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Bulletin

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

AUTUMN 2026

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- **Mark Friday 16 October in your diaries.**
- **Book your hospital foyer space.**

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 publicly demonstrated.

ANZCA will send posters and other material to hospitals in September.

Please contact communications@anzca.edu.au for more information.

RIGHT

Dr Sally Ure, ANZCA Councillor (New Zealand) featured in last year's "In Safe Hands" campaign.

ON THE COVER

ANZCA supervisor of training Dr Ann-Marie Stevenson and trainee Dr Angela Chou in Auckland. Photo: Brett Phibbs

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.

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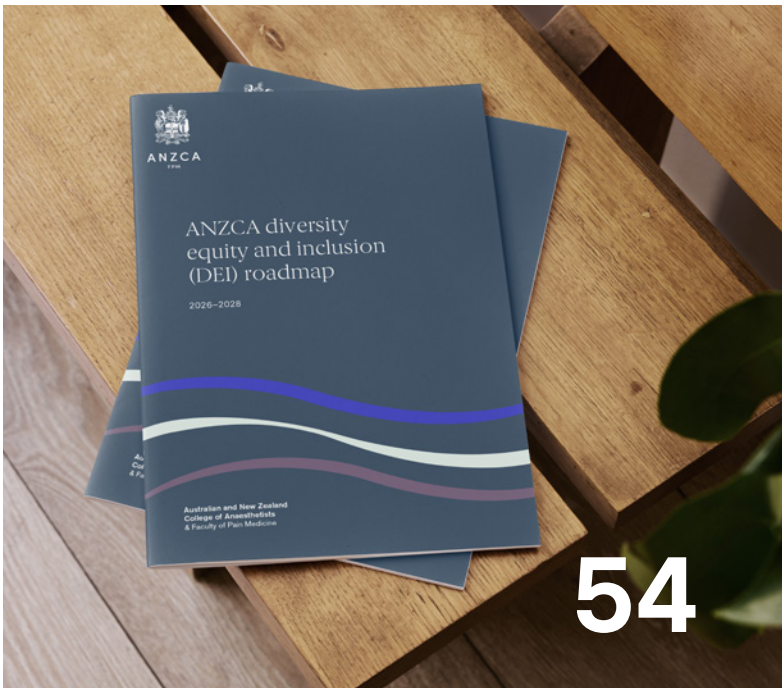

ANZCA: Quo vadis?

"People only see the decisions you made, not the choices you had."

– Jacinda Ardern, former prime minister, New Zealand

"Don't let perfection be the enemy of good."

– After Voltaire

"Once more unto the breach!"

– Shakespeare, *Henry V*

This is my last *Bulletin* president's message before I hand over to Tanya Selak, ANZCA Vice-President and President-Elect, at the Auckland Annual Scientific Meeting. I will continue as a councillor and Immediate Past-President. My inner geek is thrilled that my last full day as president will be Star Wars Day (May the fourth).

While wanting to avoid cliches I can't think of a better line than to say it has been an honour and a privilege to serve as ANZCA president for the last two years.

It has also been enjoyable, challenging, frustrating, exciting, depressing … but always interesting. Particular highs have been the new fellows at the College Ceremony and calling an amazing group of very humble fellows to tell them they were receiving ANZCA awards. The worst lows have been the sudden unexpected deaths of trainees and fellows, mainly from suicide.

I used to think the whole "reflection" thing was a bit soft and fuzzy, but I've changed my mind. The quotes above represent some of the things I have reflected on over the past two years.

The first quote is a reminder that leadership requires decisions from choices. That involves collaboration and consultation but does require decisiveness. A buffer against making poor decisions is that our primary strategic body is ANZCA Council which is well supported by fellows and staff. The 15-member council elected by fellows has constitutionally-required geographic representations across Australia and New Zealand and collectively consider and debate (and at times argue!) about matters vital for the college.

Further, unlike some drama-filled colleges our system of board (council) electing the chair (president) from the board is in line with good governance of not-for-profit for-purpose companies, which is what ANZCA is.

The second quote reminds us that no matter how obsessive we are, and let's face it anaesthetists (and probably pain medicine specialists) are rather obsessive, we sometimes just need to crack on at less than 99 per cent completeness in college operations, clinically, and life in general.

The third Shakespearean military quote reflects low level warfare dealing with governments and regulatory bodies in both countries. They shall remain nameless but exemplified by the gripping Kruk report "Independent review of health practitioner regulatory settings" and subsequent regulatory dysfunction.

Quo vadis means, "where are you heading?" I think ANZCA is heading in the right direction, continuing to evolve in capability as a leading specialist medical college working on both sides of the Tasman, and beyond.

The predominant ongoing activities of the college are aligned with the "big five" of priorities identified by more than 90 per

cent of respondents in the fellowship survey: training, safety and quality, professional documents, continuing professional development (CPD), and government advocacy.

Nonetheless, I recognise that three groups who are often at the "pointy end" are trainees, supervisors of training, and heads of departments and we can continue to do more to support those three groups in addition to regional and national committee office holders.

While some are doubtful, I firmly believe that perioperative medicine is a big part of the future of both anaesthesia and pain medicine. It will help deliver on our purpose "to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, optimising health and reducing the burden of pain".

Like perioperative medicine, research isn't for everyone. However, all members of ANZCA, particularly fellows, must be scientifically literate. That is, while only some need to produce the evidence, all need to be able recognise scientific gems or garbage.

Research literacy and methodological rigour must extend to quality improvement and assurance. I completely reject the proposition that quality work is not research and lower standards are acceptable.

Using garbage evidence to guide healthcare is dangerous. ANZCA will continue to support fellows and co-investigators in research that can have profound implications on practice. We must however do better with college-led scientific literacy derived from the scholar role in training and continuing professional development in practice. Further, our research and other new knowledge should be presented primarily at the ANZCA Annual Scientific Meeting; the Americans and Europeans can wait.

Finishing a term such as ANZCA president involves a lot of thank yous, which could occupy this entire piece. My colleagues at the Austin Hospital in Melbourne have been incredibly supportive. ANZCA Council, a group more diverse than some think, has the best interests of the college as their guiding principle. ANZCA staff including past chief executive officer (CEO) Nigel Fidgeon and current CEO Lance Emerson are the quiet achievers.

My second biggest thank you goes to the amazing fellows, specialist international medical graduates (SIMGs), trainees, and GP anaesthetists who are the volunteer heart of the college.

My biggest thank you goes to my family, particularly my wife Cyndy who has supported, advised, and cajoled me across 35 (and counting) years of ANZCA including failing the primary exam (twice!).

I hope fellows, trainees, SIMGs, and staff see ANZCA as an institution that is socially progressive, financially conservative, and academically astute; an organisation they want to belong to.

A big positive is that I think the vast majority of our fellows can expect to have rewarding professional careers into the future in anaesthesia, pain medicine, and now perioperative medicine.

I hope as president I have played a part in that positive future.

Professor Dave Story
ANZCA President

ABOVE

ANZCA Council, February 2025.

College continues government talks on key issues

It is nearly four months since I started as chief executive officer at ANZCA, and I continue to be struck by both the scale of ANZCA's work and the strength of its voice.

It is an honour to be entrusted with leading an organisation that plays such a critical role in medical education, patient safety, professional standards and system leadership across Australia and New Zealand.

One of my early priorities has been to spend time with fellows, trainees and specialist international medical graduates (SIMGs).

REGIONAL MEETINGS

I have started attending regional meetings, first in New South Wales and followed by Western Australia, where we held our February ANZCA Council meeting.

While in WA, members of the WA Regional Committee, ANZCA President Professor Dave Story, FPM Dean Dr Dilip Kapur and I met with WA Health's Acting Chief Medical Officer and we agreed in principle with a statement of intent and discussed training site bottlenecks and perioperative medicine.

In NSW we are in talks with government about streamlining the trainee selection process and addressing the number of independent trainees in NSW who sometimes struggle to progress with some aspects of training.

My regional visits will continue in the months ahead with regional committee meetings in Queensland, South Australia and Tasmania, alongside trans-Tasman engagement, starting with the Auckland Annual Scientific Meeting (ASM) which I'm very much looking forward to attending in early May.

These conversations with anaesthesia and pain fellows, trainees and SIMGs have enabled me to better understand the issues in different jurisdictions including the pressures and opportunities facing us.

ADVOCACY

Advocacy is a key focus for me, having spent more than 25 years in CEO, senior executive and board leadership roles across membership, government, not-for-profit and research organisations in the health sector.

Most recently I worked as the Deputy Secretary (one of the second-in-charge) of the Victorian Department of Health. That experience has reinforced for me the importance of structured, proactive, evidence-based advocacy, and being part of the solution – particularly for a college operating across multiple health systems.

ANZCA already does this work well and my focus is on strengthening it further, ensuring our advocacy is coordinated and responsive to the distinct contexts in which our members practise.

I would like to acknowledge the important work being undertaken by the college under ANZCA's Reconciliation Action Plan (RAP) recommendations. I am proud to support this work as the RAP champion, and to see it embedded across college activities.

ANZCA is highly active in working with our specialist colleagues in shared advocacy. In early March, President Professor Dave Story and I were in Canberra for a Council of Presidents of Medical Colleges (CPMC) meeting attended by the Australian Minister for Health and Ageing Mark Butler.

The CPMC meeting started with a rural workshop opened by Emma McBride, Assistant Minister for Rural and Regional Health, and the report "Exploring Innovative Models to Streamline and Shorten the Training Pathway for Specialists Project" was also discussed.

CPMC also launched a "Professionalism Framework – Ethical Billing and Fee Transparency". The Hon Rebecca White MP, Assistant Minister for Women, Assistant Minister for Health and Aged Care, Assistant Minister for Indigenous Health attended the launch along with many other MPs and senators from all sides of politics.

I was struck by ANZCA's role as a leader among the colleges that make up CPMC.

While in Canberra, Professor Story and I took the opportunity to meet with key officials in the health minister's office and some of the most senior public servants in the health and Medicare Benefits Schedule workforce. At these meetings, we reinforced the importance of ANZCA's role as a trusted, authoritative contributor to national policy conversations, and also discussed the importance of perioperative medicine and pain medicine.

CONNECTING WITH OTHER COLLEGES

Professor Story and I recently met with College of Intensive Care Medicine (CICM) President Associate Professor Peter Kruger and the CICM CEO Daniel Angelico where we discussed pathway progress. We have recently mapped the end-to-end journey of participants and are in the process of developing the implementation pathway. We are planning for the first pilot intake this year.

Our collaboration with other medical specialists is critical. Professor Story and I have had numerous meetings with Royal Australasian College of Surgeons (RACS) President Professor Owen Ung and RACS CEO Stephanie Clota to discuss issues of mutual importance.

OUR VOLUNTEERS

Finally, I want to acknowledge the extraordinary contribution of ANZCA volunteers. Across council, committees, working groups, exam processes, education and advocacy, ANZCA and the Faculty of Pain Medicine is sustained by clinicians who give their time, expertise and judgment – often invisibly and always generously.

I remain in awe of the depth of commitment shown by our fellows and trainees, and profoundly grateful for the care they bring not only to patients, but to the profession and to each other.

ANZCA and FPM simply could not do its work without you.

Lance Emerson
ANZCA Chief Executive Officer

Letters to the editor


FACULTY OF PAIN MEDICINE

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.

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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

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DISAGREEMENT OVER INTRAOPERATIVE METHADONE RISK

The *ANZCA Bulletin* article (Spring 2025) "Caution needed with intraoperative methadone use in opioid-naïve patients" implies that the use of methadone for perioperative analgesia carries greater risk than the use of other opioids, a view with which I disagree.

All techniques of opioid analgesia after major surgery of course introduce a finite risk of over-sedation and opioid-induced ventilatory impairment (OIVI). The authors outline important methods of reducing those risks, including suitable dosing (in particular a reduction in dose with increasing age); adequate monitoring; great caution with the concomitant use of other central nervous system depressants, most importantly benzodiazepines; and particular caution in patients with known or likely obstructive sleep apnoea. But none of this is unique to methadone.

The suggestion that methadone, given intraoperatively, should be regarded as similar to the postoperative prescribing of regular long-acting opioids (against which ANZCA's *PS41* guideline cautions) is incorrect. Intravenous methadone has a peak effect within 15 minutes, so its level, and its respiratory depressant effect, will be stable (and falling) once the patient is in a post-anaesthesia care unit (PACU). Excessive narcotisation is highly likely to be detected and treated in this safe setting (as appears to be the case[1]), before the patient is sent to the ward. (Clearly, further dosing with methadone beyond the PACU is not part of any intraoperative dosing regimen).

Delayed respiratory depression is not noted with methadone, and was not mentioned in the Safer Care Victoria practice guideline[2] referenced by the authors.

The authors stress their concerns and cautions around the use of methadone in opioid-naïve patients. In the perioperative context, the great majority of our patients are in fact opioid-naïve, and the tailoring of dosing and monitoring regimens to a presumed opioid-naïve patient is standard.

Data around the safety of methadone use in the perioperative setting continue to be published. A forthcoming systematic review and meta-analysis will be a welcome addition[3].

Dr Richard Barnes FANZCA
Victoria

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LET US NOT NEGLECT ANAESTHESIA 101

One of the core skills of being an anaesthetist is our mastery of the management of airway – the most basic of which is the ability to perform bag mask ventilation.

Over the years, I have noticed a gradual but definite decline in our skill to perform a one-person bag mask ventilation.

More are resorting to a two-person bag mask ventilation where the bag is usually handed over to a less experienced person. The second person does a two-handed technique of holding the mask. By giving away the control of the bag, one loses the control of the ventilation and the feedback on how well we are ventilating the patient.

These changes are partly related to the more frequent use of supraglottic airways where in the past we would have just held a mask.

Over time, I fear the most basic of our airway skills will disappear. This may lead to more can't intubate, can't oxygenate situations.

We should personally and collectively consciously aim to master the skill of one-person bag mask ventilation, maintain it, and teach and promote it to the up-and-coming anaesthetists so that the skill does not go the way of the dodo.

Dr Sai C Fong FANZCA
Townsville

BLUE BOOK ARTICLE UNDER MICROSCOPE

The publication of *Australasian Anaesthesia* ("The Blue Book") each year by the college provides interesting reading.

The topical article on hyperangulated videolaryngoscopy (HAVL), by Boyd and Dinsmore in the latest edition caught my attention but on some points I must disagree.

I began using HAVL soon after it was introduced to Australia in the early 2000s, since which I have used it for virtually every intubation – about 8000 in total.

The MacIntosh blade VL is of no advantage in intubation, compared to a direct vision MacIntosh blade.

It is merely a more comfortable mechanism with better optics.

The game changer is HAVL.

The technique for HAVL is completely different from that using a MacIntosh blade, requiring 50+ intubations before the realisation that a dynamic situation with soft hands between scope and tube is necessary, minimal elbow extension and positioning the larynx in the upper third of mid screen.

Thus positioned, the percentage of glottic opening – "pogo" construction is unnecessary and irrelevant.

It is mandatory to use the UNMODIFIED factory-made rigid HAVL stylet for every HAVL intubation. Inexperienced users may see fit to bend or modify the stylet. This is never necessary, distorting the perfect complementation of the stylet facilitated curve of the tube with HAVL.

HAVL was never designed to be used with bougies, including the STIG manoeuvrable bougie – they are not relevant or useful in a HAVL intubation.

Endotracheal rotation of the tube to counteract anterior tracheal wall impingement, or cricoid pressure to facilitate entry of the tube into the trachea is not needed with correct technique.

This involves introducing the well lubricated tube, with stylet in situ, into the mouth pointing laterally, and then rotating the tube anticlockwise through a right angle during advancement into the oropharynx to meet the HAVL tip just proximal to the cords. The stylet is then "popped" with the intubating thumb which pushes the stylet handle upwards, unloading the stylet, the recoil from which propels the lubricated tube well into the trachea where it is easily advanced, and the stylet, tension released, is easily extracted.

The tube, stylet in situ should never actually enter the larynx – this simply causes difficulty advancing the tube and removing the stylet and potentially traumatises the upper airway.

Barring gross upper airway anatomical distortion by trauma, tumour, infection or oedema, or poor mouth opening, correct use of HAVL has made difficult adult intubations a rarity.

I cannot remember the last time that I had a difficult intubation as defined by failure at first attempt and need to bag-valve mask.

Dr Stuart Skyrme-Jones, FANZCA
Victoria

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

ANZCA and government

Health funding, rural workforce and training dominate 2026 agenda

AUSTRALIA

2026-2031 health reform agreement approved

The next iteration of the cross-government National Health Reform Agreement (NHRA) for the 2026-2031 period was finally agreed by all Australian governments on 30 January 2026.

The NHRA is an agreement between the Australian government and all state and territory governments and is the key mechanism for the transparency, governance and financing of Australia's public hospital system.

Through this agreement, the Australian Government contributes funds to the states and territories for public hospital and health services, as system managers of public hospitals. This includes services delivered through emergency departments, hospitals and community health settings.

The current NHRA covered the 2020 to 2025 period and was extended to 30 June 2026 to allow for continued discussions on a new multi-year agreement.

This new agreement (in place from July 2026) is said to be a win for the states/territories and covers an additional $25 billion in Commonwealth funding for public hospitals. The Commonwealth have indicated this is three times more additional funding for hospitals than was agreed to under the last NHRA five years ago. It also includes commitments to prevention, digital health and workforce support. It means Commonwealth funding for state-run public hospitals will reach $219.6 billion from 2026-27 to 2030-31.

Once the agreement is published, the college will review the clauses, advocating to governments for the needs of anaesthesia, pain medicine and perioperative medicine services occurring in public hospitals.

