, is not the driver of flow. To paraphrase Sir William Osler (with application of my own poetic licence), "Development of the sphygmomanometer was a retrograde step" when it comes to the issue of flow.

Dr Peter Roessler, FANZCA

NOTE THE DIFFERENCE IN BLADES ON VIDEO LARYNGOSCOPES

I read with interest the article in the Winter *ANZCA Bulletin* by Dr Huang and Dr Bowman entitled, "Video laryngoscopy trends and predictors analysed".

An informative article concerning the upsurge in use of video laryngoscopes (VL).

However, no distinction was made of the polar difference between the two blades used for VL.

The MacIntosh blade VL, used with precisely the same technique as direct vision MacIntosh laryngoscopy, confers no mechanical advantage in the case of a difficult intubation – the blades, intubating technique and visualisation is exactly the same, bar the view with VL being on a screen. It is merely a more convenient way of using the traditional MacIntosh blade, saving the operator with an arthritic neck or compromised eyesight.

It enables spectators to witness the procedure and possibly confirm correct placement of the endotracheal tube (ETT).

But the real advance in difficult airway management has come with the advent of the hyperangulated video laryngoscope (HAVL).

Unfortunately, HAVL was not mentioned or distinguished in this article.

The intubating technique with HAVL is completely different from the traditional MacIntosh blade, requiring soft hands.

Learning this very different technique, contrary to that ingrained by learning intubation with a MacIntosh blade, requires 50+ easy HAVL intubations before it should be used for a difficult intubation. This is poorly appreciated in our community.

So the study, while confirming the increasing uptake of VL and comparing various MacIntosh blade VL products, is one-dimensional and of limited significance without considering the huge leap forward made in airway management specifically with HAVL – the game changer.

A traditionally difficult intubation occurs when it's not possible to line up the mouth, oropharyngeal and tracheal axes. In these patients using HAVL, which is an indirect technique where the hyperangulated blade is seeing around the corner, necessitates an ETT shaped exactly to complement the HAVL blade shape, by the use of the curved factory made rigid stylet... UNMODIFIED by previous users. This will deliver the tube every time to the vocal cords, where the stylet is "popped" with the thumb and the tube enters the trachea smoothly if well lubricated.

The truly difficult intubations become routine, bar gross anatomical distortion – I have not experienced a difficult intubation, defined as not first pass and needing to initiate bag mask ventilation before a second attempt, for as long as I can remember.

The latest Glidescope HAVL – slimline with excellent optics – is the pick of VL.

Dr Stuart Skyrme-Jones, FRCA FANZCA


Video laryngoscopy trends and predictors analysed


Francis Xavier Lah

1946 – 2024

THANK YOU DR FRANK LAH

News of the death of Dr Frank Lah should not pass without lamentation and due acclaim for a life well-lived.

I met him as a very junior registrar at Westmead. Every enthusiastic practitioner progressing to a life of excellence in anaesthesia will have been schooled by someone like Frank Lah.

He was a role model who inspired, a boss who instructed without scolding, and an objective realist, who admitted that things can go wrong out of our control and he would inimitably say that "there but for the grace of God go I".

"Anyone could make that mistake," he would kindly remind us, knowing that being wise after the event was unhelpful.

My fondest memories of Frank were his amazing education sessions, where he would stand before us without a single note and talk unscripted for an hour, so well-grounded was his knowledge. In an age when presenters often read their whole lecture verbatim, this interactive, fearless approach was indeed spectacular, inspirational and refreshing.

Reflecting on our own youth and the potential for wonderful role models like Frank Lah to change our lives, we must not forget the healing influence we may exert daily on those now following us to ensure we reach out with all our humanity to those who might be struggling.

RIP to all who recently passed. Frank Lah, Fraser Capill, John Paull, Tim Grice.

Dr Alan Sexton, FANZCA

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

ANZCA and government

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

Progress on key training and pathway issues

AUSTRALIA

Advocacy for increase in Queensland advanced training positions

In May 2025 ANZCA wrote to Queensland Health's director general with recommendations on anaesthesia training in Queensland, highlighting bottlenecks that limit the number of trainees and the number of qualified specialist anaesthetists working in the state. The letter requested that Queensland Health funds and implements an extra 17 training positions each year across Queensland from 2026.

ANZCA, the Queensland Anaesthetic Rotational Training Scheme (QARTS) and the Queensland directors of anaesthesia group have been working together to ensure a clear pathway for Queensland trainees and identifying which hospital sites have been flagged to have projected deficits of training positions.

As a result of our correspondence, ANZCA, QARTS and the Queensland anaesthesia directors group chair met with Queensland Health twice in July 2025 to discuss and better understand these workforce issues.

Queensland Health agreed to an additional four advanced training positions this year as a result of our advocacy. While not the number we requested it is a good step in the current financial climate, acknowledging the state's workforce issues and establishing a positive ongoing dialogue with Queensland Health. This will be the initial increase in a phased approach looking at training numbers across the state and a potential further increase in future years, together with longer term planning solutions. Queensland Health sees addressing anaesthetic workforce issues across the state as a priority, with particular concern for regional areas. The college and QARTS will work with Queensland Health to inform this longer-term planning.

Meeting with South Australian health minister

The college wrote to the South Australian Minister for Health and Wellbeing, Chris Picton, in October 2024 calling for a pause on the expedited specialist international medical graduate (SIMG) pathway in Australia, and again in November 2024 regarding anaesthesia training in South Australia.

The minister offered to meet with college representatives to discuss the shortage of anaesthetists and the workforce issues in the state. A face-to-face meeting in the minister's office was held in mid-August this year.

Attended by the college president, South Australian fellow and trainee representatives, and a senior staff member of the college, the meeting covered the following:

- How we collaboratively supplement/improve the workforce pipeline for both trainees and specialists, building on what has worked well, what hasn't, and opportunities to build on.
- Subspecialty access pinch points and exposure to cases.
- The importance of the regional and rural anaesthesia workforce and distribution – treating patients locally and ensuring specialists have sufficient training/knowledge to independently treat complex and varied patient care.
- Training hub pathway from universities and medical schools.

The meeting was successful with the undertaking that the college would work with the South Australian Department of Health to review and plan workforce needs and gaps across the state and the college further reviewing subspeciality access requirements.

Update on Commonwealth Government Specialist Training Program (STP) funding for 2026

STP funding is critical to the college providing and enabling training posts and program supports in anaesthesia and pain medicine (particularly in rural and regional areas). Following the conduct of the Commonwealth government evaluation of STP in late 2024, and caretaker conventions associated with the federal election in early 2025, there was a significant lag in government decision and advice on STP funding operations and levels for the 2026 hospital employment year.

The college wrote to the Commonwealth in April 2025 to highlight the concerns and impact of the lack of information on the future of STP funding beyond current funding arrangements in creating additional capacity, opportunities and stability in recruitment for 2026 training posts.

This carries the risk of reducing the uptake of funding in rural and regional training sites and, ultimately, fewer trainees in those areas.

In late July 2025, specialist medical colleges finally received advice from the Commonwealth that the current funding will be extended by one year, at existing levels, with an anticipated redesign for the 2027 hospital employment year and beyond to occur over coming months.

This advice was then communicated to ANZCA training sites to help inform 2026 recruitment.

Regarding the STP program review and redesign, the evaluation report conducted in late 2024 found the program needed to be redesigned to improve its focus and responsiveness in line with the National Medical Workforce Strategy priority areas, including better targeting funding to regions and specialties of greatest need, and ensuring trainees are retained in these areas. KPMG will conduct extensive stakeholder consultation in the second half of 2025 – ANZCA will compile a list of stakeholders to inform this review and keep college members updated on the review's status.

Victorian Medical Specialist Training (VMST) 2026 funding grants

The Victorian Regional Training Network (VRTN) was successful in their VMST 2026 funding bids, finalised in August 2025. The program provides funding to:

- Expand medical specialist training opportunities in priority locations and disciplines.
- Encourage the establishment of structured networked arrangements across rural, regional and metropolitan health services.

Only Victorian public health services could apply for the grant; however, following a college/Victorian Department of Health meeting in December 2024 to discuss a range of workforce issues, the department encouraged the relevant health service anaesthesia services to prepare submissions relating to the items discussed in the meeting.

The VRTN was successful in nearly everything they applied for, including:

- Four expansion registrar positions for the VRTN at $110,00 each year for this two-year funding cycle, covering:
    - Latrobe Regional Hospital and South West Health Warrnambool have both agreed to expand to two VRTN registrars in 2026.
    - The other two positions are to be used at other existing VRTN sites – the aim is to reduce the need for independent trainees by having extra trainees on the VRTN rotational scheme.
    - Funding for a pain medicine trainee for Ballarat.
- $15,000 each year for two years to continue running skills workshops and training meetings.
- Accommodation support for 16 trainees ($15,000 each year) – especially helpful for the registrars in their metro year rotation. The accommodation/relocation problem will likely be addressed in the junior doctor enterprise bargaining agreement that is under negotiation.

In 2026, the VRTN will expand to 23 trainees with the first new FANZCAs starting consultant work.

These funding grants are time limited therefore the college will work with the VRTN leading up to the conclusion of funding to document the value of continued funding/positions.

NEW ZEALAND

Health New Zealand/Te Whatu Ora

The updated New Zealand Health Plan, Te Pae Waenga 2024-2027, published in August 2025 after an 18-month delay, is expected to provide a three-year costed plan for the delivery of publicly funded services by Health New Zealand, although the auditor general was unable "to obtain sufficient appropriate audit evidence to provide a basis for an opinion on the plan."

The board of Health New Zealand, disestablished a year ago due to government concerns about budget blowouts, was re-established in late July 2025. The board is chaired by Professor Lester Levy, the commissioner who replaced the former board and was mandated to deliver $NZ2 billion savings. Professor Levy described Health New Zealand as "totally bloated" with bureaucracy, though it is not clear how much of the $2 billion savings he delivered, other than through extensive job cuts throughout the health system. Dr Dale Bramley's appointment as chief executive of Health New Zealand was confirmed for a three-year term.

Health New Zealand continues to prioritise the targets set out in the government policy statement largely aimed at reducing waiting times for elective surgery and tertiary services. The government is intent on increased collaboration with the private sector to address the persistent workforce shortages contributing to long waiting lists. The Royal Australasian College of Surgeons' position statement, *Principles for Outsourcing Planned Care Surgery,* has provided a starting point for discussion with Te Whatu Ora. Health minister Simeon Brown advised Health New Zealand he expected a move towards longer term agreements with private hospitals (10 years). Negotiations for "long-term" surgical service panel agreements of two years, rather than one, are underway.

ANZCA contributed anaesthesia and pain medicine training data to the Council of Medical Colleges to support their development of "a comprehensive picture of specialist training over the last 10 years, including the current capacity to train and anticipated demand for specialists" in response to a request by the Ministry of Health.

The critical shortage of GPs has also prompted approval of the business case for a graduate-entry medical school focused on primary care and rural health at the University of Waikato. The first intake is expected in 2028.

Health legislation

The New Zealand Cabinet's approval of a suite of amendments to the *Pae Ora (Healthy Futures) Act 2022* was swiftly followed by the Healthy Futures (Pae Ora) Amendment Bill. The bill follows the pattern of several contentious bills (Principles of the Treaty of Waitangi Bill, Regulatory Standards Bill and Medicines Amendment Bill) in proposing the removal of long-standing principles, values and language; reversing Te Tiriti-based partnerships empowering Māori; and strengthening ministerial control by removing criteria for ministerial appointments.

It introduces a new infrastructure committee and several new targets, including specialist assessments and elective treatment, that must be included in the government policy statement. ANZCA, together with most medical colleges, opposed the bill, noting that "although it contains important provisions to improve financial accountability, ensure transparency and to address some barriers to an efficiently operating health system, it is underpinned by a fundamental misapprehension of the principles and drivers of population health."

Public health and science

A fourth public research organisation, the New Zealand Institute for Advanced Technology (NZIAT), has been initiated, following the three created by merging the existing Crown research institutes earlier this year: Health and Forensic Science, Bioeconomy, and Earth Sciences. NZIAT's initial focus will be on artificial intelligence and quantum computing.

Life expectancy figures released by Stats NZ show a welcome increase in life expectancy at birth for Māori between 2005–2007 and 2022–2024, although life expectancy for Māori remains lower than that of other ethnic populations. Life expectancy at birth for people who identify as Māori was 75.8 years in 2022–2024, up 3.1 years from 2005–2007, a larger increase than that of other ethnic groups. Male life expectancy has increased faster than for female across all ethnicities.

SUBMISSIONS AND CORRESPONDENCE

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

Australia

- Dental Board of Australia – Revised registration standard and supporting resources for sedation in dentistry.
- National Health Practitioner Ombudsman (NHPO) – Part two of the Processes for Progress review: Draft findings and proposed recommendations regarding specialist medical colleges' assessment of overseas qualified practitioners.
- Australian Medical Council (AMC) – Review of the Standards for Specialist Medical Programs: consultation on scope and direction for change.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) – Colonoscopy Clinical Care Standard.
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – Special Interest Advanced Training module (SIM): Persistent Pelvic Pain.
- World Federation of Societies of Anesthesiologists (WFSA) – Endorsement of the Declaration on Patients' Rights to Labour Analgesia.
- Australian Health Practitioner Regulation Agency (Ahpra) – Supervised practice framework.
- Australian Medical Council (AMC) – Draft framework for managing concerns and complaints about accredited specialist medical training settings.
- Australian Medical Council (AMC) – 2025 Australasian College for Emergency Medicine (ACEM) Accreditation Extension.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) – Draft Credentialing and Defining Scope of Clinical Practice: A guide for managers and clinicians June 2025.
- Royal Australian and New Zealand College of Radiologists (RANZCR) – Draft Anaesthetic Sedation Guidelines.
- Royal Australian College of General Practitioners (RACGP) – Draft National Position statement: General Practice Multidisciplinary Teams.
- NSW government Agency for Clinical Innovation (ACI) – Minimum Standards for Safe Procedural Sedation in NSW Public Hospitals.
- KPMG on behalf of National Health Practitioner Ombudsman (NHPO) - Independent review of NHPO funding model.

New Zealand

- Medical Radiation Technologists Board and Medical Sciences Council – Draft sedation guidance for anaesthetic technicians.
- Medical Council of New Zealand – New Zealand College of Musculoskeletal Medicine (NZCMM) training program.
- New Zealand Parliament Finance and Expenditure Committee – Regulatory Standards Bill plus oral submission.
- Medical Council of New Zealand – Development of new supervision framework for International Medical Graduates.
- Medical Sciences Council – Draft sedation guidance for anaesthetic technicians.
- Medical Council of New Zealand – New Zealand College of Musculoskeletal Medicine (NZCMM) training program.
- Pharmac – Second consultation phase on possible brand changes.
- New Zealand Parliament Health Committee – Healthy Futures (Pae Ora) Amendment Bill.

ANZCA hosts Australian health minister and CPMC

The Australian Minister for Health and Ageing, Mark Butler, visited ANZCA House on 21-22 August as a guest of ANZCA and the Council of Presidents of Medical Colleges (CPMC), where he acknowledged the important role of specialist colleges in the health system.

The meeting included all presidents and CEOs of Australian specialist medical colleges, who meet quarterly to discuss national cross-college relevant items such as workforce, quality of healthcare, patient safety, and the education and training of specialist doctors.

Mr Butler had a casual breakfast chat with the chair of CPMC Dr Sanjay Jeganathan and ANZCA President Professor David Story before the formal day one program began.

Later, addressing the CPMC meeting, Mr Butler spent 45 minutes outlining his second-term priorities including reform of the National Disability Insurance Scheme and programs for children with mild-moderate developmental delays, the final stages of the five-year public hospital funding agreement, private hospital viability concerns, medicines system challenges, and the digitisation of the health system.

Government organisations are regular attendees of CPMC meetings where they provide relevant organisational updates. These include the Australian Medical Council, National Health Practitioner Ombudsman, Medical Board of Australia, Australian Health Practitioner Regulation Agency and the Australian Government Department of Health, Disability and Ageing.

Mr Butler's attendance was a recognition of the CPMC's advocacy to further government collaboration and dialogue.

ABOVE

ANZCA President, CPMC Chair and CEO meet with Hon Mark Butler MP, Australian Government Minister for Health and Ageing and his staff in the Ulimaroa building at ANZCA

Media coverage

ANZCA CLINICAL TRIALS NETWORK (CTN) CELEBRATES 30 YEARS

Professor Tomas Corcoran, deputy chair of the ANZCA Clinical Trials Network Executive was interviewed for ABC Radio Adelaide's *Drive* program on 6 August about the CTN and the Reduction Of Chronic post-surgical pain with Ketamine (ROCKet) trial. The CTN 2025 Strategic Research Workshop was held in Glenelg, South Australia and ABC Adelaide featured a preview segment on the meeting and a seven-minute interview with host Nikolai Beilharz about the ROCKet trial.

CONCERNS OVER OPERATION OUTSOURCING

ANZCA New Zealand National Committee chair Dr Graham Roper was interviewed by Radio New Zealand and Newstalk ZB following an ANZCA media release expressing concerns over Health NZ outsourcing elective procedures to private hospitals. The release was also included in reporting on 12 June by New Zealand Doctor online, MSN New Zealand, the Radio New Zealand website, Scoop, and the *Otago Daily Times*.


Study finds $50,000 spinal cord devices come with serious risks

SPINAL CORD IMPLANTS

FPM's Director of Professional Affairs, Associate Professor Mick Vagg was interviewed for a *Sunday Age* article on 20 July about spinal cord implants. The article followed the release of the largest-ever study of spinal cord stimulators in the *Medical Journal of Australia*. Associate Professor Vagg said he used the devices on a small group of patients "with generally good to excellent results."

NEXT YEAR'S ANZCA ASM

A *New Zealand Herald* article on 4 July featured next year's ANZCA Annual Scientific Meeting in Auckland. The report said nearly 2000 anaesthetists would attend the meeting at the new NZ International Convention Centre which is due to open early next year.

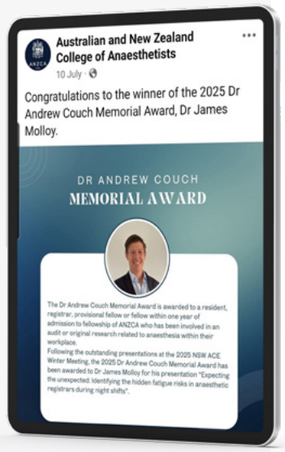
NORTHERN BEACHES HOSPITAL SAFETY CONCERNS

Whistleblowers say warnings about patient safety at Northern Beaches Hospital in NSW have been ignored according to an ABC *7.30* report on 9 June. The report said an anonymous anaesthetist claimed in a confidential submission to a NSW parliamentary inquiry that staffing levels in their department were very unsafe and that on one occasion "we had absolutely zero capacity to deal with any emergency at all during a normal weekday". The anaesthetist warned that after hours "there is no capacity for a third patient, whether it be for an emergency caesarean or an epidural for a woman in labour". Trainee supervision was also falling far below national standards, according to the submission. The anaesthetist wrote that anaesthesia trainees were supervised only four per cent of the time instead of ANZCA's recommended 80 per cent, or a bare minimum of 50 per cent supervision.

What we're talking about online

FACEBOOK

One of the most popular posts on Facebook (based on views) was a post congratulating Dr James Molloy as the winner of the 2025 Dr Andrew Couch Memorial Award. This post received 17,094 views and reached 11,913 people. This was also the most popular post on Instagram with 2228 views and 75 interactions.



Our 2025 National Anaesthesia Day #Insafehands campaign on Facebook featuring videos of ANZCA councillors has also been popular with more than 15,000 views by the *ANZCA Bulletin* deadline.

FPM dean a familiar face to Port Lincoln's First Nations peoples

"If we're serious about improving health outcomes for First Nations peoples and rural Australians, pain medicine must be part of the conversation."

ABOVE

Aboriginal health practitioner Ms Natasha Johncock with Dr Dilip Kapur at the Port Lincoln Aboriginal Health Service. Photo: Robert Lang.

When Faculty of Pain Medicine Dean Dr Dilip Kapur first began working in Port Lincoln, 650 km west of Adelaide, in 2012, pain services for the local community were virtually non-existent.

He had started consulting in the Eyre Peninsula town through an outreach program from a private clinic in Adelaide.

"I already had a connection with Port Lincoln," he explains.

"I knew a lot of people there and I was seeing a few patients from Port Lincoln at my private medical clinic in Adelaide. They'd fly over to see me. One of the allied health practices in Port Lincoln then asked if I'd be interested in doing some consulting work in Port Lincoln. So I started going there once a month."

With Port Lincoln serving a population of about 32,000 – one in six of whom identify as First Nations – the need for dedicated pain services was obvious. But it wasn't until three years ago that Dr Kapur began working directly with the town's First Nations communities through the Port Lincoln Aboriginal Health Service (PLAHS).

In 2021, the South Australian Rural Doctors Workforce Association sought to expand their chronic disease program for First Nations communities and Dr Kapur was invited to provide specialist support.

Since then, Dr Kapur has been travelling monthly to Port Lincoln for consults at PLAHS. According to PLAHS Aboriginal health practitioners Natasha Johncock and Maryanne Clements, "Dr Dilip's" presence as an on-site specialist pain medicine physician has been transformative for many clients.

"Before he started his monthly visits here clients had to be referred to the local Port Lincoln hospital, often facing a wait of up to 10 months just to see a specialist," Ms Johncock explains.

"Now they can have a one-on-one discussion with Dr Kapur about their conditions and that has made a huge difference. Some of our clients come here because they have work accidents or have other issues such as chronic pain caused by spinal cord compressions in their neck. Some of our patients have injuries that go back years.

"When they come here they know it's a culturally safe place and it's important that they feel empowered as patients when they come here."

The clinic provides transport for patients to attend the clinic and sends regular appointment reminders through text messaging and phone calls.

Ms Clements says the number of Aboriginal patients has been steadily increasing with many living with chronic health conditions such as diabetes, rheumatic heart disease and cardiovascular conditions. In First Nations communities pain is a daily reality for many.

While the availability of pain services in Port Lincoln have improved since Dr Kapur's first visit to PLAHS he says the provision of pain services in many other regional centres, including South Australia and across Australia, is still limited.

Pain is a universal experience, yet its burden is not evenly distributed.

"My colleagues in Adelaide for example are keen to expand services, but it comes down to funding. We're doing quite well here in Port Lincoln, but other parts of the state have virtually no provision," Dr Kapur says.

The *ANZCA Bulletin* recently accompanied Dr Kapur on one of his monthly visits to PLAHS. For First Nations communities across Australia, chronic pain is often a silent companion to chronic disease – frequently under-recognised and under-treated.

On the day we visited, Dr Kapur met with several PLAHS clients, all with chronic health conditions.

"Pain is such a common part of chronic disease presentations that if you're looking after chronic illness in any patient population, if you're not addressing pain issues, you will be missing out on treating something that's really important to those who are burdened by the pain," Dr Kapur explains.

"We do know that First Nations people across Australia and New Zealand – and we've got similar data from the United States and from Canada – generally have a higher burden of chronic disease, and importantly the chronic disease that they have is very frequently associated with pain. I see a lot of people with significant long-term illness, and pain is a big problem for them," says Dr Kapur.

"Degenerative disease, arthritis and diabetes are all conditions that are associated with long-term pain problems. And in a community such as this where we have, for example, a very high prevalence of diabetes, we have good care from the staff here, from the medical and allied health staff here, we have specialists coming here, but we've only relatively recently had pain specialists employed here."

Despite ongoing advocacy from local medical and allied health staff, pain medicine has only recently become a regular part of the service offering in Port Lincoln.

"Pain is such a common part of chronic disease presentations that if you're looking after chronic illness in any patient population, if you're not addressing pain issues, you will be missing out on treating something that's really important to those who are burdened by the pain."

"Access to many things that people take for granted in metropolitan regions simply isn't there in regional and remote areas. You have to work out how you're going to deal with that and help patients manage in a less well-resourced setting. That's a positive thing – it helps with prioritising care even when you return to a well-resourced environment."

Patient review surveys conducted as part of ANZCA's continuing professional development (CPD) program have been overwhelmingly positive about the PLAHS service.

"People have been delighted to have a pain specialist here," Dr Kapur notes.

Local GPs have also welcomed the support. Chronic pain comprises a significant portion of general practice presentations – about 22–25 per cent in metropolitan areas, but closer to 30 per cent in regional and remote settings. This is due to older patient populations and higher rates of chronic disease, particularly among First Nations communities.

ABOVE

Port Lincoln is located on the shore of Boston Bay in South Australia's Eyre Peninsula. Photo: Siobhan Spence

"The great majority of the time, my medical colleagues here are doing very well," Dr Kapur says.

"But having specialist backup is useful – not just for medication prescribing, but also for professional reassurance. It's positive for clients and for GPs."

With the need to expand access to specialist pain services in regional and remote centres, the Faculty of Pain Medicine is leading the Flexible Approach to Training in Expanded Settings (FATES) program. FATES, which is funded by the Federal Department of Health and Aged Care, focuses on initiatives that aim to expand specialist pain medicine training in regional Australia. While FATES does not fund pain medicine posts directly, it enables the accreditation of regional and rural training sites, opening pathways for future pain specialists to train in diverse environments.

"There are wonderful opportunities for training in regional, rural, and remote settings," Dr Kapur explains.

"The type of medicine is different. You see people with more advanced disease because local specialist access is limited. The patient demographics are different too – more First Nations patients, different occupations, and a strong sense of independence."

Dr Kapur says the shortage of pain medicine specialists in regional Australia is stark.

"It's extreme. There are no pain specialists in the whole of the Northern Territory for example. Outreach services from South Australia are limited and mostly confined to Darwin and Alice Springs – and even those are intermittent."

The situation, according to Dr Kapur, is similar across other states.

"Regional Victoria is improving as colleagues move into those areas. Regional New South Wales is more difficult. There are visits to some centres, but it's intermittent. It's a big ask – people don't come to places like this for the money. It's more remunerative to stay in city clinics or operating theatres."

Port Lincoln is an eight-hour drive by road from Adelaide. Flying is the faster alternative, but for patients with chronic pain who are unable to access pain treatment closer to home, air travel can be uncomfortable and even prohibitive.

"The planes are small, the weather can be rough, and if you've got post-surgical back pain, for example, it's not a pleasant experience," Dr Kapur notes.

Through FATES, the faculty is laying the groundwork for sustainable, equitable access to pain care across Australia.

"Pain is a major issue in chronic disease," Dr Kapur says.

