ANZCA
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Australian Health Practitioner Regulation Agency (Ahpra) Accreditation Committee Targeted Consultation

DRAFT NATIONAL SCHEME PROFESSIONAL CAPABILITIES FRAMEWORK AND PILOT CAPABILITIES ON FAMILY, DOMESTIC AND SEXUAL VIOLENCE (FDSV) AND DIGITAL HEALTH

Australian and New Zealand College of Anaesthetists (ANZCA) consultation response

29 July 2026

About ANZCA

The Australian and New Zealand College of Anaesthetists (ANZCA), comprising the Faculty of Pain Medicine (FPM) is the professional body responsible for the postgraduate training programs of specialist anaesthetists and specialist pain medicine physicians.

We are one of the largest medical colleges in Australia and New Zealand with 10,000 members.

A key role of the college is fostering the highest standards of clinical practice, safety and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. We do this through our robust training programs, rigorous standards, continuous education, mentoring and supervision of junior doctors, advocacy, and research.

Consultation scope

The Australian Health Practitioner Regulation Agency (Ahpra), through the Accreditation Committee has requested ANZCA feedback via a targeted consultation process on a proposed National Scheme Professional Capabilities Framework that would establish a set of common professional capabilities expected of all registered health practitioners in Australia, regardless of profession or clinical setting.

As an initial pilot, the two priority areas are:

- Family, Domestic and Sexual Violence (FDSV), and
- Digital Health.

Eight questions were posed.

ANZCA consultation feedback

1. How clear is the role of the common professional capabilities, and how they complement profession-specific capabilities in the regulatory context?

ANZCA support

ANZCA supports the intent of establishing common professional capabilities that describe a shared baseline of knowledge, skills and professional behaviours expected of all regulated health practitioners. The consultation document clearly positions these capabilities as complementary to, rather than a replacement for, profession-specific capabilities, with profession-specific requirements taking precedence where a deeper level of capability is required, to reflect the complexity, context, and scope of individual disciplines. This distinction is important for specialist medical practice, including anaesthesia, pain medicine and perioperative medicine, where practitioners work in high-acuity, complex and team-based settings and require advanced clinical judgement, procedural skills, leadership and risk management capabilities beyond any shared baseline.

Integration with existing frameworks

ANZCA considers that the framework would be strengthened by more explicit guidance on how common capabilities will interact with existing specialist training standards, accreditation requirements, continuing professional development (CPD) frameworks and National Board expectations. In particular, implementation should avoid duplication or confusion where colleges and specialist medical programs already embed relevant professional capabilities in curricula, assessment, accreditation and CPD processes.

Combination of subject areas

However, it is unclear why two entirely different subject areas, FDSV and digital health, has been combined in an overall pilot framework. It is also unclear whether these capabilities will remain linked during implementation. Separating the implementation of these professional capabilities may provide greater clarity and reinforce the importance of each area in its own right.

Medical education continuum

Further, these capabilities may be more appropriately incorporated into undergraduate and early postgraduate training, rather than specialist medical education, as they are arguably better addressed earlier in the medical education continuum.

2. How appropriate is the level of detail in the draft capabilities for supporting flexible and practical implementation across different settings and uses?

Flexibility across professions and settings

The level of detail is broadly appropriate for a common, cross-profession framework. The use of high-level capabilities supported by enablers provides enough direction to support education, accreditation, CPD and professional reflection, while allowing flexibility across professions and settings. This is particularly important for anaesthesia, pain medicine and perioperative medicine, where the application of common capabilities will vary significantly between operating theatres, pain services, pre-admission clinics, intensive care-adjacent environments, rural settings, private practice and multidisciplinary perioperative care models.

Different practice contexts

However, some enablers may need clearer wording to avoid implying that every practitioner must develop the same depth of capability in areas that are highly dependent on clinical context, scope of practice and local service arrangements. For example, expectations around referral pathways, documentation, digital health governance and advocacy should acknowledge that specialists may have different responsibilities depending on whether they are practising in public or private settings, as trainees or consultants, and whether they have access to organisational systems and supports.

ANZCA would support the inclusion of implementation examples or descriptors that distinguish between baseline awareness, practice-level application and advanced or leadership-level capability. This would help preserve flexibility while making the capabilities more usable for specialist colleges, education providers, employers and practitioners.

3. To what extent are the draft professional capabilities relating to family, domestic and sexual violence (FDSV) appropriate and applicable across all regulated health professions? What additional capabilities, if any, should be considered?

FDSV shared baseline

ANZCA supports the inclusion of FDSV capabilities as a shared baseline across regulated health professions. Anaesthetists, specialist pain medicine physicians and perioperative medicine practitioners may encounter victim-survivors in contexts where trauma, distress, communication barriers, coercive control, physical injury, chronic pain, medication use, disability, mental health concerns or dependence on carers may be

relevant to clinical care. The draft capabilities appropriately emphasise recognition, trauma-informed responses, culturally safe communication, referral, documentation, collaboration and awareness of practitioner wellbeing.