Doctors in SA issue three-point plan ahead of state election

As part of the lead up to the 2026 South Australian state election to elect the 56th Parliament of South Australia held in March 2026, the South Australia (Medical) College Chairs Committee (an alliance of 10 medical colleges who together represent the majority of doctors in the state) have developed a statement calling for an overarching health strategy to ensure every person in the state can access safe, timely care from a qualified health professional, no matter where they live. The strategy calls for:

- The mapping of healthcare gaps in South Australia.
- A commitment to growing a sustainable medical workforce.
- The removal of unnecessary barriers through a statewide process to recognise doctors' credentials across all health services.

Western Australia Chief Ministers Office meetings

In December 2025 and February 2026, the ANZCA president, CEO, WA regional committee chair and education officer, and FPM dean met with the WA Health Chief Medical Officer to discuss ways of enhancing strategic communication channels. Discussed at the meeting were a draft statement of intent between ANZCA and WA Health, the current environment of training sites and positions, and perioperative medicine.

It is hoped this ongoing dialogue will help support our discussions on regional workforce sustainability, increasing trainee numbers and addressing bottlenecks, accreditation and the impacts of national reforms across the state.

Queensland

The Queensland Anaesthetics Rotational Training Scheme (QARTS) was successful in attaining temporary Queensland Health funding for strategic work on the state's regional workforce including training bottlenecks as well as business-as-usual functions managing 300+ trainees. It comprises six months of funding for five hours per senior medical officer, per week and covers the rotational coordinator plus the four rotational supervisors across Queensland. QARTS and ANZCA are looking to work with Queensland Health in the first half of 2026 to extend this funding, with an initial meeting held on 12 February 2026.

CPMC meeting and rural workshop at Parliament House

The recent 4-5 March 2026 Council of Presidents of Medical Colleges (CPMC) meeting was held at Parliament House in Canberra, with ANZCA President, Professor Dave Story and CEO, Dr Lance Emerson in attendance. The meeting was also attended by the following Australian government ministers:

- Health Minister Mark Butler
- Assistant Minister for Rural and Regional Health Emma McBride
- Assistant Minister for Women, Assistant Minister for Health and Aged Care, and Assistant Minister for Indigenous Health Rebecca White.

A cross-college rural workshop occurred as part of the meeting, in collaboration with the National Rural Health Commissioner, Professor Jenny May. The workshop focused on increasing the rural and regional specialist workforce.

The workshop also included presentations from the Commonwealth Department of Health, Disability and Ageing with regards to proposed changes to the Specialist Training Program (STP) funding and the Australian Medical Council's proposed standard changes that relate to rural and regional training. ANZCA was also asked to provide a short presentation on place-based training network case studies.

CPMC's "Professional Framework - Ethical Billing and Free Transparency" was launched at the meeting. All colleges, including ANZCA, had input into this document.

While in Canberra, Professor Story and Dr Emerson met with a range of Australian Government stakeholders – Minister Butler's adviser, MBS Policy teams and the Health Resourcing team.

MBA training survey results

The Medical Board of Australia (MBA) has released the 2025 Medical Training Survey results and data, available at: www.medicaltrainingsurvey.gov.au, the seventh wave of data collection.

The Medical Training Survey is a national, profession-wide survey of all doctors in training in Australia and is a confidential way to get comparative data to strengthen medical training. Those surveyed include interns, hospital medical officers, resident medical officers, non-accredited trainees, postgraduate trainees, principal house officers, registrars, specialist trainees, international medical graduates and career medical officers who intend to undertake further postgraduate training in medicine.

Static reports are available nationally, by state/territory, specialist medical college, doctor in training cohort, Aboriginal and Torres Strait Islander trainees and gender.

In 2025, more than 18,000 trainees responded to the survey, from nearly 50,000 that were invited to respond (36.7 per cent response rate). 372 of those respondents were from ANZCA covering both anaesthesia and pain medicine (74 per cent from metropolitan, 25 per cent from regional and 1 per cent from rural). Some of the responses relating to ANZCA participants are summarised below, additional information is available from the ANZCA specific college report located at: www.medicaltrainingsurvey.gov.au/Results/Reports-and-results.

ABOVE

Professor Dave Story, speaking at the CPMC rural workshop in Parliament House, Canberra.

		Total agree or good	Neutral	Total disagree or poor
I would recommend my current training position to other doctors	**ANZCA**	**88%**	**7%**	**4%**
	National	*83%*	*12%*	*5%*
I would recommend my current workplace as a place to train	**ANZCA**	**85%**	**10%**	**5%**
	National	*83%*	*12%*	*6%*
Quality of orientation	**ANZCA**	**86%**	**12%**	**3%**
	National	*79%*	*18%*	*3%*
Quality of clinical supervision	**ANZCA**	**94%**	**5%**	**1%**
	National	*89%*	*9%*	*2%*
Quality of teaching sessions	**ANZCA**	**85%**	**13%**	**2%**
	National	*86%*	*12%*	*2%*
Quality of training to raise patient safety concerns	**ANZCA**	**89%**	**11%**	**1%**
	National	*86%*	*12%*	*2%*

National Strategic Framework for Chronic Conditions 2026–35

In early March 2026, the Australian Government released the *National Strategic Framework for Chronic Conditions 2026–35*. The framework sets a 10-year direction to advance prevention, management, and integrated care for chronic conditions. It places a strong emphasis on person-centred, multidisciplinary care, digital integration and equity for priority populations.

There is clear alignment of this framework to pain medicine and perioperative medicine solutions and the integrated care and multimorbidity agenda. The college will consider how we position pain medicine and perioperative medicine in the context of addressing this document and in conversations with government.

Aligning with the focus areas of the framework, the government is investing $109.9 million over three years from 2026-27 (and $38.3 million per year ongoing from 2029-30) in an associated ongoing, competitive grant program. This grants program may present opportunities for collaborative or capability-based cross-college proposals. The new program is under development and will open for applications in mid-2026, with funding and activities commencing from December 2026. The college will monitor the Framework and grants process for updates.

NEW ZEALAND

Government

The government's recent 10-year Health Digital Investment Plan (HDIP) promising to "balance immediate stabilisation with long-term advancement and innovation" was brought into sharp focus in December 2025, as lengthy, widespread IT outages in South Island hospitals disrupted emergency departments, and laboratory and inpatient systems.

These were followed in January 2026 by regional IT failures in the North Island, forcing hospital staff to resort to pen and paper and whiteboards, as digital access to patient information and communications was blocked. Privacy shortcomings were also exposed by a cyberattack on the privately-operated patient portal "Manage My Health", widely used by general practices, which compromised about 120,000 patient files.

The Ministry of Health is reviewing the data breach and will provide a report in April 2026. Another cyberattack in February 2026 prompted health portal MediMap to seek a court injunction to prohibit the sharing of stolen data.

On a more positive note, despite the re-emergence of measles cases across New Zealand late last year, Api Poutasi, Director Pacific Public Health, reported that 81.3 per cent of Pacific children were fully immunised by two years of age, up from 71.5 per cent in 2024. He attributed the almost 10 per cent year-on-year increase to "the joint commitment of Pacific health providers, workforce and communities."

A late date for the next general election has been set for 7 November 2026, with the final day for enrolment being 23 October, rather than election day as previously conducted.

Health NZ | Te Whatu Ora

Health Minister Simeon Brown's letter of expectations expressed his pleasure at "a renewed focus on the needs of patients and on delivering the government's (five) health targets" and set out his priorities for 2026-27. Chief among these is to enable decision-making as close to care delivery as possible, while maintaining system-wide consistency and accountability.

Local districts and regions will be empowered to plan and manage services, within their allocated budgets and clinical input at the hospital level, while volume targets for services will be set at a national level.

Workforce expectations include a direction to reduce dependence on locums by recruiting permanent senior medical officers and to improve the retention of specialists by ensuring junior doctors are offered jobs before leaving for overseas fellowships.

The letter did not mention the expected $500 million reduction in operating costs needed to achieve the required "break even" financial position but was explicit about expecting tradeoffs between in-house personnel and outsourced staffing to be "appropriate".

Increased outsourcing and 10-year contracts for elective surgery are part of a growing trend towards the privatisation of health services says Auckland Law School Professor Jaime King. Comparing privatisation in New Zealand with the health system in the United States, Professor King warns that New Zealand is at "a tipping point".

Accident Compensation Corporation (ACC)

New Zealand's universal, no-fault accident compensation scheme is under significant financial pressure as costs for rehabilitation, compensation and treatment support have more than doubled over the past decade.

A key driver of escalating costs is that people are taking longer to return to work and independence, particularly those with non-serious injuries who should be able to recover faster with the right support. To avoid a predicted and unsustainable shortfall of $23 billion by 2030, ACC has developed a "Turnaround Plan" with priorities and targets focused on improved rehabilitation and organisational performance, and cost-effective support for injured people.

Faculty of Pain Medicine leaders including the Dean, Dr Dilip Kapur, and FPM New Zealand National Committee (NZNC) chairs, Dr Charlotte Hill and Dr Paul Vroegrop, met with ACC leaders in Christchurch in March to discuss how multidisciplinary specialty scopes in pain and perioperative medicine can improve treatment funding decisions and deliver "care that leads to lasting recovery". The FPM NZNC nominated three specialist pain medicine physicians to the core External Advisory Group on Improving Elective Surgery Performance. The group is tasked with developing templates to support consistent treatment funding decisions.

Medical Council of New Zealand | Te Kaunihera o Rata o Aotearoa

In response to the proposed regulation of physician associates/physician assistants (PAs), at the direction of the Health Minister, ANZCA recommended the medical council's sole focus should be on providing an entry point for overseas trained PAs to practice safely within well-defined boundaries.

They can subsequently be supported into training for recognised scope of practices in New Zealand such as nurse practitioner, anaesthetic technician, or paramedic. ANZCA's preferred title for the scope is "clinical assistant".

Reports

The Salvation Army's annual State of the Nation report took a new approach this year, drawing on a wellbeing framework – Te Ora o Te Whānau, and examining the evidence across six areas of social wellbeing. A troubling picture, especially for children and young people, was painted through reversal of recent child poverty gains, domestic violence and homelessness increasing and 90,000 young people without work, education or training. There are signs of progress, however, including a reduction in youth offending and an increase in public housing supply. Yet persistent pressures remain, such as ongoing poverty and material hardship, economic strain, housing instability, continued overrepresentation of Māori in the criminal justice system and concentrated social hazard harm.

There were few surprises in the New Zealand Institute of Economic Research's report to Medicines New Zealand comparing New Zealand's public health and disability expenditure against selected OECD countries. New Zealand is an outlier in its very low allocation of resources to pharmaceuticals – 4.9 per cent of health budget compared to 13.3 per cent in comparable countries, very high allocation of resources to delivering health services, and lower health-adjusted life years. The report questioned whether decision-makers were fully reflecting the critical role that medicines play.

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. Where appropriate, our submissions to public inquiries are available on the college website following the closing date. For a listing of recent submissions visit www.anzca.edu.au/safety-advocacy/advocacy.

Australia

- Australian College of Rural and Remote Medicine – Review of the Rural Generalist Curriculum
- Department of Health, Disability and Ageing – Pricing Framework for Australian Private Hospital Services
- Australian Medical Association – Fees List: Request for Feedback on Pain Medicine Services
- Royal Australasian College of Surgeons – Flexible Approaches to Training in Expanded Settings (FATES) 2 Rural Accreditation Models Final Report
- Streamliners – Care Pathways Australia 2026-2030
- Department of Health, Disability and Ageing – Medical Practitioners Workforce Survey
- Royal Australasian College of Physicians – Youth Appropriate Health Care position statement
- Therapeutic Goods Administration – Proposed amendments relating to transparency of disruptions to supply of a medical device
- Medical Board of Australia – Streamlining the Specialist pathway
- Jobs and Skills Australia – 2026 Occupation Shortage List Stakeholder Survey
- Medical Board of Australia – Recency of practice registration standard review

New Zealand

- Te Whatu Ora Health NZ – Draft Statement of Intent on Private Training
- Medical Sciences Council of New Zealand | Te Kaunihera Pūtaiao Hauora O Aotearoa – Anaesthetist Technicians and Safe Sedation Standard
- Pharmac | Te Pātaka Whaioranga – Community access to treatments for trauma and medical emergencies and ketamine for palliative care
- Medical Council New Zealand | Te Kaunihera Rata o Aotearoa – Regulation of physician associates/assistants
- Dental Council New Zealand | Te Kaunihera Tiaki Niho o Aotearoa – Updated Sedation Practice Standard
- Medical Council New Zealand – Model Standards for College Accreditation
- Health NZ | Te Whatu Ora – Ngā Paerewa Health and Disability Services Standards Review
- The college also endorsed the Council of Medical Colleges | Te Kaunihera o Nga Kareti Rata o Aotearoa submission on Health NZ's proposal for a formal process to enable Hospital and Specialist Services regions to make advance offers of future employment to fellows and Resident Medical Officers going overseas for training.

Media coverage

ANZCA'S PRESIDENT-ELECT

ANZCA Vice-President and President-Elect Dr Tanya Selak was profiled in an online article in the *Illawarra Mercury* on 10 February "From London terror to Wollongong: Tanya is breaking new ground for regional anaesthetists".


ILLAWARRA MERCURY 175 YEARS

Medical milestones

From London terror to major milestones

The same article was reproduced as a page one article in the newspaper's print edition on 17 February.

The article noted that Dr Selak's election "represents multiple milestones: She is the first president from outside a metropolitan centre, the first president who is an Australian and New Zealand dual citizen, and the first president from NSW in 20 years."

"Anaesthetists undergo a lengthy training pathway to qualify for the specialty," Dr Selak said.

ASSOCIATE PROFESSOR LACHLAN MILES

Melbourne FANZCA Associate Professor Lachlan Miles featured in a 1700-word feature article in the *Herald Sun* on 14 February "Back from the dead" about the Austin Hospital's Victorian Complex Oncovascular Group (V-COG), a multidisciplinary team of surgeons and anaesthetists who assess complex cancer patients to see if they are viable for a rare surgery technique.

The article described how the team, which included A/Prof Miles, saved the life of patient Hock Yap by stopping his heart to remove advanced cancer in a process that highlighted the hospital's extraordinary teamwork and innovation.

A/Prof Miles was also interviewed by NOVA radio hosts Jase and Lauren for a segment on 11 February "An anaesthetist reveals everything you need to know about 'going under': Anaesthetist Lachlan answers all your surgery questions."

GASTRIC EMPTYING

ANZCA President Professor Dave Story was interviewed for an ABC article on 22 December 2025 about patients not declaring their use of GLP-1 receptor agonists ahead of surgery. Professor Story said they slowed digestion, which could potentially increase the risk of pulmonary aspiration during surgery. Professor Story was also interviewed for ABC radio and ABC TV news broadcasts about the issue.

"The major problem we're trying to prevent is aspiration of gastric contents. That is where someone regurgitates what's in their stomach, and it's breathed into their lungs or passes into their trachea," he said.

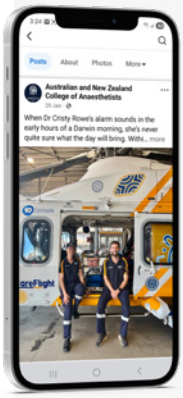
The ABC interview was a follow-up to an *AusDoc* article in which Professor Story highlighted the trend of some patients arriving for surgery without declaring their GLP-1 receptor agonist use.

PELVIC PAIN

FPM's Director of Professional Affairs Associate Professor Mick Vagg was interviewed for a 1300-word page one *Sunday Age* article "Why some doctors think endometriosis is being treated with unnecessary surgery" on 8 February 2026 about pelvic pain treatments and concerns that many surgeons believed surgery was the only option for treating endometriosis.

The article noted that the faculty released its own position statement on the treatment of pelvic pain because of its concerns about the emphasis on surgical treatment for the condition.

What we're talking about online



One of the most popular posts on Facebook (based on views) was the Summer *ANZCA Bulletin* cover article on ANZCA's CareFlight NT trainees. The post received 31,351 views, 134 interactions and 20 link clicks. This was also the top post on Instagram (based on views) with 4994 views and 92 interactions.

Other top stories across our social media channels, based on views and engagement included a Facebook link to an ABC story interviewing ANZCA President Professor Dave Story about patients not declaring their use of GLP-1 receptor agonists ahead of surgery.

The post received 10,252 views, 69 interactions and 357 link clicks. On Instagram, the most popular post (based on views) was a feature story on FPM Dean Dr Dilip Kapur working in Port Lincoln at the Aboriginal Health Service. This received 2769 views and 17 interactions.

Other popular posts included:

- Call for abstract submissions for the ANZCA ASM.
- Video on how doctors communicated in the 1980s from the Geoffrey Kaye Museum.
- Perioperative medicine symposium.
- FPM's visit to Townsville and Mackay to highlight the impact and opportunities of regional pain medicine.

Safety and quality

Kickstart your NRFit project

Having just completed neuraxial regional fit (NRFit) rollouts at three hospitals across two Australian states, Dr Patrick Glover, from the Gold Coast Hospital and Health Service (GCHHS) in Queensland and Dr Wei Low from Goulburn Valley Health (GVH) in Victoria encourage others to make the switch.

This article follows previously published ANZCA NRFit rollout guidance[1,2] and articles written by Dr Matt Drake on his personal experience with a rollout in New Zealand[3]. It aims to give easy-to-understand, practical advice on where to start and what to say to get the ball rolling in your hospital.

BACKGROUND

It has been nine years since ANZCA and the Australian Commission on Safety and Quality in Health Care (the commission) advised us to change our equipment.

NRFit is a connector change for spinal, epidural, and regional devices to make them incompatible with Luer style syringes. In essence it aims to prevent wrong route injections in two ways. Firstly, by making the connection of medication in a NRFit syringe to a Luer device impossible, and secondly by having yellow colour coding to help reduce drawing up errors (similar to red syringes for muscle relaxants).

Compatibility between neuraxial/regional and intravenous devices has led to multiple deaths and serious incidents throughout the world. Errors have occurred by injecting medications intended for the intravenous (IV) route into a neuraxial space where significant toxic effects have occurred (tranexamic acid, vincristine and digoxin seem the most toxic) or by injecting local anaesthetics (intended for a neuraxial/regional route) intravenously.