"If we're serious about improving health outcomes for First Nations peoples and rural Australians, pain medicine must be part of the conversation."

Carolyn Jones
Media Manager, ANZCA

ABOVE

Children's artwork is featured on the walls of the Port Lincoln Aboriginal Health Service. Photo: Siobhan Spence

PILOT PROGRAM FOR FLEXIBLE ACCREDITATION PATHWAYS FOR REGIONAL PAIN MEDICINE UNITS

FPM has received funding from the Australian Government's Department of Health and Aged Care to enhance access to pain medicine training by identifying and approving flexible accreditation models that support rural-based pain medicine training.

The Flexible Approach to Training in Expanded Settings (FATES) project aims to:

- Identify accreditation pathways that support regional based pain medicine training.
- Consider for approval a preferred accreditation pathway to support rural training.

Each regional pain unit is unique. The flexible options are designed to be adaptable to different regional contexts – with different strengths, resources, and community needs – allowing units to choose what works best for them.

Flexible accreditation supports regional training and helps retain doctors in these communities.

The pilot does not include funding for trainee positions. The faculty expects to work with accredited pilot units to explore funding opportunities for trainees when the pilot program has ended.

Feedback and evaluation of the pilot will guide future improvements.

ANZCA launches new Innovate Reconciliation Action Plan

ANZCA is proud to launch its new Innovate Reconciliation Action Plan (RAP) 2025–2027, marking the next stage of our college's reconciliation journey.

Underpinned by the RAP framework of relationships, respect and opportunities, our RAP reflects our ongoing and renewed commitment to our reconciliation vision, supporting Aboriginal and Torres Strait Islander peoples' training and career opportunities, health and wellbeing. This plan builds on the achievements of our first Innovate RAP and outlines clear, measurable actions to drive reconciliation outcomes both within our institution and through our circle of influence.

The 2025–2027 RAP strengthens our focus on:

- Embedding cultural learning into training, assessment, and professional development.
- Supporting and increasing the Aboriginal and Torres Strait Islander anaesthesia and pain medicine workforce.
- Building and maintaining strong and respectful partnerships with Aboriginal and Torres Strait Islander communities, patients, and health organisations.
- Ensuring that Aboriginal and Torres Strait Islander voices guide our work through the Indigenous Health Committee, projects and dedicated working groups.

We encourage you to read the Innovate RAP 2025–2027 on the ANZCA website and consider how you can contribute to reconciliation.

OUR VISION FOR RECONCILIATION

Our commitment to reconciliation and achieving health equity for Aboriginal and Torres Strait Islander peoples is enshrined in our constitution.

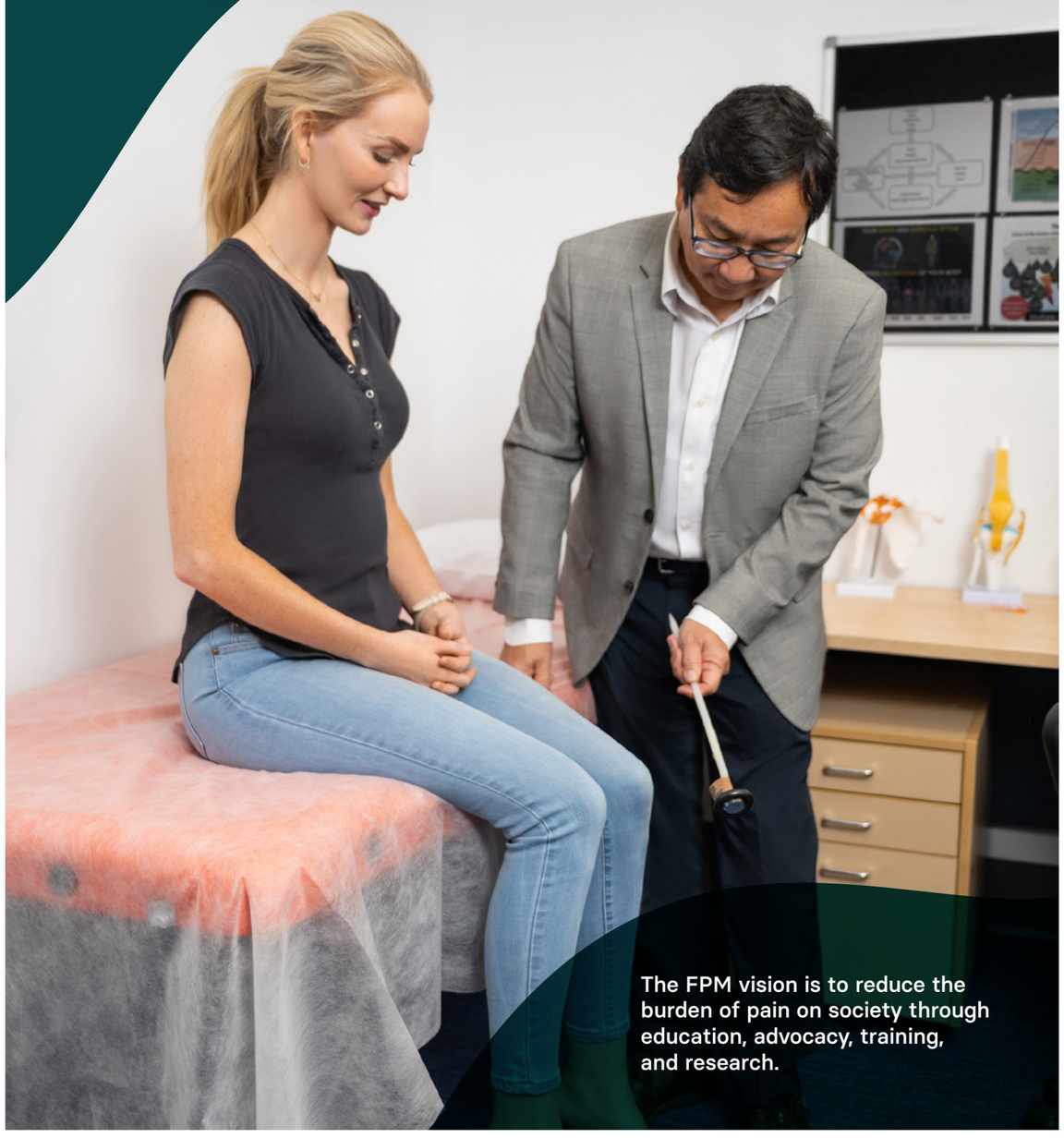
Our vision for reconciliation is an Australian nation where:

- Our shared history is accepted, allowing for a process of recognition and healing.
- All Australians value Aboriginal and Torres Strait Islander cultures and heritage as a proud part of our national identity.
- Equity exists between Aboriginal and Torres Strait Islander peoples and other Australians in all areas, including training, employment and career opportunities, health and wellbeing.

IN THE CONTEXT OF OUR ORGANISATION, THIS REPRESENTS:

- High quality patient care and training in anaesthesia, pain medicine and perioperative medicine that values our shared history and is equitable, culturally safe and free from racism.
- Providing culturally safe and tailored career support that aims to ensure Aboriginal and Torres Strait Islander trainees and peoples interested in a career in anaesthesia, pain medicine and perioperative medicine receive the guidance, mentorship, and resources needed to succeed.
- A workplace that values our shared history and is equitable, culturally safe and free from racism.

Faculty of Pain Medicine



The FPM vision is to reduce the burden of pain on society through education, advocacy, training, and research.

Challenging unproven therapies in an era of declining trust

The three previous articles I have contributed to the *ANZCA Bulletin* explored different dimensions of professionalism in medicine, these being competence, integrity, and self-care. Together, they highlighted how professionalism sustains trust between doctors and patients.

That theme now faces its sternest test.

Across the Organisation for Economic Co-operation and Development (OECD), surveys indicate that more than 40 per cent of people report no or low trust in government and related institutions. Confidence is particularly low among those experiencing financial insecurity, limited education, or discrimination. These groups are heavily represented among people living with chronic disease, including chronic pain. It is unsurprising that they may have particularly low confidence in institutions, including health systems.

Although surveys continue to show relatively high levels of trust in doctors in Australia and New Zealand, there is no reason to assume this position is unassailable. The experience of the US provides a cautionary tale. In 2020, Gallup polling indicated that 67 per cent of Americans viewed doctors positively. By 2024, that figure had fallen to 53 per cent.

Trust, once lost, is difficult to recover.

Several factors contribute to this erosion. Some are related to error. Serious medical mistakes are uncommon, but when they occur they are instantly amplified by a media environment hungry for stories of failure. Headlines portraying doctors as dismissive of symptoms later found to herald life-threatening illness can dominate newsfeeds worldwide within hours. Rare events are presented as common, fuelling suspicion and undermining trust.

A second factor is the modern "infodemic." The World Health Organization defines this as a situation where an overabundance of information, much of it false or misleading, circulates rapidly. This creates confusion and risk-taking behaviour that undermines health.

While the COVID-19 pandemic brought this phenomenon into sharp relief, it is not new. Historians of the 1918 influenza pandemic describe similar dynamics, though modern digital platforms have magnified the speed and reach of misinformation to an unprecedented degree. Patients now often arrive at consultations armed with material of uncertain provenance, some of it persuasive, much of it misleading.

A third factor arises from government policy. Professor Louise Stone has argued that the federal government's enthusiasm for expanding the role of allied health providers in primary care has inevitably come at the cost of eroding confidence in general practitioners. Although her critique focused on primary care, similar tensions are apparent in specialist settings, including pain medicine and anaesthesia. When policy appears to sideline doctors, patients may reasonably wonder whether the system itself questions our value.

This is the context in which pain specialists are asked to provide guidance when patients seek access to unproven or ineffective therapies. The question is: how should professionalism guide our response?

Competence must remain our first obligation. Many patients turn to alternative providers not because they are irrational, but because they have not felt listened to. Demonstrating competence in the consultation, listening deeply, placing the story within its psychosocial and cultural context, and conducting a detailed, expert examination, reduces the allure of simplistic solutions offered elsewhere.

Integrity is equally vital. Patients often request therapies with little or no evidence of benefit, sometimes promoted at high cost by providers with vested interests. Professionalism demands that we resist both financial temptation and the easier path of acquiescence. Saying "no" is not always comfortable, but integrity requires that we stand firm against interventions likely to harm or exploit. In pain medicine, where patients are desperate for relief, our responsibility is to protect as well as to treat. Professionalism is tested most in situations where declining to provide a therapy risks disappointing a patient, yet it is precisely in these moments that our integrity matters most.

Care for the carer also plays a role. It takes emotional energy to empathise with distress and still decline inappropriate requests. The risk of fatigue, cynicism, or avoidance is real. Sustaining professionalism requires deliberate self-care,

boundaries, peer support, and reflective practice. A doctor who remains calm, compassionate, and realistic provides not only a role model but also the relational safety in which difficult truths can be received.

Underlying all these is the social contract of professionalism. Trust in institutions may be faltering, but the patient sitting across the desk still looks to their doctor for honesty, humility, and accountability. If we model these qualities consistently, we help preserve confidence in medicine itself. Professionalism is more than a code of conduct; it is a promise to act in patients' best interests, even when doing so is unpopular or inconvenient.

The proliferation of unproven therapies presents pain specialists with a particular challenge. Meeting that challenge does not require forceful persuasion or paternalism. Instead, it calls for the steady application of professionalism: competence that reassures, integrity that protects, self-care that sustains compassion, and the reaffirmation of our social contract. In this way, we not only steer patients away from poor choices but also contribute to the preservation of the very trust upon which our profession depends.

Dr Dilip Kapur
Dean, Faculty of Pain Medicine

References

1. OECD. Government at a Glance 2025. Paris: OECD Publishing, 2025. Available at: https://www.oecd.org/en/publications/government-at-a-glance-2025_0efd0bcd-en
2. Gallup. Ethics of Professions. Gallup Poll, 2024. Available at: https://www.oecd.org/en/publications/government-at-a-glance-2025_0efd0bcd-en
3. World Health Organization. Infodemic management: WHO framework. WHO, 2020. Available at: https://www.who.int/health-topics/infodemic
4. Stone L. Redistributing trust: professionalism, policy and expanding scope of practice in primary care. Insight+ (MJA), 2024. Available at: https://insightplus.mja.com.au/2024/47/redistributing-trust-professionalism-policy-and-expanding-scope-of-practice-in-primary-care/

News update

2025 NATIONAL PAIN WEEK

The faculty supported National Pain Week from 21–27 July, an annual initiative led by Chronic Pain Australia to raise awareness and improve the management of chronic pain.

This year's theme, "Pain takes a nation", calls for government to make pain a national health priority, highlighting the widespread personal, economic and social impacts of chronic pain.

At the launch event, "The state of pain," FPM Dean Dr Dilip Kapur joined sector leaders to mark the release of the 2025 National Pain Report – the most extensive to date – capturing the lived experience of more than 4500 Australians.

The report highlights challenges in accessing timely care, and the significant impact of pain on work, family life and mental health.

The week also saw the release of Chronic Pain Australia's white paper, a national plan for action shaped by people living with pain.

Director of Professional Affairs FPM, Associate Professor Mick Vagg and FPM Executive Director, Martina Otten, joined Chronic Pain Australia and colleagues across the pain sector at Australia's Parliament House to support the call to recognise chronic pain as a national health priority and a condition in its own right.

The 2025 National Pain report is available on the Chronic Pain Australia website.

ABOVE

From left: FPM Director Professional Affairs Associate Professor Mick Vagg and FPM Executive Director Martina Otten with pain medicine sector leaders at Parliament House, Canberra.

NEW FELLOWS

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

Dr Rohan Karkala Kamath, FFPMANZCA, FRACGP (Vic)

Dr Maleeka Khullar, FFPMANZCA, FRANZCP (Vic)

Dr Melani Mahendran, FAChPM, FFPMANZCA, FRACP (NSW)

Dr Thea Morris, FCICM, FFPMANZCA (ACT)

We also congratulate the following doctor on their admission to FPM fellowship through completion of the Specialist international medical graduate pathway.

Dr Andy Kwok, FFPMANZCA (Vic)

NATIONAL PAIN EDUCATION STANDARDS NEARING COMPLETION

The last few months have seen the Australian Standards for Pain Management Education undergo major consultation as the project moves into its final stages.

From 23 June to 18 July 2025, the draft standards were released for national consultation via an online, open-access survey, inviting feedback from organisations, workshop participants and individuals who had registered their interest.

A total of 164 responses were received, with strong support: more than 94 per cent of respondents endorsed the overarching themes, more than 90 per cent supported the associated standards, and nearly 85 per cent agreed with the detailed criteria.

FPM Project Manager Gen Nolan, who has led the development of the standards, said the results reflected both strong support and recognition of their value.

"These standards are evidence-based and stakeholder-informed, and the national consultation has certainly given a sense that people, organisations and colleges are very keen and see the positive aspects of adopting these standards."

Alongside the national survey, the faculty convened the Pain Management Education Roundtable at ANZCA House in July, welcoming 24 representatives from ANZCA and FPM and other specialist medical colleges. The forum reinforced the importance of strengthening pain education across disciplines. Dr Noam Winter, board sponsor of this project, co-convened the roundtable with FPM Dean Dr Dilip Kapur presenting a discussion on the current state and challenges of pain management education in Australia.

"We know that best evidence-based practice is through multi-disciplinary care," said Dr Noam Winter.

"But it's estimated that up to 80 per cent of Australians living with chronic pain may be missing out on best-practice treatments, and the only solution to that is going to be improving knowledge and health practitioner knowledge."

As the project nears completion attention has turned to the online hub, which will be the central platform for launching and promoting the standards.

The hub will feature background information, downloadable resources and multimedia content to help educators, practitioners and consumers engage with the standards.

To support this work Ms Nolan travelled to Sydney in August to record interviews with members of the Governance Advisory Group, including Nidia Raya Martinez from the Federation of Ethnic Communities' Councils of Australia and Associate Professor Michael Reynolds from Indigenous Allied Health Australia.

Their perspectives on cultural safety and inclusion will form part of the hub's resources, underscoring the importance of ensuring pain education is relevant and accessible for all Australians. Dr Kapur said the breadth of engagement is what makes the project so significant.

"In addition to the incredible professional medical stakeholder input we've had to this project, we've also had vital input from patient groups, from allied health professionals and from people on the periphery in policy.

"The type of work that we're doing here is very important in setting benchmarks and standards," he said. "The standards are a quantum leap from what is out there at the moment, and I'm hoping this will start a much broader process for changing the landscape of pain education."

With FPM Board approval now confirmed, the draft standards will be submitted to the Department of Health on 13 October 2025. In parallel, development of the online hub continues, ensuring Australia's first national standards for pain management education will be launched with accessible, practical resources to support their implementation.

Scan here for more information

ABOVE FROM LEFT

Delegates of the pain management education roundtable at ANZCA House in Melbourne.

Filming Nidia Raya Martinez from the Federation of Ethnic Communities' Councils of Australia in Sydney.

FPM BOARD APPOINTMENTS AND COMMITTEES

The following is a list of FPM individual appointments and chairs of FPM committees. Further details of committee members can be viewed on the website.

FPM Dean	Dr Dilip Kapur
FPM Vice-Dean	Dr Leinani Aiono-Le-Tagaloa
FPM Executive Committee	Dr Dilip Kapur
Training and Assessment Executive Committee	Dr Leinani Aiono-Le-Tagaloa
Professional Affairs Executive Committee	Professor Michael Veltman
Training Unit Accreditation Committee	Dr Louise Brennan
Learning and Development Committee	Dr Tipu Aamir
Examination Committee	Dr Aarathi Vaska
Research Committee	Professor Damien Finniss
Scientific Meetings Committee	Dr Noam Winter
Procedures in Pain Medicine	Associate Professor Mick Vagg
Pain Medicine Journal, Senior Editor	Associate Professor Marc Russo

FPM AUSTRALIAN REGIONAL AND NEW ZEALAND NATIONAL COMMITTEES

Elected national and regional committees act as a conduit between fellows and trainees in the regions and the FPM Board to which they report.

The committees assist with:

- Implementing college policy in their regions.
- Advising FPM Board on issues of interest to the faculty and its fellows and trainees in the regions.
- Representing the faculty and promoting the specialty in the regions.
- Developing and maintaining relationships with key regional stakeholders.
- Training, continuing medical education, and other professional activities at a regional level.

New Zealand National Committee chair	Dr Charlotte Hill
New South Wales Regional Committee chair	Dr Andrew Weiss
Queensland Regional Committee chair	Dr Gunjeet Minhas
South Australia and Northern Territory Regional Committee chair	Dr Irina Hollington
Victorian Regional Committee co-chairs	Dr Louise Brennan Dr Guy Buchanan
Western Australia Regional Committee co-chairs	Dr Alireza Feizerfan Dr Jennifer Morgan
FPM representative on ANZCA Tasmanian Regional Committee	Dr Nina Loughman
FPM representative on ANZCA ACT Regional Committee	Dr Romil Jain

New scholar role activities to support learning

For many years, the clinical case study has been a major barrier to FPM trainees completing the requirements of training within the two years of clinical experience. Trainees will often focus on the examination components of training, with more attention given to fellowship examination and long case assessment. The clinical case study remained the forgotten assessment, left until the very last minute, presenting a major hurdle to the completion of training.

The clinical case study was also considered by many trainees to be an onerous assessment, with little relevance to an individual's own academic interests. Ideally, scholarly activities should build on emerging research in pain medicine while also supporting the creation, dissemination, translation and application of findings to inform improved patient care. In this way, the assessment no longer aligned with the FPM curriculum's scholarly outcomes, which was of course its original intention.

As part of an overarching review of the assessment philosophy and structure of pain medicine training undertaken by the FPM Learning and Development Committee, the decision was made to phase out the clinical case study and introduce a suite of scholar role activities. It was felt that the suite of new activities should provide foundations that scaffold life-long learning in pain medicine, while also contributing to the education of patients and their families/whanau/surrogates, other healthcare providers, trainees, students and the broader population.


FPM

Faculty of Pain Medicine
ANZCA

Scholar role activity guideline – Presentation at a scientific meeting

Introduction

Participation in conferences at a national or international level provides an important opportunity to network with others in the field of pain medicine. Presenting at a conference allows trainees to demonstrate their expertise, research or ideas to a broader audience thereby increasing visibility within their field. The act of preparing and delivering a presentation enhances communication, public speaking and organisational skills while also building confidence in speaking to large groups. In this scholar role activity, you will be expected to prepare and present on a topic at a scientific meeting.

Planning the Presentation

The trainee must select the topic for presentation in consultation with the Supervisor of Training/ Practice Development Stage Supervisor prior to commencing work on the presentation. The topic should be clinically relevant to the department and/or trainee.

Process

In this activity the trainee will be expected to plan, deliver, evaluate and reflect on a presentation for a scientific meeting, including:

- Development of an abstract for submission.
- Development of the presentation which may include an oral presentation and/or poster presentation.
- The Supervisor of Training or nominated assessor will be expected to evaluate and provide feedback on crucial aspects of the presentation including audiovisual, presentation content and modality, prior to the presentation itself.
- The trainee will be expected to complete a self-assessment of own performance reflecting on the feedback received in the evaluation.

This activity provides an opportunity for trainees to submit relevant research to conferences such as the ANZCA Annual Scientific Meeting and FPM Symposium. Eligible trainees may be recognised for their contributions to the field of pain medicine via the FPM Best Free Paper Award and the FPM Dean's Prize.

early during their core training stage which of the six scholar role activities they wish to undertake. This should be discussed with the supervisor of training (SOT) at the first in-training assessment. Once completed, trainees will be able to have their scholar role activity assessed and signed off by their supervisor of training. A trainee may also nominate another fellow within the department to supervise and sign off their scholar role activity.

SCHOLAR ROLE SUITE

In 2025, trainees have been given the opportunity to complete the clinical case study in its existing format or undertake a clinical audit relevant to pain medicine practice. However, from 2026, trainees will have the opportunity to choose from a selection of six distinct scholar role activities:

1. Clinical audit or quality assurance project within pain medicine.
2. Literature review relevant to pain medicine or a proposed research project.
3. Presentation on a subject relevant to pain medicine at a scientific conference.
4. Deliver a series of tutorials or workshops relevant to pain medicine.
5. Demonstrate active contribution to applied research in pain medicine.
6. Enrolment and completion of a university-level subject in either research or education.

WHAT DOES THIS MEAN FOR TRAINEES?

Trainees will have the opportunity to choose education and learning based scholarly activities, as well as research-based activities. It is anticipated that having a variety of scholar role activities will also cater to the heterogenous nature of trainee's backgrounds. It's recommended that trainees decide early during their core training stage which of the six scholar role activities they wish to undertake. This should be discussed with the supervisor of training (SOT) at the first in-training assessment. Once completed, trainees will be able to have their scholar role activity assessed and signed off by their supervisor of training. A trainee may also nominate another fellow within the department to supervise and sign off their scholar role activity.

WHAT DOES THIS MEAN FOR SUPERVISORS OF TRAINING?

From 2026, supervisors of training will be expected to be more actively involved with a trainee's scholar role activity. Guidelines on the requirements to successfully complete an activity will be available in the FPM training support resources area of Learn@ANZCA. Once a trainee has completed their activity, the corresponding evaluation will need to be completed via the ePortfolio. This process will be similar to that required to complete existing workplace-based feedback activities. In most instances, the supervisor of training will be able to sign off completion of a scholar role activity.

2026 IMPLEMENTATION

To support a smooth transition to the new suite of scholar role activities, several resources are currently being developed. In addition to the guidelines describing each activity, video support resources will also be developed for supervisors of training. The scholar role liaison will also be a point of contact within the faculty for both trainees and supervisors of training. The scholar role liaison will be able to provide advice to supervisors of training about the scope and quality of a trainee's project proposal.

In specific situations – such as previous research contribution – publication relevant to pain medicine or completion of a university level subject, a trainee will be able to apply for recognition of prior learning. Further details will be included in by-law 4 in December.

It's hoped that the reinvigorated suite of scholar role activities will ignite a passion for research and education, not only in our trainees, but also our fellows, that will continue to add to the research identity of our faculty for many years to come!

Dr Supriya Chowdhury, FANZCA, FFPMANZCA
FPM Learning and Development Committee

Caution needed with intraoperative methadone use in opioid-naive patients

Global changes in opioid stewardship have led to substantial reforms, including implementation of script monitoring across Australia and reduced perioperative use of slow-release opioids.

Reflecting these changes, ANZCA's *PS41* guideline advises caution with long-acting opioids in opioid-naïve patients, due to the increased risk of inadvertent oversedation and opioid-induced ventilatory impairment (OIVI).[1]

Recent reports to the regional and national committee chairs of the Faculty of Pain Medicine have raised concerns over adverse outcomes following intraoperative intravenous methadone use, specifically in opioid-naïve Australian patients. Methadone's long and variable half-life, as well as its risk of delayed and prolonged respiratory depression, are particular concerns in this population.[2] Some cases have led to significant morbidity and pending medicolegal review. This has prompted the Victorian Perioperative Consultative Council's updates to their "good practice points" in May 2025, which strongly recommend close overnight postoperative monitoring and caution with concurrent sedative medications.[2] Through the Australian and New Zealand Tripartite Anaesthetic Data Committee's WebAIRS an analysis of case reports is pending; however, voluntary reporting may limit data representativeness.[3]

BACKGROUND AND INDICATIONS

The role of methadone in multimodal perioperative analgesia has expanded since 2010, particularly in the US. Interest surged after Kharasch et al. highlighted longer postoperative pain relief with intraoperative methadone compared to sufentanil, although study limitations – chiefly around patient-controlled analgesia (PCA) management and opioid dosing – cast doubt on generalisability.[4,5] The drug's prominence is further underscored by ANZCA FPM's 2025 Best Free Paper Award with an randomised controlled trial in cardiac anaesthesia.[6] Due to its rapid onset, prolonged effect, reasonable cost, and action at both opioid and NMDA receptors, methadone may be a candidate for intermediate and major surgery.[4] However, its utility in overnight or short-stay procedures remains controversial over safety concerns, as intraoperative dosing poses titration challenges and methadone's half-life varies widely (mean ~22 hours; range 4–190 hours), calling for robust large-scale clinical trials.[7,8,9]

CLINICAL BENEFITS AND EVIDENCE

Postoperative methadone may reduce pain scores for up to 24 hours, yet most studies neglect to measure patient-centred functional outcomes.[10] Meta-analyses show that methadone does not meaningfully decrease total opioid consumption or accelerate postoperative analgesic needs versus other opioids; after 24 hours, any pain score advantage disappears. Evidence is therefore insufficient to conclusively support perioperative methadone over established opioid regimens.[10]

DOSING CONSIDERATIONS

Anaesthesia literature describes various methadone dosing protocols, with studies citing either ideal body weight-based regimens (0.1–0.15 mg/kg) or fixed 20 mg doses in adults.[4] There is consensus that opioid doses should be determined primarily by age, given older patients' heightened sensitivity and the drug's unpredictable pharmacokinetics.[1] "Low" mg/kg dosing remains undefined for elderly or comorbid patients given the risks of accumulation and altered metabolism, further complicating perioperative use.