Limits of the practitioner's role

From ANZCA's perspective, the capabilities should more explicitly recognise the limits of the practitioner's role and the importance of safe escalation pathways. In anaesthesia and perioperative care, contact with patients may be brief, time-critical or occur when the patient is sedated, distressed, cognitively impaired or accompanied by another person. Anaesthetists are often not the primary treating practitioner and may have limited opportunities for longitudinal follow-up. In pain medicine, longer-term therapeutic relationships may create different opportunities and obligations for identification, support and referral. The capabilities should therefore avoid implying that all practitioners are expected to conduct detailed FDSV assessment or intervention, and should instead emphasise recognising indicators, responding safely, documenting appropriately and referring to specialist services where required.

ANZCA's trauma-informed care

ANZCA is committed to supporting the integration of trauma-informed care —an approach that recognises and responds to people's experiences of trauma, adapting practice to promote safety and prevent further harm. Integration of trauma-informed care will continue in 2026 - aligning requirements with existing trauma-informed care principles already embedded within training and practice is critical.

Additional capabilities

Additional capabilities or enablers that could be considered include:

- recognising heightened risk in settings involving disability, cognitive impairment, chronic pain, dependence on carers, opioid or sedative use, pregnancy, older age, cultural and linguistic diversity, and Aboriginal and Torres Strait Islander peoples
- understanding consent, privacy and confidentiality issues where patients are accompanied by a family member, carer or potential perpetrator
- identifying safe opportunities for private communication with patients, particularly in preoperative, procedural and pain medicine settings
- understanding mandatory reporting and jurisdictional legal and ethical obligations, including in relation to children and vulnerable adults
- recognising the potential impacts of trauma on consent, pain experience, procedural anxiety, perioperative planning and recovery.

4. To what extent are the draft professional capabilities relating to digital health appropriate and applicable across all regulated health professions? What additional capabilities, if any, should be considered?

Digital health capabilities

ANZCA supports the inclusion of digital health capabilities as a priority area. Digital health is increasingly central to anaesthesia, pain medicine and perioperative medicine, including electronic medical records, electronic prescribing, My Health Record, telehealth, remote monitoring, virtual pre-admission models, clinical decision support, audit and outcomes data, patient-reported outcome measures, digital consent processes and emerging artificial intelligence (AI) tools. The proposed capabilities appropriately cover safe use of digital technologies, professional obligations, data integrity, cyber security, collaboration, patient participation and equitable access.

ANZCA recommends that the digital health capabilities give greater attention to clinical safety, accountability and practitioner obligations when using AI, automated decision support, digital scribes, remote monitoring devices and patient-generated data. In anaesthesia and perioperative medicine, digital systems may influence medication safety, airway planning, risk stratification, escalation decisions and perioperative communication. In pain medicine, digital tools may support longitudinal care but can also create risks if information is incomplete, poorly integrated or not clinically validated.

Terms used in the document

The document's use of the term "AI" appears to be focused primarily on large language models (LLMs), rather than encompassing the broader range of AI technologies such as machine learning and predictive analytics. It may be helpful to clarify this distinction and to provide further examples of how LLMs could support improved patient communication, including the development of clearer patient information, tailored educational materials, and enhanced communication support across diverse patient groups.

Additional capabilities

Additional capabilities or enablers that could be considered include:

- understanding the limitations, bias and clinical governance requirements of AI and decision-support tools
- maintaining clinical accountability when using digital tools, including AI-generated outputs or automated summaries
- recognising risks associated with fragmented digital records across public, private and cross-jurisdictional care
- ensuring digital communication supports safe handover and continuity of care across multidisciplinary perioperative teams
- supporting equitable access for patients with low digital literacy, disability, language barriers, limited internet access or complex care needs
- understanding medico-legal responsibilities for documentation, data quality, consent, privacy and cyber security.

5. What practical impacts or challenges should be considered when planning implementation? Does organising the capabilities under the domains affect implementation?

Partnership

Implementation should be developed in partnership with National Boards, specialist medical colleges, accreditation authorities, education providers, employers and consumers, with sufficient lead time and clear guidance on how the framework will be used in accreditation, registration, CPD and regulatory assessment.

Staged implementation

Implementation should be carefully staged and aligned with existing accreditation, training and CPD cycles. Specialist medical colleges already maintain comprehensive curricula and professional standards, and many of the proposed capabilities are already embedded across training, assessment, CPD and specialist practice. A key implementation risk is duplication, where colleges, education providers, employers and practitioners are required to remap existing standards to a new framework without clear regulatory benefit.