Japan transitioned to NRFit in 2021 while the National Health Service (NHS) in the UK completed its transition to NRFit in January 2025.

ANZCA and the commission have published extensive guidelines on the NRFit rollout[1].

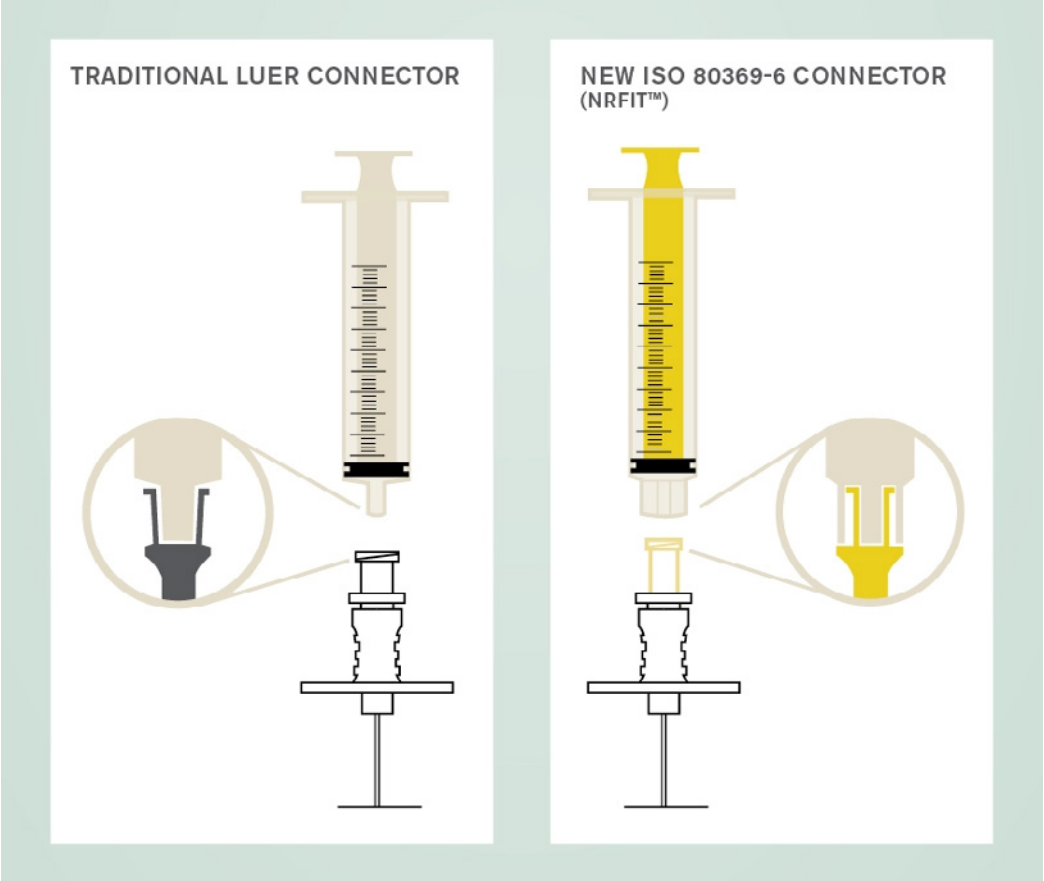
Most people that have read them have slowly recoiled in horror and dropped the idea after a few months of trying. It seems too big, too hard and the involvement of many other craft groups and executive can be seen as a big hurdle. Add to this that an NRFit rollout is to be done in one day and there is no clear backout path if issues arise.

In Australia there is no federal or state body that is leading the rollout, which means someone must take control of the process and push it through locally. If you have the energy and can make the time it is a very worthwhile project. There are major advantages of taking control locally; faster rollout timelines, rationalising or expanding stock lines, and large cost savings by returning stock to suppliers or moving it to other facilities.

ABOVE FROM TOP

From left: Courtney Silby (clinical nurse consultant) with anaesthetists Dr Patrick Glover and Dr Toby Snook at Robina Hospital.

NRFit stock at Robina hospital.



LEFT

Diagram comparing the Luer connectors and NRFit conectors.

STEPS TO GET STARTED

Get the anaesthetists on board first, they use 90 per cent of the products and are usually the easiest to convince, as almost all products are a simple "like for like" swap out. Get a decision to pursue the rollout from your consultant group/ quality and safety group. If required, there are countless horrific examples of adverse events (death, paralysis, and so on) published. There is no better motivator than local cases including adverse events where harm has occurred, and near miss events. Highlighting these through your anaesthesia mortality and morbidity or quality and safety systems with NRFit as the solution should help get traction with other departments.

Get your executive/medical administration on board. All large facilities will require executive support for the project. This may take many meetings, but there can be two large benefits. The first is funding for allocated nursing time. The second is that approval from executive teams/committees can be a fantastic resource to motivate reluctant areas to get on board as well as helping to grease the gears of procurement.

Assemble a core team. This will vary depending on hospital size and complexity. One motivated person is enough for a day surgery, but a group of two or three is much more manageable for a hospital with an emergency department and an ICU. A mix of medical and nursing staff is very useful as education across departments will be required for both nurses and doctors. There are many ways to structure this which will be up to the individual hospital.

- At GCHHS we were approved funding for an acute pain service (APS) nurse to work on the project from five to eight days a fortnight at different stages of the project. This was vital for the Gold Coast rollout and is highly recommended for larger facilities. APS staff have close links to anaesthesia, surgical wards and intensive care units (ICU) which was a huge help at GCHHS.
- At GVH, the roll out was led by a full-time consultant anaesthetist, supported by the operating theatre nurse unit manager (NUM) and a team of clinical nurse specialists (plus NUMs in each clinical area). Education was rolled out via clinical educators. A clinical product nurse was key to liaise between central supplies and the suppliers.
- Anaesthesia departments that have input into the rosters for anaesthesia nurses/techs or APS nurses could potentially leverage this to allow a faster allocation of staff and faster rollout.

Getting everyone onboard with the idea, convincing your executive and arranging a team will require a lot of conversations and meetings. At the start many legitimate questions will not be clear to your new team.

We have tried to give realistic discussion points here but remember the basics of the plan are simple – be guided by the commission rollout guidelines. This will make most groups happy that a robust and well-planned rollout will occur.

DISCUSSION POINTS DURING MEETINGS

Timeline
Expect it to take at least six-12 months. Standalone day surgery units with only a few items and craft groups could be completed faster but realise it is a marathon not a sprint.

Multiple hospitals in your network?
Start small (day surgery) and work up, this was a very useful strategy at the GCHHS.

Will every department swap over?
There may be good clinical reasons for a department or area not to change over. No NRFit radiofrequency ablation catheters? Proceduralists not happy with the NRFit version of what they currently use?

These are not good reasons to abandon the project.

NRFit equipment and Luer equipment should not be both available in the same workspace. This means you can simply quarantine stock from different departments in these situations.

GVH and Varsity Lakes Day Hospital were able to completely convert all areas. Robina did require quarantining plans in some areas. Overseas experience points to quarantining occurring almost universally in larger facilities. This will take some thought, but don't be disheartened and abandon the project.

Supply concerns
Remember that due to COVID and the IV fluid shortage, supply issues will be front of mind. It is not possible to borrow from a hospital down the road. Your supply plan is critical. You need to plan for two issues:

- Stock shortages/delayed delivery times: The most common path is to simply keep more on site. By keeping three months' supply on site and requesting suppliers also keep three months' supply offsite in their own warehouses, you have a large buffer to ride out these issues. Our experience has been that suppliers realise this is an issue holding hospitals back and have been very accommodating. It is vital to provide a forecast of the quantities of each item required to help decide your own initial order and allow suppliers to determine how much stock to bring into Australia.
- Contingency plans for product recalls: It doesn't matter how much you have in storage if a product recall occurs. Mitigate this risk by confirming multiple suppliers for as many items as possible prior to rollout. Products with only one supplier may induce heartburn in your executive/supply team. Luckily most of these products will be regional catheters – most anaesthetists will understand that you can substitute one catheter for another (or just use an epidural kit) in supply shortages. It will be useful to make this clear during the planning phase to those less familiar with our equipment. Original Luer items may have only one supplier at present (Regional pump lines at GCHHS for example), so changing to NRFit may not represent an increase in risk.

"It seems too big, too hard and the involvement of many other craft groups and executive can be seen as a big hurdle."

Stock management
Stock is king – what you need and how much. Make it your priority from the start. It is easy to lose sight of this, but everything else should take second place. Use your past year's orders as a guide but remember to talk to each area as practices change. If you don't have the right stock on rollout day you are in trouble.

Stock timelines will decide your rollout date – you can decide a rollout date once you have confirmation from suppliers that all the requested products will be available and have workable quarantine plans for areas that may not change over. We advise to start ordering stock at least three months before rollout day.

Perform a stocktake one month before rollout day to allow time to fix any ordering shortfalls/mistakes. A second stocktake one to two weeks before rollout day to box up stock for each department/area will be very useful. This repeated stocktake process was used at both hospitals and we found so many issues we would describe it as indispensable to our success.

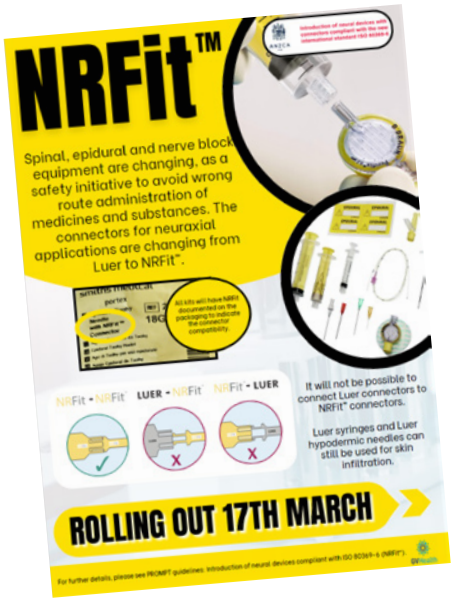
Costs
You may get questions about expected cost increases. Most equipment is similar in price to Luer versions. The added costs come from new NRFit specific syringes, drawing up needles, and caps. At Robina hospital (400 beds, seven theatres) this was projected to be around $A400 a week across the entire hospital with anaesthesia accounting for 90 per cent of that cost.

CHALLENGES AND TIPS

- Order plenty of NRFit drawing up needles (filter and non-filter) as you will need them to draw into NRFit specific syringes. Irritating as it is, plastic local anaesthetic ampules only fit Luer lock syringes. NRFit syringes will not be able to access these ampules without a drawing up needle (or gally pot).
- When GVH trialled the equipment, we ran out of NRFit needles so had to cut our trial period short. We also found that viscous fluids (for example, steroid preparations used by medical imaging at GVH) cannot be drawn up with filter needles, so we needed non-filter needles supplied.
- Deciding on how many specific NRFit syringes and needles you order can be challenging as no hospital keeps data on why you used a specific syringe/cannula. It is easier to count the number of spinals, epidurals and blocks you do and extrapolate syringe/needle usage from that (roughly two to three times that amount).
- As the commission guide discusses, some proceduralists use spinal/epidural equipment in unusual circumstances. Identifying these uses by asking each craft group is vital.

  Supply reports can be used to cross check or to identify other unexpected areas that are ordering spinal/epidural/block needles. Common examples are interventional radiology for joint and deep cavity injections. Orthopaedics for joint aspiration and local infiltration for hip and knee arthroplasties. Urologists (gel for rectal spacer to minimise radiation exposure) and maternal foetal medicine.
- NRFit epidural blood patch: This may require a change in practice to decant (rather than pass) drawn-up blood from a Luer syringe into an NRFit syringe or empty the blood into a sterile pot to draw it up into the NRFit syringe. There is no longer a supplier for an epidural blood patch kit in Australia. There is a butterfly needle with a one-way valve that allows connection to NRFit syringes to draw blood but is not widely available at present.
- Caudal anaesthesia: The most practised technique for paediatric caudal anaesthesia is to inject local anaesthetic into the caudal canal using a soft intravenous cannula-over-needle device. There are no NRFit versions of this cannula. Only rigid caudal needles are available in the NRFit range. Regional Anaesthesia UK (RAUK) and the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) have written to industry to consider the production of NRFit compatible equipment for this purpose[4]. For now, local risk assessment after examining the available NRFit version is the key prior to rollout.

"NRFit is a huge step forward for patient safety."



- Transfer of patients utilising NRFit equipment (for example, epidural catheters) to non-NRFit hospitals (or vice versa) is an ongoing discussion. One of the team (NRFit or APS) is consulted for an individual plan if transfers are required at present at GCHHS. We have approached the Regional Anaesthesia Special Interest Group committee to consider three main pathways, which we hope will lead to clarity for other hospitals making the change to NRFit.
- Rollout day practicalities: There are many safe ways to organise your rollout day. Varsity Lakes Day Surgery took about two hours to change out all stock. The Robina hospital rollout took roughly four hours for the emergency department, ICU, and the wards, then four hours for theatres.

  After Luer stock removal, you need to make additional shelf room for new NRFit equipment such as syringes, drawing up needles and caps, then apply correct labelling to allow easy reordering. It is important to check all areas, such as cupboards, trolleys, and ultrasound machines for hidden stashes of Luer stock, and educate staff as you go. Staff at Robina Hospital found handouts with what stock items were changing in each area very useful.

  At GVH, roll out occurred on a Monday and our anaesthesia clinical nurse specialists (one of them so happened to be working on the Sunday before) helped by stocking up all NRFit items in "block trollies" in operating theatres, so that they were ready to go from roll out day. Luer items were easy and quick to remove on the day. The other clinical areas took around two to three hours to changeover, with the lead anaesthetist and clinical product nurse depositing boxes of pre-allocated items to all the NUMs in those areas and collecting Luer items for quarantine.

FINAL WORDS

NRFit is a huge step forward for patient safety.

It is best done slowly and methodically over many months. This will be challenging to achieve if it is in response to an error that causes death or paralysis in your hospital.

Quick action may be expected in these circumstances (particularly now that successful rollouts have occurred in Australia). This will make any rollout considerably more stressful (but not impossible).

Ideally your rollout will happen before this occurs. Many planned rollouts in Australia have stalled or failed and there are many reasons for this. It is important to be realistic and realise there will be many hurdles to overcome, and it will take longer than you expect.

Many will see the inherent benefit and be supportive, but most will find discussing it boring or mildly irritating. Know that if you are doing it proactively, you won't get any plaudits for patients not having adverse events.

You will never know how many lives you have changed, and most staff won't notice the change after the first week.

Taking on a NRFit project in your hospital under these circumstances is an altruistic service. If you are not put off by the last few sentences you may have what it takes to see it through!

Hopefully this article helps you get perspective and get stuck into an NRFit rollout locally.

Dr Patrick Glover, FANZCA, Gold Coast Hospital and Health Service

Dr Wei Low, FANZCA, Goulburn Valley Health

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1. https://www.safetyandquality.gov.au/sites/default/files/2019-12/introduction_of_iso_80369-6_neuraxial_connector_devices_to_australia_2019_0.pdf
2. Lansdown A, Lamond C, Mainland P. Royal Prince Alfred prepares for changeover. ANZCA bulletin. 2019;28(3):19-19.
3. Drake M. NRFit update from New Zealand. ANZCA Bulletin. 2020;29(1):20-22.
4. https://www.apagbi.org.uk/downloads/news/caudal-nrfit-statement-apa-rauk-final.pdf

MORE INFORMATION

For more information on the neural connector changeover, including a link to the ANZCA Library Guide, please go to www.anzca.edu.au/safety-and-advocacy/standards-of-practice/neural-connector-changeover.

At the 2026 Auckland ANZCA Annual Scientific Meeting Dr Matt Drake is facilitating a workshop on the changeover, recounting his experiences in overseeing the roll-out in Auckland hospitals in 2021.

ABOVE FROM LEFT

NRFit roll-out poster displayed in all relevant clinical areas at GVH.

Some of the team members celebrating the NRFit roll-out at GVH from left to right: Dr Wei Low, consultant anaesthetist; Belinda Keast, clinical product nurse; Andrea Stevens, nurse unit manager for operating theatres; Emily Wood, clinical support nurse operating theatres.

WebAIRS

What webAIRS can't tell us – under-reporting in anaesthesia

The webAIRS incident reporting system has become an important part of patient safety work within ANZCA, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists. Developed by clinicians and supported over many years, it now includes more than 13,000 reports from anaesthesia practice across Australia and New Zealand. It has been particularly useful for identifying recurring problems, emerging risks, and common human factors issues, and it continues to inform education, safety alerts, and policy discussions.

As webAIRS has grown, it is worth reflecting not only on what the data shows us, but also on what it misses. Like any voluntary reporting system, webAIRS gives us a partial view of what happens in everyday practice. Thinking about under-reporting helps put the data in context and avoids expecting it to answer questions it was never designed to answer.

WHAT IS UNDER-REPORTING?

Under-reporting does not simply mean that too few incidents are submitted. It reflects a series of steps that must occur before a clinical event ends up in a database.

First, the event must be recognised as an incident. Many near misses, workarounds, and system issues are not obvious at the time, or only become clear later. Second, the event must be seen as something worth reporting. Clinicians constantly make informal judgements about whether something is serious, unusual, or useful enough to document. Third, there must be enough time, energy, and psychological safety to actually sit down and complete a report.

At each of these points, incidents can drop out. This usually happens not because clinicians do not care about safety, but because of the realities of clinical work.

WHY DON'T CLINICIANS REPORT INCIDENTS?

The reasons clinicians do not report incidents are familiar and come up regularly in Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) discussions.

One common view is that incidents without patient harm are of limited value. Near misses are often seen as successful recoveries. If the patient was ultimately fine, reporting can feel unnecessary. In practice, these events often provide the most useful insight into system weaknesses, but they are also among the least likely to be reported.