SAFETY, OIVI, AND NALOXONE USE

The current research is limited regarding perioperative respiratory risk. A retrospective study suggested no increased OIVI risk with methadone, but event numbers (just three requiring naloxone) were too low for meaningful conclusions.[11] Weingarten and Sprung note sample sizes of over 20,000 per cohort are necessary to reliably detect differences, while outdated dosing and absent respiratory rate data undermine current studies.[12] The rates of naloxone use following intraoperative methadone or morphine are similar (0.62% vs 0.56%), signalling that approximately one in 200 patients may experience significant opioid-related harm; however, varying definitions of naloxone triggers complicate further interpretation.[13]

MONITORING AND PRACTICE RECOMMENDATIONS

All surgical patients given opioids – including methadone – face risks of OIVI, requiring regular sedation assessment, ideally with sedation scores.[1] Marked variability exists between Australian and international practices for monitoring, reflected in literature and across healthcare facilities.[14] Governance, staff training, and documentation are inconsistent, while technological support remains limited: pulse oximetry is unreliable (especially with supplemental oxygen) and the risk of missed hypoxaemia is high when checks are intermittent. Continuous oximetry and centralised monitoring are rare in Australian general wards or day surgery, and CO_2 monitoring is uncommon.

We believe that for intraoperative methadone use, patient selection should be meticulous, excluding those with sleep-disordered breathing or obstructive sleep apnoea. Routine methadone prescribing demands robust systems – expert oversight, established order sets, workforce training, sufficient staffing – with heightened sedation score monitoring for at least one postoperative night, irrespective of the care environment. Clear communication with nursing staff is vital. Co-administration of other long-acting opioids and other sedative adjuncts should be avoided, and naloxone co-prescription should be mandatory.

While methadone's unique pharmacological profile has prompted renewed perioperative interest, there are safety concerns with insufficient evidence to demonstrate functional benefits over traditional opioids. Until more robust trial data emerge, caution – anchored in vigilant monitoring and multidisciplinary systems – should guide clinical practice for opioid-naïve patients.

Dr Irina Hollington, FFPMANZCA, FPM Board member, SA
Dr Andrew Weiss, FFPMANZCA, NSW

References

1. ANZCA FPM (2023) PS41(G) Position statement on acute pain management 2023. Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. https://www.anzca.edu.au/getattachment/558316c5-ea93-457c-b51f-d57556b0ffa7/PS41-Guideline-on-acute-pain-management
2. Safa, Care Victoria, Victorian Perioperative Consultative Council. https://www.safercare.vic.gov.au/publications/methadone-use-in-the-postoperative-setting-clinical-practice-point
3. ANZTADC Home Page for WebAIRS
4. Kharasch ED. Intraoperative methadone: rediscovery, reappraisal, and reinvigoration? Anesth Analg. 2011 Jan;112(1):13-6. doi: 10.1213/ANE.0b013e3181fec9a3. PMID: 21173206; PMCID: PMC3689220.
5. Gottschalk A, Durieux ME & Nemergut EC (2011) Intraoperative methadone improves postoperative pain control in patients undergoing complex spine surgery. Anesth Analg 112(1): 218-23.
6. https://www.anzca.edu.au/about-us/our-culture/recognising-excellence/fpm-best-free-paper-award Accessed August 2025
7. Komen H et al., 2019. Intraoperative methadone in same-day ambulatory surgery. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC6995343/
8. Myles, Paul S.; Brummett, Chad M. M.D. Consideration of Methadone as an Analgesic Option for Short-stay Surgery. Anesthesiology 139(4):p 374-376, October 2023. DOI: 10.1097/ALN.0000000000004681
9. Schug SA, Palmer GM, Scott DA et al (2020) Acute Pain Management Scientific Evidence 5th edition. Melbourne, Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. https://www.anzca.edu.au/safety-advocacy/advocacy/college-publications Accessed August 2025
10. Cheriyan T, Gaber M, Glenn T et al (2022) Effect of intraoperative methadone vs other opioids on postoperative outcomes: a meta-analysis of randomized controlled studies. Pain 163(2): e153-e64.
11. Lumsden S, Kharasch ED, Speer B et al (2024) Intraoperative Methadone Administration Is Not Associated With an Increase in Perioperative Use of Naloxone: A Retrospective Study. Anesth Analg 138(5): 1145-47.
12. Weingarten TN & Sprung J (2024) Intraoperative Methadone: Safe for Widespread Use? Anesth Analg 139(4): e43-e44.
13. Carlé N, Nikolajsen L & Uhrbrand CG (2025) Respiratory Depression Following Intraoperative Methadone: A Retrospective Cohort Study. Anesth Analg 140(3): 516-23.
14. https://www.safetyandquality.gov.au/sites/default/files/2022-04/opioid-analgesic-stewardship-in-acute-pain-clinical-care-standard.pdf Accessed August 2025

Developing and revising our "prof docs" – a rigorous process

ANZCA and FPM have 51 professional documents and joint statements that are routinely reviewed and sometimes newly developed through a thorough process that calls on latest evidence and the recognised expertise of their authors.

ANZCA professional documents – fondly known as "prof docs" – provide fellows and trainees, healthcare organisations, and our practice community with clearly articulated recommendations and statements regarding the expectations for our practice environment and the roles we undertake.

Their importance is reflected by the rigorous process under which they are developed, including evidence review where appropriate, consultation and expert advice. They are core documents for our profession, must be studied by trainees as part of their training, and particularly support our training hospitals. FPM has similar processes for its prof docs and operates under the umbrella of ANZCA.

Professional documents support the ANZCA Standards for Anaesthesia and FPM's *PS11(PM): Procedures in pain medicine clinical care standard 2020*.

The newly developed appendix to the *CP24 Policy for development and review of professional documents* provides a quick guide to the pathways and approval processes involved in the development and review of ANZCA prof docs.

The *CP24 appendix on ANZCA professional document development pathways* was created to clarify the development process, including which groups are involved at each stage and the specific steps required for different types of document development. The pathways include the development of a new professional document, a formal review of an existing one, or an internal review.

Requests to develop a new prof doc are initially submitted to the directors of professional affairs (DPAs) in the Policy and Communications unit of ANZCA. A clear explanation of the need for the document and the benefits it would provide is required.

When considering whether to proceed, the following factors are taken into account: whether the proposal aligns with the college's purpose, vision, and strategic plan; whether it has the potential to significantly enhance safety or improve outcomes for patients and the broader community; its relevance and importance across the profession and the college; the resource requirements and the organisation's capacity to support the development; and the urgency of the proposed document. The recommendation to develop the new professional document is presented to the relevant oversight committee and council for approval.

Following approval to proceed, a document development group (DDG) is established. An expression of interest for DDG membership is sought via the *ANZCA E-Newsletter* and through relevant organisations including non-anaesthetists.

After initial development or review and oversight committee approval, the documents are circulated for stakeholder consultation for four to six weeks. The feedback received is considered by the DDG and the revised documents are submitted for approval before being piloted for 16 weeks on the ANZCA website. All feedback from the pilot period is taken into account and the resulting documents are submitted for approval. The final versions are subsequently published on the ANZCA website.

The need for review of documents is prioritised based on consideration of the level of significant knowledge or practice change that makes current recommendations outdated. This can include new evidence, a change in scientific evidence, political imperative or new college regulations.

Where there is a significant change in scientific evidence or college policy, a comprehensive review of the existing professional document and background paper is undertaken. A comprehensive review follows the same process as developing a new professional document.

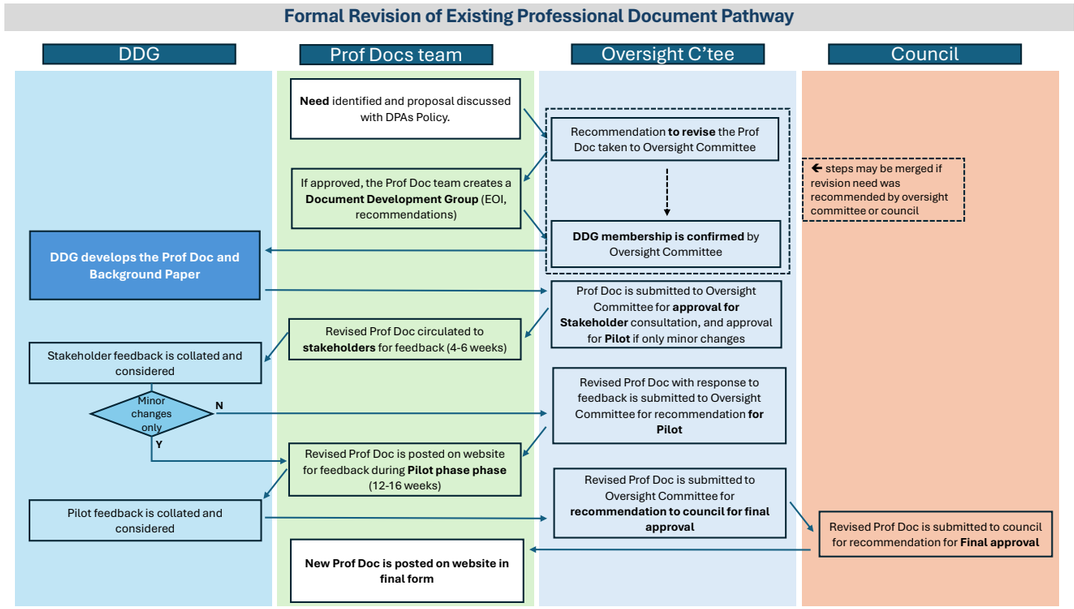
An internal review is conducted when only specific sections of an existing professional document require revision, rather than a full review of the entire document. As such, sections of the document that aren't being revised remain unchanged and are generally not subject to stakeholder feedback.

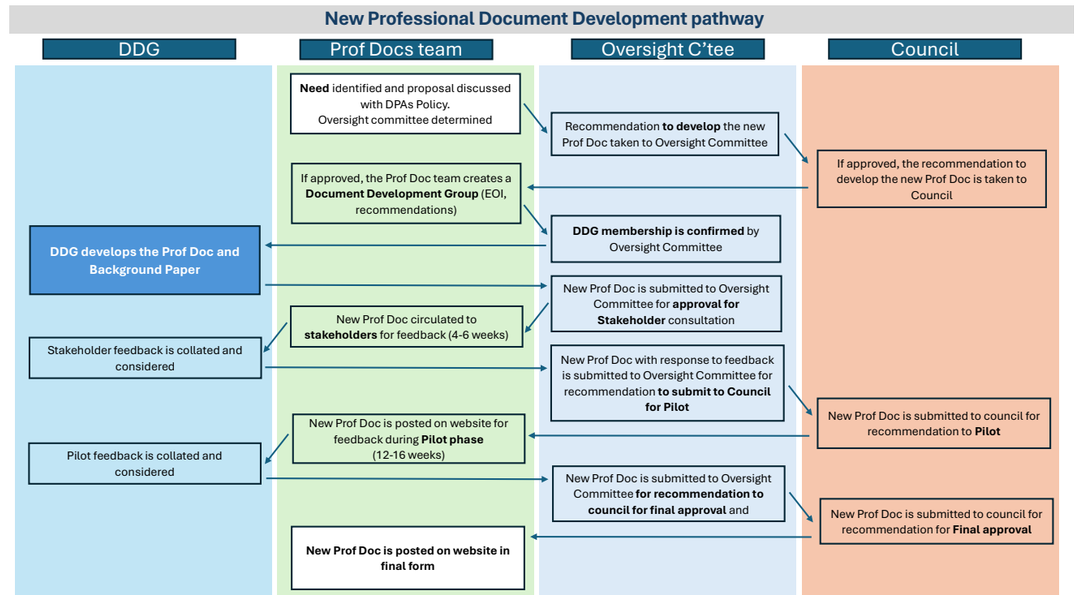
The DPAs lead the internal review, seeking expert input as needed, and submit the revised content to the oversight committee for approval. The review should not result in any change to the overarching policy direction. However, if new or conflicting evidence arises during the internal review, the DPAs may recommend a comprehensive review and refer this to the oversight committee for consideration.

For further information on the professional document process, please refer to *CP24 Policy for development and review of professional documents* and accompanying background paper *CP24BP*.

Professor David A Scott
Dr Michelle Mulligan
ANZCA Directors of Professional Affairs, Policy

"In ANZCA fellowship surveys, our prof docs are consistently in the top three valued roles of the college along with training for fellowship and safety and quality.





Gastric ultrasound training at Gold Coast Health Service

Queensland anaesthetist Dr Patrick Glover explains how he went from being a gastric ultrasound sceptic to a staunch advocate.

If you had asked me what I thought of gastric ultrasound two years ago, you may have noticed my eyes roll a little before I answered. Since then, like many of my colleagues at the Gold Coast Hospital and Health Service (GCHHS), I have radically changed my opinion and gone on to be a strong advocate for every anaesthetist to learn this skill.

Here I explain why by documenting the path we took in our hospital district.

Like many, our journey began with the uncertainty of how to deal with a patient on a glucagon-like peptide-1 (GLP-1) agonist. In 2022 and 2023 multiple cases were submitted via our quality and safety reporting system who were found to have full stomach at endoscopy despite being adequately fasted – the common factor being GLP-1 agonist use. It became clear that this was only going to increase with the popularity of these medications for both diabetes and weight loss.

Like most, we reviewed available guidelines, undertook literature reviews and investigated our options – longer fasting, liquid diets, cessation of medications and use of prokinetics – but all had their issues and the evidence base was weak. Guidelines from various authorities did not fit easily into our hospital protocols or instil confidence that our management of these patients was supported by robust evidence. In early 2024 we decided to investigate gastric ultrasound to risk-stratify our patients.

Our challenge with point-of-care gastric ultrasound (POGUS) were the unknowns. How accurate was it? How easy was it to learn? How many people would be interested in learning it? How much experience should you have before you perform an investigation where aspiration and death could be the result of getting it wrong?

It slowly became clear after an exhaustive review by our quality and safety provisional fellow Kyle Lindfield that POGUS was not new and had a solid evidence base (certainly in comparison to our current standard of fasting preoperatively and trying to infer gastric contents from history or examination). Achieving competency and maintaining currency were our next challenges. The evidence and guidelines around other skills pointed to around 30 scans with supervision for competency (after gaining knowledge and studying cases in a structured course).

"Our aim was to support interested anaesthetists to undertake a formal training pathway facilitated by our department."

ANZCA subsequently released a document *PG47 Guideline on training and practice of perioperative diagnostic point-of-care ultrasound (POCUS) 2025* which will help all departments/practitioners with this initial step.1

Our aim was to support interested anaesthetists to undertake a formal training pathway facilitated by our department. Due to lack of any local training courses and the variable quality of online courses, this process was vital to address governance concerns from all our teams (anaesthesia, nursing and procedural). We wanted to be confident in the investigation and results. It was also important to integrate it into our current quality and safety reporting framework and highlight and review any false negative results (the highest risk error).

There were several sceptics in our large department of more than 109 consultants and a robust discussion ensued.

I have paraphrased their concerns (with a gentle rebuttal) below:

They raised valid points such as:

- *"If you are worried, you should just put an endotracheal tube (ETT) in."*

  Sensible advice, but what about cases where an ETT is impractical or high risk?

  Should we do it for those cases where sedation has obvious advantages (cataracts, endoscopy and transesophageal echoes)? In highly co-morbid patients how will you manage their haemodynamic risks?

  Key point: POGUS simplifies this, if your result is low risk – you can continue with your anaesthetic as you would normally for this surgery/procedure. If it is high risk, you can either optimise (our preferred approach) or proceed with a rapid sequence intubation (RSI) after discussing with your patient and surgeon. This allows you to proceed knowing you had a good justification for the intubation and a solid consent process.

- "Rapid sequence induction (RSI) is routine for us, POGUS is not."

  Unfortunately, every year patients with full stomachs die from aspiration after having an RSI. We have seen this at our institution, and mortality reports from ANZCA and other sources also show this to be the case.[2] This raises the valid question of whether you should put an elective patient on GLP-1 agonist at this risk. Ideally, we should be optimising to avoid this scenario. POGUS allows you to optimise with confidence.

  Apart from aspiration, different induction techniques come with their own subset of risks. Arguably RSI has a higher risk of anaphylaxis, haemodynamic compromise, failed intubations and dental/oral trauma than sedation. These risks should not be dismissed but integrated once you have a firm risk assessment of aspiration.

  Key point: POGUS can help you quantify aspiration risk for the patient in front of you, immediately before the procedure. It can help you weigh those risks for your patient against RSI risks in a way that everyone will understand. POGUS stands out as the only modality that allows you to optimise then check the result to ensure your optimisation has succeeded prior to proceeding.

- *"What about the 5 mm endoscope in ANZCAs guidelines;[5] you can do those awake?"*

  Even if the patient does consent, we barely have enough 5 mm endoscopes in our tertiary centre, let alone our satellite hospitals or in the small private facilities many of us work at.

  Key point: It is hard to argue it is not the gold standard investigation, but at our institution, it is just impractical for most patients. It doesn't help us outside endoscopy.

- *"Don't worry about the 5 mm scope, I'll just get the endoscopist to have a quick look and clear out the stomach first."*

  Two standout problems exist with this logic. First, a patient can aspirate prior to the scope insertion. Second, solid food is hard to suction.

  The primary goal of endoscopy is to visualise the upper gastrointestinal tract. This is challenging if it is covered in food. An audit of our local diabetics having upper endoscopy over four years (unpublished) showed that our patients on GLP-1 agonists had higher rates of procedural abandonment (8.51% vs 1.28%)

  Key point: Even if the patient doesn't aspirate, it still costs our health system more. Repeating procedures instead of targeted optimisation on the day of a procedure is a poor use of our health dollars.

- *"We've been dealing with grey-zone 'fasted' patients for years – emergency cases, opiates and pain pre-op – why the big change now?"*

  Agree, but how often have you had reflux on a laryngeal mask airway or a frank aspiration in a patient who claims to be fasted or you assess as low-risk based on their history?

  A gastric ultrasound study in Europe scanned more than 2000 consecutive patients with even the smallest risk for aspiration (obesity, T2DM, well controlled reflux).[5] It showed high-risk stomach contents in 14 per cent of elective patients and 21 per cent of emergency patients. Perhaps this explains the latest addition in the *Safety of Anaesthesia* report (2018-2020)[2] which notes that aspiration was the cause of death in half the anaesthetic-attributable deaths in Australia, and contains this chilling quote:

  "Anaesthetists should be aware that fatal aspiration can and does occur in well-fasted patients, and not just in cases traditionally deemed as 'high risk'."

  The previous report suggests:[6]

  "The fact that drug anaphylaxis and pulmonary aspiration persist as leading causes of anaesthesia-related death reinforces the need for research into reducing their occurrence." POGUS seems to fit this theme well.

  Wouldn't it be useful to have an objective measure to guide your decision for any patient where you had doubts?

- *"How long is this going to take! I've worked hard to eliminate other delays in patients coming to theatre."*

  Key point: The average time for a scan is three to five minutes, easy scans can be completed in 30 seconds or less. Our experience is that around 10 per cent may need optimisation (in our institution we rely heavily on intravenous metoclopramide) then a re-scan, with a wait time of around five to 15 minutes in between.

  This compares favorably to other options in the latest guidelines (ETT insertion, erythromycin infusion and 5 mm scope).

A 24-hour clear fluid diet, followed by standard 6-hour fasting is less of a delay issue and more of a patient risk/irritation issue. At our institution most day surgery patients are called 15 hours before, making advising most patients of a 24-hour fast impossible without major logistical changes. The risk of extended fasting for brittle diabetics is not underestimated by our endocrinology team. Anecdotally it is unnecessary for 90 per cent of patients on GLP-1 agonists, and patients intensely dislike prolonged fasting.

OUR POGUS PROGRAM

I would encourage every department to consider the benefits of creating a critical mass of anaesthetists comfortable with POGUS. We quickly realised we did not have the local expertise to run the course at GCHHS so we sought the help of Dr Nav Sidhu from North Shore Hospital, Auckland.

Dr Sidhu has published extensively on POGUS[9,10,11,12] and kindly agreed to run a modified version of the course he has been teaching for many years. Combining an experienced trainer with our local faculty was invaluable in rolling out such a course. It allowed us to ask questions and gain knowledge and teaching insights which were vital during the set up and running of our course.

Our course would not be hard to replicate for many departments. It was conducted over one weekend and aimed at completing most of the requirements from *PG47* on the day, with an additional 10 scans supervised either directly or remotely post course. During subsequent courses we have actively encouraged other departments (Tweed Hospital and Sunshine Coast University Hospital) to participate in our mentoring program and attend en masse to build capacity for their own local training.

We conducted post-course meetings and surveys to help understand the weakness of our rollout and how it has affected clinical practice.

The key findings of our survey were that three months after the course 91 per cent of attendees felt more confident dealing with patients on GLP-1 agonists. One hundred per cent would recommend learning gastric ultrasound to a colleague.

To keep the knowledge growing we have held follow-up education sessions on interesting cases, the use of the sip test and the use of prokinetics. We also have a WhatsApp special interest group and have identified new mentors to bolster our support group.

"No other group can take ownership of aspiration prevention like we can in anaesthesia."

From a quality and safety perspective we were keen to keep track of potential issues. We actively sought cases for discussion of learning points, particularly the highest risk false negative scans. We have completed thousands of POGUS scans (1300 reported at the initial three-month review from survey respondents).

I estimate that since the initial course we would have completed 5000 scans on real world patients. We have had two false negatives scans reported at endoscopy, luckily without any adverse outcomes. One false negative involved food that coated the whole stomach in a fine film (suspected low risk of pulmonary aspiration). In the second, the pylorus was mistaken for a closed antrum, but the stomach contained undigested food and fluid, considered high risk for pulmonary aspiration. Both were in our first weeks of experience with the technique. We have altered our teaching to reduce the risks of these errors occurring again.

While initially these cases were a cause for concern, on reflection, we noted that in the two years before our POGUS course where we used fasting status and history-taking to guide our management, we had almost 20 cases of full stomach found at endoscopy across GCHHS. Many argue that anything less than 100 per cent accuracy for POGUS is unacceptable, but we accept this every day when we rely on fasting guidelines and history-taking.

Widespread implementation of POGUS still has its challenges. But during the last year with the publication of guidelines by ANZCA recommending gastric ultrasound for risk stratification in patients taking GLP-1 agonists[3] and clear recommendations on training requirements[1] prior to using this technique, two large hurdles have been removed.

POGUS will be a vital skill for anaesthetists in five to 10 years. No other group can take ownership of aspiration prevention like we can in anaesthesia. My view is that we need to step up and learn something new to improve the outcomes for our patients.

Ask yourself if there was a question that you could ask that would improve your chance of identifying a patient with a full stomach, would you ask it?

Gastric ultrasound allows us to listen to the stomach immediately pre-induction to increase our chance of identifying a high-risk situation – surely as a craft group we should put in the time to master it?

Dr Patrick Glover, FANZCA
Anaesthetic consultant, Gold Coast

References

1. Australian and New Zealand College of Anaesthetist; PG47 Guideline on training and practice of perioperative diagnostic point-of-care ultrasound (POCUS) 2025
2. Australian and New Zealand College of Anaesthetists: Anaesthesia Related Mortality in Australia 2018 – 2020. Editor: S Jenkins.
3. Clinical Practice Recommendations regarding patients taking GLP-1 receptor agonists and dual GLP-1/GIP receptor co-agonists prior to anaesthesia or sedation for surgical and endoscopic procedures, 2025. Australian and New Zealand College of Anaesthetists; Gastroenterological Society of Australia; National Association of Clinical Obesity Services; Australian Diabetes Society.
4. Clinical Practice Recommendation On Periprocedural Use Of GLP-1/GIP Receptor Agonists, 2024. Australian and New Zealand College of Anaesthetists; Gastroenterological Society of Australia; National Association of Clinical Obesity Services; Australian Diabetes Society.
5. Baettig SJ, Filipovic MG, Hebeisen M, Meierhans R, Ganter MT. Pre-operative gastric ultrasound in patients at risk of pulmonary aspiration: a prospective observational cohort study. Anaesthesia. 2023 Nov;78(11):1327-1337. doi: 10.1111/anae.16117. Epub 2023 Aug 16. PMID: 37587543.
6. Australian and New Zealand College of Anaesthetists:Anaesthesia Related Mortality in Australia 2015-2017. Editor: S Jenkins.
7. Pan, X., Chai, J., Gao, X. et al. Diagnostic performance of ultrasound in the assessment of gastric contents: a meta-analysis and systematic review. Insights Imaging 15, 98 (2024).
8. Perlas,A. Arzola,C. VandePutte,P.Point of care gastric ultrasound and aspiration risk assessment :a narrative review. Can J Anaes 2018 65:437-448
9. Erythromycin :Australian Injectable Drugs Handbook, 9th Edition 2025. AIDH - ERYthromycin
10. Sidhu, NS. Anaesthesia Reports 2022 'Water challenge' to improve diagnostic accuracy in gastric point-of-care ultrasound Vol 10,Issue 2 Dec 2022
11. Sidhu, NS. Robertson, K. Anaesthesia Reports 2022. Atypical gastric ultrasound appearance immediately after food intake. Volume 10 issues 2 Dec 2022
12. Sidhu, NS. White, C. Pozaroszczyk, A. Anaesthesia. Development of a direct observation of procedural skills tool for gastric ultrasound. 2022 Jun;77(6):712-714
13. Sidhu, NS. Pozaroszczyk AJ. Australian Anaesthesia 2023. "Do you feel hungry?" Using gastric Ultrasound to eliminate guesswork in perioperative airway management. Pg 115-121. Editor M.Doane

Safety alerts

Safety alerts appear in the "Safety and quality news" section of the *ANZCA E-newsletter* each month. A full list is available on the ANZCA website: www.anzca.edu.au/news-and-safety-alerts

Recent alert:

- Propofol pump software error (20 August 2025)

Anaesthesia delivery systems are not fail-safe

Ensuring the correct function and integrity of our anaesthesia delivery systems is not just a primary examination challenge – it is a core part of everyday anaesthesia.