ANZCA mapping

ANZCA has undertaken an initial mapping exercise against the proposed professional capabilities framework and relevant ANZCA educational materials. From a curriculum perspective, the concepts and outcomes within the framework align closely with ANZCA's Graduate and Program Outcomes currently under development. The professional capabilities appear to provide a common cross-professional foundation, while ANZCA's curriculum translates these capabilities into the context of specialist anaesthesia practice. As a result, there does not appear to be any conflict between the intent of the professional capabilities framework and ANZCA's curriculum or accreditation requirements. Rather, ANZCA's outcomes appear well aligned with the direction being signalled by Ahpra, particularly in areas such as lifelong learning, scholarship, leadership, advocacy, professionalism, collaboration, and person-centred care.

Challenges

Practical challenges include:

- alignment with existing specialist training curricula, assessment standards and accreditation requirements
- avoiding additional administrative burden for specialist colleges and education providers
- ensuring appropriate lead time for curriculum mapping and implementation
- clarifying expectations for trainees, fellows, supervisors and specialist international medical graduates
- recognising differences between public, private, regional, rural and remote practice settings
- ensuring access to training and referral resources, particularly for FDSV and digital health
- avoiding a "one-size-fits-all" compliance approach that does not reflect scope of practice or clinical context.

Domains

The four domains (The Professional, The Communicator and Collaborator, The Lifelong Learner, and The Leader and Advocate) are broadly sensible and align with familiar professional capability frameworks. However, some capabilities may sit across multiple domains, particularly in specialist medical practice. For example, digital health safety is not only a professional responsibility but also a leadership, communication, quality and lifelong learning issue. Similarly, FDSV requires professional awareness, trauma-informed communication, collaboration, advocacy and reflective practice. Domain organisation is useful for structure, but implementation guidance should make clear that capabilities are interconnected rather than confined to a single domain.

6. What additional tools, guidance, or resources would support implementation?

Practical resources

ANZCA would support the development of practical implementation resources that help professions and education providers map the common capabilities to existing frameworks without creating unnecessary duplication. This could include mapping templates, worked examples, implementation guidance for accreditation authorities and guidance on how common capabilities should be considered in CPD and specialist training contexts.

Useful resources may include:

- a mapping tool showing how the common capabilities align with existing National Board, specialist college and accreditation standards
- guidance on expected levels of capability across career stages, including students, trainees, newly qualified practitioners, specialists and supervisors
- profession-specific implementation examples, including examples for acute care, procedural care, chronic pain, perioperative medicine, private practice and rural settings
- FDSV referral pathway guidance that can be adapted by jurisdiction and local health service
- practical guidance on safe documentation, confidentiality and escalation in FDSV contexts
- digital health safety checklists, including guidance on AI, digital scribes, cyber security, data quality and clinical accountability
- case studies demonstrating application in multidisciplinary care
- resources for supervisors and educators to support teaching, assessment and reflective practice.

7. What areas should be prioritised for future development of common professional capabilities, and why?

Future common capabilities

ANZCA supports future development of common capabilities in areas where there is a clear public safety benefit and where consistency across professions would strengthen team-based care. Priority areas may include cultural safety, interprofessional collaborative practice, racism and discrimination, communication, clinical handover, health equity, patient safety, practitioner wellbeing and responding to deteriorating patients. The consultation document identifies cultural safety, interprofessional collaborative practice, racism and discrimination, and mental health as likely future areas, and ANZCA considers these highly relevant to anaesthesia, pain medicine and perioperative medicine.

Priority areas

For anaesthesia and perioperative medicine, interprofessional collaboration and communication are particularly important because safe care depends on coordination across surgeons, anaesthetists, nurses, allied health practitioners, primary care, pain services and hospital systems. For pain medicine, future capabilities should recognise the importance of multidisciplinary care, trauma-informed practice, stigma reduction, safe prescribing, communication with patients experiencing persistent pain, and coordinated care across sectors.

Pain education standards

ANZCA's Faculty of Pain Medicine has recently launched the Australian Standards for Health Practitioner Pain Management Education to support greater consistency and quality in pain management education across the health professions. These standards have recently been endorsed by the Council of Presidents of Medical Colleges (CPMC). The development and implementation of the education standards mirror the intent of the professional capabilities approach and reflects pain management education as a fundamental requirement of both undergraduate medical and early postgraduate medical education.

Other areas

ANZCA would also support future common capabilities relating to:

- cultural safety and culturally responsive care, including for Aboriginal and Torres Strait Islander peoples
- team-based communication, escalation and clinical handover
- climate and environmental sustainability in healthcare
- practitioner health, fatigue management and psychological safety
- safe use of medicines and prescribing stewardship, where relevant to scope of practice.

8. Do you have any additional comments or feedback?

ANZCA would encourage Ahpra and the Accreditation Committee to adopt a flexible, proportionate and outcomes-focused approach. The framework should support safe, person-centred and team-based care while recognising that the application of common capabilities will differ by profession, scope of practice, level of training, clinical setting and patient population.

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