Normalisation plays a role as well. Practices that initially feel uncomfortable or risky can become routine over time, particularly in busy or resource-limited environments. Once something is seen as "how things usually go", it is less likely to trigger a report.

Time and fatigue remain major barriers. Reporting often happens after hours, at the end of a long list, or days later when details are less clear. Even a straightforward reporting system takes effort, and it competes with rest, family life, and the need to mentally switch off after work.

Despite clear no-blame messaging, concerns about judgement and consequences still matter. Some clinicians worry about how reports might be perceived, or whether they could lead to scrutiny or medico-legal issues. These concerns may be greater for trainees, locums, or those working without strong local support.

There is also genuine uncertainty. Many anaesthesia events sit in grey areas. It is not always clear whether something represents an error, an expected complication, a system problem, or just bad luck. When it is unclear how to label an event, reporting is easily postponed and often forgotten.

WHAT DOES THIS MEAN WHEN WE LOOK AT WEBAIRS DATA?

Recognising under-reporting does not undermine the value of webAIRS, but it does shape how the data should be read.

WebAIRS is best thought of as a way of detecting patterns, rather than measuring how often things actually happen. The number of reports for a given issue does not tell us how common that issue truly is. Similarly, the absence of reports does not mean an issue does not exist.

Some types of events are more likely to be missed, including near misses, cognitive slips, fatigue-related problems, and production pressures that do not lead to a clear adverse outcome. Other events, particularly those that are dramatic or emotionally charged, may be more likely to be reported.

For this reason, webAIRS data should not be used to rank individuals or institutions, it was never intended for that purpose. Its real strength lies in highlighting recurring themes and shared vulnerabilities across practice, especially when reports are reviewed over time.

WHAT WEBAIRS DOES WELL

Acknowledging under-reporting does not detract from the strengths of webAIRS. Even with incomplete reporting, certain themes appear repeatedly and consistently.

The narrative sections of reports are particularly valuable. They provide insight into decision-making, communication problems, equipment issues, and system pressures that are difficult to capture in other ways. Reviewing these reports, especially in groups, often reveals patterns that are not obvious from individual cases alone.

Serious but uncommon events can still be identified, and these have led to safety alerts, changes in guidance, and focused education. Ongoing issues such as medication errors and airway-related problems remain visible over time, despite variation in reporting behaviour.

In this sense, webAIRS does not aim to capture everything. It helps point attention towards areas where further discussion and improvement are needed.

IMPROVING THE VALUE OF REPORTING

Much of the focus around incident reporting is on increasing the number of reports submitted. While engagement matters, the usefulness of reports is just as important.

Clear descriptions of what happened, why it happened, and how the situation was managed are often more helpful than detailed classifications. Near misses and seemingly minor events frequently highlight system problems that would otherwise remain unnoticed.

At a local level, normalising brief reporting, providing feedback to reporters, and using webAIRS cases in morbidity and mortality meetings or teaching sessions can reinforce the idea that reporting leads to learning. These are approaches many departments already use, often informally.

For individual clinicians, it may help to think of reporting as a way of sharing experience, rather than admitting fault.

A SHARED RESPONSIBILITY

WebAIRS reflects anaesthesia practice as clinicians choose to record it. What appears in the database depends on what we notice, what we decide is worth reporting, and what we have the capacity to write down.

As the database continues to grow, the challenge is not only to encourage reporting, but to read the data with an understanding of its limits. Used in this way, webAIRS remains a practical and valuable patient safety tool, not because it tells us everything, but because it helps us notice patterns, prompt discussion, and learn from one another's experience.

LOOKING AHEAD: INVITING FEEDBACK FROM USERS

As webAIRS continues to evolve, it is timely to reflect not only on how the data are used, but also on how the system itself is experienced by those who use it. Voluntary reporting systems depend on trust, usability, and perceived value. Understanding what clinicians find helpful – and what they find frustrating – is essential.

The webAIRS website and its functionality are currently under review to improve usability and ensure the system continues to meet the needs of clinicians in everyday practice. This review offers an opportunity to consider not only technical performance but also how reporting fits into real-world clinical workflows.

Rather than making assumptions about what users want, one obvious next step is simply to ask. Feedback from clinicians could help guide future refinements to the webAIRS portal and reporting process, whether incremental or more substantial.

Questions that may be useful to explore include:

- What is the best aspect of webAIRS from a user perspective?
- What do you find most unsatisfactory about the current system?
- What one or two features or changes would most improve a future version of webAIRS?

Dr Tim Basevi FANZCA
The ANZTADC Case Report Writing Group

We welcome your feedback – please complete the survey by scanning the QR or visiting bit.ly/webairs26

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:

- Residual anaesthetic drugs in the dead space volume of IV lines' – 21 Oct 2025.

Perioperative medicine

Perioperative medicine continues to gain momentum

Perioperative medicine (POM) continues to gain traction across Australia and New Zealand, with interest strong and participation broadening.

ADVOCACY

Advocacy for perioperative medicine remains a core focus, and the college has developed resources that explain perioperative medicine to decisionmakers and to stakeholders beyond our specialty.

The college has produced a short explainer video "Perioperative medicine: The pathway to better surgical care" and an accompanying booklet "Perioperative medicine: A better experience for surgical patients".

The animated video follows the journey of "Joe" who needs surgery for bowel cancer. His co-morbidities aren't considered before his operation, and his surgical pathway is impacted. Joe's story is retold, this time under the care of a perioperative medicine team, which highlights the benefits for Joe and the healthcare system.

The booklet highlights the benefits of perioperative medicine and includes examples of how it is making a positive difference in hospitals throughout Australia and New Zealand. These stories will be added to over time.

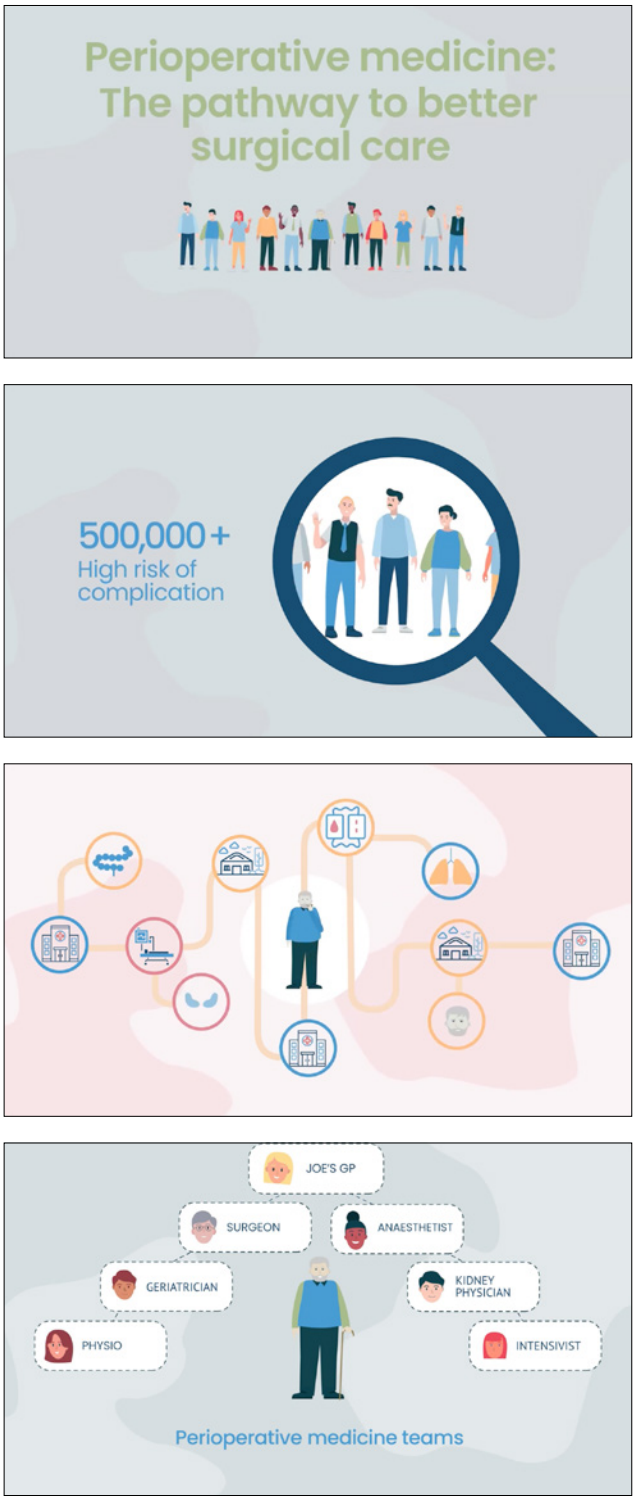
The aim of these resources is to articulate the value of perioperative medicine in clear, practical terms, highlighting better patient outcomes, more efficient care pathways and a more sustainable health system.

The video was played during a presentation by Dr Sean McManus at a recent conference of the Surgical and Perioperative Innovation Collaborative (SPICA) in Brisbane. Dr McManus, who is vice-chair of the Chapter of Perioperative Medicine Board and interim chair of the ChPOM Advocacy and Policy Committee, said the presentation and video were well received.

The video and the booklet can be found on our website at www.anzca.edu.au/chapter-of-perioperative-medicine/advocating-for-perioperative-medicine.

Alongside this, government engagement has continued to build. The benefits of perioperative medicine have been raised in recent meetings with the advisor to Australian Health Minister Mark Butler, Australian Government Department of Health, Disability and Ageing executive staff, WA's Acting Chief Medical Officer Andrew Jamieson, and SA Health's Planned Surgery Reform Clinical Oversight Committee.

This work is underpinned by the chapter's Advocacy and Policy Committee, which brings together multidisciplinary expertise to guide our engagement.



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Stills from the animated perioperative medicine video.

EDUCATION

Trimester 1 of 2026 commenced in February with 57 unit 1 enrolments (preoperative assessment) and 46 in unit 2 (preoperative planning), more than double the enrolments for the same trimester last year.

Importantly, this cohort reflects the multidisciplinary foundations of perioperative medicine. While anaesthetists remain strongly represented, there is continued engagement from physicians, general practitioners and, increasingly, intensivists.

The chapter has now welcomed 801 graduates of the Chapter of Perioperative Medicine across both the POM course and recognition pathway. In February, 15 participants became graduates via the POM course, bringing the total number to 32 since 2025, while the recognition pathway accounts for the majority of the chapter's graduate cohort at 769. Course graduates represent multiple jurisdictions, including Victoria, NSW, Queensland, SA, WA, Tasmania and New Zealand.

Hospital engagement continues to expand and there are now 37 approved clinical immersion sites delivering the course across Australia and New Zealand. More hospitals are being onboarded. Expanding our presence to rural and regional sites is a core focus of the college in 2026.

The chapter is now reassessing aspects of course delivery to ensure it remains fit for purpose as participant numbers increase. Two working groups have been established to support this process – one focused on reviewing internal and external assessments, holding its first meeting this month, and another reviewing knowledge checks within the online modules, commencing in June – with deployment of updates anticipated in 2027. Recruitment of additional unit leads is also under way to support delivery as enrolments increase.

A new participant workshop model is being rolled out this year, combining online delivery with inperson sessions. A workshop in July will be delivered online, while a twoday inperson workshop is planned for November in the lead-up to the POM Special Interest Group (SIG) meeting in Tasmania.

Communication skills will be a central component, reflecting the importance of effective conversations with patients, families and multidisciplinary teams throughout the perioperative journey.

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

What Aboriginal people in the NT value during the operation journey

IMPLICATIONS FOR NT PERIOPERATIVE CARE FROM OUR MJA STUDY

Asking and listening to what Aboriginal people in the Northern Territory (NT) value during the operation journey provided a multifaceted entry point into culturally safe models of care.

This question prompted discussion not only of experiences within hospitals, but of lives, relationships and obligations that need to be carefully navigated while receiving care –"Mob understand that sickness needs operations … yeah we do want to stay [in hospital] … but … we have sick elderly back on Country and other [ceremony or funeral time] obligations."[1]

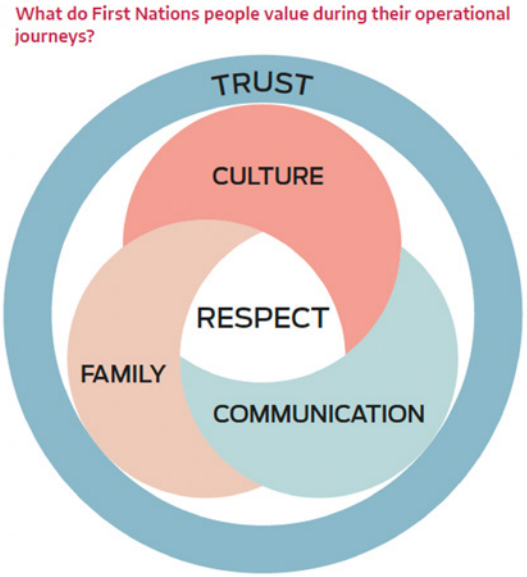
Our recent qualitative study published in the *Medical Journal of Australia* (MJA), funded by an ANZCA Health Equity Grant 2022, explored what is important to Aboriginal people through the perioperative process[1].

As a clinician-researcher working in the NT, my daily work reaches beyond anaesthesia provision in the operating theatre and even beyond perioperative medicine, providing holistic multidisciplinary care, including pre-operative optimisation and post-operative rehabilitation. In the NT, this care extends to community health and strengthening cultural safety as we continue to witness the persistent impact of colonisation and ongoing intergenerational trauma.

Globally, surgical conditions account for one-third of all disease burden[2], but we know that postoperative outcomes for First Nations Australians remain underreported. Inequities in life expectancy and health outcomes persist for First Nations people in Australia, with the complex multifactorial aetiology including chronic disease burden, limited access to health care services in geographically remote areas, social determinants of health, and systemic barriers despite supposed universal healthcare[3].

In the NT, First Nations people comprise 30 per cent of the population yet are over-represented in hospitals, experiencing delayed presentations, longer elective surgery waiting times, and higher emergency-to-elective surgery ratios[4-6].

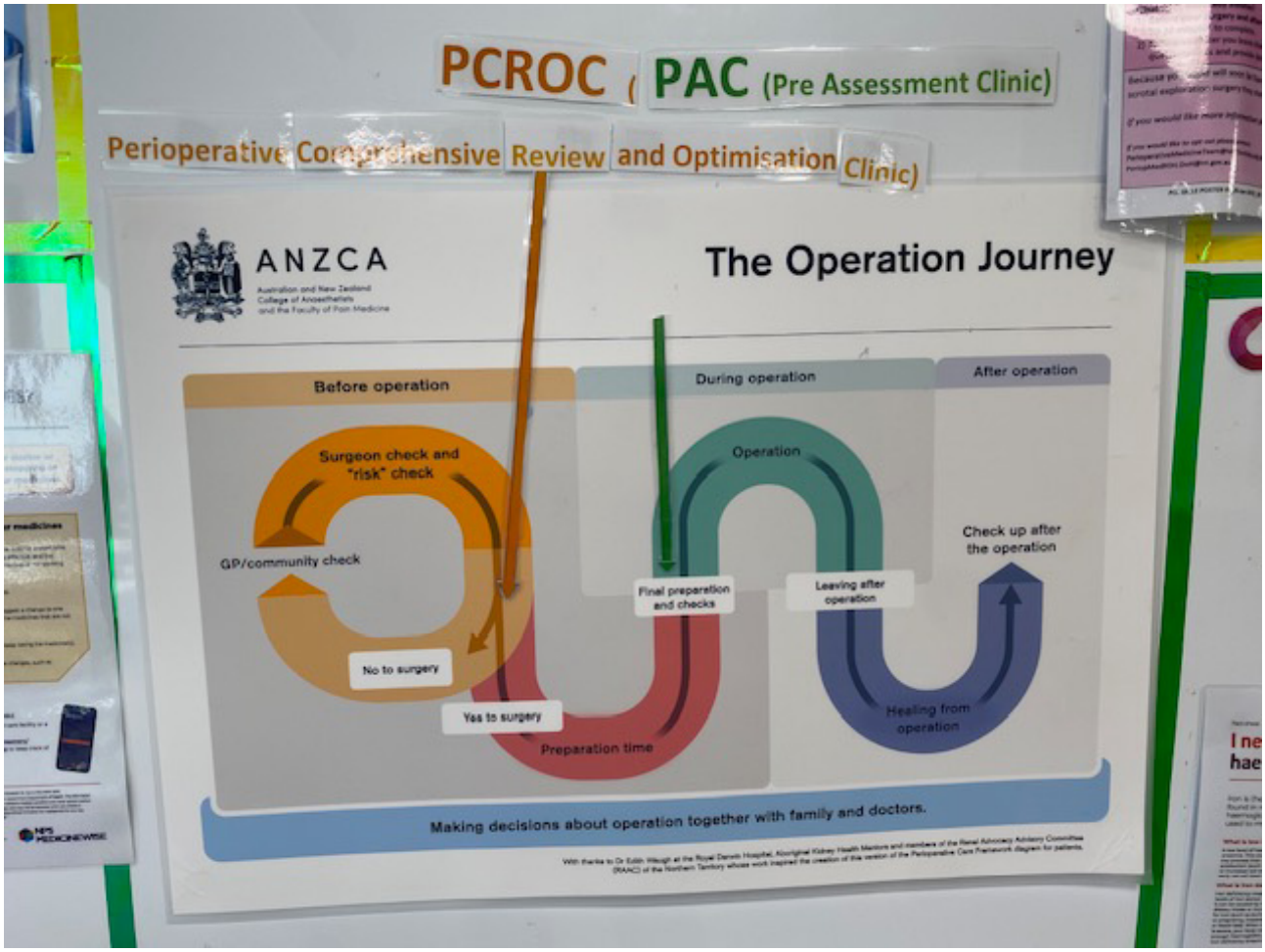
Building on epidemiological exploration of postoperative outcomes, we partnered with Aboriginal co-researchers to understand what families and communities prioritise in the operation journey – their stories highlighted the mismatch between health system outcomes and values of those the service is meant to serve.