Anaesthesia machines are a vital part of the safe provision of ventilation for patients under anaesthesia, in addition to the delivery of volatile anaesthetic agents. The current generation of machines differs markedly from the simple "Boyle's machine" with a few rotameters supplying a backbar. Our anaesthetic machines, or workstations, have become increasingly sophisticated and complex over the years and incorporate aspects of monitoring of gas mixtures and ventilatory parameters.

As a result of their complexity and capability, the type of checking needed to ensure safe operation is grounded in internal "self-checks" conducted by the machine's software to assess the correct operation of many internal components and absence of gas leaks. Although checking processes differ between machines, the check also must include components outside the machine such as gas delivery and circuit integrity.

Anaesthesia delivery systems also extend to infusion pumps that deliver anaesthetic agents such as for total intravenous anaesthesia (TIVA).

CHECKING SYSTEMS

ANZCA's *PG31 Checking anaesthesia delivery systems* outlines three levels of checking.

The level one check is a detailed check, performed by trained service personnel, of all systems before being placed into use. This applies to all new systems, as well as all systems after servicing or repair.

The level two check is typically done at least at the start of each anaesthetic list daily or when components of the circuit are changed.

The level three check should be performed before commencing anaesthesia for each patient. The responsibility for verifying that these checks have been done ultimately lies with the anaesthetist using the machine.

Level one and level two checks themselves may be reasonably delegated to suitably trained biomedical, nursing or technical staff; however, level three checks should be performed by the anaesthetist.

The level three checks are an important final safety step, and it must be recognised that if the circuit or components have been changed then their correct function needs to be reconfirmed (that is, a level two check incorporating that new component).

An example of the importance of this was the recent manufacturing error which resulted in plastic film remaining over the patient filter at the Y-piece. This created a complete obstruction at this point and would only be detected by a properly performed two-bag test (or equivalent) with the filter in place. The static semi-automated pressure test on most machines would not detect this. It has been recognised that ANZCA's PG31 is not clear on whether the filter should be in place on the Y-piece (or coaxial tubing) when checking this, and so this was clarified in an advisory [link https://www.anzca.edu.au/news-and-safety-alerts/checking-anaesthetic-breathing-filters-for-obstructions-or-leaks]

LEAKS

WebAIRS has recorded several anaesthesia delivery system-related events, and these will be reviewed in detail in a future issue of the *ANZCA Bulletin.*

Examples include a tubing leak noted just after intubation where a large leak in the anaesthetic circuit was observed. The circuit was inspected and a tear in the anaesthetic tubing was located close to the expiratory port. It was assumed that the circuit had been damaged when the anaesthetic machine was moved. The circuit was replaced and the patient did not desaturate at any stage. The circuit had been checked at the start of the list, but not before this case.

It was recommended the circuit be checked prior to each case as well as at the start of the list. Other cases identify that the tubing can also be split when placed in tight tubing holders. Another incident recorded a leak from an incorrectly seated desflurane vaporiser, which would have been detected during the level two or level three check if performed after the vaporiser was attached.

ALARMS

For anaesthesia machines another area of recent concern is how alarm enunciation is managed. ANZCA is of the view that new high-level alarms (for example, oxygen supply failure or ventilator disconnection) should always be enunciated visually and audibly, even if an "alarm pause" or "audio pause" mode is activated. ANZCA has worked on this issue with manufacturers and, through our representatives, the International Standards Organisation.

There are many more elements to checking the anaesthesia delivery systems, including of course ensuring intravenous connections for TIVA are intact and not leaking and that infusion pumps are correctly programmed with reliable power supplies.

Dr David A Scott, AM
ANZCA Director of Professional Affairs, Policy

PG 31 - CALLING FOR EOIS

To best support and advise current practice, the ANZCA Safety and Quality Committee has approved the updating of *PG31 Checking anaesthesia delivery systems* which was last reviewed in 2015. Anyone who is interested in joining the document development group for this revision should contact profdocs@anzca.edu.au

Blood transfusion safety: The 2022-23 STIR report

Adverse events associated with blood transfusion can be serious, continue to occur and many may be preventable. This is highlighted in the Blood Matters program's *2022-2023 Serious Transfusion Incident Report (STIR)*. The report's contents are of relevance to the broader anaesthesia community.

In the 2022-23 period, 245 notifications of adverse events associated with transfusion were received from 50 health services in Victoria, the ACT, SA and the NT. Of these, 209 reports were validated, with 141 clinical reactions and 68 procedural events. There was one International Safety rating 1 level event. This all occurred in the context of about 332,000 blood components issued throughout the four jurisdictions. In Victoria it was estimated there was one clinical reaction for every 194 units of red cells administered, with reactions less common for other product types.

The 141 clinical reports are classified by reaction type and were classified as depicted in figure 1 (figure 3 from the STIR report, reproduced with permission).

The report has a series of key messages a number of which are relevant to anaesthetists.

Of the incidents, approximately a third were procedural events and two thirds clinical reactions. Positive patient identification was highlighted as important to prevent procedural errors, such as incorrect blood component transfused and wrong blood in tube events. Clinical reactions may not be preventable, however risks to patients can be reduced by ensuring transfusions occur only if there is demonstrated clinical need. Below are some illustrative cases from the report.

CASE STUDY 1

Prescription of blood products

An elderly patient attends a health service for a neurosurgical procedure and is found to have a raised international normalised ratio (INR) – 1.5. The INR was repeated, but fresh frozen plasma (FFP) was prescribed and administered before the result (1.3) was obtained. Fifteen minutes into the transfusion of FFP the patient became itchy, anxious and hypotensive. The transfusion was stopped, treatment administered and a tryptase taken which was later demonstrated to be elevated.

Background – unnecessary prescription

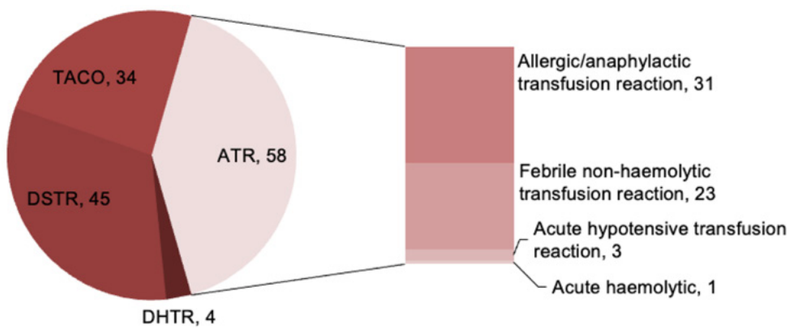
Anaphylaxis to blood products is most often seen with FFP (39 per cent) and platelets (54 per cent). A recent *Blood Matters* audit of FFP usage demonstrated that 42 per cent of FFP use was non-aligned with guidelines.

Relevant to this case the Australian and New Zealand Society of Blood Transfusion (ANZSBT) and the Royal Australasian College of Physicians (RACP) "Top 5 recommendations on low value practices in transfusion", states "Do not transfuse standard doses of FFP to correct a mildly elevated (< 1.8) international normalised ratio (INR) prior to a procedure". Some surgical specialties, such as neurosurgery may have different thresholds in certain circumstances.

Key message

Blood components should only be prescribed to patients when there is an indication of need based on the patient's current clinical condition. Blood products should not be administered solely to correct a pathology result (INR, Hb).

Figure 1. Validated clinical reactions TACO - Transfusion associated circulatory overload; DSTR - Delayed serologic transfusion reaction; ATR - Acute Transfusion Reactions; DHTR - Delayed haemolytic transfusion reaction



CASE STUDY 2

Administration of blood products

A unit of RhD negative blood was collected from a blood transfusion laboratory for a patient with low haemoglobin.

Two nurses took the unit of blood to the patient's bedside, and one nurse checked the patient's identification band whilst the second nurse reviewed the paperwork. The patient had a surname the first nurse found difficult to pronounce and spelt the patient's name, to which the second nurse replied "Yes".

The blood transfusion was commenced and later a third nurse noted the patient details on the blood and identification band did not match. Fortunately, the unit was ABO compatible.

Background – improper checking

The Australian Commission on Safety and Quality in Health Care (ACSQHC) standard 7 recommends the practice of "double independent checking" of blood products and the inclusion of the patient themselves in product checking wherever practical.

Double independent checking requires two clinicians to each make the required checks sequentially, rather than as a pair. The first clinician will check the patient's identification, involving the patient wherever possible. They will then check the prescription and the blood product and associated paperwork match.

The checking procedure must ensure the correct patient is receiving a compatible blood component that is not expired and fully aligned with the prescription (accounting for factors such as seronegative, irradiated etc). Once the first clinician is content with the checks they are repeated independently by the second clinician and administration of the product does not begin until the second check is successfully completed.

Key message

It is recommended that double independent checking of all blood components is undertaken. Double independent checking does not appear to be consistent practice amongst anaesthetists.

CASE STUDY 3

Management of blood product reactions

A patient suffered significant blood loss during major orthopaedic surgery, requiring the transfusion of RBC, FFP and cryoprecipitate. During administration of a unit of RBC, they became tachycardic and febrile with rigors but without significant hypotension or respiratory symptoms. The infusion of RBC was stopped, and the patient was treated symptomatically.

Background – blood transfusion reaction

In complex transfusion scenarios such as massive haemorrhage with coagulopathy, anaesthetists need to maintain a high index of suspicion for blood product reactions, especially where there are multiple potential causes of new symptoms. In this case the correct action was to stop the transfusion.

Investigation of a febrile transfusion reaction may involve an appropriate septic work-up for the patient and returning the unused product to the blood transfusion laboratory so it can be re-assessed for compatibility and cultured to assess for bacterial contamination.

Key message

The treatment of transfusion reactions is largely symptomatic. If an anaphylactic reaction is suspected the appropriate algorithms should be followed. Determination of the cause requires investigation of the patient and examination of any residual un-transfused product by the blood transfusion laboratory.

CONCLUSION

Blood transfusion is a common and often life-saving intervention that is associated with risk factors that can be mitigated by appropriate practice.

Key strategies for anaesthetists to be aware of include:

- Avoiding unnecessary transfusion.
- Performing sequential double independent checking.
- Maintaining a high degree of suspicion for transfusion reactions.
- Assessing the patient appropriately and returning unused product to the blood transfusion laboratory if a blood transfusion reaction is suspected.

Dr Ben Slater, FANZCA
Chair, Hospital Transfusion Committee, St Vincent's Hospital Melbourne

Professor David A Scott, AM FANZCA
ANZCA Director of Professional Affairs, Policy

Acknowledgement

Thanks to Professor Zoe McQuilten, School of Public Health and Preventive Medicine Monash University and Consultant Haematologist Monash Health for her review of this article.

RESOURCES

STIR Reports (2022-23)
www.health.vic.gov.au/patient-care/serious-transfusion-incident-reporting-system-stir

Blood Matters Audit Reports (Administration of FFP)
www.health.vic.gov.au/patient-care/blood-matters-audit-reports

ANZSBT Guidelines for the Administration of Blood Products
anzsbt.org.au/guidelines/guidelines-for-the-administration-of-blood-products/

Evolve recommendations (RACP) for the Administration of Blood Products
www.racp.edu.au/evolve/recommendations/australian-and-new-zealand-society-of-blood-transfusion

Scan to view the National Blood Authority's *Patient blood management guideline for adults with critical bleeding* with updates to the standard adult dose of fibrinogen achievable with cryoprecipitate (Sep 2025).

WebAIRS

Deciphering malignant hyperthermia

Imagine that you are on call. It is 8pm when you are asked to anaesthetise a fit 27-year-old man who has no underlying medical conditions. He presents with acute appendicectomy with a hint of early systemic inflammatory response syndrome (SIRS). His pulse is 100/min, blood pressure is stable and temperature is 38°C.

His white cell count is 13x10^9/L and renal function and electrolytes are normal. You do a standard rapid sequence induction. The intubation took a bit longer than expected. As you are inserting the endotracheal tube (ETT), you hear the heart rate drop to 50/minute.

Once the ETT is secured, the electrocardiogram registers a few wide ventricular complexes. The pulse is palpable but weak. The NIBP is 80/34. You give intravenous fluid. The heart rhythm settles back into sinus and the heart rate picks up. The blood pressure stabilises with some vasopressor support.

The temperature probe reads 38.5°C. You make your working diagnosis as sepsis. You allow surgery to proceed. A urinary catheter is inserted. General anaesthesia is maintained with sevoflurane.

You notice that the $ETCO_2$ is a bit higher than usual at 55 mmHg once pneumoperitoneum is established but you are able to control it by increasing minute ventilation. The operation is straightforward and concluded within an hour. All haemodynamic signs settle intraoperatively. At the conclusion of surgery, he does not require any vasopressor support. Intra-operatively, urine production is slow and the urine appears concentrated.

In the post-anaesthesia care unit, the urine appears very dark and you suspect myoglobinuria and order more fluids. The patient is stable otherwise and is sent back to the ward. You check the blood test results the next day and see that the creatine kinase (CK) is very high at 8400 U/L.

Malignant hyperthermia (MH) has an Australian beginning. Meticulous history-taking and vigilant observations under general anaesthesia led to discovery of this interesting entity, a disease that is triggered by general anaesthesia and which otherwise may never declare itself.[1]

The year was 1960. A young 21-year-old man presented for surgery for lower limb compound fracture in Melbourne. He gave a family history involving ten of his relatives dying under or shortly after general anaesthesia with ether or ethyl chloride.

The anaesthetist involved was Dr Villiers. He and the orthopaedic surgeon, Dr Mills, took the time before starting the operation to interview the patient and his GP who was able to confirm this unsettling family history. Dr Villiers used halothane instead of ether as it was the new inhalation drug.

After induction with thiopentone, within half an hour of introducing halothane, the patient developed tachycardia and hypotension, observed to be hyperventilating with a cyanotic tinge and became hot and sweaty.

The operation was hastily completed and anaesthesia was stopped. Yet the patient remained hot and unconscious. Ice was borrowed from the cardiac theatre and the patient was packed in ice. Despite not knowing what this mysterious illness was at the time, or having any specific treatment for it, the patient regained consciousness after half an hour and survived to tell the tale.

He and his family were very generous and helpful in providing details about their family's anaesthetic history. That prompted the start of Dr Denborough's lifelong study on malignant hyperthermia. Subsequent to our lucky Australian patient, the mortality elsewhere was reported to be very high, up to 80 per cent in the 1970s.[2]

In the last 65 years, thanks to study into MH internationally, we now know much more about it. The pathophysiologic process is dysregulation of intracellular calcium homeostasis in skeletal muscle leading to a hypermetabolic state. It is a hereditary disease with variable penetrance. More than 100 mutations in the RYR1, CACNA1S and STAC3 genes have already been found to be associated with MH; some are considered pathogenic so that genetic testing is possible.[3,4]

Now we know how to prepare for a MH-susceptible case, and how to manage and treat an acute episode. We rehearse managing it in simulation sessions. Guidelines are published by various organisations on the acute management and the availability of dantrolene wherever MH-triggering drugs may be used.

International centres are set up for MH testing, including four in Australasia: Sydney, Melbourne, Perth and Palmerston North in New Zealand. The mortality rate has decreased significantly and is recently reported to be five per cent.[2]

WebAIRS started in 2009 and has since accumulated several dozen reports relevant to MH. In the preliminary analysis, it is apparent that clinical signs while under general anaesthesia can overlap with a few other conditions which can itself be the reason for surgery.

The challenge seems to be diagnosing it correctly while it is unfolding in front of your eyes. Several reports alluded to the fact that patients are not as ardent about MH as anaesthetists and some have not mentioned the known history of MH. There are also patients who have not been tested despite having a suspicious episode.

Communication breakdown is a recurring theme. The final WebAIRS analysis will provide a detailed report on the clinical presentation, diagnostic considerations, management strategies undertaken by the treating anaesthetist, and outcome of the cases.

Returning to the opening scenario, would you have done things differently? Would you have declared MH at any point or continued to manage it as sepsis? Would you have given dantrolene or merely stopped sevoflurane and switched to TIVA? What would you do when you see the CK result? In your hospital or practice, is there a system to alert anaesthetic staff about a past episode of MH? Is there a reliable way to find out what the MH test result is for a patient?

After decades of research and education, MH can still be a challenge, not only testing the vigilance and knowledge of the anaesthesia team, but also the resilience of systems designed to safeguard patients. Each encounter with MH is a reminder of the robust protocols and communication portals that are in place, thanks to our diligent predecessors.

As our understanding of its pathophysiology deepens and our management strategies evolve, the story of MH is transformed from one of near-certain fatality to one of expectance and survival.

**The opening scenario is a fictional narrative; any resemblance to actual events is coincidental.*

Dr Cheryl Yeung, FANZCA
Dr Martin Culwick, FANZCA
The ANZTADC Case Report Writing Group

References

1. Ball C. Unravelling the mystery of malignant hyperthermia. Anaesth Intensive Care 2007; 35 (Supp 1): 26-31.
2. Rosenberg H, Pollock N, Schiemann A et al. Malignant hyperthermia: a review. Orphanet Journal of Rare Diseases 2015; 10:93.
3. Rosenberg H, Sambuughin N, Riazi S, et al. Malignant Hyperthermia Susceptibility. 2003 Dec 19 [Updated 2020 Jan 16]. In: Adam MP, Feldman J, Mirzaa GM, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington, Seattle; 1993-2025. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1146/
4. European Malignant Hyperthermia Group. https://www.emhg.org/genetics

Additional resources and recommended readings

1. ANZCA https://www.anzca.edu.au/getContentAsset/895dc123-5cfc-417f-b9b2-9f7b43461d68/80feb437-d24d-46b8-a858-4a2a28b9b970/ANZCA-FPM-CPD-Malignant-hyperthermia-ER-session-guideline.pdf?language=en
2. MHANZ https://malignanthyperthermia.org.au/
3. MHANZ Information for anaesthetists
4. https://malignanthyperthermia.org.au/information-for-anaesthetists
5. MHANZ Malignant Hyperthermia resource kit
6. https://malignanthyperthermia.org.au/malignant-hyperthermia-resource-kit

Perioperative medicine

ANZCA's new Chapter of Perioperative Medicine is overseeing the Course in Perioperative Medicine and our advocacy efforts in this growing area of medicine.

Continued growth for POM chapter

CHAPTER GRADUATES NOW TOTAL 780

Our Chapter of Perioperative Medicine continues to grow. We now have 780 graduates including 11 who have completed the course. The other 769 graduates were assessed by the Recognition Pathway Working Group.

After many exhausting months, this working group has completed its review, with the final meeting held on 22 July. Thanks to Dr Vanessa Beavis who led this process and personally committed an enormous amount of time assessing applicants.

A total of 835 applications were received by the working group. Of these, 769 (92 per cent) were deemed eligible and are graduates of the Chapter of Perioperative Medicine, allowing them to use the post nominals GChPOM.

While most nominated FANZCA (465) as their primary fellowship, there was a pleasing spread of other specialist groups (FRACP – 165; FCICM – 81; FRACS – 16; FRACGP 19; FACRRM – 9; FRNZCGP – 1; others – 13).

Of the successful applicants, 223 were from Victoria, 135 each from Queensland and NSW; 123 from New Zealand; 63 from SA; 51 from WA; 13 from Tasmania and six each from the NT and ACT. A total of 14 were from overseas.

ANZCA COURSE WORKSHOP CHANGES

From 2026, we will have a new workshop structure for those participating in the course.

Workshops will no longer be required for completion of each of the six individual units of study, rather participants must attend a one-day online workshop and a two day in-person workshop to complete the course.

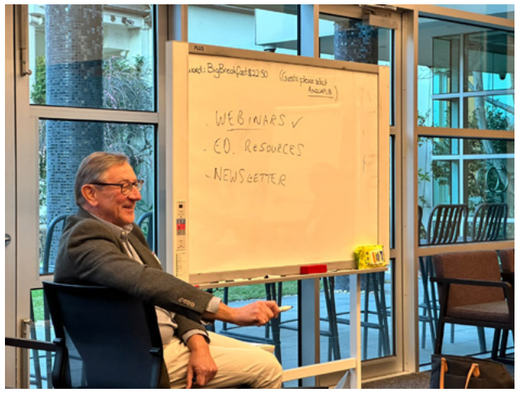
Participants will need to have completed a minimum of two units of study before attending the workshops.

COMMITTEES MEET

On 1 August the college hosted members of the chapter's Advocacy and Policy Committee and the Education and Assessment Committee for an in-person meeting. All colleges collaborating with ANZCA on perioperative medicine were represented at the meeting.

The group discussed chapter professional documents, strategies to broaden engagement including with allied health professionals, guidance for setting up perioperative medicine services in hospitals, and plans for a national "POM roadshow" to demonstrate the perioperative medicine pathway.

We also discussed the recent survey of chapter graduates. A third of graduates responded to the survey, and their input will give us a better understanding of the graduates and help us in our goal of expanding perioperative medicine.



ABOVE FROM TOP

The college hosted members of the chapter's Advocacy and Policy Committee and the Education and Assessment Committee for an in-person meeting.

Chair, Chapter of Perioperative Medicine Board, Dr Chris Cokis.

CLINICAL IMMERSION SITES

We now have 33 clinical immersion sites approved to deliver the course, the latest being Toowoomba Hospital, Sunshine Coast University Hospital, the Royal Brisbane Hospital and Palmerston North Hospital in New Zealand. A further 22 hospitals have started the process of becoming clinical immersion sites for the course.

Dr Chris Cokis
Chair, Chapter of Perioperative Medicine Board

SCHOLARSHIP

Two scholarships are being offered in 2026 to support two clinicians to undertake the ANZCA Course in Perioperative Medicine and become a graduate of the Chapter of Perioperative Medicine (GChPOM).

The Alan and Kate Gibson Fellowship aims to find emerging leaders in perioperative medicine and support specialist doctors committed to advancing the field. One scholarship will specifically support a clinician working in a regional or rural setting.

More information is available at anzca.edu.au/news-and-safety-alerts/2026-scholarship-opportunities-in-perioperative-medicine.

Clinical immersion sites:

Australian Capital Territory	South Australia
Canberra Hospital	Royal Adelaide Hospital
Queensland	**New South Wales**
Ipswich Hospital Logan Hospital Princess Alexandra Hospital Royal Brisbane and Women's Hospital (2026) Sunshine Coast University Hospital Toowoomba Hospital	John Hunter Hospital Prince of Wales Hospital Westmead Hospital Royal North Shore Hospital Royal Prince Alfred Hospital Blacktown Hospital Liverpool Hospital
Tasmania	**Western Australia**
Launceston General Hospital Royal Hobart Hospital	Fiona Stanley Fremantle Hospitals Group
Victoria	**New Zealand**
Alfred Hospital Austin Hospital Royal Melbourne Hospital Peter MacCallum Cancer Centre University Hospital Geelong Western Health St Vincent's Hospital Melbourne Monash Health	Te Toka Tumai Auckland City Hospital Christchurch Hospital Middlemore Hospital North Shore Hospital Palmerston North Hospital Wellington Regional Hospital Waikato Hospital

2026 course dates

Trimester 1	2026
Enrolment period	24 November 2025 – 25 January 2026
Commencement/completion	9 February 2026 – 19 April 2026
Trimester break	20 April 2026 – 31 May 2026
Trimester 2	**2026**
Enrolment period	9 March 2026 – 10 May 2026
Commencement/completion	1 June 2026 – 9 August 2026
Trimester break	10 August 2026 – 20 September 2026
Trimester 3	**2026**
Enrolment period	29 June 2026 – 30 August 2026
Commencement/completion	21 September 2026 – 30 November 2026
Trimester break	1 December 2026 – early February 2027
Participants completed at least 2 units of study:	
1 day online workshop	TBC in 2026
2 day in-person workshop	TBC in November 2026

Patients home safer and sooner with advanced recovery room care model

New data is showing the benefits of the Advanced Recovery Room Care (ARRC) model of perioperative care which was introduced in 2023 at the Royal Adelaide Hospital (RAH).

ARRC is an anaesthesia-led intervention that aims to bridge the gap between standard post-anaesthesia care and intensive care by providing focused, multi-professional care to intermediate-risk surgical patients to reduce postoperative morbidity and mortality.

Selected patients are transferred to the ARRC facility within the RAH where they are closely monitored for 12-24 hours following surgery by a team of doctors, nurses and physiotherapists.

The most recent annual report of the RAH and its ARRC registry, presented at the 2025 ANZCA Annual Scientific Meeting (ASM) in Cairns, shows substantial improvements in morbidity and mortality, and decreased hospital utilisation, including:

- The rate of complications has been halved.
- Mortality has decreased by 35 per cent (equating to 120 lives saved per year).
- Post-operative emergency department presentations have decreased by 50 per cent.
- Each patient experiences at least six fewer days in hospital or supported care, freeing up about 9000 bed days, 2000 nursing home bed days, and 2000 hospital-in-the-home days.

These results clearly show the value of early investment in targeted, evidence-based optimal clinical care.

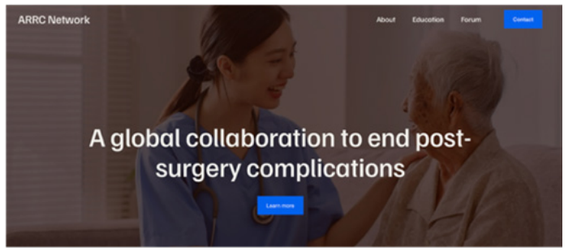
WHAT'S NEXT FOR ARRC?

The ARRC Network has been established to support and promote best practice in early postoperative care to improve care for patients and value (outcome and cost) for care providers.

Several sites in Australia and overseas have, and are, implementing this approach. To support this, the Network is developing online resources to help others get started and improve outcomes, including:

- A start-up toolkit.
- Economic and business data to assist with C-suite discussions.
- Evidence on topics relevant to the field.
- A chat room to facilitate discussion and future directions.

The ARRC network also has funds available to support sites collecting data to add to the ARRC registry. To join the network, or if you have any inquiries, please email Professor Guy Ludbrook (guy.ludbrook@sa.gov.au)



The value of postoperative care will be covered in the first World Congress of Postoperative Care – to be held at the British Library in London from 7-9 July 2026, in parallel with the Evidence Based Perioperative Medicine (EBPOM) World Congress of Evidence Based Medicine meeting.

Professor Guy Ludbrook, FANZCA
Adelaide Medical School, Faculty of Health and Medical Sciences

Professor Mike Grocott
Anaesthesia and Critical Care Medicine, University of Southampton, UK

Recent publications

Tran L, Stern C, Harford P, Ludbrook G, Whitehorn A. Effectiveness and safety of enhanced postoperative care units for non-cardiac, non-neurological surgery: a systematic review protocol. *JBI Evid Synth.* 2024 Aug 1;22(8):1626-1635

Ludbrook G, Leaman EE, Grocott MPW, Royse C, Sleigh J, Clarke-Errey S, Solomon LB. Delayed Mortality in Patients Receiving Postoperative High-Acuity Care. *JAMA Surg.* 2025 Mar 1;160(3):356-357

Ludbrook GL, Koning N, Sammour T. Evaluation of enhanced recovery room care models. *Anaesth Intensive Care.* 2025 May;53(3):204-206.

Glance L, Grocott M, Maddox K, Scott M, Ludbrook G. Transforming Postoperative Care: Advanced Recovery Room Care for Intermediate-Risk Noncardiac Surgical Patients. *Anesthesiology* 2025 (in press)

Ludbrook G, Grocott M, Tran L. Using Recovery Rooms (PACUs) differently – addressing the hidden pandemic. *ICU Management and Practice* 2025 (in press)

Xin, L., Smith, Z. and Salamon, Y., 2025. The experiences of nurses' hand hygiene compliance in advanced recovery room care (ARRC): A descriptive phenomenological study. *Journal of Perioperative Nursing, 38*(2).

Tom's travels: British anaesthetist decides to call New Zealand home

His medicine career has taken him all over the world, from the UK to Peru, Kenya, the Himalayas, and even the Sahara Desert, but it was the lure of a life in Auckland that finally led Dr Tom Cope to settle down.

Hailing from Cornwall in England, Dr Cope is a senior medical officer at Auckland City Hospital, having previously worked in Auckland as an anaesthetic registrar for almost two years from 2016 while on a break following his core anaesthetic training in the UK.

It was during that time he met his now-wife Amy, and while they returned to the UK in early 2018, a combination of the New Zealand lifestyle and a desire to be closer to Amy's extended family meant a move back to Auckland was always on the cards.

Dr Cope says he approached the ANZCA specialist international medical graduate (SIMG) process with some trepidation, but found the SIMG process and his performance assessment to be more straightforward than expected.

"In hindsight, it was just such an easy process and nowhere near as intense as I thought it was going to be."

ABOVE

Auckland City Hospital senior medical officer Dr Tom Cope.

In particular he appreciated the support from his SIMG co-ordinator in the New Zealand office and his assessors.

"It was a very organised but friendly day. I got the feeling everyone was there to make it work, rather than try to catch me out, which was nice."

Further smoothing the process was Dr Cope's decision to align his SIMG application process with his Medical Council of New Zealand vocational registration application.

"It just made so much sense to get them done at the same time, so my advice would be if you're applying for vocational registration, start the SIMG process at the same time, I think that was super helpful."

Now fully settled back into New Zealand's largest city, Dr Cope says the Auckland lifestyle is a good fit for him and Amy and their family, which has expanded to include two children.

"I've always lived by the sea, it's quite an important part of life for me really. For me I cycle to work, it's amazing, I cycle past the water, I can see it out the windows at work.

"Auckland's an incredible city and we're very lucky that we've got family here, it'd be a harder move to do as a consultant if I was by myself, but actually having family here means you're almost a layer deep in the city already."

While training, Dr Cope took two years out to take part in expedition medicine, spending time in the Himalayas, Peru, the Sahara Desert, and later working in Kenya.

"I've been lucky that I've worked in a lot of places around the world and done some pretty cool stuff, probably part of that is what attracted me to medicine in the first place and part of what attracted me to anaesthetics is it's such a mobile job."

Having travelled so widely in his career has helped give Dr Cope a strong awareness of cultural differences and the importance of cultural safety.

"Medicine is probably one of the best jobs for meeting people you wouldn't meet in other circles of life, and I think it's important I acknowledge that and make sure I understand my own cultural bias – things are different in the UK, there's differences here, and it's important to be aware of them. There's lots of really good resources and the CPD from ANZCA is helpful."

Looking back, Dr Cope is pleased to have undertaken the SIMG process.

"It's nice to have the credibility to be able to say the college has assessed me and I'm up to scratch.

"I think if you want to work in a system, it's good to be an active part of the training, and being part of the college I think is important. I'm glad I've done it, I think it was a very worthwhile process."

Reon Suddaby
Senior Communications Advisor – New Zealand, ANZCA

Nominations for ANZCA Council Awards are now open

Award Title	Criteria	Eligibility
Robert Orton Medal	The highest award the college can bestow on its fellows. It recognises distinguished service to anaesthesia, perioperative medicine and/or pain medicine.	Fellows of the college.
ANZCA Medal	Recognises major contributions by fellows to the status of anaesthesia, intensive care, pain medicine or related specialties.	Fellows of the college.
ANZCA Council Citation	Awarded to an ANZCA fellow in recognition of significant contribution to a college project or ongoing college activities.	Fellows of the college.
ANZCA Recognition	Recognises significant contributions at a regional level to anaesthesia, perioperative medicine and/or pain medicine.	Fellows, trainees and SIMGs of the college.
ANZCA Star	Awarded in recognition of those who make extraordinary and critically important contributions (clinical or non-clinical) in times of major disaster, conflict or in other circumstances outside the college.	Fellow, trainee, SIMG of the college or department.

It's time to recognise the members of our college who make a difference to anaesthesia and pain medicine, with nominations for the 2025 ANZCA Council Awards now open.

ANZCA has a suite of awards that recognise the achievements and contributions of our fellows, trainees, specialist international medical graduates (SIMGs) and departments. The awards are a chance for our members to celebrate the contributions and outstanding achievements of individuals within their departments or communities.

For more information on the nomination process and selection criteria, visit the college website via www.anzca.edu.au/councilawards

ENTRIES CLOSE ON FRIDAY 31 OCTOBER 2025

The award recipients will be announced at the 2026 College Ceremony in Auckland as part of the 2026 ANZCA ASM on Saturday 2 May.

If you require assistance, please contact the membership services unit at membership@anzca.edu.au

Submissions open on Monday 15 September 2025. Submissions close at 5pm AEDT on Friday 31 October 2025.

ANZCA
FPM

CALL FOR ABSTRACTS

NOW OPEN

What's more rewarding than showcasing your research at Australasia's premier anaesthesia meeting? The 2026 ANZCA ASM will be attended by more than 1500 delegates in Tāmaki Makaurau Auckland, Aotearoa New Zealand.

"As Abstract and ePoster Convenor for the 2026 ANZCA ASM, I warmly invite submissions spanning the full spectrum of anaesthesia, pain and perioperative medicine. We especially welcome abstracts that bring fresh perspectives, advance the science of our specialty, and explore new approaches to equity, safety, and sustainability. I look forward to receiving your contributions and to an inspiring and engaging program."

Dr Amy Gaskell, Abstract and ePoster Convenor

KEY DATES

Program available
Late November 2025

ASM registrations open
Early December 2025

Abstract submissions close
18 January 2026

Abstract notification to authors
Early March 2026

FPM Symposium
1 May 2026

ANZCA ASM
1–5 May 2026

HERENGA WAKA
FROM HOME TO HOME
HERENGA TĀNGATA
ANZCA ASM AUCKLAND 1-5 MAY 2026

Care without cost thanks to ANZCA fellows and New Zealand charitable trust

A charitable trust and hospital in New Zealand's fastest-growing city is providing free surgery to some of the community's most needy – and it's being done with the help of almost 20 ANZCA fellows.

Hamilton-based Braemar Charitable Trust owns Braemar Hospital which, alongside its regular roster of inpatient private surgeries, day-stay procedures and specialised medical services, runs a free community surgery program.

The program includes paediatric, dental, plastic, oral and general surgeries, and has been running since 1971 when the trust began, but the number of surgeries has steadily increased since 2016. The program has since expanded to include community surgery days, where the hospital devotes an entire day to free procedures, and surgeons, anaesthetists and staff donate their time.

Surgery recipients are referred by specialists, GPs, dentists and nurse practitioners as well as community health providers, with preference given to people who have been declined or have little chance of timely surgery in the public system, and do not otherwise have the means to pay for the procedure privately.

FROM LEFT

ANZCA fellow Dr Aidan O'Donnell.

Braemar Hospital, Hamilton, New Zealand.

Dr Aidan O'Donnell is one of 19 ANZCA fellows who have carried out free surgeries at Braemar, having completed nearly 20 procedures himself, and says the experience is hugely rewarding.

"I'm giving anaesthetics for free, to needy members of the community, mostly to children, but occasionally adults, and that gives me that sense of feeling like I'm making a contribution."

More than 70 people received free surgeries or procedures across two days at the end of last year, and the latest community surgery day involved up to 35 people receiving procedures including general surgeries, gynaecological surgeries, endoscopies, dental treatment and children's general surgery procedures.

In the past financial year, the trust enabled 159 free surgeries, up 124 per cent on the previous year. It spent $NZ88,000 on associated costs but estimates the surgeries would have cost $500,000 if performed privately. In the first five months of this financial year, another 77 free surgeries have been provided, and the trust has spent $50,000.

Dr O'Donnell says the charitable work of Braemar has changed its perception, even among those who work there.

"A lot of people, like me, thought that Braemar was just another private hospital, and for them to find out Braemar is run as a charity, I think people feel more ethically comfortable. Even if they are working for Braemar, they know the money that's generated is going into charitable causes."

The number of referrals for community surgeries is almost doubling each year, and the trust is further growing its reach by connecting with other health organisations, women's refuges and Māori communities in the hope of better addressing unmet health needs.

Additionally, the trust provides scholarships, health training and invests in medical research. Dr O'Donnell sits on the board that decides the disbursement of the charitable funds.

The trust has also come on board as a sponsor of this year's Aotearoa NZ Anaesthesia Annual Scientific Meeting to be held in Hamilton from 12-15 November.

Braemar Charitable Trust manager Paula Baker says research and community relationships are used to identify unmet and unseen health needs in the community. The trust then works to address these, alongside surgeons and anaesthetists who contribute their time, with help from some external funders.

She says the trust is unique in that it owns a private hospital as one of its charitable pillars.

"So, we can contribute in a pragmatic way to achieve health equity outcomes in our community; we're not constrained by systems, approval levels, politics or boundaries."

Braemar Hospital is situated next to the publicly funded Waikato Hospital, and many of the local ANZCA fellows work at both sites.

It's a fitting arrangement for the two organisations working side-by-side to improve health outcomes for their region.

"By providing that care at Braemar, we're also shortening the waiting list over the road at Waikato (Hospital) so it's got that extra benefit," Dr O'Donnell says.

"It's nice to be part of a group of people who have an interest in doing something a little bit bigger than just looking after yourself. They're interested in improving communities, improving families, just giving a little bit back to the community."

Reon Suddaby
Senior Communications Advisor – New Zealand, ANZCA

Research

ANZCA supports research in anaesthesia, pain medicine and perioperative medicine to improve patient outcomes through funding and resources, collaboration, and networks.

CTN workshop reaches stratospheric heights

A record turnout, late breaking ROCKet trial results, and future-focused debates

Stunning sunsets and ocean views in Glenelg, South Australia, set the backdrop for the largest Clinical Trials Network workshop since 2009 – with delegates from across Australia, New Zealand and Hong Kong.

Attendance increased 20 per cent to 215 delegates (including for the first time more than 100 fellows), with greatly increased representation from South Australia. The program was designed to be more accessible for new and emerging investigators, opening with a mentoring session to connect delegates with peers, and included an emerging investigators session. Sixty-five first-time delegates joined many returning participants, strengthening succession across the network.

A lively pre-workshop discussion examined how the ANZCA curriculum could effectively address the research literacy requirements for trainees. The two-day program that followed focused on the science of clinical trial design and delivery. Keynote addresses challenged our thinking, with insights from South Australia's Chief Medical Officer Dr Michael Cusack, statistician Professor Kate Lee, and health economist and implementation scientist Dr Lisa Higgins. Eighteen new proposals were presented by emerging and established investigators, sustaining a strong pipeline of clinical trials and innovative methodology.

The space-themed conference dinner, in celebration of the completion of the Reduction Of Chronic post-surgical pain with Ketamine (ROCKet) trial, transported delegates to a galaxy far, far away. The night included fancy-dress, game prizes, interstellar playlists and a special tribute to Associate Professor John Rigg as we marked 30 years since recruitment began for the Multicentre AuSTralian Study of EpiduRal Anaesthesia in High-risk Surgery (MASTER) – the CTN's first collaborative trial. ANZCA President Professor Dave Story congratulated Dr Matthew Bright on being awarded the Emerging Investigators Prize for his presentation on the WAVELET-II study, "Individualised haemodynamic optimisation informed by the lower limit of cerebral autoregulation during personalised external aortic root support (PEARS) surgery".

On the final day Professor Philip Peyton presented the early first-hand results from the ROCKet trial, followed by energising debates and a panel discussion on the future of innovative trials, traditional randomised controlled trials and platform trials across the network. Post-workshop meetings enabled paediatric and New Zealand craft groups to reflect and continue the conversation.

Before the workshop, CTN Chair Professor Tomas Corcoran raised community awareness on ABC Adelaide radio, highlighting the ROCKet trial, the CTN and the workshop. The CTN Executive also met for a strategy day to develop a new strategic plan for the network focused on sustainability, mentoring pathways, academic career development, broader research engagement and strengthened governance.

Thank you to our sponsor Spiral Software for supporting the workshop. We'd also like to thank the convenors, AV partner Wallfly, the ANZCA Foundation, delegates, speakers, chairs and organisers for making this meeting a standout success.

We look forward to welcoming delegates to the Gold Coast in 2026!

ABOVE FROM LEFT

Glenelg jetty at sunset.

Delegates celebrating at the 2025 CTN space-themed dinner.

Patients hailed as lifeblood of CTN trials

The day before her surgery at Ballarat Hospital in mid-2023, Hannah Cozens received a phone call from Natasha Brice, a clinical trials co-ordinator at Grampians Health.

Ms Brice, or Tash as she's known by Hannah, was recruiting for patients for the ANZCA Clinical Trials Network's (CTN) Reduction Of Chronic post-surgical pain with Ketamine (ROCKet) trial.

Hannah had been diagnosed with a rare and aggressive invasive breast cancer. In the days, weeks and months after her mastectomy Tash was her frontline link to the ROCKet trial. The trial examined if ketamine – commonly administered by anaesthetists for pain relief during surgery – given intravenously before and after surgical incision for up to three days reduced the incidence of chronic post-surgical pain.

Chronic post-surgical pain is a common and debilitating complication of major surgery, with significant impacts on quality of life.

Nearly two years to the day since she connected with Tash and the ROCKet trial, Hannah was a guest speaker at the 2025 ANZCA CTN Strategic Research Workshop in Glenelg, Adelaide. In front of more than 200 delegates she gave a frank but inspiring account of her surgical journey and why she didn't hesitate when Tash asked her if she would be interested in participating in the trial.

"Before my surgery, what started as pain had quickly developed into a nasty large weeping fistula on my left breast with high fevers, many hospitalisations with doctors and nurses scratching their heads, lots of drugs, and worse," Hannah told the delegates.

"There was only one path for me and that was to have a mastectomy. I was booked in for the surgery and on 27 August 2023, I was introduced to ROCKet.

"I received a call the day before my surgery from a nurse named Tash Brice, and she explained that I was undergoing surgery that fell into a framework for a medical trial and would I be interested? I don't know why, but I said yes.

"And to this day, that is why people ask me, why did you say yes? I've thought about that a lot and I've often joked that it was because of Tash. She was kind. She was gentle and understanding. She listened to me. I was a really scared mum. I had to say goodbye to my kids who were going off to school that morning and pretend that everything was alright, though I didn't feel like anything was alright.

"I felt supported by her and I felt like I had an ally in my team as I had been dismissed a lot. She told me about the trial and made it sound like a no-brainer. She explained that if I had ketamine, maybe I wouldn't be in pain anymore. She also explained that I may be given a placebo but regardless, I would be helping someone in the future.

"The next day, after the surgery, Tash came and saw me. Then I went home. They followed up in a week, then at three months and then at 12 months. Tash kept in touch with me like an old friend. Then three months ago, Tash called again. She asked me to participate in something again, which was to speak with you all today. And you know what I said? Yes.

"I don't know if I received ketamine and I never will, but I can say it's one of the best things that I have done."

As a result of her participation in the ROCKet trial Hannah is now a member of a patient sub-committee examining recruiting barriers for clinical trials with CT:IQ, a national collaborative body of clinical trials stakeholders. Hannah is also keen to continue to work with the CTN due to her positive experience.

She says her participation in the ROCKet trial has given her "a greater appreciation and an understanding of all the medication that I've had to take as a breast cancer patient and all the things that I've gone through.

"Somebody else did that in another trial and that's offered me a second chance at life so I can watch my children grow."

The ANZCA CTN celebrates 30 years of clinical trial recruitment this year. It has come a long way since Perth anaesthetist Associate Professor John Rigg began a research partnership in 1989 with clinical epidemiologist Professor Konrad Jamrozik. They later developed the Multicentre AuSTralian Study of EpiduRal Anaesthesia in High-risk Surgery (MASTER) trial, the first National Health and Medical Research Council (NHMRC) funded multicentre randomised clinical trial (RCT) in Australia led by anaesthetist researchers, including Associate Professor Brendan Silbert, Professor Paul Myles and Professor Philip Peyton.

The ANZCA CTN now has more than 70 hospital sites participating in CTN-endorsed trials across Australia and New Zealand and has collaborations with multiple international groups.

The ROCKet trial's lead investigator Professor Philip Peyton told the *ANZCA Bulletin* that patients like Hannah are the lifeblood of clinical trials. The ROCKet trial recruited hundreds of patients from Australian and New Zealand metropolitan and regional hospitals, as well as Hong Kong. At least a quarter of the 4884 patients from 36 hospitals who participated are from Australian regional cities such as Ballarat, Geelong, Mackay and Shepparton. Grampians Health, which manages Ballarat Hospital, recruited 560 patients for the trial, more than any other Australian site.

LEFT FROM TOP

From left: Natasha Brice, Professor Philip Peyton and patient Hannah Cozens.

CTN delegates gather for a 30 year celebration photo with MASTER trial chief investigator, Associate Professor John Rigg, centre.

The trial's last patient was recruited in March this year and Professor Peyton hopes to publish the results before the end of the year.

The ROCKet trial received two NHMRC grants of $A4.8 million in 2017 and $A967,000 in 2023 with additional funding from the ANZCA Foundation for piloting, long-term follow-up and biomarker sub-studies. The primary trial endpoint of chronic pain at 12 months after surgery was revised to three months based on the new World Health Organization International Classification of Diseases (ICD-11) definition of chronic post-surgical pain.

Professor Peyton says the trial's focus on chronic pain after surgery meant it could capture the patients at the greatest risk of chronic pain – especially those who had abdominal, lung or breast cancer surgery.

"I'm in awe of Hannah's contribution to our research as somehow, in the midst of an awful situation, she found room to say she would work with us on the trial and I'm deeply grateful for that.

"The trial is also a testament to the enthusiasm and support of the ANZCA CTN and also to regional centres such as Ballarat Hospital through Grampians Health who did a fantastic job of working with patients who selflessly volunteered to be involved. The contribution by regional centres makes up about one quarter of the patients we studied.

"When you undertake any trial activity you are ultimately indebted to those patients who make that leap in the middle of their own medical/health crisis to look beyond their own immediate needs to the big picture which ultimately benefits healthcare and the community.

"We are utterly beholden to our patients in the end, their volunteerism and their trust. They are trusting us to look after them and we are trying to improve outcomes from where they might otherwise be with more targeted and sophisticated care."

Professor Peyton says the participation of regional hospitals in the ROCKet trial has helped diversify the CTN.

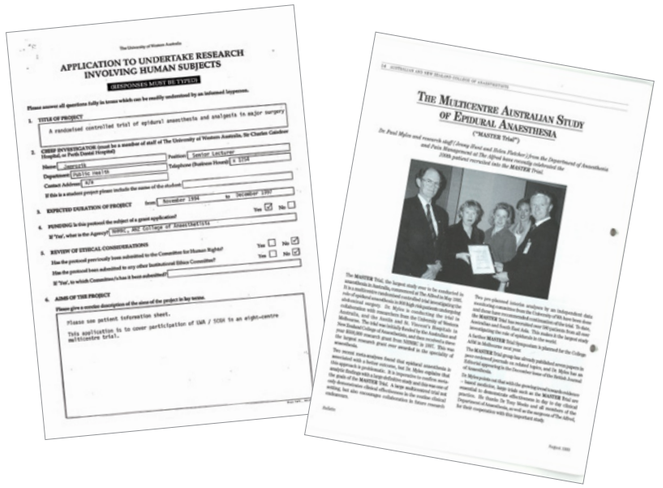
"We are broadening our recruitment base and we are getting greater involvement from patients from the regions. This means the results of the trials are generalisable to a much broader cross-section of the Australian community than would otherwise be the case.

"Part of the rationale for multicentre trials is to come up with a result that you can be confident is not just applicable to one hospital or one surgical unit or department."

Professor Tomas Corcoran, chair of the CTN Executive and chief investigator for the Perioperative ADministration

ABOVE

Hannah Cozens and Professor Tomas Corcoran at the CTN meeting.



APPLICATION TO UNDERTAKE RESEARCH INVOLVING HUMAN SUBJECTS

THE MULTICENTRE AUSTRALIAN STUDY OF EPIDURAL ANALGESIA

("MASTER TRIAL")

LEFT

A copy of the first CTN research application, with tearout of the ANZCA Bulletin *1999 article on the CTN MASTER Trial.*

of Dexamethasone and Infection (PADDI) trial and the Long-term Outcomes of Lidocaine Infusions for persistent PostOperative Pain (LOLIPOP) trial, agrees.

"Clinical trials are really important. If we don't have patients enrolling in clinical trials and we don't examine the scientific basis behind what we do, it means we fail to advance medicine and we certainly fail to advance the quality of the care that we give to the population.

"We are very grateful for the patients who participate. Without patients contributing to these trials we wouldn't be able to advance the care we deliver. It allows us to develop science around the treatments that we administer to patients. It also means we can say to patients 'there is a percentage risk of you developing this but there is also a percentage benefit you may get from this intervention that we will give to you' – all of it from scientific data that has been generated from patients enrolling into clinical trials."

ANZCA President Professor Dave Story acknowledges the contributions of both patients and the CTN trial co-ordinators in the success of the ANZCA CTN.

"Clinical trials would not succeed without the research co-ordinators so it is very important that hospitals see the co-ordinators as an important investment, rather than a burden. It's important to remember that the combination of clinical care, research and education enhance each other.

"We want to reduce the overall complications of patients in Australia and New Zealand and with the research we do in the clinical trials network virtually all the outcomes are related to postoperative complications and how to reduce them.

"And with the evolution of perioperative medicine at ANZCA, our clinical trials are now adding to the evidence base for perioperative medicine."

Carolyn Jones
Media Manager, ANZCA

ANZCA CTN TOOLKIT: BUILDING RESEARCH CAPABILITY

The ANZCA Clinical Trials Network (CTN) has launched a new toolkit for trainees, fellows, investigators and research co-ordinators featuring more than 30 tailored resources designed to strengthen trial readiness, support emerging investigators, and build research co-ordinator capability.

The content draws on CTN workshops, educational sessions, surveys, and contributions from research co-ordinators, fellows, trainees and invited experts. Resources are grouped into four themes:

- **Research co-ordinators:** glossary, theatre 101, and career pathways.
- **Getting trials started:** feasibility, budgets, and site readiness.
- **Building research departments:** business cases to employ research co-ordinators, rural engagement, and stakeholder partnerships.
- **Anaesthesia investigators:** research idea development, grant writing, publishing, and showcasing research.

Each resource was co-developed through drafting by the CTN office and invited authors, Anaesthesia Research Co-ordinators Network (ARCN) sub-committee input, CTN Executive review and approval, and final formatting and editing by the CTN office.

All documents are published and searchable on the ANZCA Institutional Research Repository (AIRR) with digital object identifiers (DOIs), and are linked from the CTN website. More tools will be added over the coming months, and we acknowledge the many contributors, including ANZCA communications and library teams, who made this publicly available resource possible.

The toolkit can be accessed via www.anzca.edu.edu/ctn

Foundation update

NEW SERIES OF REPORTS ON FUNDED RESEARCH OUTCOMES

Findings from ANZCA Foundation-funded research projects, and their implications for clinical practice, are being presented in a new series of articles in the *ANZCA Bulletin* through a new foundation initiative supported by the ANZCA communications team.

Starting in this issue, the reports will include several exciting "world-firsts". References to peer-reviewed publications resulting from the funded studies will be available from the ANZCA Library and on the ANZCA website.

The initiative aims to deliver accountability to donors and the fellowship, highlight the advances and benefits delivered by the foundation's support for research, promote awareness of peer-reviewed literature in the areas around these studies, and drive growth in future medico-philanthropic support for the work in the specialties supported by the foundation.

CLINICAL TRIALS NETWORK STRATEGIC WORKSHOP, ADELAIDE, 8-10 AUGUST

A record number of more than 220 delegates (pictured above) attending the ANZCA CTN workshop in Adelaide from 8-10 August reflected strong growth in interest in conducting or participating in multicentre trial research to deliver new evidence for questions in anaesthesia, pain medicine and perioperative medicine.

Many of the presenters graciously acknowledged the vital importance of earlier foundation donor-funded research grants in establishing pathways towards securing large government grants for multicentre trials led by anaesthetists and pain medicine physicians.

This year further value was generated from the meeting through follow-on meetings for the Society for Paediatric Anaesthesia (SPANZA), and on New Zealand and Australian cross-Tasman research collaboration.

FUNDRAISING HIGHLIGHTS

In August, a wonderfully generous second donation of $A50,000 was received from Mrs Jan Russell to extend the W. John Russell ANZCA Research Award, which recognises research studies in anaesthetic equipment and engineering, education, and patient safety.

This year the foundation has had the enormous privilege of being advised by two retired fellows of their intentions to each make bequests to the foundation of about $A500,000 each for the future advancement of anaesthesia and pain medicine.

Significant applications for three proposed studies in paediatric anaesthesia have been lodged with the 7 Telethon Trust in Western Australia, while an application for $A100,000 will be lodged with the Medibank Community Fund this month for the implementation of the proven Advanced Recovery Room Care (ARRC) model led by Professor Guy Ludbrook from Royal Adelaide Hospital.