Yarning covered both the practical and tangible things that people want in their perioperative journeys, as well as the underlying ethics and principles for care. Image courtesy of MJA.

TOP

Peter Henwood, David Croker (at the back, from left); Neil Wilkshire and Professor Dave Story (at the front, from left) at the Royal Darwin Hospital and Menzies School of Health Research.



"We have to talk first and make sure that my family understands … that gives you the time and your family [the] time to talk about it and make that decision what's best … it's a cultural thing before we make that next step. … Patient and family should be informed after the operation about findings. Nobody told me what to do, no follow-up."[1].

In partnership with Aboriginal co-researchers, who have lived experience of operations, and through community-based participatory action research, we engaged in yarning, deep listening (Dadirri), and collaborative reflection[7,8].

Eighteen Aboriginal participants from urban, regional and remote NT communities participated in yarning circles held in Darwin (May 2023–September 2024). Co-researchers included Aboriginal kidney health Mentors who co-led yarning sessions, analysis and interpretation (HREC NT Health/Menzies 2022-4467). This bulletin provides an overview of the MJA article, which has the full methodological detail, supporting information and checklists following the CONSIDER/COREQ frameworks[1].

Respect emerged as a foundational principle throughout the perioperative journey[1]. Participants described respect as being heard rather than dismissed. Respect for cultural protocols, such as kinship roles, gender norms, and bereavement practices, was important for people having surgery. Experiences of decisions bypassing patients and discarding traditional foods were framed as profound disrespect spanning personal, cultural and spiritual domains – "I brought her [a relative having surgery] in a kangaroo tail, turtle and all the yam … they got it, and they threw it in the bin. The nurse said 'it is not lunch'. And that was not for them [to say]."[1].

Family involvement in decision-making and support is essential. Decisions are not always individual: specific kin may be given 'permission' to provide instructions on care, reflecting collective decision-making, spiritual support, and information relay to broader networks[1]. Participants emphasised the need for a consistent support person from consultation through recovery and the importance of Aboriginal staff, advocate and navigator roles.

Culture and *connection to Country* underpin healing. Practices including smoking ceremonies, traditional medicines and bush foods were needed alongside biomedical care[1]. Marginalisation of these practices eroded trust. Post-surgery recovery also required support to return to community and Country.

Communication wove through these domains: clear, culturally framed explanations allowing families time to discuss was central. Participants emphasised that fear-based ultimatums ("surgery or die") may lead to disengagement[1]. Limited access to interpreters and inconsistent messaging from health staff were common communication challenges. Navigator roles and clear handovers between tertiary and primary care were suggested solutions.

When respect, family, culture and communication coalesced, participants described safety, belonging and empowerment. *Trust* emerged as the unifying outcome of repeated respectful interactions; its absence drove fear, disengagement, and care avoidance[1].

For anaesthetists, our article in the MJA provides a number of important insights. Learning about local First Nations practices is a starting point. For example, in the NT, asking patients "where is your home Country" or "what languages do you speak" can help to make connections. Asking "Who else needs to be here?" may provide an opportunity to follow cultural protocols[1].

Structurally, embedding Aboriginal liaison officers and patient navigators within perioperative teams can help people journey from pre-op assessment to discharge. This mirrors ANZCA frameworks and reflects the relational priorities of looking after people who are having surgery[9].

Adapting assessments to allow family decision-making and telehealth handovers may enhance continuity of care. These align with regulatory shifts that treat culturally unsafe care as professional misconduct under National Law[10]. Encouragingly, ANZCA continuing professional development and perioperative curricula are working towards integrating First Nations-informed content on shared decision making and pathway design[11].

Beyond asking and listening to what Aboriginal people value in the operation journey, we also need to act. How can we develop culturally safe perioperative care models?

How do we embed respect for Aboriginal peoples, families, communities, practices and ways of sharing information? Working together to take careful and collaborative action is needed to achieve "better outcome[s] for Aboriginal people going through the hospital system … [to] not [be] afraid … from babies to old people."[1].

Dr Edith Waugh, FANZCA
Dr Sophie Pascoe
Royal Darwin Hospital, NT

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Scan to read the qualitative study published in the *Medical Journal of Australia*

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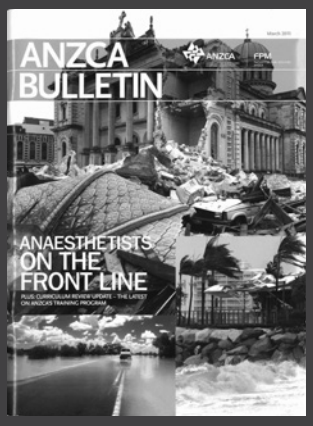
The Indigenous version of the Australian and New Zealand Perioperative Patient Pathway (ANZPPP) at RDH.

Dr Edith Waugh at Royal Darwin Hospital.

On the frontline



Fifteen years ago, the *ANZCA Bulletin's* cover feature was "Anaesthetists on the frontline" which highlighted the work of fellows and trainees in crisis on Australian and New Zealand shores – the Christchurch earthquake and floods and a cyclone in Queensland.

The humanitarian work of our fellows and trainees is also undertaken offshore – through direct clinical care as well as improving education and training in low- and middle-income countries but also when crises occur.

This includes providing medical aid in conflict zones.

Over the past two years a number of our fellows and trainees have travelled to conflict zones including Gaza, Ukraine, Israel and Sudan, taking them away from their families to care for those in difficult and even dire circumstances.

Carolyn Jones spoke to some of them.

Professor Dave Story
ANZCA President

Providing care in a Ukraine war zone

When Hobart anaesthetist Dr Rowena Grice arrived in Ukraine in September 2024, she experienced a healthcare system operating under relentless pressure where the boundaries between emergency medicine, intensive care and retrieval were blurred by the realities of war.

For nearly three months, Dr Grice worked with the German international emergency response organisation CADUS as part of a small mobile team delivering critical care to soldiers and civilians injured on or near the frontline. Their workplace was not a hospital ward, but an ambulance – one she describes as a "floating ICU".

"We were essentially transporting critically unwell patients away from the frontline," she explains.

"They'd had initial damage control surgery, and our role was to stabilise them and then move them to safer, better-equipped tertiary hospitals."

Operating out of bases in Dnipro in eastern Ukraine and rotating through locations closer to active conflict zones such as Sumy and Sloviansk, Dr Grice worked as part of a three-person clinical team with a Ukrainian driver and a paramedic or nurse. About 70 per cent of their patients were military personnel, with the remainder civilians caught in the crossfire.

The injuries were confronting in both severity and scale.

"It was horrendous polytrauma and worse than I anticipated," she says. "Multiple amputations, devastating head injuries, pelvic fractures, massive blood loss. Patients were often incredibly unstable."

Inside the ambulance, care mirrored that of an intensive care unit but in far more precarious circumstances. Dr Grice and her colleagues managed airways, titrated analgesia, inserted arterial and central lines, and treated fluctuations in blood pressure during journeys that could last several hours.

A couple of times a week the ambulance team would transport patients to a specially equipped, nine carriage intensive care unit train where another medical team would take over the patients' care.

"Many of them were so unwell," she says. "You were trying to make sure they didn't deteriorate further – or die – on the way."

At times, despite every effort, patients did arrest during transport. In one case, a young man with multi-organ failure required resuscitation in the back of the ambulance.

"We got him back, but he was incredibly sick. You knew some of them weren't going to survive," she reflects.

While the mobile unit was relatively well supplied thanks to international support, conditions in frontline hospitals were stark. Staff were often exhausted and under-resourced, with clinicians working far beyond their usual scope.

"We were working in a country where resources are now pretty basic. Their resources are severely depleted and the

FROM LEFT

Fellows on humanitarian missions are often confronted with makeshift equipment.

The "floating ICU" train used by medical teams in Ukraine.

ABOVE FROM TOP

Dr Rowena Grice treating a patient in one of the Ukraine ambulances.

Dr Grice in one of the local cantinas.

"It was horrendous polytrauma and worse than I anticipated. Multiple amputations, devastating head injuries, pelvic fractures, massive blood loss. Patients were often incredibly unstable."

Ukrainians themselves appear to be exhausted. You had physiotherapists running surgical units, people learning procedures on the spot because there was no one else available."

For Dr Grice, one of the few advantages of the ambulance setting was the ability to deliver a higher standard of care.

"Once patients were with us, we could provide proper monitoring and interventions that weren't always possible in the hospitals," she says. "We gave them the best possible care that we could because outside of that little ambulance bubble, it was a country absolutely depleted."

The risks extended beyond the clinical. Ambulances could become targets, with Russian drones tracking movements along evacuation routes.

"You had to change routes, hide under trees," she explains. "There were missile strikes nearby, and we spent time in bunkers waiting for clearance to move."

Despite this, Dr Grice says she rarely felt personally afraid, instead taking cues from local colleagues.

"The Ukrainian drivers were extraordinary. They knew the roads, the risks, and they kept us moving."

It is the people of Ukraine, she says, who have left the deepest impression.

"Their resilience and dignity are incredible. They are proud, united and compassionate and they don't deserve what's happening to them."

Among the many cases she encountered, one stands out: A local woman injured by a drone strike while staying on her farm with her husband.

"He put her in a wheelbarrow and ran for two kilometres trying to find help," Dr Grice recalls. "Eventually she reached us, and we had to fully resuscitate her in the ambulance."

Stories like this were not uncommon and contributed to what Dr Grice describes as the most difficult aspect of her experience: The sense of limited impact in the face of overwhelming need.

Now back in Hobart, Dr Grice continues her work in anaesthesia while maintaining a strong commitment to humanitarian medicine. She is planning further overseas work later this year and hopes to continue contributing where she can.

"At the end of the day, I'm just looking after the patient in front of me," she says.

"It's just that sometimes, that place happens to be a little more unusual."

**Fellows interested in humanitarian missions can contact Dr Grice at rowena.grice@ths.tas.gov.au*

Working at the limits of medicine

When Australian anaesthetists Dr Saira Hussain, Dr Wajdi Hadi and Dr Saya Aziz travelled to Gaza on recent humanitarian missions each knew they were entering an environment unlike anything they had encountered before.

What awaited them was not simply a shortage of resources, but a fundamental re-shaping of anaesthesia practice in which survival, adaptability and collective decision-making replaced the systems and safeguards taken for granted in high-income health settings.

Across different hospitals and deployments, their experiences converge on a shared reality: delivering anaesthesia in Gaza means working at the limits of medicine, often without functioning or limited medical or monitoring equipment and sporadic electricity. Doing so while under constant threat, alongside colleagues who are simultaneously clinicians, survivors and carers for their own families.

PRACTISING WITHOUT A SAFETY NET

For Dr Hussain, working at Nasser Hospital in southern Gaza meant practising anaesthesia in an environment where the basics could not be assumed. On her second mission in July 2025, she found that not a single anaesthesia machine was fully functional. Dr Hussain has been on three humanitarian missions to Gaza including with the Norwegian Aid Committee (NORWAC) and the UK-based International Disaster & Emergency Aid with Long-term Support (IDEALS).

“Some were missing capnography, others had damaged ventilator bellows, missing cables or parts,” she recalls. Equipment had been damaged during military incursions, explosive events or rendered unusable because replacement parts were unobtainable under blockade conditions.

While essential anaesthetic drugs were available on a limited basis, the absence of reliable monitoring profoundly altered clinical decision-making. “You may have the drugs, but not the monitoring you would normally rely on,” Dr Hussain says. “Every decision has to be carefully weighed, because the margin for error is so small.”

Similarly, when Dr Hadi arrived at Al-Shifa Hospital in Gaza City with the Palestinian and New Zealand Medical Association (PANZMA), he encountered a once-major tertiary teaching hospital reduced to a fraction of its former capacity. Only two operating theatres were functional, yet the demand for surgery and emergency care was relentless.

On a typical day, the team managed 20-30 major surgical cases. Dr Hadi says during mass casualty events following airstrikes that number surged dramatically, with up to 80-120 critically injured patients arriving at the emergency department within a short period.

“The most profound challenge was the scarcity of resources,” Dr Hadi says.

ABOVE FROM TOP

Anaesthetist Dr Saira Hussain (centre) with colleagues in Gaza.

Fellow Dr Wajdi Hadi (sitting in front) with a Gaza hospital medical team.

Anaesthetist Dr Saya Aziz in a Gaza hospital operating theatre.

FROM LEFT

Dr Wajdi Hadi surrounded by devastation in Gaza.

Conditions inside a Gaza hospital operating theatre.

Dr Saira Hussain working in theatre.

"Anaesthesia became focused on immediate survival rather than optimal care." Pain management, postoperative comfort and longer-term outcomes were often secondary to the imperative of keeping patients alive through surgery.

Infrastructure limitations shaped every aspect of care. There was no functioning recovery area, intensive care capacity was effectively absent, and monitoring equipment was minimal. Patients who would ordinarily require postoperative ventilation were frequently extubated immediately after surgery because there was nowhere else to take them.

"These decisions were ethically confronting and clinically distressing," Dr Hadi reflects, "but unavoidable."

For Dr Aziz, who spent a month at Al-Shifa Hospital late last year, the shortages were similarly stark as she and her colleagues worked long hours to keep patients alive in a place where almost every pillar of modern perioperative care had collapsed.

"Working in Gaza required a fundamental recalibration of everything I know about safe anaesthesia," she reflects.

"My training and instincts as a FANZCA, built on protocols and safety standards, had to be set aside. To be of any use, I had to accept a new reality — the very concept of patient safety, as we define it, did not exist there.

"Basic monitoring was a luxury. Capnography and oxygen saturation probes were often broken or uncalibrated. Blood pressure cuffs were filthy, reused hundreds of times. There was no functioning suction, no air supply on anaesthesia machines, and minimal CO_2 absorbers – forcing high-flow techniques without the ability to measure volatile concentrations or depth of anaesthesia.

"Airway management was improvisational. Laryngoscopes often had no batteries. Single-use equipment was reused without cleaning. Paediatric endotracheal tubes were scarce, despite children making up a significant proportion of patients. "I had never done so many oesophageal intubations in my whole career," Dr Aziz says. "You relied on instinct, intermittent monitoring and hope."

Drug shortages compounded the challenge. Antibiotics were unavailable. Local anaesthetics had often lost potency due to broken "cold" chains. Syringes containing ketamine or muscle relaxants were reused between patients. There were no paper or pens for charts. Patient identification relied on family testimony or a blood group handwritten on a scrap of paper.

"Clinical decision-making shifted toward risk prioritisation and minimalist intervention. External jugular cannulation became a necessary proficiency, employed when conventional access was precluded by extensive burns, the need for multi-limb amputation, or the absence of central line supplies.

"For trauma patients, already at highest risk of awareness, I had to consciously tolerate that risk, minimising anaesthetic doses in the absence of any depth monitoring."

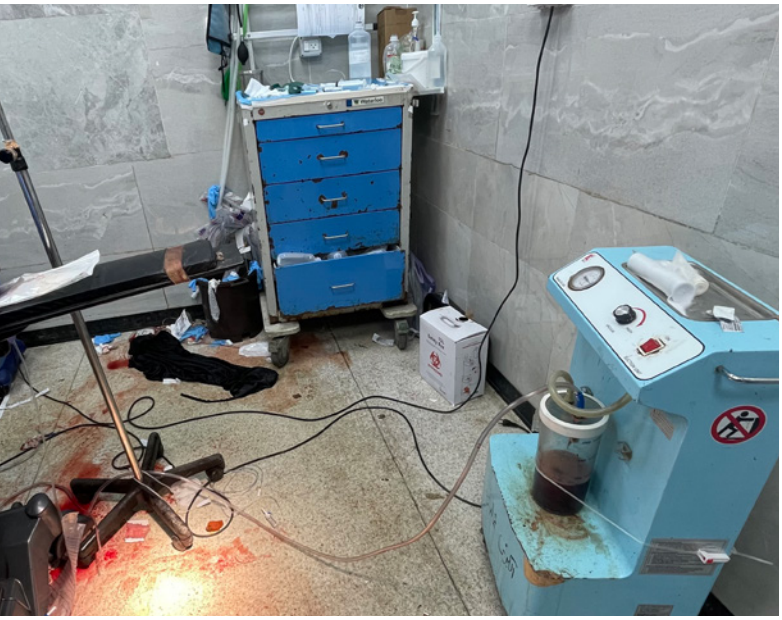
A DIFFERENT KIND OF EXPERTISE

One of the striking features of practising in Gaza, all three anaesthetists note, is that the local clinicians are not under-trained or inexperienced. Before October 2023, Gaza had a functioning health system with specialist training programs, medical schools and tertiary hospitals.

Dr Hussain emphasises the importance of deferring to local leadership. "It's critical to take the lead from senior local clinicians because they understand the system, the constraints and the risks better than anyone."

Teamwork and adaptability are essential. Difficult decisions are made collectively, often under immense pressure, with each choice potentially affecting patient survival. "Every decision could be a life-or-death decision," she says.

Dr Hadi describes how formal systems quickly fell away under pressure, replaced by trust-based collaboration with decisions rarely made alone. "During mass casualty events, there's no hierarchy in the traditional sense," he says. "You do whatever is needed, as a team."



For Dr Aziz, the commitment of local staff was one of the most powerful aspects of her experience.

"Medical students whose universities had been destroyed volunteered to run emergency departments, insert chest drains and place central lines. Anaesthetic technicians functioned at registrar level, cannulating, resuscitating, suturing and scrubbing. They were the backbone," Dr Aziz says.

"Their adaptability was born of absolute necessity."

TRAUMA

Patient injuries were severe and complex. Dr Hadi describes managing patients with devastating shrapnel injuries involving multiple organ systems, often requiring several surgical teams operating simultaneously while he struggled to maintain haemodynamic stability.

"Massive transfusion was routine," he says. "In one week, I administered more blood products than I had used in more than a decade of anaesthesia practice in Sydney."