2025/26 RESEARCH GRANTS ROUND

The three peer reviews required for each of the 56 funding applications for studies to commence in 2026 were received ahead of the annual all-day face-to-face grants meeting of the research committee on 5 September. The meeting has now been completed, and all applicants will be advised of the outcomes by the end of October.

Thanks to the high quality of applications and the funding donated each year by foundation donors and patrons, the annual ANZCA Foundation research grants round regularly delivers a success rate of about 40 to 50 per cent.

Foundation research grants audit completed

The foundation has committed significant additional time and effort to a comprehensive independent audit of its research grant process by PKF Australia between January and August. The final report commended the integrity of the grant assessment process and indicated no areas of significant concern.

The audit also reinforced the importance of several planned or in-process foundation initiatives, including enhanced reporting of research outcomes, investing in multi-skilling, building a new grant database, and streamlining the grant application process through enhanced digital support.

ANZCA research – the outcomes

IMPACTS OF RECENT FOUNDATION-FUNDED RESEARCH

ANZCA has allocated $A1.5 million or more each year for research in anaesthesia, pain medicine, and perioperative medicine. In the first of an ongoing series, we bring you results from some of the research projects supported by grants funded through ANZCA Foundation investment earnings, foundation donors, and college support, and allocated by the ANZCA Research Committee through the ANZCA Foundation.

This collection of reports on studies led by ANZCA fellows, and completed over the past three years, demonstrates many new contributions to the science and practice of anaesthesia, pain medicine and perioperative medicine. Often including 'world-firsts', they have increased the knowledge that equips our fellows, and other specialists and healthcare professionals, to continually improve clinical practice and patient outcomes within our challenging health system.

All of these studies have been published in leading peer-reviewed journals, presented at major scientific meetings, or in most cases, both.

SURGERIES GENERALLY SAFE, BUT FOUND TO BE CUMULATIVELY ASSOCIATED WITH COGNITIVE DECLINE

Academic Enhancement Grant: Collaboration, mechanisms and modulation: improving perioperative brain health

Professor Robert Sanders, The University of Sydney, received the ANZCA Academic Enhancement Grant in 2023 for this research program. His team included Associate Professor Lis Evered, St Vincents Hospital, Melbourne; Professor Andrew Davidson, Royal Children's Hospital, Melbourne; and Professor Gideon Caplan, University of NSW.

$A100,000

Completed in 2024 and leading to a publication in The Lancet Health Longevity, this program aimed to guide best clinical practice in Australia, revolutionise understanding of acute illness and surgery mechanisms altering cognitive trajectory, and lead international trials on delirium prevention, addressing a significant knowledge gap.

The first project, translating research into national standards and a collaborative network, led to a paper describing Australian views of the European Society of Anaesthesiology and Intensive Care perioperative guidelines being accepted by Anaesthesia & Intensive Care, and an active consumer group in partnership with the ANZCA Clinical Trials Network (CTN).

The second project aimed to determine whether cumulative hospitalisations lead to chronic inflammation, neurodegeneration, and long-term cognitive decline, using UK Biobank data from 2006-2023. Primary outcomes were hippocampal volume and white matter hyperintensities, and surgeries were calculated cumulatively from eight years before baseline.

With 492,802 participants included and 46,706 undergoing MRI, small adverse associations with cognition were found per surgery. Surgeries were associated with smaller hippocampal volume, greater white matter hyperintensities volume, and neurodegeneration of the insula and superior temporal cortex.

The team concluded that surgeries are generally safe, but cumulatively associated with cognitive decline, and that neurodegeneration and perioperative brain health should be prioritised for older, vulnerable, and multiple-surgery patients.

The third project, conducting new trials informed by discovery, collaboration and new networks, led to the NHMRC-CTC-funded DECIDE trial investigating dexmedetomidine and delirium-free survival after cardiac surgery. An adaptive platform trial is being set up including an agreement on the required simulations, for which the team is seeking further funding.

This program has fundamentally advanced scientific knowledge of brain health and current best practice, defined the scope of potential cognitive harm and brain degeneration that may follow surgery, and evaluated the suitability of current guidelines for protecting brain health in Australian practice.

The team is now designing new trials to define therapies to protect our patients.

WHY IMMUNE-SUPPRESSING TREATMENTS MAY NOT WORK ALONE IN PREVENTING COMPLICATIONS

Project grant: RELIEF Genomics: Analysis of the impact of pre-existing differential DNA Methylation on inflammatory gene expression and the inflammatory response to major abdominal surgery

In 2024 the final report was received for this study led by Dr Chris Bain of Alfred Health, Melbourne, who received the Harry Daly Award for the highest ranked grant application in 2015. The team included Professor Andrew Shaw, Vanderbilt University, USA; Professor Tomas Corcoran, Monash University and University of Western Australia; and Dr Bozaoglu Kiymet, Baker IDI Heart and Diabetes Institute, Melbourne.

$A139,849 over two years

The study explored how DNA and gene activity influence inflammation after major abdominal surgery. A sub-study of the ANZCA CTN-endorsed RELIEF trial (3,000 high risk patients), RELIEF Genomics investigated whether pre-existing DNA changes (DNA methylation) may affect gene expression, and how the body responds to the stress of surgery.

This study, the first multi-omic analysis of its type in perioperative medical research, provided new insights into why some patients experience excessive inflammation after surgery, leading to complications. The analysis provided the foundations for a model of how postoperative systemic inflammatory dysregulation (PSID) develops, and the potential utility of corticosteroids in modifying the host response. It has been re-presented widely, and re-validated with an analysis of over 2500 RELIEF trial patients investigating the association between inflammation and patient-centred outcomes after major abdominal surgery.

The research also confirmed that increased inflammation (measured by C-reactive protein levels) is linked to poor quality of recovery and persistent disability, and highlighted the importance of inflammation as an independent modifiable risk factor mediating clinical outcomes. The findings support personalised perioperative medicine, utilising biomarkers to individually tailor treatment interventions such as steroids and antibiotics.

The key study outcomes:

- Confirmed that pre-existing DNA changes influence post-operative inflammation, and that DNA patterns of DNA methylation changes occur after surgery. The study did not find a link between pre-existing gene activity and inflammation afterwards
- Identified and validated of a harmful state of PSID, a widespread immune system disturbance affecting hundreds of genes
- Found that certain genes predict PSID, and poor recovery outcomes, well before symptoms appeared.
- Explained why immune-suppressing treatments like steroids may not work alone in preventing complications.

WORLD FIRST TECHNIQUES LEAD TO DISCOVERY IN CRPS

Project grant: Immune-to-brain signalling in CRPS: unravelling the detrimental relationship between inflammation and autonomic dysfunction

In 2022 Associate Professor Marc Russo, Hunter Pain Specialists, University of Newcastle and University of Sydney NSW, received an ANZCA Foundation Project Grant for this study. The team included Associate Professor Paul Austin, Professor Luke Henderson, and Professor Andrew Harman, University of Sydney; Professor Peter Drummond and Adjunct Professor Philip Finch, Murdoch University, Perth; and Dr Peter Georgius, Sunshine Coast Clinical Research, Queensland.

$A120,000 over two years

This Chronic Regional Pain Syndrome (CPRS) study has found for the first time that specific immune cells (Langerhans cells and CXCR3+ lymphocyte cells) were closer to nerves in the affected skin of CRPS patients, which may contribute to persistent pain.

It also found that the sensory cortex, thalamus and hypothalamus – brain regions responsible for pain and autonomic responses - respond differently to heat pain in patients with CRPS, suggesting these brain changes are responsible for propagating ongoing pain and autonomic symptoms in CRPS patients.

The study, Immune-to-brain signalling in CRPS: unravelling the detrimental relationship between inflammation and autonomic dysfunction, led by the University of Sydney's Associate Professors Marc Russo and Paul Austin, was completed this year. It also included two technical world-firsts: the first ever ultra-high resolution functional MRI study in CRPS, and the first high-parameter assessment of neuroimmune interactions in CRPS affected tissues.

These insights may lead to changes in clinical practice in treating CRPS. Understanding the pathogenic immune cell-nerve interactions could lead to targeted anti-inflammatory pain treatment strategies, and appreciating the pain pathway changes in specific brain regions could help to develop therapies to alter aberrant activity. Finally, identification of predictive immune biomarkers could enhance earlier diagnosis and treatment before long standing changes occur in the brain.

FIRST DEMONSTRATION OF MYOCARDIAL OEDEMA AS A COMPONENT OF INCREASED LEFT VENTRICULAR MASS IN PREECLAMPSIA

Project: Myocardial structure in preeclampsia using cardiac magnetic resonance and transthoracic echocardiography

Professor Alicia Dennis at The Royal Women's Hospital, Melbourne, received one of the foundation's project grants in 2017 for this study, completed in 2024. The team included Dr Sylvia Chen, Epworth Hospital, Melbourne; Dr Julian Castro, St Vincent's Hospital, Melbourne; and Dr Allan Wesley, The Prince Charles Hospital, Brisbane.

$A66,591

This was the first study to use cardiac magnetic resonance (CMR) to determine myocardial structure in women with preeclampsia, and the first to demonstrate myocardial oedema as a component of increased left ventricular mass in these women.

Preeclampsia is a devastating high blood pressure problem of pregnancy, with childbirth the only cure. Professor Dennis' team believed the key to understanding why preeclampsia occurs, and to finding better treatments, was to examine the heart using transthoracic echocardiography (TTE) and CMR, and aimed to improve understanding leading to better monitoring and the use of different medications to reduce complications in preeclampsia.

The specific aim was to define myocardial tissue characteristics using CMR and correlate with TTE in the antenatal period, determining whether observed changes return to non-pregnant reference values by six months post-birth.

This research work was the first-time in which analysis of the heart muscle was shown in patients with preeclampsia. It demonstrated that in a small cohort of patients the myocardial thickness observed on echocardiography was due to myocardial oedema, and not myocardial fibrosis, improving understanding of the pathophysiology of the condition, with implications for future treatments.

The study was an important one in a series of projects being led by Professor Dennis to understand the structure and function of the heart in people with preeclampsia, the underlying pathophysiology mechanism behind the condition, and potential solutions to the problem of high blood pressure in pregnant people. It contributed to Professor Dennis' 2023 Fulbright Scholarship to undertake further work in this area at the Brigham and Women's Hospital, and Harvard Medical School in Boston, USA, in 2023.

For information on key publications for these studies, please refer to 'Awarded grants and outcomes' on the 'Research grants' page of the ANZCA website.

CONTACT AND SUPPORT

To donate, please use the subscriptions form, search 'GiftOptions – ANZCA' in your browser, or scan the QR code.

For queries, contact:

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

Ebony Mourad, Fundraising Administration Officer, emourad@anzca.edu.au

Research grants program:

Susan Collins, Research and Administration Co-ordinator, scollins@anzca.edu.au

ANZCA Clinical Trials Network:

Karen Goulding, CTN Manager, karen.goulding@monash.edu

Expanding the scope of research in anaesthesia, pain medicine, and perioperative medicine

ABOVE

Darwin anaesthetist and researcher, Dr Edith Waugh, whose research is funded by a Health Equity Project grant.

When we think about research in anaesthesia, pain medicine, or perioperative medicine, large clinical trials and basic science investigations often come to mind. However, research is not solely about p-values and randomised controlled trials. Qualitative research offers a different lens to understand the underlying reasons, motivations, and interpretations behind human behaviour and experiences. It relies on data that is descriptive and not easily converted into numbers, such as interview transcripts, field notes, or visual materials.

Studies that explore the *how* and *why* questions often provide deeper insights into the social and technical environments in which we work. To answer these questions, we must engage with qualitative research, which helps generate explanations and new hypotheses. Increasingly, researchers are turning to mixed methods approaches, combining qualitative techniques with traditional statistical methods. This integration requires a distinct set of skills and perspectives.

THE ROLE OF THE ANZCA PROFESSIONAL PRACTICE RESEARCH NETWORK (PPRN)

The ANZCA Professional Practice Research Network (PPRN) was established to support and develop research in areas that have historically been under-represented in grant applications and publications. These include professionalism, advocacy, and quality improvement – such as educational research, usability, wellbeing, and communication.

The college is committed to supporting these non-traditional areas. The annual ANZCA competitive research grants now include a grant award specific to PPRN projects. Additional resources to support scholarship development are now also available through the ANZCA Library.

IMPACT AND RELEVANCE OF PPR RESEARCH

PPR research benefits all fellows and trainees by directly influencing how we educate, support wellbeing, and design safe, productive work environments. Examples include:

- Educational research to improve training outcomes.
- Studies on communication with patients and families.
- Research into the usability of tools and systems.
- Exploration of the social dimensions of clinical work, both inside and outside the operating theatre.

It has been inspiring to witness the growth of these research areas. Notably, the highest-ranked ANZCA research grants in 2024 and 2025 were awarded to PPR projects focused on wellbeing and burnout, and on empowering operating theatre teams to speak up about safety concerns.

RIGOUR IN QUALITATIVE RESEARCH

Qualitative research has sometimes been perceived as less rigorous than "number-based" clinical trials. However, it demands a similarly robust design. This includes careful attention to methodology, minimising bias, and ensuring a representative sample. In focus groups and surveys, questions must be relevant yet non-leading, allowing participants to express their views freely. Analysis must follow recognised methods and be grounded in a theoretical framework. Participants are often invited to review how their responses have been interpreted, providing clarification and ensuring accuracy.

SUPPORTING FIRST NATIONS AND MĀORI RESEARCH

In addition to the expansion of PPR-related research, there has been a welcome increase in First Nations and Māori research. The ANZCA Research Committee has broadened its grant assessment criteria beyond "international competitiveness" to include research that addresses local populations and disadvantaged groups. This ensures that research important for our regional context, often overlooked by international teams, is now being supported in addition to the highly valued work that our research community has achieved over many years.

ANZCA-funded research continues to have a significant global impact, and we remain a leading voice in anaesthesia, pain, and perioperative medicine.

HEALTH EQUITY AND GLOBAL DEVELOPMENT

Beyond the annual grants, the ANZCA Foundation also funds health equity and overseas development projects. Many of these intersect with PPRN themes, particularly around social and economic service improvements.

A recent example is the work of ANZCA fellow Edith Waugh, whose research – funded by a Health Equity Project grant – examines the perioperative journey of Aboriginal people in the Northern Territory. This project exemplifies the kind of meaningful, locally relevant research that the college is proud to support.

Associate Professor Stuart Marshall, FANZCA
Professor Kirsty Forrest, FANZCA
Associate Professor Matthew Doane, FANZCA

KEY PRINCIPLES OF HIGH-QUALITY QUALITATIVE RESEARCH:

Engages affected individuals from the outset, ensuring the research addresses what matters most to them.

Co-designs the research project in collaboration with participants, fostering shared ownership and relevance.

Recognises and reflects on researcher bias, promoting transparency and reflexivity throughout the process.

Includes a representative and diverse sample, capturing a broad range of perspectives and experiences.

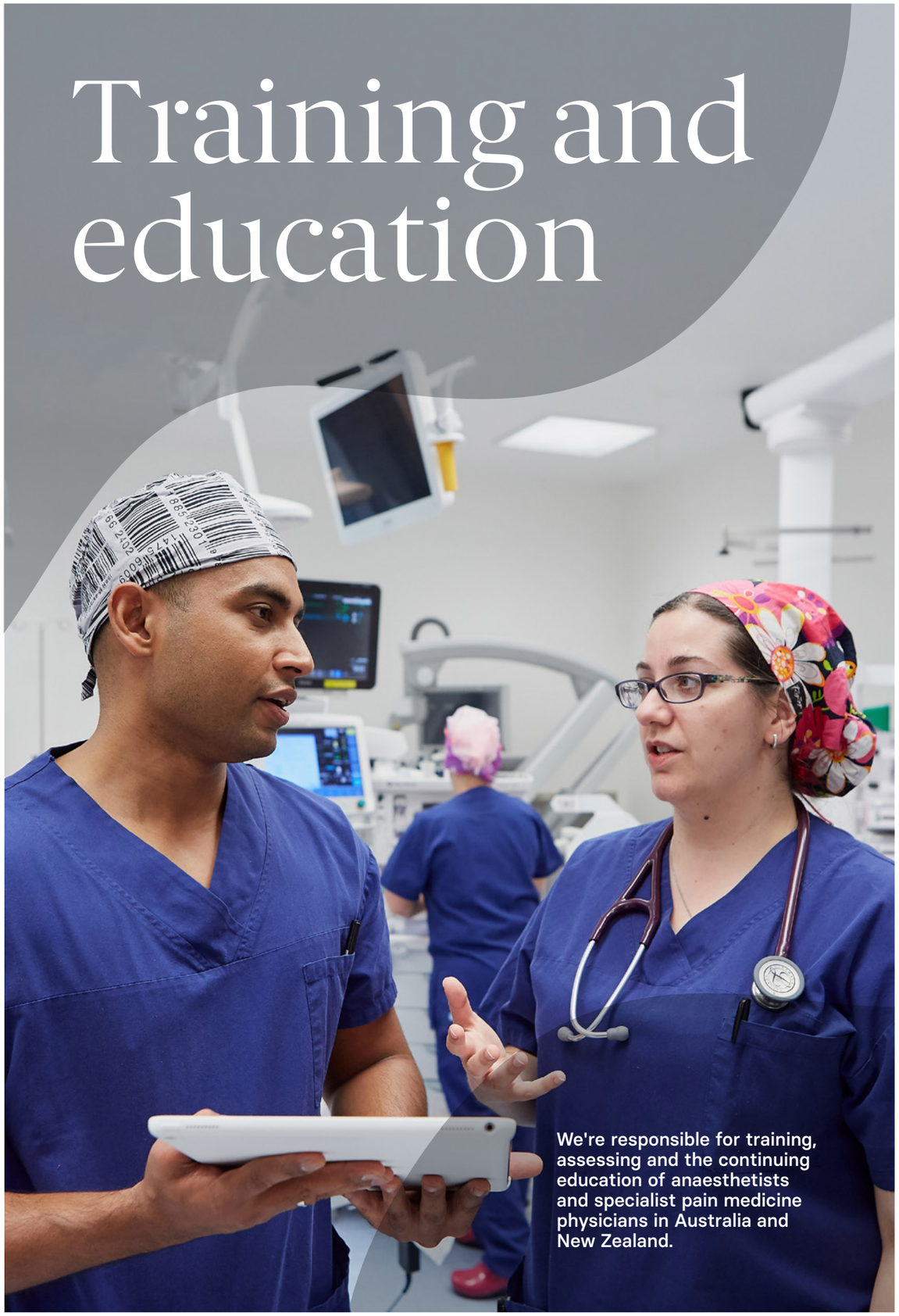
Is grounded in robust theoretical frameworks, providing depth and context to the inquiry.

Uses rigorous and well-established analytical methods, ensuring credibility and reliability of findings.

Respects cultural protocols and traditional methodologies, such as yarning circles or Kaupapa Māori principles.

Offers participants the opportunity to review and respond to findings before publication, respecting their voice and agency.

Training and education



We're responsible for training, assessing and the continuing education of anaesthetists and specialist pain medicine physicians in Australia and New Zealand.

Recognising Adelaide anaesthetist's years of trainee support

Anaesthesia trainee Dr Phil Harford celebrates specialist anaesthetist Associate Professor Venkat Thiruvenkatarajan.

In South Australia many anaesthesia trainees have worked and collaborated with Associate Professor Venkat Thiruvenkatarajan (Thiru) over a nearly 20-year career at The Queen Elizabeth Hospital (TQEH).

Originally trained in anaesthesia at Christian Medical College Vellore, India, Associate Professor Thiru immigrated to South Australia and began work as a consultant anaesthetist in 2008 after receiving his FANZCA.

He has played a pivotal role in establishing a clinical research stream within the anaesthesia department, fostering extensive collaborations with fellow clinical researchers both within Australia and internationally, including partnerships with various clinical departments and medical technology companies.

In addition to his clinical responsibilities, Associate Professor Thiru has made substantial contributions to clinical anaesthesia research, enhancing the evidence base for key techniques and perioperative considerations that improve patient safety. Collaborating closely with the endocrinology department at TQEH, he has published 11 articles focused on euglycaemic diabetic ketoacidosis linked to the newly introduced diabetic medications, the gliflozins, including a landmark systematic review published in the *British Journal of Anaesthesia* in 2019. His findings have been incorporated into organisational guidelines, such as those from the Australian Diabetes Society and ANZCA, directly translating research into improved patient outcomes.

Associate Professor Thiru's primary area of interest and expertise is in enhancing airway management during anaesthesia, with a strong emphasis on promoting high-flow nasal oxygen (HFNO) across diverse clinical settings. In the last five years he has contributed to 18 publications on improving airway management outcomes, exploring HFNO's applications, including its safety for procedural sedation during endoscopic retrograde cholangiopancreatography (ERCP). His outstanding work in this area was recognised with the John Smith Airway Paper of the Year Award in 2023 (seventh place) by the Association of Anaesthetists of Great Britain and Ireland (AAGBI). He has also collaborated with the distinguished UK expert, Professor Anil Patel, renowned for integrating the THRIVE methodology into clinical anaesthesia practice.

While Associate Professor Thiru has achieved success in his research career individually, he has also supported many prevocational trainees both before and during their training as ANZCA specialty trainees. He invited me to participate in a grant application that received the Elaine Lillian Kluver ANZCA Research Award in 2023, and he later supervised my own research thesis, which was awarded a Master's degree.

In the past decade he has successfully supported 13 trainees to enter specialty training, while also fostering their development as early career researchers. As a result of his mentorship, these prospective trainees have been credited with a total of 18 publications. Additionally, he supported and supervised nine other trainees during their training program, who have been credited with a total of 14 publications over the same period.

In the last 12 months, he has contributed to trainee-led projects that won both the Gilbert Troup Prize, the highest award at the Australian Society of Anaesthetists' annual scientific meeting, and the Emerging Investigator Award from the Australian Society of Anaesthetists for an article published in *Anaesthesia and Intensive Care*. In his last 60 publications, 80 per cent featured junior team members as co-authors, including 11 medical students.

In recognition of his exceptional contributions to both the University of Adelaide and the wider community, Associate Professor Thiru received the university's Outstanding Achievement Award in 2020.

I am not unique in the mentorship that Associate Professor Thiru has offered me as he has helped countless trainees in South Australia on their journey to becoming specialist anaesthetists.

He embodies many of the qualities that exemplify our profession – collaborator, scholar and medical expert – and continues to drive our specialty forward.

In his own words: "*The progress of our specialty is driven by clinical research; without it, the field risks stagnation, becoming reliant on established practices rather than evolving with scientific advancements.*"

Dr Phil Harford
Anaesthesia registrar
Flinders Medical Centre

ABOVE

From left: Trainee Dr Noor Baig, Dr Venkat Thiruvenkatarajan and Dr Phil Harford.

Simulation-based education: Keep it simple, SMART

LEFT and RIGHT

Healthcare simulation training at Royal Perth Hospital involves a team of consultants and nurse practitioners who use readily available equipment and facilities for their post-anaesthetic care unit education and training program for nursing staff.

Royal Perth Hospital is a large tertiary centre in Perth, Western Australia, with a 21-bed post-anaesthetic care unit (PACU). Within the department of anaesthesia and pain medicine, there is an active group of consultants who are regularly involved in healthcare simulation training across the hospital. Two provisional fellowship positions in simulation are also offered annually.

In January 2025, a team formed to develop a simulation-based tutorial program for the PACU nursing staff as part of the development of their education program. This included a consultant anaesthetist from the simulation group, a recent simulation fellow and the PACU clinical nurse (CN). Simulation in healthcare has long been established as an effective method of education and training. It plays a pivotal role in enhancing healthcare processes, contributing to safe workplace culture and ultimately improving mortality, morbidity and patient experience.[1] We used it here both to refresh technical knowledge and skills, and to reinforce crisis resource management (CRM) principles such as effective teamwork and communication.

Our program was straightforward to set up, took relatively little time to plan and run, and received excellent feedback. There were no equipment costs as we used readily available training equipment and conducted the sessions in situ. It all came together through the enthusiasm and dedication of a small team with experience and interest in simulation training. By sharing our approach, we hope to inspire others who identify an educational gap to undertake a simulation educator course and consider initiating a similar project.

LEARNING OBJECTIVES AND LOGISTICS

A survey was conducted among PACU nursing staff to evaluate their perceived confidence in managing several common emergency scenarios, as well as in calling for help. The question was also asked: "What scenarios or complications in the postoperative setting scare you the most?" Combining these responses with electronic data from the past twelve months detailing all events reported in the PACU, eight scenarios were developed to address the group's educational needs. The sessions were scheduled once a month and were of thirty minutes' duration, with a maximum of three participants. To increase fidelity and accessibility, the location was in a private corner cubicle within the PACU, with curtains drawn to increase psychological safety.

Each scenario design followed the same framework: learning objectives, equipment required, faculty required, mapping to relevant standards or guidelines. Insights from courses such as the ANZCA Educators Program were pivotal in guiding the development of three SMART (specific, measurable, achievable, relevant, and timely) learning objectives for each topic. Other material prepared included a short clinical handover for each scenario and a completed anaesthesia and drug chart. We elected to keep patient and surgical history concise to maintain focus on achieving the learning objectives.

Our simulation equipment included a basic head-and-neck mannequin, training equipment from our anaesthetic and PACU departments and scenario-specific adjuncts such as intravenous fluids and surgical drains. To simulate the vital sign monitor a free, open-source online simulation software[2] was linked to a computer screen placed behind the head of the bed. A facilitator controlled all vital signs via their mobile device, adjusting them according to how the scenario progressed.

SESSION FORMAT

Each session was designed to follow a similar structure:
1. Pre-brief, including introductions, faculty roles, confidentiality, respect and the fiction contract, and the basic assumption (maximum 5 minutes).

2. Simulation component (10-15 minutes).

3. Debrief and tutorial (10-15 minutes).

The most junior PACU nurse takes handover and commences their routine assessment, escalating for more help as the scenario evolves. The two other nurse participants wait outside the bedspace and can respond to a request for assistance. Participants are encouraged to retrieve equipment as they would in reality, and to verbalise how and who they would call for extra help.

Each session can be run by two facilitators (one anaesthetist, one nurse), but having a second anaesthetist is helpful. Faculty roles include playing the part of the embedded sim personnel anaesthetist or nurse, controlling the technology, and a facilitator. Following this, a short debrief around the bedspace is led by the facilitator, encouraging reflection on both technical skills and CRM principles. A short, interactive tutorial on the topic follows, ensuring the learning objectives are met. If time permits, the participants can be invited to practise skills on the mannequin. Afterwards, a follow-up survey gauges their confidence in managing this scenario post-simulation and allows for free text feedback to the team.

FEEDBACK

One hundred per cent of participants reported increased confidence in managing events such as laryngospasm, acute oxygen desaturation, postoperative haemorrhage, fast atrial fibrillation and seizures. Feedback was focused on the safe, non-judgemental learning environment, approachable teaching style and overall enjoyment of the sessions.

LESSONS LEARNED AND FUTURE DIRECTIONS

We demonstrated the feasibility of setting up a simple yet effective simulation education program. The main driver was the enthusiasm of our team, bolstered by the positive feedback we received. Tweaks to the format and scenarios have been made over time, based on our experience and participant suggestions. All our resources are now compiled in one dedicated file in the PACU office, with the hope that any anaesthetist and nurse with a simulation interest can select a scenario and run it that very same day.

We foresee many future avenues of application for this project. It could be extended to nursing staff in other areas who recover our post-anaesthesia patients, such as gastroenterology. Specific scenarios could be written based on major unexpected events that occur in the PACU, to aid in the learning and staff development process. The program is already underway in another local tertiary hospital, and we plan to share it further to supplement education for our PACU nurses and contribute towards improving patient outcomes.

Dr Hannah Wray, Provisional fellow
Dr Jingjing Luo, FANZCA
Ms Keisha Pavin, Registered Nurse
Royal Perth Hospital

Dr Wray is happy to be contacted for further advice on how to set up such a project, and to share the group's resources, including the prewritten scenarios. Contact: misshannahwray@gmail.com

References:

1. Diaz-Navarro, C., Armstrong, R., Charnetski, M. *et al.* Global consensus statement on simulation-based practice in healthcare. *Adv Simul* 9, 19 (2024)
2. Nunn, S. *Gas Notes Simulation Monitor* https://sim.gasnotes.net

ANZCA
FPM

Steuart Henderson Award

Nominations are being received for the 2026 ANZCA Steuart Henderson Award: awarded to an individual associated with ANZCA or FPM who has demonstrated excellence and provided outstanding contribution, scholarship, and mentorship to medical education in the fields of anaesthesia and/or pain medicine.

For nomination information including eligibility criteria visit the ANZCA website.

Nominations close 15 November 2025.

ANZCA
FPM

Dr Ray Hader Award for Pastoral Care

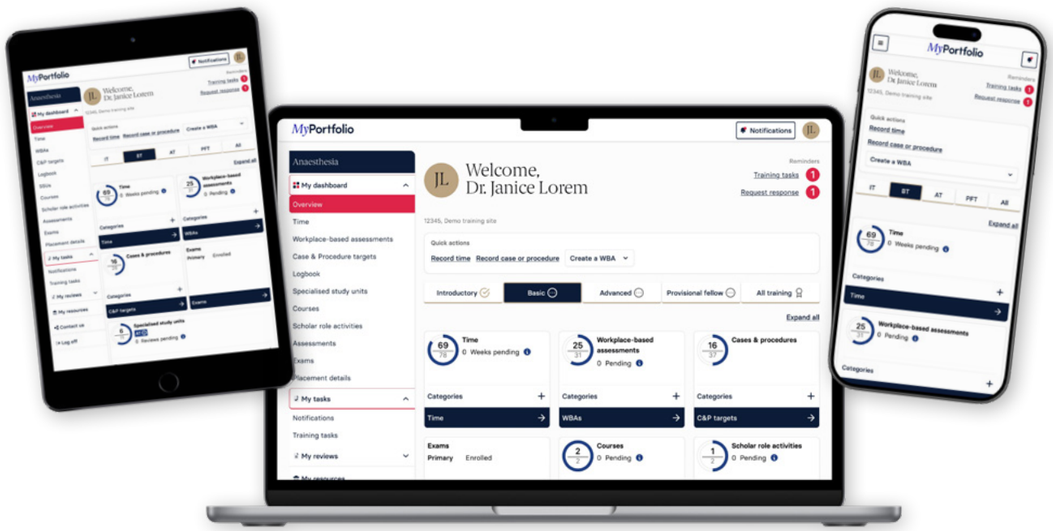
This award acknowledges the significant contribution by an ANZCA fellow or trainee to the welfare of one or more ANZCA trainees. The nature of such a contribution may be direct, in the form of support and encouragement, or indirect through educational initiatives or other strategies.

The award is named after Dr Ray Hader, a Victorian ANZCA trainee who died of an accidental drug overdose in 1998 after a long struggle with addiction. Established in memory of Dr Hader by his friend Dr Brandon Carp, this award promotes compassion and a focus on the welfare of anaesthetists, other colleagues, patients and the community. In 2012, Dr Carp agreed to continue sponsorship of the award and to expand the criteria to recognise the pastoral care element of trainee supervision.

The winner of the award receives $A2000 to be used for training or educational purposes. Any ANZCA fellow and/or trainee can be nominated for this award. View the full nomination process and application forms on our website.

Nominations must be emailed to training@anzca.edu.au by Monday 27 October 2025.

MyPortfolio: A carefully designed step forward



The college is pleased to announce the upcoming release of MyPortfolio, our new digital platform designed to support trainees throughout their entire training journey.

The first release is scheduled for late November 2025, and will replicate the core functionality of the current training portfolio system (TPS). This deliberate approach allows all users time to become familiar with the new platform before we introduce further enhancements in early 2026. The college has taken a measured and thoughtful approach – rather than launching all features at once, we are prioritising stability, usability, data accuracy and familiarity. This phased rollout ensures that users can build confidence in the system before engaging with new tools and workflows.

This project has been shaped by extensive consultation and collaboration from the very beginning. Insights have been instrumental in ensuring that MyPortfolio is not only fit for purpose but also intuitive and aligned with real-world training needs. By involving users early and often, we've been able to design a system that works well from day one, minimising disruption and maximising confidence in the transition.

Looking ahead to Q1 2026, we will introduce a suite of enhancements and new features based on user feedback and evolving training requirements. To support this, we are developing a comprehensive training package, including instructional videos, step-by-step guides and training, to ensure all users feel supported and informed. Rest assured that at go-live there will be additional support available to assist with transition, answer your questions, and gather feedback to continuously improve the guiding resources and materials.

We're excited about the future of MyPortfolio and grateful for the ongoing engagement of our training community. Your feedback continues to shape the platform, and we look forward to delivering a system that grows with your needs.

If you have questions or require more information please contact elevate@anzca.edu.au.

Open access, greater impact

How ANZCA Library is empowering researchers

ANZCA Library continues to play a pivotal role in supporting the college's research community, most recently through its participation in a transformative "read and publish" agreement with Springer Nature (as previously reported in the Autumn 2025 *Bulletin*). This consortia deal, which came into effect on 1 January 2025, enables ANZCA, FPM (and CICM) fellows and trainees to publish open access in eligible Springer and Palgrave hybrid journals without incurring article processing charges (APCs) – a significant financial and academic benefit.

A recent example of this in action is the publication of the article "Fluid responsiveness and hypotension in patients undergoing propofol-based sedation for colonoscopy following bowel preparation: a prospective cohort study" in the *Canadian Journal of Anesthesia*. Led by Dr Megan Allen FANZCA, the research team – Michael Kluger FANZCA, Frank Schneider FANZCA, Kaylee Jordan FANZCA, John Xie MD and Kate Leslie FANZCA – utilised the Springer Nature agreement to publish their findings open access, saving on an article processing fee (APC) of $US4390, or roughly $A6717 at current exchange rates.

Dr Allen highlighted the importance of this initiative:

"Having secured ANZCA Foundation grant funding to undertake this study several years ago, my budget did not include funds for article processing fees. Without ANZCA entering the consortia deal, I would have needed to either self-fund this [article], which is quite expensive, or accept the reduced exposure of subscription-only access. The new ANZCA arrangement to allow open access publication at no cost to investigators is a fantastic benefit."

The Springer Nature consortia deal is part of a broader movement within academic publishing to make research more accessible and equitable. By removing financial barriers to open access, ANZCA is helping ensure that fellows' and trainees' work reaches the widest possible audience without paywalls or delays. The deal covers a wide range of journals including *Journal of Anesthesia*, *Canadian Journal of Anesthesia*, *Intensive Care Medicine* and *Current Pain and Headache Reports*.

The benefits of open access publishing extend beyond just cost savings. Research shows that open access articles are more widely read and cited than those behind paywalls. A systematic review[1] published in *PLOS One* found that nearly 48 per cent of studies confirmed a citation advantage for open access articles, with some reporting increases of up to 83 per cent. Since Dr Allen's article was published in April, it has already been accessed over 1200 times, as well as being cited in two other articles – an encouraging sign of early engagement and visibility.

This success story also underscores the value of ANZCA Foundation grants, which continue to enable high-quality research that advances anaesthesia, pain medicine and perioperative medicine. Dr Allen and her colleagues received funding from the ANZCA Foundation to conduct this study, and the subsequent open access publication will amplify its reach and potential impact.

By combining funding support with strategic library initiatives like the Springer Nature deal, ANZCA is enabling researchers to maximise the visibility and accessibility of their work. This particularly applies to those fellows and trainees who may not have access to publishing deals available through most Australian and New Zealand universities. ANZCA Library remains committed to supporting open access publishing; we hope to be able to enter into more deals with journal vendors that allow our researchers to make their work free for anyone to read. For more information on how to take advantage of the Springer Nature agreement or other publishing support, visit the ANZCA Library website or contact the library team directly.

Reference

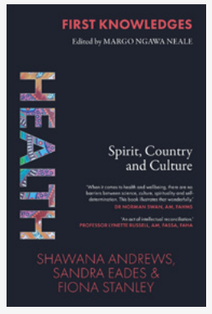
Langham-Putrow A, Bakker C, Riegelman A. Is the open access citation advantage real? A systematic review of the citation of open access and subscription-based articles. PLOS One. 2021;16(6):e0253129. doi:10.1371/journal.pone.0253129

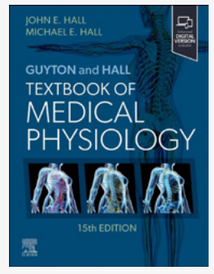
LEFT

Dr Megan Allen.

Latest books

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





Contact the library

+61 3 9093 4967 | library@anzca.edu.au

anzca.edu.au/library

Self matters

Kindness in healthcare: small acts, profound impact

Auckland anaesthetist Dr Jo Sinclair is the curator of the *ANZCA Bulletin's* Self Matters column. Here she explores kindness in healthcare.

When we talk about healthcare, we often focus on precision, performance, and protocols. Yet just as vital to safety and quality is something quieter: kindness.

Professor Catherine Crock AM has spent more than two decades championing this idea through the Hush Foundation and the Gathering of Kindness. More recently, her son Dr James Phillips, an anaesthetist, has joined her in showing how kindness shapes culture, performance, and patient safety.

I spoke with Cath and James about their experiences. What emerged is a reminder that kindness is not "soft" or optional – it is central to safe, sustainable, and human healthcare.

If you, or someone you know, has a wellbeing story you'd like to tell, please email me at Joanna.Sinclair@tewhatuora.govt.nz

Dr Jo Sinclair, FANZCA

BEYOND PAIN RELIEF: A WHOLE ENVIRONMENT

Cath's journey began in paediatric haematology where children endured repeated invasive procedures. Families helped her see that it wasn't just the pain that distressed them, but the whole environment – the noise, the chaos, the lack of calm. One of the things they suggested would help was music.

That feedback led to Cath establishing the Hush Foundation, bringing composers into hospital spaces to reflect on what those sound environments are like, and how clinical teams could help to reduce patient stress and anxiety through the use of the right sort of music. The Hush Foundation has now produced 25 albums of newly-composed music by about 150 different Australian composers. But the project has expanded beyond soundscapes.

Through a Churchill Fellowship, Cath saw how staff behaviour and organisational culture were inseparable from patient safety.

"It's very difficult to deliver patient-centred care if staff themselves don't feel cared for," she explains.

Out of this insight came three plays portraying real stories of communication, kindness, and error. Each lasts half an hour and is followed by a facilitated discussion. For the past decade Cath has also hosted the Gathering of Kindness, an annual meeting of people interested in improving kindness at every level of healthcare.

WHY KINDNESS MATTERS

James has been able to work with his mother on multiple occasions over his career – she taught him to do lumbar punctures when he was a paediatric resident, and then he was able to anaesthetise for her lists as an anaesthetic registrar and then a fellow. He is, unsurprisingly, well-versed in both the theory and practical application of kindness in clinical settings.

For James, kindness is both a value and a safety tool.

"There are two reasons to be kind," he says. "First, it's simply the right thing to do. But second, the evidence is clear – kind teams perform better, and patients are safer."

He recalls a theatre list where a coordinator brusquely told the team to hurry or cases would be cancelled. Morale collapsed, efficiency worsened, and mistakes crept in. On another day, a leader offered encouragement and asked what support was needed. The result was the opposite: cohesion, calm, and better performance.

Kindness, James stresses, doesn't need to be time-consuming. A smile, a thank you, a genuine check-in with colleagues are seconds out of a day, but with disproportionate impact.

MORE THAN "BEING APPROACHABLE"

Both Cath and James emphasise that kindness underpins psychological safety. It's not enough to be approachable – leaders must actively invite concerns. James reflected on an incident where a colleague failed to raise an airway problem because she assumed he knew best. "That moment taught me you have to explicitly ask for input," he says.

Simple rituals help. Pre-list huddles that begin with introductions and a check-in create openness. Post-list huddles that include gratitude reinforce team connection and improvement. These practices build the trust needed for people to speak up – a foundation for patient safety.

STRUCTURAL KINDNESS AND LEADERSHIP

Kindness must also be designed into systems.

"How can you be kind in your workplace if the workplace is structurally unkind?" Cath asks. Rosters, policies, and performance pressures either support or undermine kindness.

Leaders can make a difference by showing curiosity – walking the floor, listening, and asking staff about "the pebbles in their shoes." Small gestures matter too. James recalls as an intern being thanked by the head of department during a gruelling shift: "Six seconds of her time made me feel seen and valued. It made all the difference."

START SMALL, START NOW

For those wondering how to begin, Cath's advice is simple: start where you are. Bring the word kindness into meetings. Begin with a moment of gratitude. Check in with your team before diving into the agenda. Notice the ripple effects.

Professor Catherine Crock AM is a physician at the Royal Children's Hospital in Melbourne and a prominent advocate for patient-centred care. In 2000, she founded the Hush Foundation, a charity dedicated to transforming healthcare by fostering kindness and integrating the arts into medical settings.

Professor Crock has implemented numerous initiatives to enhance collaboration between patients, families, and healthcare professionals, aiming to improve the overall healthcare environment. Under her leadership, the Hush Foundation has produced original music, theatre, and literature to promote cultural change, staff wellbeing, and patient safety within healthcare institutions.

Professor Crock was awarded a Churchill Fellowship in 2009 and a Member of the Order of Australia in 2015, for her services to medicine, community and the arts. In 2023, she received an Australian Independent Records Award for her outstanding contribution to Australian music. Her dedication to improving patient experiences and fostering a culture of kindness in healthcare has made her a respected figure both nationally and internationally.

Dr James Phillips is a consultant anaesthetist in Melbourne. He spent several years training in paediatrics in Melbourne and Alice Springs before moving into anaesthesia. In 2023 he completed a fellowship at the Royal Children's Hospital and The Alfred hospital, and is now working part time at The Alfred and part time looking after three boisterous young children. Dr Phillips has a special interest in wellbeing, kindness and teaching, as well as using simulation to improve communication and teamwork.

ABOVE FROM LEFT

Dr James Phillips with his mother Professor Catherine Crock and son Henry at the ANZCA College Ceremony in Brisbane in 2024.

Professor Crock with musicians Ed LeBrocq (left) and Slava Grigorian.

James agrees: "Kindness doesn't compete with efficiency. Often it takes no extra time at all – and it prevents errors, builds trust, and improves outcomes."

Consider the new junior doctor who makes a substandard phone referral – perhaps they are overwhelmed, stressed and in need of some help, rather than just a "bad doctor". Yet they are more likely to be dismissed, or meet resistance to their request, rather than getting the help they need, which in turn may become a patient safety issue.

A HUMAN FOUNDATION

Healthcare will always involve complexity, urgency, and challenge. But amid that, kindness reminds us of our shared humanity. It fosters connection, safety, and meaning in our work.

As Cath explains: "Bring your whole self to work, connect with curiosity and respect, and we get the best out of everybody."

Kindness, then, is not a luxury. It is a clinical, cultural, and moral imperative. And it starts with the smallest of actions.

References

1. https://www.hush.org.au
2. https://www.civilitysaveslives.com/theevidence
3. https://insightplus.mja.com.au/2017/35/patient-staff-safety-and-wellbeing-time-for-kindness/
4. https://insightplus.mja.com.au/2020/24/covid-19-a-chance-to-embed-kindness-in-our-health-care/
5. Brewster DJ, Rees CE, Leech M, Thompson G. Kindness and competition: Are we striking the right balance in medical education? AMJ 2018;11(5):313–315.

Free ANZCA Doctors' Support Program

Converge international

How to make an appointment:

To speak with a counsellor over the phone or make an appointment to see a consultant for a face-to-face session:

- Telephone 1300 687 327 in Australia or 0800 666 367 in New Zealand.
- Email eap@convergeintl.com.au
- Identify yourself as an ANZCA/FPM fellow, trainee or SIMG (or a family member).
- Appointments are available from 8am to 6pm Monday-Friday (excluding public holidays).
- 24/7 emergency telephone counselling is available.
- Go to your app store to download the Converge International app.

HELP IS ALSO AVAILABLE VIA THE Doctors' Health Advisory Services:

NSW and ACT	02 9437 6552
NT and SA	08 8366 0250
Queensland	07 3833 4352
Tasmania and Victoria	03 9280 8712
WA	08 9321 3098
Aotearoa New Zealand	0800 471 2654
Lifeline	13 11 14
beyondblue	1300 224 636

WELLBEING HUBS

For Aboriginal and/or Torres Strait Islander Peoples

Australian Indigenous HealthInfoNet. Connection. Strength. Resilience. Social and Emotional Wellbeing Resources at healthinfonet.ecu.edu.au/

www.13yarn.org.au

wellmob.org.au

For Māori

Kaupapa Māori wellbeing services at https://www.wellbeingsupport.health.nz/available-wellbeing-support/kaupapa-maori-wellbeing-services/

Are you an emerging leader in anaesthesia or pain medicine?
Do you want to meet and learn from like-minded emerging leaders?
Do you want to enhance your leadership within your workplace?
Are you within five years of fellowship (taking into account career disruption)?

THEN APPLY NOW FOR THE 2026 ELC!

To apply, simply complete the online application form available on the meeting webpage (available via the QR code) and email a copy of your curriculum vitae to the meeting organiser (events@anzca.edu.au) by **Thursday 23 October 2025.** Successful applicants will be notified in mid-December.

THINKING OF APPLYING FOR THE 2026 EMERGING LEADERS CONFERENCE?

Check out what a few of our 2025 delegates had to say about their experience.

The overarching theme that I came away with at this year's Emerging Leaders Conference (ELC) was connection – to people, to understanding their important whys, and to the land itself.

We were welcomed on arrival by Gavin Singleton, a member of the local Yirrganydji people, the traditional custodians of the area. He left us with a powerful invitation: go down to the water and introduce yourself to the land. It was a deeply grounding concept – a way of connecting to place that I had never clearly articulated before.

One of the most valuable aspects of the ELC was the opportunity to speak with leaders beyond the formal sessions. These candid conversations offered insights, inspiration, and future relationships that few other meetings could offer. It also allowed meaningful connections with fellow participants – people from across our specialty whom you may never have otherwise had the opportunity to engage with.

To any new ANZCA leader contemplating applying, I would say unequivocally: the three days were inspiring, energising, and not to be missed.

Dr Lisa Barneto, FANZCA

I was lucky enough to be a presenter at the ELC last year at Mt Tamborine, the land of the Yugembeh-speaking Wangerriburra people. I was invited back this year as a delegate, this time at Port Douglas, the land of the Yirrganydji people.

Being a recent new fellow, it provided a great opportunity to review the vision of the leaders of ANZCA and FPM. The ELC allowed for honest conversation about our shortcomings as a college, a challenge of a hopeful direction that embraced diversity, and inclusion of different ideas, values and culture to truly reflect the communities we all service.

I would recommend any new fellow who wants to see improvements in our college, hospitals and departments to attend the ELC in 2026. There you'll find mentors and like-minded colleagues who will help you develop resilience and the skills needed to face the new and old challenges that we all face as anaesthetists.

Dr Gene Slockee, FANZCA

The ELC provided an exceptional platform to connect with emerging leaders in anaesthesia and pain medicine from across Australia, New Zealand, and internationally. A central theme of the conference was leadership at all stages of one's professional journey. The sessions were thoughtfully designed to encourage delegates to embrace leadership roles early and to develop a proactive mindset towards effecting positive change. The emphasis on adventurous and reflective leadership resonated strongly with me, reinforcing the importance of self-awareness and resilience in clinical, managerial and academic settings. Standout sessions focused on navigating hierarchy within healthcare environments, supporting colleagues through medico-legal issues, and a workshop on self-awareness and habits. Attending the 2025 ELC has been a profoundly enriching experience. I am grateful for the opportunity and committed to applying these learnings to my professional development and clinical practice.

Dr Zoe Vella, FANZCA FFPMANZCA

SCAN TO APPLY

Addressing the Christmas workforce rostering bias

Workforce rostering during holiday periods is a well-recognised challenge, particularly in healthcare, where a continuous uninterrupted service must be maintained.[1] A growing conversation in workplace equity is the concept of "Christmas bias": the tendency for child-free employees to be more frequently scheduled to work during major holiday periods, while colleagues with children are often prioritised for leave.[2-8]

This pattern is rarely intentional: rather, it often develops informally as workplaces seek to accommodate employees with family responsibilities. However, when examined through a diversity and inclusivity lens, it raises important questions about how leave is allocated and whether existing practices unintentionally place a disproportionate burden on certain population groups.

The impact of holiday rostering extends beyond family status. Employees from diverse cultural and religious backgrounds may also experience an expectation to cover shifts during Christmas, particularly if their own significant holidays, such as Ramadan, Hanukkah, Diwali, or Lunar New Year, are not as widely recognised in leave planning.[9,10]

UNDERSTANDING THE BROADER IMPACT

Hours at work mean fewer hours socialising with family and colleagues and gaining "social capital". Social capital may play a more significant impact in workplace advancement than actual contributions at work.[11-13]

Furthermore, a truly inclusive and balanced workplace reflects a mix of backgrounds, life stages, and personal circumstances, including employees with children, those without, single individuals, LGBTQ+ professionals, and those from different cultural and faith-based traditions. When a workplace regularly struggles with leave planning because a significant portion of the workforce falls into a single demographic (for example, primarily parents of school-going children), this may indicate an opportunity to enhance workforce diversity and inclusivity.

Beyond equity concerns, holiday rostering practices can have unintended social and psychological effects. Employees without children, particularly those who are single or have family overseas, often rely on holiday periods as their only opportunity to reconnect with loved ones. When they are routinely expected to work while others celebrate, it can contribute to feelings of perceived unfairness, social isolation and exclusion. A perception of unfairness has been associated with an increased risk of burnout.[14]

FOSTERING AN INCLUSIVE APPROACH TO LEAVE PLANNING

As medical professionals we recognise the importance of fair and transparent workforce policies that support all staff members. With some thoughtful adjustments, rostering decisions can better reflect the diverse needs of the entire team. Some strategies for consideration include:

- Rotational scheduling – ensuring that major holiday shifts are shared over time so that no single group is consistently assigned to work during festive periods.
- Recognising diverse personal commitments – supporting all employees – whether they are parents, caregivers, or simply need time with loved ones – by acknowledging that everyone's non-work time is valuable.
- Inclusive workforce planning – if rostering challenges frequently arise due to leave requests from one particular demographic group, this may be an opportunity to assess whether the workforce composition could be more diverse.
- Encouraging open discussions – creating space for staff to communicate their availability and preferences for holiday shifts can foster collaboration and shared decision-making, reducing the risk of unintentional bias.

BUILDING AWARENESS FOR A MORE EQUITABLE WORKPLACE

The goal of this discussion is not to remove flexibility for parents but rather to ensure fairness for all employees. Recognising Christmas bias does not mean shifting the burden to another group, it simply means ensuring that rostering practices are equitable, inclusive, and considerate of all team members.

By fostering transparent leave planning and inclusive scheduling approaches, we can create a workplace where everyone feels valued and respected, ensuring that holiday rostering is fair, balanced, and sustainable for the entire team.

Dr Gladness Nethathe, FANZCA (Queensland)
Dr Benn Lancman, FANZCA (Victoria)
Members, Gender Equity Sub-committee

References

1. Hurt GM, Dexter F. Narrative review of mathematical and psychological studies of staff scheduling for holidays as applicable to anesthesiologists and nurse anesthetists. J Clin Anesth. 2023 Sep;88:111142. doi: 10.1016/j.jclinane.2023.111142. Epub 2023 May 6. PMID: 37156087.
2. https://news.st-andrews.ac.uk/archive/child-free-employees-face-christmas-bias-according-to-university-of-st-andrews-business-school-research/
3. https://www.abc.net.au/news/2024-12-23/the-pressure-to-work-holiday-periods-when-you-dont-have-kids/104651918
4. https://www.hrgrapevine.com/content/article/news-2017-08-15-childless-employees-are-picking-up-the-slack-from-parents
5. https://wearechildfree.com/childfree-at-work/
6. https://www.hertelier.com/post/childfree-women-face-more-challenges-than-you-think-at-work
7. https://childfreehappilyeverafter.com.au/childfree-at-work/childfree-at-work-survey/
8. https://www.semanticscholar.org/paper/Childfree-Women%3A-Navigating-Perceptions-and-a-McCluskey/fe1f8a09c8dd464df489269d234b22e93827ca02
9. https://www.brightmine.com/us/resources/hr-strategy/dei/accommodating-religious-holidays/
10. 2025 Calendar of cultural and religious dates. Department of Home Affairs Website. Department of Home Affairs Website. Available at: https://www.homeaffairs.gov.au. Accessed September 12, 2025
11. The Importance of Social Capital in the Workplace and How Individuals and Organizations Can Support Its Development. January 2013. In book: The fulfilling workplace: The organization's role in achieving individual and organizational health (pp.105-117).Publisher: Gower
12. Jutengren, G., Jaldestad, E., Dellve, L., & Eriksson, A. (2020). The Potential Importance of Social Capital and Job Crafting for Work Engagement and Job Satisfaction among Health-Care Employees. International journal of environmental research and public health, 17(12), 4272. https://doi.org/10.3390/ijerph17124272
13. Pihl-Thingvad, S., Winter, V., Schelde Hansen, M., & Willems, J. (2022). Relationships matter: how workplace social capital affects absenteeism of public sector employees. Public Management Review, 26(4), 1033–1060. https://doi.org/10.1080/14719037.2022.2142652
14. Howard, L.W., Cordes, C.L. Flight from Unfairness: Effects of Perceived Injustice on Emotional Exhaustion and Employee Withdrawal. J Bus Psychol 25, 409–428 (2010). https://doi.org/10.1007/s10869-010-9158-5

A first for PNG team leading Solomon Islands workshops

A team from Papua New Guinea (PNG) has for the first time led an obstetric and paediatric anaesthesia course in Solomon Islands.