Dr Hussain describes young patients with treatable tumours awaiting evacuation for definitive care. At the time of deadline, in early February the Rafah border crossing between Egypt and Gaza partially reopened, allowing some Palestinians to travel for medical treatment after being closed for nearly two years.

Dr Hussain encountered many patients in the paediatric ward at the ceiling of optimisation for their surgical condition – awaiting clearance to leave Gaza through open border crossings for surgical management.

One patient, a teenage girl with a suprasellar tumour (a slow-growing tumor that can cause severe visual impairment in one or both eyes if they press directly on the optic nerves), underwent surgery locally.

"You may have the drugs, but not the monitoring you would normally rely on. Every decision has to be carefully weighed, because the margin for error is so small."

"After months of waiting for evacuation the tumour had grown significantly, forcing a more invasive surgical approach due to unavailable equipment. The child died and had her evacuation eventuated some month before, the outcome would more than likely have been very different."

Dr Hadi recounts patients whose resilience was as striking as their injuries: a 10-year-old boy who survived entrapment under rubble and a child returning for dressing changes after a leg amputation.

SUPPORTING EACH OTHER

Dr Hussain describes one of her most important roles while on a humanitarian mission as supporting colleagues – sometimes it's simply giving someone a break during a case, sharing food, or sitting together over tea.

"Listening to their stories," she says, "their history and their ongoing worries."

Dr Aziz similarly reflects on the importance of small moments of normality – shared meals, brief laughter, mutual checking-in – in sustaining morale amid constant strain.

For all three anaesthetists, the psychological load was cumulative. Cases blurred into one another, often without closure. Just as one crisis stabilised, another would arrive.

"You don't process it in real time," Dr Hadisays. "You just keep going."

LEAVING FAMILY BEHIND

A confronting aspect of these missions was leaving family and loved ones behind, knowing the risks were real and unpredictable. Several other anaesthetists including Perth FANZCA Dr Emma Giles and Adelaide fellow Dr Waleed Alkhazrajy, a member of the ANZCA South Australian and Northern Territory Regional Committee, have also travelled on humanitarian missions to Gaza.

Dr Hadi left three children in Australia, acutely aware of the possibility that he might not return. "No preparation can truly mitigate that," he reflects. "What sustained me was the conviction that, as a doctor, I had an obligation to help where the need was greatest."

The three anaesthetists, as is the case with other humanitarian workers, prepared written wills, including burial instructions in the event of death.

Dr Hussain credits the unwavering support of her husband and family for enabling her work. "They're nervous, of course," she says, "but they understand my sense of duty." Practical coping strategies such as noise-cancelling headphones and small distractions during rare downtime, helped her manage.

For Dr Aziz, the decision to leave her family without knowing whether she would return was difficult. "I didn't tell them I was going to a conflict zone; I said I was going on a mission. My three-year-old asked: 'Are you like Buzz Lightyear in *Toy Story*? Going to outer space?' In a way, it felt exactly like that.

"I had little time to dwell on the separation because the preparation was all-consuming and intensely stressful. We were limited to one medium suitcase, a backpack, and three kilograms of food for the month. I had to source and pack critical medical equipment and medicines for the hospital and for myself. The list was exhaustive: laundry soap, a washing line, a collapsible bucket, body wipes, a kettle, a water filter, chlorine tablets. It felt like preparing for an expedition to the most remote place on Earth, with medical evacuation deemed near impossible.

LESSONS CARRIED HOME

Returning to Australia, all three anaesthetists describe a shift in perspective that extends well beyond the operating theatre.

Dr Hussain says she is more conscious of resource use and less reliant on disposables. She has also expanded her skill set, learning ultrasound-guided nerve blocks for pain management that she had not previously used in Australia.

"I'm always learning here," she says. "And I carry that learning with me, and endeavour to share it wherever I practise."

Dr Hadi speaks of renewed humility and gratitude for stable systems, functional equipment and multidisciplinary support.

"Returning to Australia felt like being given a second chance at life. I have a far deeper appreciation for safety, stability, and the healthcare resources we often take for granted. The experience reinforced my belief that the world is not divided into isolated pockets of suffering and comfort – we are one global community.

"It has strengthened my commitment to responsible resource use, professional humility, and advocacy for disadvantaged populations. It has also profoundly reshaped my understanding of what truly matters in medicine and in life."

For Dr Aziz, the experience has reshaped how she thinks about her specialty.

"We achieved so much with so very little. I learned in crisis, care is defined not by technology, but by the decision to act, to do something. It has instilled in me a permanent sense of perspective: I will no longer 'sweat the small stuff' in our well-resourced system here. The scarcity there makes you intensely creative and focused solely on essential care."

Dr Indu Kapoor's humanitarian work in South Sudan

Late last year, Wellington paediatric anaesthetist Dr Indu Kapoor travelled to South Sudan for her first assignment with Médecins Sans Frontières/Doctors Without Borders (MSF).

She spent nearly eight weeks at the Amoth Bek Hospital in Abyei, a disputed region on the border of Sudan and South Sudan. The hospital is run jointly by the South Sudan Ministry of Health and MSF.

Dr Kapoor's work in Abyei is a powerful reminder of the role anaesthetists play far beyond the operating theatre by adapting, leading and delivering care where it is needed most.

Abyei sits in a volatile region administered by the United Nations, with ongoing violence and a steady influx of patients fleeing the civil war further north in Sudan. The region is governed by the Abyei Special Administrative Area Government with support from the United Nations Interim Security Force for Abyei (UNISFA) for security, stabilisation, demilitarisation and protection of civilians.

With most hospitals in Sudan destroyed, patients often travel for days – by vehicle or on foot – to reach care.

"One woman walked two hours with a six-week-old baby while septic from a breast abscess, came for treatment, and then walked two hours home again because there was nowhere for her to stay," Dr Kapoor recalls.

"The el-Fasher conflict in western Sudan is about four hours from the Abyei hospital. All the hospitals were destroyed there due to the conflict so we treated many people affected by violence including those with burns, drone attacks and injuries from stray bullets."

"Often you know what a patient needs, but you also know it's not going to be possible in many cases. You're constantly balancing what is ideal care with what is possible."

ABOVE

Dr Indu Kapoor (left) on the first leg of her Sudanese mission having just arrived in Agok.

LEFT

Dr Indu Kapoor with an anaesthesia machine and monitor at the Amoth Bek Hospital.

OPPOSITE PAGE

Associate Professor Joel Symons in an Hadassah Hospital operating theatre.

The MSF hospital provides only acute and emergency care. There is no elective surgery. Trauma dominates the workload: gunshot wounds, blast injuries, burns, amputations of hands, feet, fingers and toes, and severe infections. Paediatric cases are common, including burns, sepsis, cerebral malaria and trauma. Obstetric emergencies and urgent laparotomies also feature prominently.

"Often you know what a patient needs, but you also know it's not going to be possible in many cases. You're constantly balancing what is ideal care with what is possible. There's no out of hours medical imaging and no advanced imaging at all, for example," Dr Kapoor tells the *ANZCA Bulletin*.

Anaesthesia in Abyei looks very different from Australia or New Zealand. There are no trained physician anaesthetists on site. Care is delivered by nurse anaesthetists and clinical officers with limited formal training, supported by rotating international specialists such as Dr Kapoor.

Dr Kapoor's role was hands-on and supervisory, delivering anaesthesia, supporting colleagues, reviewing equipment and pharmacy stock for 2026 and ensuring safe standards in an environment with minimal ongoing education or support.

The type of anaesthesia is tailored to these unique conditions. General anaesthesia is avoided wherever possible with ketamine sedation the preferred option. Oxygen is supplied solely via concentrators, powered by a recently installed solar system. There is a single draw-over anaesthesia machine — a Glastovent — used for the most complex cases.

"It's not something we ever use in high-income countries, but it's invaluable in this setting because it doesn't rely on piped oxygen or cylinders," says Dr Kapoor.

Despite the limitations, care continues around the clock. The hospital operates 24 hours a day, seven days a week. During the monsoon season, malaria surges, including cases of cerebral malaria in children and adults. Cholera had only just been contained. Patients arrived malnourished, exhausted and often critically unwell.

For Dr Kapoor, the emotional burden was significant, particularly when caring for children with preventable injuries.

"That was the hardest part," she says.

"Burns and trauma that were entirely avoidable. You lose patients here, and that's something we are not used to in our usual practice."

Yet there were moments of deep reward. Safe obstetric care meant mothers and babies survived where they otherwise may not have. Abscesses were drained, infections treated, pain relieved.

"You constantly reframe," she says. "You remind yourself that some care is better than no care."

Living conditions for Dr Kapoor and her colleagues were basic — a small thatched very clean hut, outdoor showers and toilets and communal meals. The security, sanitation and logistics were meticulously managed by MSF.

"They do this extraordinarily well," Dr Kapoor says. "You feel safe, even in a difficult place".

"The reason I wanted to work with MSF is because of their organisational philosophy of independence, neutrality, impartiality, humane care according to medical ethics and needs and most importantly for me, their willingness to speak out when silence would cause harm."

When she returned to Wellington, the contrast was stark.

"It makes you profoundly grateful," Dr Kapoor reflects. "For the systems we have, the resources, the care we can provide, and it makes you more thoughtful about not wasting any of it."

Médecins Sans Frontières/Doctors Without Borders is looking for anaesthetists to join its team internationally. For more information visit www.msf.org.nz

Frontline care moves underground

When missile alerts sound in West Jerusalem, clinical care does not stop – it moves underground.

During Associate Professor Joel Symons' humanitarian deployments to Hadassah Hospital following the deadly October 7 2023, attacks in Israel by Hamas, entire wards were ready to be relocated four floors underground within hours, allowing surgery, anaesthesia and critical care to continue uninterrupted.

Purpose-built underground facilities, regular drills and clear lines of leadership meant that even during periods of heightened threat, patient care remained safe, coordinated and calm.

For A/Prof Symons, the experience underscored the importance of preparedness and systems-based resilience in healthcare. Working in a hospital designed to function fully during emergencies was both confronting and reassuring. He says he felt confident in the protocols in place and the professionalism of the teams delivering care.

"I had two missiles, not while I was in the hospital, but we had two missile alarms while I was in Israel – one in December last year. It's become a way of life there. You go into the bomb shelter and that's it. If there's a missile alarm, there's always a warning and you've got about 30 seconds or a minute to get to a bomb shelter.

"The systems work," he reflects, "and everyone knows exactly what to do."

With expertise in trauma care and perioperative medicine the Melbourne anaesthetist has now undertaken three humanitarian deployments to Hadassah Hospital in Ein Kerem since October 2023 when he responded to a global expression of interest call-out by Israeli hospitals. He has been joined at different times by other Australian anaesthetists including FANZCA Dr Dan Zeloof.

While on his visits A/Prof Symons performed anaesthesia on emergency and elective patients, supervised registrars, and contributed to education and simulation training. These included delivering airway workshops and supporting simulation-based learning using an ORSIM flexible bronchoscope simulator which he fundraised for in Australia and delivered to the hospital last year.

One of the most striking aspects of his experiences, he explains, was the diversity of patients and staff at the hospital.

"The very first patient I looked after was a young Palestinian girl who needed emergency plastic surgery," he recalls.

"It became apparent very, very quickly that this was a multicultural society that treated all comers irrespective of race or religion."

That philosophy extends across the hospital workforce where, he says, Jewish, Muslim and Christian clinicians work side by side, united by a shared commitment to patient care.

"Everyone worked perfectly together for the common goal of helping humanity and helping patients," A/Prof Symons explains.

Working in a hospital designed to function fully during emergencies was both confronting and reassuring

The security context in Israeli hospitals is ever-present with ongoing heightened preparation needed. On his second visit to Hadassah in October 2024, Iran launched dozens of missile attacks on Israel and another hospital in the south was hit.

Regular security drills, clearly defined roles and robust infrastructure enable Israeli hospital teams to adapt rapidly without compromising patient safety.

Beyond his clinical contribution at Hadassah, A/Prof Symons' involvement has expanded into longer-term global collaboration. He and Dr Zeloof are now board members of ISAAC18 – International Support for Anesthesia and Critical Care in Israel – a newly formed international group of more than 250 anaesthetists.

Established in the wake of October 7, the group aims to provide coordinated support through education, research and clinical engagement in Israel and other regions affected by crisis.

"Out of tragedy has come collaboration," he says.

"It's opened doors and brought people together."

A/Prof Symons says his Israel visits have reinforced core professional values shared across ANZCA's fellowship.

"This is about treating humans – irrespective of who they are. It's been incredibly fulfilling for me as a clinician."

His work highlights the role anaesthetists can play in humanitarian settings, and the contribution of ANZCA fellows to global care, education and professional solidarity.

Training and education

Supervisors of training drive the next generation of anaesthetists

Supervisors of training (SOT) are the most important people in supporting and developing the next generation of anaesthetists in Australia and Aotearoa New Zealand. They are pivotal in maintaining the extremely high standards of anaesthesia safety that is synonymous with being a FANZCA. Being an SOT is definitely one of the most rewarding ways to engage with trainees and the college.

Among junior doctors, anaesthesia is extremely popular. Training sites see very large numbers of applicants, and the quality of applications is outstanding. In many hospitals, senior consultants often joke that they would never be able to get a training job now. The number and quality of applicants reflect the rewarding specialist community we enjoy, but also reflects an extremely well developed, structured training program that produces world-class specialists.

There are nearly 2000 ANZCA trainees across Australia and New Zealand. These trainees are directly supported by 461 SOTs. This is a huge network of fellows, making a massive contribution to the education and professional development of our trainees and ensuring that the extremely high standards of anaesthesia care we currently enjoy are maintained.

Supervisors of training are a diverse group. Some SOTs are very senior, having worked in clinical anaesthesia for decades, while others are younger with recent memories of the training program. Some are quite academic, others are more clinically orientated. While many work in the public sector, some work in the private sector and make a critical contribution to ensuring trainees enjoy a great breadth of experience and diverse caseloads in the private sector.

THE SOT NETWORK: BIG AND WELL SUPPORTED

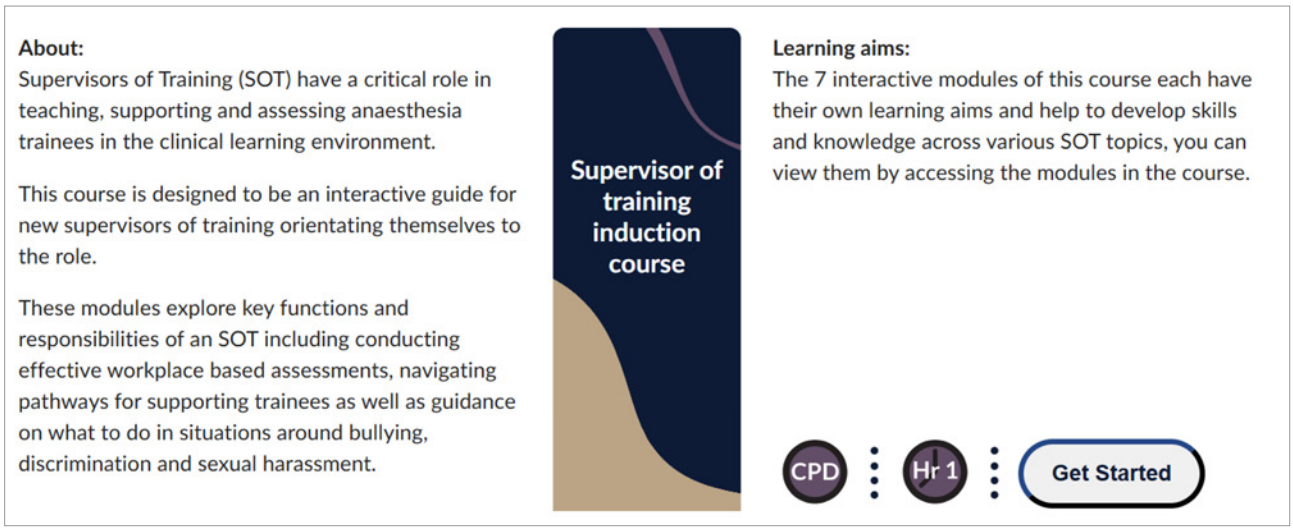
All accredited training sites need a SOT. In some smaller training sites, there may only be one SOT. These individuals are vital to the delivery of the ANZCA training program and often ensure that trainees have vital access to regional hospitals as part of their training. Larger hospitals typically have several SOTs. Regardless of the number of SOTs within a hospital, there are extensive support networks in place. Some of these are official, others unofficial, but all are vitally important.

Within a hospital, SOTs are supported by each other and often work together. Beyond this, SOTs will be supported by other colleagues with interests in trainee education, teaching and wellbeing, as well as the head of department.

Within rotational networks, there is a vast array of people who support the SOTs. These include SOTs at other hospitals, as well as the rotational supervisors (ROTs) who have oversight of the trainees within that rotational scheme.

Beyond this, all jurisdictions have an education officer (EO). The EO serves as a conduit between the college and the SOTs in their jurisdiction. The EOs are also part of a binational network, where there is extensive sharing of ideas and challenges. The most important job of the EO is to directly support SOTs. All jurisdictions will run regular SOT meetings: These meetings are actively supported by ANZCA and are a wonderful forum to get to know your SOT colleagues. It becomes rapidly apparent that challenges are shared and solutions are communal. It is amazing how much can be achieved both during the meeting and with a coffee during the breaks!

Finally, ANZCA provides enormous support for SOTs and truly understands the importance of the role. From the start, there are online resources to help understand the role of the SOT and to ensure that you have the tools to do the job. The SOT induction resources, found in Learn@ANZCA, are extremely helpful and qualify for continuing professional development points.



All of the tools needed as an SOT are available in one place at the SOT Support Hub (https://libguides.anzca.edu.au/supervisors). Here, one can also find links to other valuable resources including the ANZCA Educators Program and guides to mentoring. The training program handbook rapidly becomes the SOTs go-to-guide.

There are always workshops for new and existing SOTs at the annual scientific meeting – these are free to attend and really enjoyable. Within the college, there are lots of people there to help: the training team, the MyPortfolio team and the directors of professional affairs. Email correspondence between SOTs and training@anzce.edu.au is prioritised and always very helpful.

The role of SOT takes time. As such, ANZCA mandates that SOTs are provided with protected clinical support time to do this. The recommended allowance is one session a week for every five vocational trainees. In some departments, this is averaged out over terms or semesters, with the peak activity periods typically falling at the start and end of allocated terms.

WHAT DOES A SOT ACTUALLY DO?

SOTs typically have a dual role – working with trainees to support them through training and working with their department to build and optimise the training environment.

When there is more than one SOT, individual departments will decide how the responsibilities are divided. In some units, an individual SOT will be allocated trainees at various levels that they will work with longitudinally, while other units may have SOTs allocated to specific training phases. In these larger departments, it is advisable for the SOTs to meet regularly and discuss the progress of all trainees within the department.

In terms of trainee support, SOTs guide their trainees through multiple checkpoints built into the training program. These include clinical placement reviews, core unit reviews and specialised study unit signoffs, all of which serve as an opportunity to touch base and review progress. These formal checkpoints also provide an opportunity to discuss wellbeing and plan towards future goals.

Some trainees will require additional support for various reasons. The SOT needs to understand the challenges faced by the trainee and formulate a plan whereby the trainee, their support network and the department are aligned to enable the trainee to achieve their training goals. Sometimes, this can be managed informally within a department and sometimes requires initiation of an ANZCA trainee support process (TSP). The SOT may need to advocate for their trainee, either at a department level (clinical allocations, rosters, leave etc) or at a college level (exemptions, extensions, special consideration).

SOTs set the tone for education and training within their departments. The role of the SOT is highly respected and valued by anaesthetic departments, as well as medical administrators. As such, this facilitates SOTs serving as trainee advocates and optimising the training environment. This may mean working with clinical and administrative staff to support safe and equitable rostering or working with senior clinicians undertaking workplace-based assessments. Invariably, SOTs will have some input into the teaching programs run by departments.

Thoughts from SOTs

"It is so rewarding to nurture junior anaesthetists through their training. I feel like a proud parent when I see how well they've done."

Dr Lanie Stephens, Canberra

"The opportunity to help trainees feel supported and guided to build a strong foundation to be the next generation. The chance to help those who don't have a straightforward path through training, which also helps keep a pulse on how the department is going. An important opportunity to make important changes and liaise between employers and the college."

Dr Alex Henry, Melbourne

"It is a busy but incredibly rewarding role. It has given me the opportunity to build relationships that have lasted beyond the completion of training. There is great camaraderie among all the SOTs – we support and learn so much from each other. Our regional meetings are some of the best days of my year."

Dr Sally Wharton, Sydney

"It's very rewarding helping to support and guide trainees through their training pathway and help them develop into skilled colleagues, who I then get to enjoy working with as fellow consultants. The insights, skills and relationships that I've developed through being an SOT have provided me with many rewards which keep me thoroughly enjoying the role, even when challenges arise."

Dr Carolyn Wood, South Australia

"Being an SOT is about more than teaching. It's an opportunity to mentor and to shape our trainees into the professionals that we all aspire to be as fellows."

Dr Rowan Ousley, South Australia

"It is very rewarding to be part of the process where you are able to support trainees transforming into your trusted colleagues over the ANZCA training program."

Dr Maggie Wong, Melbourne

A good SOT needs to be visible and approachable within a department. It's imperative that trainees and consultants alike can chat with an SOT about challenges and concerns, as well as goals and aspirations. A good SOT also needs to be fair and considered.

BENEFITS OF BEING A SOT

Being an SOT brings incredible professional satisfaction. It allows for the development of deep, meaningful relationships with trainees.

Having worked with individual trainees over several years, often navigating highs and lows along the way, there is a sense of genuine pride and connection when seeing these trainees succeed. This may be mastering a particular skill, achieving a degree of clinical independence, passing an exam or ultimately becoming a FANZCA.

It is a great privilege to share the journey with our next generation of anaesthetists. Every trainee is unique and comes with different clinical skills and experience, as well as different life experiences. Understanding this can make a real difference to a trainee and their path through to fellowship.

There are numerous non-technical skills which SOTs will invariably develop in the role. These will include communication, teaching, delivering feedback, having difficult conversations and both objective and subjective assessment.

At a broader level, being an SOT means being part of an extensive network of like-minded individuals, all motivated to facilitate excellent training opportunities. The role is valued by the trainees, by the hospital and by the college.

Being a SOT provides a robust platform to advocate for trainees and the broader training environment within your department, hospital and more broadly. Every training site has some potential to improve, and this change is often driven by SOTs.

Lastly, being a SOT opens doors to other opportunities. These might include trainee recruitment and onboarding, rostering and allocations, training site accreditation, mentoring and wellbeing, ANZCA sub-committees. The list goes on.

WHO SHOULD CONSIDER BEING AN SOT?

To become a SOT, you must be a FANZCA and not be sitting for any college examinations, including for FPM. However, the most important thing is an interest in education and an understanding of the training program. A good SOT will be highly skilled in providing feedback to trainees, which can seem like a daunting task. Nevertheless, this is a critical skill but one which can be learnt and finessed.

Prospective SOTs are nominated by the head of department to the EO in that jurisdiction. Appointments are for three years, with the option to remain in the role for up to 12 years.

If this sounds like you, it's time to think about taking the next step. You won't regret it.

Dr Adam Eslick, FANZCA Canberra
Dr Jen Taylor, FANZCA Auckland
Dr Tim Hodgson, FANZCA Gold Coast

On behalf of ANZCA's Education Officer Network

SOT profile

Dr Ann-Marie Stevenson (above) was a supervisor of training (SOT) at Health NZ – Taranaki for six years. The hospital has an allowance for nine trainees and two supervisors. She has recently taken up the SOT role at Health NZ – Waitematā in Auckland, where she is a fellow supervisor responsible for seven fellows.

Dr Stevenson is also a primary examiner.

HOW IS YOUR SOT ROLE UNIQUE?

My role in Taranaki was unique in that I supervised trainees during both their introductory training period and their provisional fellowship time – supporting them at both the beginning and end of their training journey. Working in a small regional centre in New Zealand can be new for some trainees who may not have lived outside a major city before. I enjoy showing them that smaller centres still offer exposure to a wide range of cases and significant clinical complexity.

Moving back to a larger centre allows me to focus more on trainees nearing the end of their training. This includes helping with career planning and the development of non-clinical interests and professional portfolios.

WHAT DO YOU LIKE ABOUT YOUR ROLE?

I enjoy guiding trainees through both the start and the completion of their training. Witnessing and contributing to a trainee's evolution can be extremely fulfilling. I also enjoy drawing on my educational experience to support them throughout their educational journey. The New Zealand and Australian SOT network has been incredibly supportive and is a great source of shared advice and knowledge to help us better support trainees.

WHAT ARE SOME OF THE CHALLENGES?

I still remember my own time as a trainee and how valuable my SOT was. It's important to recognise that trainees face a wide range of challenges, both clinical and non-clinical. In smaller departments this can be particularly challenging, but I've learnt the importance of clearly defining the SOT role and delegating rostering and education tasks to other colleagues.

I also strongly encourage mentorship for all trainees, as there may be times when they prefer support from someone outside the formal SOT role.

WHAT WOULD YOU SAY TO COLLEAGUES CONSIDERING BECOMING A SOT?

I feel a real sense of pride seeing my trainees become consultants and knowing I've played a part in guiding their journey.

I completed a clinical education certificate during my fellowship year, which has been extremely helpful in providing effective feedback and managing challenges.

Having a SOT mentor or being part of a rotational SOT network is invaluable for supporting trainees and ensuring their educational and welfare needs are met. The ANZCA website offers excellent eLearning courses and resources, and the ANZCA annual scientific workshops have also been very useful.

WHAT'S YOUR BEST TIP FOR TRAINEES PREPARING FOR EXAMS?

I have many tips particularly for the primary exam, including:

- Using the curriculum as your primary reference.
- Looking at the Learn@ANZCA resources at the start of your journey compiled by previous successful trainees, examiners, SOTs and performance psychologists.
- Using the recommended texts – found in the ANZCA online library.
- Booking a preparation course – I helped establish the Waitematā PREP course.
- Practising short-answer questions and vivas – finding a past candidate or fellow who can mark or give this these to you.
- Remembering to focus on the "WHY" and "HOW" of the material often displays understanding of a topic.

ANZCA
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Australasian Anaesthesia submissions

We're seeking expressions of interest for contributions to the next edition of Australasian Anaesthesia (the Blue Book).

Before starting your article, we ask you to submit a form to the editorial team for review. This is intended to avoid unintentional duplication of submissions, and ensure the topic and format proposed are appropriate for the scope of the Blue Book.

This form must be completed, with the topic approved and an editor assigned, prior to an article being submitted for review. Please send the completed form to bluebook@anzca.edu.au.

Visit anzca.edu.au for more information and the form.

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Exam updates · Events and courses · Committee vacancies
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2. Click "Update my contact details"
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If you're worried that you're not receiving our emails, please check your junk and spam filters and, if necessary, add @anzca.edu.au or @anzca.org.nz to your address book.

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

On behalf of the national organising committee, we warmly invite you to join us at the 2026 ANZCA ASM, in Auckland/Tāmaki Makaurau, Aotearoa New Zealand. The theme of the meeting is “Herenga Waka Herenga Tāngata: From home to home”, representing the journey of anaesthesia – from the decision to undergo surgery through to recovery and the patient returning home – as well as the parallel of the anaesthetist’s journey and their professional wellbeing.

The college worked with designer, Chloē Reweti (Ngāi Te Rangi, Ngāti Ranginui, Ngāti Porou), and cultural advisor, Tui Blair (Ngāti Whātua), to settle on the 2026 theme and design, which reflect Aotearoa New Zealand’s natural environment and its cultural significance for Māori. Join us in Auckland/Tāmaki Makaurau for learning, networking, and connection in May!

Dr Kerry Benson-Cooper
2026 ANZCA ASM Convenor

EXPERIENCE HISTORY, COURAGE AND CULTURE ON THE BIG SCREEN!

Thursday 30 April, 6–8.30pm
New Zealand International Convention Centre (NZICC)

ANZCA ASM delegates-only cultural safety screening:
Ka Whawhai Tonu

Step into the world of Aotearoa New Zealand, 1864, and witness a pivotal moment in history brought to life in the powerful new film *Ka Whawhai Tonu.*

Set during the Waikato land wars, this gripping story follows two teenagers thrust into the chaos of battle, forced to navigate impossible odds and fight for their futures. Through their eyes, you'll experience a tale of resilience, identity, and the enduring strength of Māori communities during one of the most defining conflicts of the era.

After the film there'll be an exclusive live Q&A with both the producer and director of *Ka Whawhai Tonu*. Hear firsthand about the making of the film, the cultural consultation behind it, and the importance of keeping these stories alive.

Attending this session counts as your **annual cultural safety CPD requirement**, making it the perfect opportunity to deepen your understanding while enjoying an unforgettable cinematic experience.

Scan here to register

Faculty of Pain Medicine

Holding the line: Reflections from the dean

As I approach the end of my term as dean of the faculty I have never been more aware of both the honour of holding this position and the responsibility it carries. Two years has been long enough to develop a better understanding of the complexities we face as a specialty but it could never be long enough to achieve resolutions of them.

When I started my term, I was aware that the task would involve balancing immediate responsibilities in education, training and professional standards with the longer-term work of advocacy and system reform. However, throughout the faculty's area of responsibility and influence, progress is necessarily incremental.

Many years ago, a senior colleague told me that the role of a researcher was, metaphorically, to dig a trench 500 metres deep and half a metre long. Heading a specialist medical college could not be more different. It is perhaps better viewed as trying to hold a front 50 kilometres wide while making progress a few centimetres at a time. Unsurprisingly, progress can often seem slow. Relationships with government and partner organisations develop over years rather than months. The effects of educational initiatives are often only seen long after they are introduced. Nevertheless, the progress achieved by the faculty in the 27 years since its launch has been substantial and continues, being built patiently by successive groups of fellows, trainees and faculty staff.

In the field of education, development of scholar role activities and changes to the exam structure, particularly the introduction of the multiple-choice question (MCQ) exam in 2026 are important advances. After considerable work, we are also close to finalising the entrustable professional activities portfolio, an important step in strengthening competency-based training.

The Flexible Approach to Training in Enhanced Settings (FATES) initiative achieved important goals in accrediting training units away from metropolitan centres, a key development in rebalancing the maldistribution of the pain medicine workforce.

In Australia, the federal government's acceptance of the faculty's national Standards for Health Practitioner Pain Management Education. was a major achievement and has opened a range of opportunities to develop approaches to education through a wide range of disciplines. The standards are an important benchmark, with implications across the region.

An important consequence of the development of the educational standards has been an extension of the faculty's engagement with other medical colleges. In particular, the general practice colleges in both Australia and New Zealand together with the Australian College of Rural and Remote Medicine have all engaged positively with the faculty to look at ways of improving education in pain medicine among their fellows and trainees. Similar initiatives have recently involved the Australasian College for Emergency Medicine and our options for expanding the profile and reach of pain medicine across these important areas are promising.

Unfortunately, many of the most intractable problems facing our specialty remain. Funding for pain services, particularly in the public system, remains severely restricted which denies adequate care to large numbers of patients. Other funding mechanisms remain fragile and I am especially concerned by developments involving the Accident Compensation Corporation in New Zealand, where the unique skills of specialist pain medicine physicians are in danger of being overlooked.

Commercial pressures are also significant and across the region, the attitude of private health insurers towards pain medicine services, while never enthusiastic, has deteriorated.

Against this background, an area of the faculty's activity that has never been more important is that of advocacy. In this space I have been greatly encouraged by the enthusiasm and commitment of fellows throughout Australia, New Zealand and internationally who have helped in the development of the faculty's first advocacy work plan. This has seen close liaison with consumer groups, including the ongoing development of a pain-focused consumer group in New Zealand. I anticipate that in coming years, this will become one of the most important areas of the faculty's activity.

I am also greatly encouraged by the maintenance of the faculty's international profile and the development of the International Education Network which, in bringing together our valued colleagues in Hong Kong and Singapore is an encouraging sign for maintenance of high-quality pain medicine standards and services throughout the broader Australasian region.

The faculty has strong foundations and our relationship with ANZCA has never been better. The ANZCA strategic plan emphasises the important role that the faculty plays in developing high quality education, training and professional services through a very broad domain. ANZCA has maintained exceptional professional standards over many years and this has allowed the faculty to define itself, with confidence, as an international leader in professional standards for pain medicine.

As my term as dean concludes, I remain confident that the Faculty of Pain Medicine will retain its preeminent international position as the first, and leading, peak medical body for the education, training and support of pain medicine specialists.

Dr Dilip Kapur
Dean, Faculty of Pain Medicine

News update

2026 FPM BOARD ELECTIONS

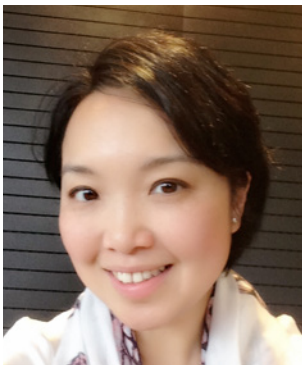
The Faculty of Pain Medicine received three nominations for two elected vacancies on the FPM Board, and an election was held between 31 January and 16 February 2026.

The faculty is pleased to announce that the following two candidates were successfully elected to the FPM Board:

Dr Dilip Kapur (SA) and Dr Glen Sheh (NSW).

Thank you to all candidates who nominated for the 2026 FPM Board election, and to the fellows who participated in the ballot. The election outcome will be formally ratified at the FPM Annual Business Meeting, to be held in Auckland, on Sunday 3 May 2026.

Dr Dilip Kapur



Dr Glen Sheh

RECENT FPM SUBMISSIONS AND ADVOCACY

December 2025

Letter to Accident Compensation Corporation (ACC) (NZ): Changes to secondary care service delivery – engagement in conceptual design.

January 2026

Letter to Australian Department of Health, Disability and Ageing: Medicare Benefits Schedule (MBS) continuous review request response: MBS items 132 and 133 – access for specialist pain medicine physicians.

Response to the Care Pathways Australia 2026-30 consultation, a national plan for healthcare integration.

FPM 2026-27 Australian Government pre-budget submission to Treasury, targeted investment to progress Goal 2 of the National Strategy for Health Practitioner Pain Management Education.

Meeting with Victorian Department of Health regarding bridging the gender pain gap report.

February 2026

Meeting with the Royal Australian College of General Practitioners (Rural Education Committee to discuss pain medicine training opportunities for practitioners in rural and remote areas.

Pain Sector leadership group meeting in Canberra.

Meeting with ACC regarding treatment decision-making framework.

Consultation: Reviewing the safety and regulatory oversight of unapproved medicinal cannabis.

Therapeutic Goods Administration consultation: Proposed amendments relating to transparency of disruptions to supply of a medical device.

Response to Victorian Health Minister, the Hon Mary-Anne Thomas MP, calling for collaboration on pelvic pain and endometriosis care.

Provider briefing: Recent updates to Department of Veterans' Affairs medicinal cannabis framework.