The Safer Anaesthesia From Education (SAFE) workshops, focusing on obstetric and paediatric anaesthesia, were held at the National Referral Hospital in Honiara under the World Federation of Societies of Anaesthesiologists (WFSA) endorsed program from 2–6 June.

The program attracted nearly 30 local participants including anaesthesia consultants and registrars, paediatric and obstetric consultants, registrars and nurses, rural generalist doctors and medical officers and surgical department representatives for each course.

The initiative brought together anaesthesia and perioperative care professionals from across Solomon Islands, PNG and Australia, with the goal of strengthening capacity in delivering safe and effective anaesthesia care, particularly in maternal and child health.

The participation of the PNG team was made possible through an ANZCA Health Equity Projects Fund grant which provided travel and accommodation for five of the facilitators.

The PNG team included anaesthetists Dr Pauline Wake (leader), Dr Keno Temo and Dr Lisa Akelisi, who worked with the in-country coordinator, Dr Jack Puti, to facilitate the program.

The Australian facilitators included Dr Yasmin Endlich, Dr Michael Cooper, Dr Nur Lubis and Dr Sei Nishimura.

Certification ceremonies were held for participants after the two workshops with the superintendent of the National Referral Hospital, Honiara, Dr Janella Solomon, and a representative from the Australian Department of Foreign Affairs and Trade (DFAT).

It is hoped that the involvement of the National Referral Hospital and DFAT will allow for partnerships for future SAFE programs and collaborations between PNG, Solomon Islands and Australia.

Dr Wake and Dr Endlich conducted a "grand round" session at the National Referral Hospital during the visit where they discussed available training pathways for Solomon Islands doctors in PNG and opportunities for postgraduate and subspecialty training via the University of Papua New Guinea.

Positive feedback was given by participants in the workshops with interest expressed by participants and administrators for future courses in perioperative safety, rural anaesthesia, and neonatal emergency care. Another SAFE paediatric and obstetric course, led by anaesthesia colleagues from PNG and Solomon Islands, is being planned for 2026.

Global Development Committee Chair Dr Yasmin Endlich said the SAFE courses were a great success as they helped strengthen the capacity of the Solomon Islands anaesthesia department and health workforce, and fostered networking and relationships within the Pacific anaesthesia community.

"The exciting part about the SAFE course is that for next year it is hoped that it will be held in Solomon Islands by a nearly purely Pacific team: the three anaesthetists from PNG, together with three anaesthetists from Solomon Islands and myself as the only Australian in a supporting role.

"The delivery of the SAFE courses was made possible with the support of organisations such as ANZCA, the WFSA, the University of PNG's School of Medicine and Health Sciences, Port Moresby General Hospital and the National Referral Hospital, Honiara" she explained.

"This initiative not only met its objective of knowledge and skills training but also expanded the understanding of perioperative team roles and multidisciplinary collaboration in maternal and child care."

ABOVE FROM LEFT

PNG-led workshops in the Solomon Islands focused on paediatric and obstetric anaesthesia.

To donate, please use the subscriptions form, search 'GiftOptions – ANZCA' in your browser, or scan the QR code.

Samoa simulation training a drawcard for paediatric anaesthesia course

In May 2025, Tupua Tamasese Meaole (TTM) Hospital in Apia, Samoa was the setting for a week of immersive, simulation-based training in paediatric anaesthesia emergencies.

Across five days, 55 healthcare professionals including anaesthetists, paediatricians, emergency clinicians, and nurses participated in the Pacific Paediatric Anaesthesia IN-situ Teams (PAINTS) course. This one-day multidisciplinary program was designed to teach the recognition and structured management of critically unwell children using principles from simulation courses developed at The Children's Hospital in Westmead.

Developed in 2022 by anaesthetists Dr Nilru Vitharana and Dr Sally Wharton, and supported by grants from the ANZCA Foundation, Pacific PAINTS was created for health practitioners across the Pacific nations. Having been held in Fiji and Timor-Leste, the May course marked its first delivery in Samoa. This was facilitated by Dr Vitharana, Dr Wharton, and co-facilitator Dr Mari Koyanagi with the support of TTM Hospital's head of anaesthesia Dr Cecilia Vaai Bartley.

Samoa is a nation of about 200,000 people spread across two main islands, with TTM Hospital serving as the country's main referral centre. Like many Pacific nations, the Samoan healthcare system faces challenges typical of resource-limited settings: constrained critical care infrastructure, limited sub-specialty services, and a stretched workforce. In paediatrics, these challenges are heightened by the urgency and complexity of high-acuity cases, often managed without immediate access to specialist teams.

The PAINTS simulations focused on real-life anaesthesia emergencies encountered in paediatric settings including sepsis, airway compromise, anaphylaxis, trauma, and burns. The scenarios were deliberately low fidelity, developed with the region's limited resources in mind and with an emphasis on environmental sustainability.

Content was thoughtfully tailored to align with local protocols and team structures, encouraging teams to problem solve within their real-world context. Through scenario-based learning and structured debriefs, participants explored both technical and non-technical skills, highlighting system-based challenges such as role clarity, communication, escalation pathways, and equipment readiness. The course is multidisciplinary to reflect the team response to crises in paediatric anaesthesia. Both nursing and medical staff from the anaesthesia, emergency, paediatric and intensive care departments participated as mixed teams in the scenarios.

Participant feedback was overwhelmingly positive. Many valued the rare opportunity to practise in multidisciplinary teams, reflecting on situations that are high stakes but infrequent.

"What I liked most about this course is that we all got the chance to perform different simulations and participate with colleagues from other areas, where every member had a part in the paediatric emergency."

ABOVE

Happy PAINTS participants at the end of the day.

"Words of appreciation to our teachers for this wonderful course and for their lovely heart and kindness throughout. Really appreciated."

In addition to the in-situ course delivery, the PAINTS team was invited to present at TTM Hospital's weekly continuing medical education (CME) session where Dr Koyanagi revisited core resuscitation algorithms and highlighted key updates to the advanced paediatric life support guidelines.

Dr Bartley was instrumental in coordinating staff rosters and embedding the course into the hospital's education calendar without disrupting clinical services. Several departments within the hospital already conduct regular in-situ simulation in coordination with other Australian specialist colleges, with sessions occurring as often as weekly or fortnightly – a testament to the hospital's proactive culture of learning.

Simulation is increasingly recognised as a vital tool in anaesthesia and critical care education. It promotes interprofessional learning, boosts confidence in emergency scenarios, and can be readily integrated into ongoing training. For resource limited environments like Samoa, this kind of adaptable, locally-driven education has the potential to significantly enhance both individual and team readiness.

As part of ANZCA's broader commitment to supporting healthcare education in the Pacific region, the PAINTS course continues to grow. While the course itself may be brief, the facilitators hope it contributes to a lasting impact on confidence, preparedness, and team dynamics.

The facilitators would like to sincerely thank the staff of TTM Hospital for their warmth, professionalism, and enthusiasm, and acknowledge the ongoing support of ANZCA in empowering clinicians across the Pacific.

Dr Mari Koyanagi, FANZCA
Great Ormond Street Hospital, UK
Royal North Shore Hospital, NSW

Dr Nilru Vitharana, FANZCA
The Children's Hospital at Westmead, NSW

Dr Sally Wharton, FANZCA
The Children's Hospital at Westmead, NSW

Acknowledgements

This activity was supported in full by a Health Equity Projects Fund grant from the ANZCA Foundation.

ABOVE FROM LEFT

Dr Cecilia Vaai Bartley and team.

Dr Nilru Vitharana, creator of Pacific PAINTS course.

Jeanette Rae Thirlwell

1938 – 2025

Jeanette was an outstanding paediatric anaesthetist in Sydney. She spent her second year in 1963 at the Royal Alexandra Hospital for Children (the Children's Hospital at Camperdown) where she was later to devote her clinical career.

Jeanette grew up in Sydney and attended North Sydney Girls High where she was vice-captain and excelled at languages and hockey. She graduated in medicine from the University of Sydney in 1962 and represented in A-grade hockey. She also maintained her love of music, playing cello and piano, and was an avid concert-goer.

Jeanette undertook her anaesthesia training and extensive higher-level paediatric anaesthesia in Nottingham, Rotterdam, Hobart, Melbourne and Sydney, and spent two years as an assistant professor at Stanford University, California. She returned to the Children's Hospital at Camperdown in 1971 where she was to spend the next 35 years of her professional career, finishing at the Children's Hospital at Westmead in 2005. A major component of her clinical work was for paediatric cardiac surgery.

Jeanette Thirlwell was widely known to the anaesthesia communities of Australia, New Zealand and globally due to her skills in medical publishing. She started in 1976 as assistant to Ben Barry, founding editor of *Anaesthesia and Intensive Care*, and this led to more than forty years with the journal. She became assistant editor in 1979, was awarded a Diploma of Publishing and Editing in 1989, and held various positions, becoming the executive editor from 1993–2014. Nothing happened within the journal without Jeanette knowing about it and being sure it was correct!

In 2005 she and her friend Dr Richard Bailey initiated the journal's annual History Supplement which continues to publish scholarly works. They edited this for nine years. It is appropriate that the annual Best Paper Award in *Anaesthesia and Intensive Care* was renamed the Jeanette Thirlwell Best Paper Award in 2014.

Jeanette loved history and was a stalwart of all areas of anaesthetic and medical history. Jeanette was a friend and supporter of Dr Gwen Wilson, a renowned anaesthetic historian who recorded the history of the development of anaesthesia in Australia from 1846–1962. Jeanette edited the two volumes of Gwen's *One Grand Chain: The History of Anaesthesia in Australia*, which was published by the college. She also coordinated the Gwen Wilson Archives Project cataloguing all of Dr Wilson's historical records that are archived within ANZCA and the ASA. Jeanette organised and chaired many conference sessions for the college and the ASA, including chairing the History of Anaesthesia special interest group.

Some of the major publications that Jeanette edited and was involved with include:

- 1992 Kerr D, Thirlwell J. *Australasian Anaesthesia*.
- 1995 Wilson G. *One Grand Chain*: *The History of Anaesthesia in Australia*. Volume 1: 1846-1934.
- 2004 Wilson G, Kaye G, Phillips G, Baker B. *One Grand Chain: The History of Anaesthesia in Australia*. Volume 2: 1934-1962.
- 2004 Wilson G. *One Grand Chain*. Volume 1: Book of References.
- 2014 Phillips GD. *Intensive care medicine in Australia: Its origins and development*.
- 2016 Cooper MG, Ball CM, Thirlwell JR. *Proceedings of the 8th Symposium on the History of Anaesthesia*.

Many did not realise that Jeanette also served on the publications committee of the World Federation of Societies of Anaesthesiologists and co-edited the major paediatric anaesthesia textbook *Understanding Paediatric Anaesthesia*. This became an important text in low-resource settings around the world.

Jeanette's commitments and many contributions have been acknowledged by her peers with the following awards:

1994 President's Award ASA

1997 Robert Orton Medal ANZCA

2000 Ben Barry Medal ASA

2005 Life Membership of the ASA

To all her professional colleagues, Jeanette was quiet, focused and determined to contribute and achieve – at the highest level. She had a quick, dry sense of humour, and was meticulously organised! She sat on an early Faculty of Anaesthetists Committee for the training of women in anaesthesia, wrote an editorial on this topic and was an underappreciated role model for women in anaesthesia and medicine. Her editing work was extremely time-consuming, but this was achieved efficiently along with her clinical work, a busy family life, and time for classical music, sailing and cross-country skiing.

In an email in 2007, she stated:

"I've loved my involvement in all aspects of my appointments... It gives one a sense of being able to contribute to others' progress and ultimate welfare... Medicine is such a wonderful field to work in! What a privilege!"

In 1971, Jeanette married Dr Bob Jones, a paediatric neurosurgeon, who supported her fully in all her endeavours. With Bob, Jeanette had an instant family of five teenage stepchildren, and then went on to have Caroline and Paul. She is survived by her children, stepchildren and their families.

Dr Michael Cooper, AM
Honorary Historian, ANZCA

David Peter Tomkins

1947 – 2025

David Peter Tomkins was born on 23 August 1947, in Barrow-in-Furness, a town in England's north-west. He was the second of three children, in a family that valued education and independent thought. David's early childhood was spent surrounded by open spaces and fresh air. He loved walking the hills near England's stunning Lake District, where he discovered his lifelong love of nature and the outdoors.

In his teens, Dave left the UK for South Australia with his parents and sisters. They settled in Port Noarlunga, where he completed his schooling at Seacombe High School. He was among the first students at the newly established Flinders University and later finished his medical studies at the University of Adelaide. Dave adopted the Norwood Football Club and later also became a dedicated supporter of the Adelaide Crows.

Dave began his anaesthesia training in Adelaide and, after attaining his FANZCA, broadened his experience by working for a year in Cardiff, Wales. In 1982 he joined the Department of Paediatric Anaesthesia at Adelaide Children's Hospital (now the Women's and Children's Hospital), which is when I first got to know Dave. He always said it was his dream job, and he brought a committed professional approach to his clinical work. Dave was a meticulous anaesthetist, always displaying high moral values, ethics and principles. He was highly regarded as a teacher and many anaesthesia trainees will attest to Dave's thoughtful tutelage. He developed lifelong friendships with many trainees including some from New Zealand, the UK and Holland. He was always willing to take on responsibilities and remained well-informed and up to date with new developments. In the 1980s Dave was involved in rural emergency paediatric retrievals, managed the paediatric intensive care unit for a time, and was head of the department of paediatric anaesthesia for several years. Dave was known for his sensitive care of the children and families in his care, and he was especially loved for the endless stories he told his young patients as they drifted off to sleep in theatre.

Dave married Erica in 1987 and it was a wonderful union with like-minded interests of travel, food, homemaking and family. Travel was a central part of life for Dave and Erica, with frequent trips to remote outback areas and overseas. They initially explored Australia by tent, then graduated to a Tvan off-road camper trailer and latterly they enjoyed the luxuries of an off-road caravan. They became true adventurers of the inland, returning to the bush again and again, even when their children were still in primary school and Dave was undergoing cancer treatment. They joined the "Friends of the Great Victoria Desert," a volunteer group granting them involvement in and access to some of the most beautiful and arid parts of Australia. When they tackled the iconic Canning Stock Route in Pilbara region of Western Australia their Landcruiser broke down near the Kunawarritji Aboriginal community, so they spent a week there, helping out at the local school while waiting for vehicle spare parts. Their travels were extensive over the years, but a few of the most memorable family holidays included horse-drawn caravan trips and ski trips in Victoria, as well as adventures exploring South Africa, Botswana, and Zimbabwe. After retiring in his 60s, Dave embraced a new passion for wood carving. Dave was never idle – always useful, always engaged in whatever situation or community he found himself in.

In 2000, Dave was diagnosed with prostate cancer and given a prognosis of just two years, and typically he defied that estimate by 23 years. Despite the many ensuing travails those years were never wasted, he continued his clinical work and travels whenever he could. In late 2022, Dave's health declined again when he was diagnosed with lower oesophageal and stomach cancer requiring surgery and intense ongoing chemotherapy. Unfortunately, this precluded many of the foods and comforts he loved, and put some limits on the travel that had become a way of life. Yet Dave faced it all with dignity. Even when exhausted, he remained devoted to his family and friends, always thinking of ways to help and never complaining. His passing was sudden and dignified, fortuitously allowing time for his family to be present to bid him farewell.

Dave will be remembered in countless ways – his humour, enthusiasm, commitment, compassion, warmth, genuine kindness and his hospitality. He never judged and truly listened. He told stories in the most brilliant way, turning ordinary days into adventures, and always made space and time for others. Everyone who met Dave felt they had his full attention. He leaves behind a sense of warmth, intelligence, and genuine care.

Dave is survived by Erica, children Dan, Sally, Sam, Hanna and four grandchildren.

Dave's eldest son, Dan, wrote a fitting epitaph for a much-loved friend, colleague, husband, father, and grandfather:

Dad lived a life of "enthusiasm, exuberance and enjoyment".

Johan van der Walt, MBChB FANZCA FFARCSI
Former Director of Anaesthesia, Women's and Children's Hospital, Adelaide

Written with assistance from Dave's family

Rex Pearlman

1939 – 2025

Along with his older brother Robert, who was also studying medicine, the future Dr Rex Pearlman earned selection for the Australian Combined Universities cricket team in 1959. This Australian team played six matches during a tour of New Zealand. Rex was a top order batsman, and the team did very well.

Rex also played A-grade cricket for the University of Adelaide in the early 1960s when he scored 50 runs against bowling that included perhaps the game's greatest all-rounder, the West Indian Sir Garfield Sobers, who was playing for Prospect and South Australia.

It became one of Rex's greatest memories. Another enduring memory was when – as the Glenelg Football Club doctor for many years – he performed CPR on a member of the crowd who suffered a cardiac arrest while watching his team at Glenelg Oval. At the time, CPR was an in-hospital procedure only.

Rex Pearlman's sporting prowess had become evident at Prince Alfred College, where he had excelled at cricket, athletics and Australian rules football. Later, at university, Rex became a serious weightlifter. But his active sporting pursuits were curtailed in the mid-1960s when he donned the scrubs and the busy, crowded life of a resident medical officer at the Royal Adelaide Hospital (RAH).

Rex graduated with a Bachelor of Medicine and Bachelor of Surgery from the University of Adelaide in 1963. He achieved his specialist anaesthetic qualification in 1968 when he was awarded fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, whereupon he took up a post at the Royal Adelaide Hospital, a position he held until retirement in 2005.

In 1992, Rex was a founding fellow of the Australian and Zealand College of Anaesthetists when it was formed as a body independent of the College of Surgeons. Shortly after Rex gained his specialty qualification, coronary-artery grafting was rapidly expanding. Rex then joined the small team of anaesthetists and maintained this skill throughout his career at the RAH.

As a clinician, Dr Pearlman was recognised as having a strong work ethic. He was given all the complex and difficult surgical lists at the RAH and also worked in the intensive care unit when intensive care was an emerging specialty.

He volunteered for many helicopter retrievals and Royal Flying Doctor missions when the delivery of emergency specialist anaesthesia and intensive care to rural South Australians was in its infancy.

Rex was also known for treating all colleagues – no matter their level of training – with respect. His gift to the profession was a long clinical career of sustained anaesthesia excellence while inspiring his co-workers. He was a fine role model to the many who followed him.

But even more importantly, Rex was known for demonstrating kindness and gentleness with his patients. His firm, confident, but quiet and professional voice and demeanour reassured his patients as they faced the immediate challenge of major surgery.

Rex leaves a family that misses him badly: his beloved wife Joan, Joan's daughter and son, who she says he "shared", grandchildren and great-grandchildren. He is also remembered by his sisters, brother, and nieces and nephews. His interest in football – specifically Glenelg and the Crows – and cricket never waned. He also loved his golf, 20th century history, and surf lifesaving, and played bridge with his beloved Joan.

Dr Rex Pearlman was a gentleman who leaves a wonderful record of devoted and exemplary public service.

This article first appeared in *medicSA* and is an abbreviated version of the eulogy presented by colleague and friend Dr Rob Singleton at Dr Pearlman's funeral on 13 March 2025, with contributions by fellow anaesthetist Dr Mervyn Allen.

Donald Ballantyne Sweeney

1936 – 2025

On 9 July 2025, Donald Sweeney, aged 88, passed away in Adelaide after a short illness.

Don was the youngest of five children born into a distinguished Adelaide medical family. His father, Dr James Sweeney, served as a doctor with the Australian Imperial Force on the Western Front during the First World War. His two brothers went on to prominent medical careers – one an anaesthetist in private practice, the other an orthopaedic surgeon – while his two sisters trained as nurses.

Don's childhood was spent in Croydon, North Adelaide and Tusmore. He attended primary school in Croydon, received his secondary education at St Peter's College, and went on to complete his medical studies in 1962 at the University of Adelaide. As a youngster he was an enthusiastic Scout and in his university years he represented the rifle club at intervarsity competitions.

In 1965 Don travelled to the United Kingdom to further his training in anaesthesia, working his passage as a ship's doctor through the Suez Canal. He studied for his primary at the Royal College of Surgeons in London and then worked at Leicester General Hospital, followed by a move to the Royal Postgraduate Medical School at Hammersmith Hospital in London, where he met Patricia, who became his wife in 1968. Together they formed lifelong friendships with some of the famous names in British anaesthesia who worked there. When he returned to Adelaide he continued his training at the Royal Adelaide Hospital and the Adelaide Children's Hospital (ACH) and was awarded his FFARACS in 1969, followed by his FANZCA in 1992 with the creation of the Australian and New Zealand College of Anaesthetists.

In 1971 Don joined the department of paediatric anaesthesia at the ACH, becoming its third full-time staff consultant alongside Dr Tom Allen and Dr Ian Steven. Recognising the growing demands of the hospital, Don travelled to Toronto, Canada in 1977 to study at the Hospital for Sick Children, concentrating on paediatric intensive care and the emerging field of craniofacial anaesthesia.

Don was a dedicated and skilled paediatric anaesthetist. He was a very private man of great integrity who brought his full attention and dedication to all his clinical work and was stickler for doing everything carefully and methodically. In the early 1980s Don was the mainstay of the department's attempts to come to grips with computers, wrestling with a Radio Shack TRS-80 with a 4-kilobyte processor and a dot-matrix printer.

In the mid-1970s Don was central to the establishment of the paediatric ICU in a converted ward at the ACH. Artificial ventilation was provided by Bird ventilators driving a bag-in-a-box and there was one Engstrom ventilator. Under Don's direction the PICU was staffed by the consultant anaesthetists. He also oversaw the development of the paediatric retrieval service that was managed by the on-call consultant anaesthetist with ad hoc nursing support by nurses from theatre or the PICU. The paediatric retrieval service provided extensive cover of South Australia, the Northern Territory, Broken Hill and Mildura using varied modes of air and road transport.

When the Australian Craniofacial Surgery unit was established in the latter half of the 70s in Adelaide, Don was the principal anaesthetist at the ACH for children being treated for congenital deformities and head and neck injuries. These were difficult times requiring innovation to develop new concepts and practices with anaesthesia lasting up to 14 hours before the techniques were refined and became routine. A critical component for successful outcomes was the continuity of care with the transition to postoperative intensive care, and again Don was the critical link to make the service successful with world-leading results. He also joined the craniofacial team on various outreach missions to Southeast Asia.

Outside of medicine, Don was a devoted family man. He was actively involved in his sons' activities, especially through the Sea Scouts. Family life centred around their home in Adelaide and a holiday home on the Murray River at Clayton, enjoying a variety of water activities. After his retirement in 1998, Don and Patricia continued exploring the river by boat and later travelled widely with their caravan, often planning their journeys around classical music and jazz festivals.

Don also pursued his passion for vintage cars, meticulously maintaining a 1948 MG Y-Type Saloon and a much-loved red 1952 MG TD. The latter became a familiar sight round Adelaide – top down, Don at the wheel, wearing his trademark cloth cap. It has been a privilege to reflect and document the significant pioneering achievements of Donald Sweeney, a modest and valued colleague who leaves an enduring legacy having contributed so much to the care of children in South Australia and beyond.

We extend our heartfelt condolences to Patricia, their sons Michael, Ian, Duncan and six grandchildren.

Johan van der Walt, MBChB FANZCA FFARCSI

Former Director of Anaesthesia, Women's and Children's Hospital, Adelaide

ANZCA
FPM

Benefits of fellowship

Professional documents to enhance everyday practice and patient care

Support towards research, such as grants

Access to our world-leading online CPD portfolio/app

Eligibility for ANZCA awards

High quality annual scientific meetings and specialised meetings throughout the year

Further career development in education, research and leadership

Written information to help communicate with patients

Be a part of a college that is a leader in anaesthesia, pain medicine and perioperative medicine

Only our fellows can use FANZCA or FFPMANZCA

Make a contribution to the ongoing development of our specialties

Access to research librarians and our 24/7 online library

The college advocates on your behalf for workforce wellbeing and quality of care

Access to the 24/7 doctor's health support program

Learn how to provide education to others through teaching and examining

Opportunities to network with colleagues

anzca.edu.au/fellowship/member-benefits

ANZCA
FPM

HERENGA WAKA
FROM HOME TO HOME
HERENGA TĀNGATA

ANZCA ASM AUCKLAND 1-5 MAY 2026

SAVE THE DATE

The 2026 ASM cultural advisor, Tui Blair and graphic designer, Chloē Reweti, explain the theme, "Herenga waka, herenga tāngata: From home to home."

A herenga waka is a physical place where waka are anchored at a safe harbour or resting point. The herenga waka reflects a space of connection and safety for voyaging waka. The hospital is a welcoming space where individuals come and go as needed. Patients arrive seeking care and healing, families offer love and support, and healthcare professionals dedicate themselves to guiding others through their journeys. This ebb and flow reflects the dynamic nature of a herenga waka, symbolising the continuity of life and the interconnectedness of those who pass through its doors.

Your National Organising Committee

Dr Kerry Benson-Cooper, Convenor
Dr Marta Seretny, Scientific Convenor
Dr David Sidebotham, Deputy Scientific Convenor
Dr Mark Edwards, Workshop Co-convenor
Dr Sarah Goodwin, Workshop Co-convenor
Dr Vik Singh, ELC Co-convenor
Dr Saana Taylor, ELC Co-convenor
Dr Amy Gaskell, Abstract and ePoster Convenor
Dr David Boothman-Burrell, FPM ASM Scientific Convenor
Dr Nicole Toy, Trainee Representative
Tui Blair, Cultural Advisor
Dr Sally Ure, ANZCA Councillor
Associate Professor Nicole Phillips, DPA ASMs
Dr Noam Winter, FPM ASM Officer