NEW FELLOWS

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

Dr Oluwatosin Adeyemi, FFPMANZCA FRACGP (Qld)

Dr Theodora Alexiou, FFPMANZCA FRACP (Vic)

Dr Christopher Arnott, FANZCA FFPMANZCA (Qld)

Dr Luke Arthur, FFPMANZCA FRACGP (Vic)

Dr Pedro Bernardino Campos, FFPMANZCA FRACGP (NSW)

Dr Aditi Chandak, FFPMANZCA FRACGP (Qld)

Dr Larissa Cowley, FANZCA FFPMANZCA (Qld)

Dr Mohammad Jabbarpour, FFPMANZCA FRACGP (Tas)

Dr Mohnish Jain, FFPMANZCA FRACGP (Qld)

Dr Zeyin Li, FANZCA FFPMANZCA (Qld)

Dr Janice Liu, FHKCA (Anaesthesiology) FFPMANZCA (Hong Kong)

Dr Pratima Majhi, FFPMANZCA FRACGP (Vic)

Dr Reza Modarres, FFPMANZCA FRACGP (Qld)

Dr Aidan McParland, FFPMANZCA, FRCPC (NSW) Dr Amit Sequeira, DNB Anaesthesia, FFPMANZCA (NSW)

Dr Charanya Sridharan, FRACGP FFPMANZCA (WA)

Dr Laura Prates Vitoria, FANZCA FFPMANZCA (WA)

Dr Kal Yacoub, FFPMANZCA FRACGP (NSW)

Dr Tzyy-Shyan Yang, FFPMANZCA FRACGP (WA)

We congratulate the following doctors on their admission to FPM fellowship through the completion of the pain medicine specialist international medical graduate pathway:

Dr Saurabh Nagpaul, FFPMANZCA FRCA (Vic)

Dr James Wilson, FANZCA FFPMANZCA (Tas)

Dr Zhi Hao Oon, FFPMANZCA, FRCA (SA)

FROM LEFT

Trainees at the Orientation to Pain Medicine course.

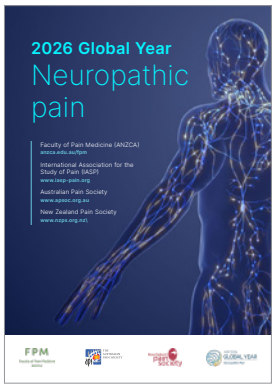
Olivia Ooi, Denise White, Olajumoke Afolabi and Steven Leonard at the course.

ORIENTATION TO PAIN MEDICINE COURSE 2026

From 28 February to 1 March, we welcomed 18 new trainees to the 2026 Orientation to Pain Medicine course at ANZCA House, with 13 attending in person and five joining online.

Across two days trainees developed a clear understanding of the structure and expectations of the training program, including assessment requirements and the support available throughout their journey. They met the FPM team, connected with peers and began establishing the professional networks that will underpin their careers in pain medicine.

We thank the convenor, Dr Kate Drummond, and the inspiring fellows and trainees who contributed to the program.



2026 GLOBAL YEAR FOR NEUROPATHIC PAIN

The International Association for the Study of Pain (IASP) has announced 2026 as the Global Year for Neuropathic Pain. This designation shines an international spotlight on a complex and often debilitating form of nerve-related pain that affects an estimated 580 to 830 million people worldwide.

The faculty, the Australian Pain Society and the New Zealand Pain Society endorse the 2026 global year and encourage members and stakeholders to engage with the campaign throughout the year.

Scan to learn more and download the campaign artwork.

NATIONAL STANDARDS FOR PAIN MANAGEMENT EDUCATION

The faculty is pleased to announce that the "Australian Standards for Health Practitioner Pain Management Education" ("the standards") have been approved by the government and are now publicly available via an online hub on the college website.

Developed during 2024–2025 through Australian government funding, the standards deliver the first of five goals identified within the "National Strategy for Health Practitioner Pain Management Education". They provide the nation's first evidence-based, consistent framework to guide pain management education across all health disciplines and levels of training – marking a first of their kind in Australia and internationally. While voluntary at this stage, the standards are designed to sit above all relevant curricula, content and teaching approaches and will help to address longstanding gaps in pain-related knowledge and skills across the health workforce.

A key principle in the development of the standards is the reflection of the Australian population, recognising how social, cultural, and demographic factors shape both people's experience of pain and their interactions with the health system. The standards address key areas, including person-centred care, communication, best practice education, evidence-based content, reflective practice and a collaborative approach to care.

The faculty's leadership in developing these standards has been recognised with additional government funding to support their promotion and adoption by key stakeholders throughout 2026.

Scan here to access the online hub and explore the Australian Standards for Health Practitioner Pain Management Education.

Taking specialist pain care beyond the city: Dr Tim Semple's 20 years of rural outreach

This year on 17 February marked an extraordinary milestone for South Australian anaesthetist and chronic pain specialist Dr Tim Semple.

He celebrated two decades of delivering chronic pain outreach services to Whyalla and regional South Australia. For 20 years, Tim has led a rural outreach service built on compassion, persistence, and a commitment to equitable access to care, no matter where patients live.

Today, Dr Semple leads a dedicated interdisciplinary team including psychologist Marie, physiotherapist Joseph, and nurse Sue. Together they conduct 12-16 multi-day visits each year, providing specialist assessment, pain education, cognitive behavioural therapy groups, and self-management support to patients who would otherwise struggle to access care. The service has grown into a model of best practice that is integrated, sustainable, and deeply connected to the communities it serves.

Rural communities such as Whyalla face well-known challenges, including economic pressures, workforce shortages, and the tyranny of distance. By consistently showing up and building strong local relationships, Dr Semple's team has created a trusted network of care that genuinely changes lives. Their work reflects a broader shift across regional Australia, moving away from high opioid use toward supported, team-based models of chronic pain management that align with Australia's National Strategic Action Plan for Pain Management.

The story began in 2005, when Dr Semple successfully applied through the Rural Doctors Workforce Agency to establish pain outreach to Whyalla and Mount Gambier. At that time, Whyalla had some of the highest opioid prescribing rates in Australia, reflecting high health burden and limited access to multidisciplinary care. Two decades later, the team's sustained presence, supported by one of the most comprehensive pain telehealth programs in the country, has improved services and outcomes across a broad regional footprint.

The program has also become a powerful training platform. Through specialist training program and structured day program opportunities, all FPM fellows in training rotate through rural and outreach work. This embeds rural exposure as a standard component of pain medicine training and enables expansion to sites such as Port Lincoln and Port Pirie.

Since 2016, the SA Health Chronic Pain Model of Care has ensured activity-based funding for outreach across regional and rural South Australia, now embedded within metropolitan local health network base budgets. This work would not be possible without the commitment of medical and allied health teams who travel, the contributions of local pain nurses including Sue, Minyon, Marie, and Deb, and the skilled administrative staff co-ordinating patients across vast catchments.

Despite these successes, outreach sits on fragile financial ground. Funding comes primarily from state-based local health network budgets, while many of the savings, including reduced patient travel, accommodation, and disruption to work and family, accrue to federal schemes and local communities. Without clear, shared federal–state commitment, programs like Dr Semple's remain vulnerable to ongoing funding pressures and periodic renegotiation, despite their alignment with national policy directions for equitable, multidisciplinary pain care in rural Australia.

Congratulations to Dr Tim Semple for his long-standing leadership and to everyone involved in sustaining this service, demonstrating what is possible when a team shares a clear purpose.

Dr Irina Hollington, FANZCA FFPMANZCA
FPM Board member

ABOVE

Dr Tim Semple and, Dr Samuel Ah Kit – Director of Medical Services at Flinders and Upper North Local Health Network.

Medical students in the pain management unit – a win-win experience

Traditional medical education devotes very little time to pain medicine or the management of pain.

The pharmacology of opioids or anti-inflammatories are covered in pharmacology, local anaesthetics might be explored when managing skin lesions, and the importance of urgent neurosurgical decompression in cauda equina syndrome will be emphasised in the emergency room.

But managing the distress of patients presenting with long histories of pain, which may be accompanied by the anguish of an adverse childhood, trauma, mental health disorders or substance misuse, rarely get the attention it deserves.

Medical students eventually qualify as junior doctors – largely unprepared for one of the most common symptoms presenting to hospital, emergency departments or primary care. They will have a basic knowledge of pharmacology intervention and may have read or seen some surgical procedures with varying success.

“Pain is invisible, difficult to define, measure and treat,” says Felicity Ramsay, who has just finished her final year as a medical student at Deakin University medical school, Waurn Ponds.

“Research shows the negative attitudes that medical students and nurses have to patients reporting pain.

“Medical students have a perception that because cure is frequently not possible, the value of patients with persistent pain, to education, is low.”

Trainees also believe that their inability to cure chronic pain leaves them confused about how to provide care, and say there is a perception that treating these patients has little educational value.

Nearly 20 years ago Professor Rollin Gallagher described how medical students had to be successful to get into and through medical school, pass exams and rejoice in positive outcomes. Patients with pain frequently report less satisfactory outcomes despite the best efforts of the practitioner. These competing approaches and outcomes eventually clash.

Deakin University's School of Medicine was established in 2008, making it Victoria's first rural and regional medical school.

From the outset, the school recognised the importance of education in pain, through the department of anaesthesia (acute pain) and jointly with the musculoskeletal (orthopaedic) modules. This was unique in Australian medical education.

The medical students reported high levels of satisfaction with their structured exposure to patients with persistent pain and learned important principles of multidisciplinary care, history taking and comprehensive formulation, by following patient lived experience.

When the curriculum structure changed, more clinical opportunities emerged (both in public and private). During the COVID-19 pandemic this led to change in the management of educational experience such as the model at Pain Matrix Geelong which encourages medical student pain education.

Students spend a week with specialist pain medicine physicians as part of their six-week critical care (anaesthesia/ critical care) attachment.

The students also learn about the use of motivational interview techniques, the exploration of developmental history, the role of procedures, the importance of allied health colleagues and the management of distress.

Students spend time with a patient to get an insight into that individual’s lived experience and the impact that persistent pain has on them. The student’s work is then presented to a Pain Matrix consultant.

Students are encouraged to introduce their own style in the language and structure of the work. Influences outside medicine from sport, music, interests, hobbies or experiences can be leveraged. Finally, their work is edited to 500 words.

The medical students’ experience demands time and effort on behalf of the specialist and the clinic.

This may have an impact on throughput and (in private practice) perhaps revenue. It is however extremely rewarding, and students report very high levels of satisfaction even after their brief exposure.

Some have commented that it has had a pivotal impact on their medical aspirations. One student remarked that the pressures of their studies during COVID had made them consider quitting.

That student successfully completed the degree and is now treating patients

Dr Diarmuid G L McCoy, FFPMANZCA FANZCA
Pain Matrix Geelong, Melbourne

ANZCA's DEI framework launched

HOW IT ALL BEGAN

Work in diversity, equity and inclusion (DEI) at ANZCA started in earnest following the startling realisation of an under-representation of female speakers for the 2017 ANZCA Annual Scientific Meeting (ASM).

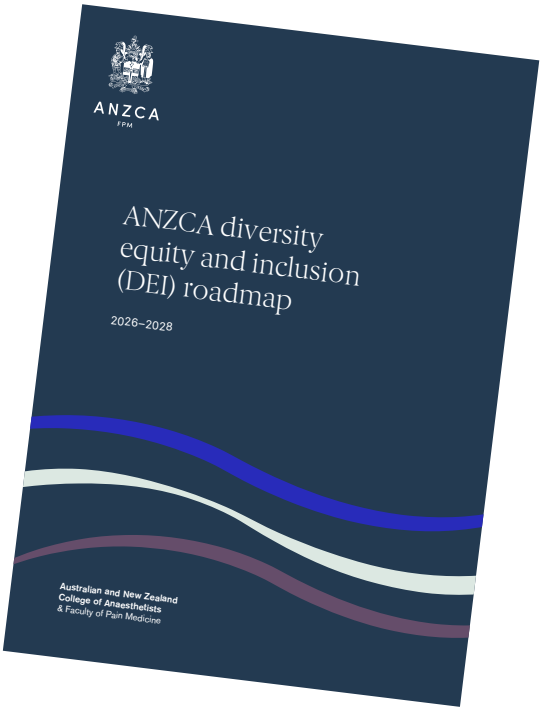
It prompted a deep dive into ANZCA's approach to the engagement of female fellows in leadership, research, conference participation, promotion and overall representation.

There was a recurring narrative of male-dominated leadership in our workplaces. There were many examples of overt sexual discrimination within departments, and in the private sector.

The response from ANZCA has been to examine its own nest. Publish the gender data. Encourage accountability of gender metrics. Form networks actively promoting the representation and promotion of female talent. Extend the work done in gender equity to all areas of diversity: race, sexual orientation, ability.

The DEI framework is the result of a decade of hard work in this space. It will be embedded into ANZCA's business as usual, and the narrative in the workplace is changing. I am very proud to have been a part of it.

Dr Bridget Effeney, FANZCA
ANZCA DEI champion



STRENGTHENING OUR PROFESSION AND THE CARE WE PROVIDE

Earlier this year the *ANZCA Diversity, Equity and Inclusion Framework (2026-2028)* and roadmap (above) were launched. These documents set out a clear, unified approach to advancing inclusive, equitable, and respectful environments across the college and the professions we serve.

This work was developed and championed through cross-college and committee collaboration and is supported by ANZCA Council and the Faculty of Pain Medicine Board, who are committed to inclusive systems and cultures that support excellence, fairness, and belonging for all.

Diversity, equity and inclusion (DEI) are integral to ANZCA's purpose and values, shaping how we train, practise and lead across anaesthesia, perioperative medicine and pain medicine, and how we care for the communities we serve.

The DEI Framework outlines our vision, principles and focus areas, while the roadmap identifies the priority actions that will guide our work over the coming years. Together, they provide a clear foundation for embedding DEI into how we work, lead and collaborate as an organisation.

ANZCA's work in this area recognises that inclusive systems support both individual wellbeing and professional excellence and are essential to a sustainable and high performing workforce.

A shared framework and common language

The *Diversity, Equity and Inclusion Framework (2026-2028)*, supported by a DEI roadmap, establishes a shared language and set of values to inform decisionmaking across the college and its functions.

It defines *diversity* as both visible and invisible differences between people, including (but not limited to) gender, cultural background, language, disability, age, geographical location and caring responsibilities. *Equity* is described as fair treatment that may involve different supports or accommodations to ensure equal access to opportunity. *Inclusion* focuses on creating environments where individuals are valued and recognised, while belonging reflects the experience of being welcomed and respected as part of a community.

Importantly, the framework applies to all interactions involving fellows, trainees and specialist international medical graduates (SIMGs) – with each other, with college staff, and with patients.

To support our work in this area, 50 college staff were provided introductory DEI training in December. Further internal training is being planned for 2026.

From commitment to action

ANZCA's *DEI Roadmap (2026-2028)* identifies eight priority areas and outlines practical actions to drive meaningful and lasting change. It focuses on building inclusive mindsets and capabilities, strengthening diversity and representation, and embedding DEI into education, training, governance and professional standards.

For members, this includes access to guidance and resources on inclusive leadership, unconscious bias, cultural competency and safety, antiracism and bystander intervention.

The roadmap also highlights the importance of regular communication, storytelling and professional development to support fellows, trainees and SIMGs to champion DEI within their workplaces.

The roadmap recognises that ANZCA must also lead by example. This includes examining representation across leadership, governance and committees, and ensuring that college systems and processes support fairness, transparency and inclusion. ANZCA will lead by learning from past experiences and committing to continual improvement.

Recognising diversity across career stages and pathways

ANZCA's approach to DEI acknowledges that experiences of inclusion and exclusion can vary significantly across career stages and professional pathways. Trainees and SIMGs, in particular, may encounter additional challenges related to training structures, assessment processes, cultural differences or workplace dynamics.

By embedding DEI principles across accreditation, education and professional standards, the college aims to create systems that support excellence while recognising diversity of experience.

Gender equity initiatives, including the Gender Equity Action Plan and associated resources, sit within the broader DEI agenda and reflect ANZCA's longstanding commitment to equitable participation and advancement across the profession.

The college also recognises the importance of culturally safe engagement with Aboriginal, Torres Strait Islander and Māori peoples, and of respecting diverse ways of knowing, being and practising medicine.

Looking ahead

ANZCA's commitment to diversity, equity and inclusion continues to evolve through the framework, roadmap and engagement with fellows, trainees and SIMGs.

This work is both a shared responsibility and an opportunity to help shape professional cultures that support belonging, excellence and high quality care. We look forward to sharing the work of fellows, trainees and SIMGs in future editions of the *ANZCA Bulletin*.

Further information, including the DEI framework, roadmap and related resources, is available on the ANZCA website or by emailing membership@anzca.edu.au.

Dr Scott Ma, FANZCA
Chair, Professional Affairs Executive Committee

Self matters

Second victim symptoms: From concept to culture change

Auckland anaesthetist Dr Jo Sinclair is the curator of the *ANZCA Bulletin's* Self Matters column.

Healthcare professionals enter medicine with the intent to heal and to do no harm. Yet adverse events, unexpected patient outcomes, and medical errors are an unavoidable reality of complex clinical systems. While the patient and their family are rightly recognised as the primary victims of such events, the emotional, psychological and professional impact on clinicians themselves has increasingly been acknowledged.

These clinicians, often described as "second victims", may experience significant and enduring distress that affects their wellbeing, professional identity, and capacity to provide safe care.

Understanding second victim symptoms, recognising their prevalence within anaesthesia and perioperative medicine, and implementing meaningful organisational responses are essential components of creating a culture of safety and wellbeing.

Dr Jo Sinclair, FANZCA

**Dr Sinclair is speaking about second victims in a session at the 2026 ANZCA Annual Scientific Meeting in Auckland on 3 May. Dr Sinclair's opinions are her own and do not necessarily reflect those of ANZCA or Health NZ.*

DEFINING THE SECOND VICTIM

The term "second victim" was first described by Wu in 2000, referring to the healthcare provider involved in an adverse patient event, who becomes traumatised by that experience.[1]

Sachs and Wheaton presented the current understanding in *StatPearls* (2023), namely that second victim symptoms can occur following errors, perceived errors, near misses, or even adverse outcomes where care met accepted standards.[2] Importantly, the clinician's perception of responsibility often drives distress, regardless of whether an objective error occurred. This is particularly relevant in anaesthesia, where clinicians frequently shoulder personal responsibility for high-stakes decision-making in time-pressured environments.

Common symptoms

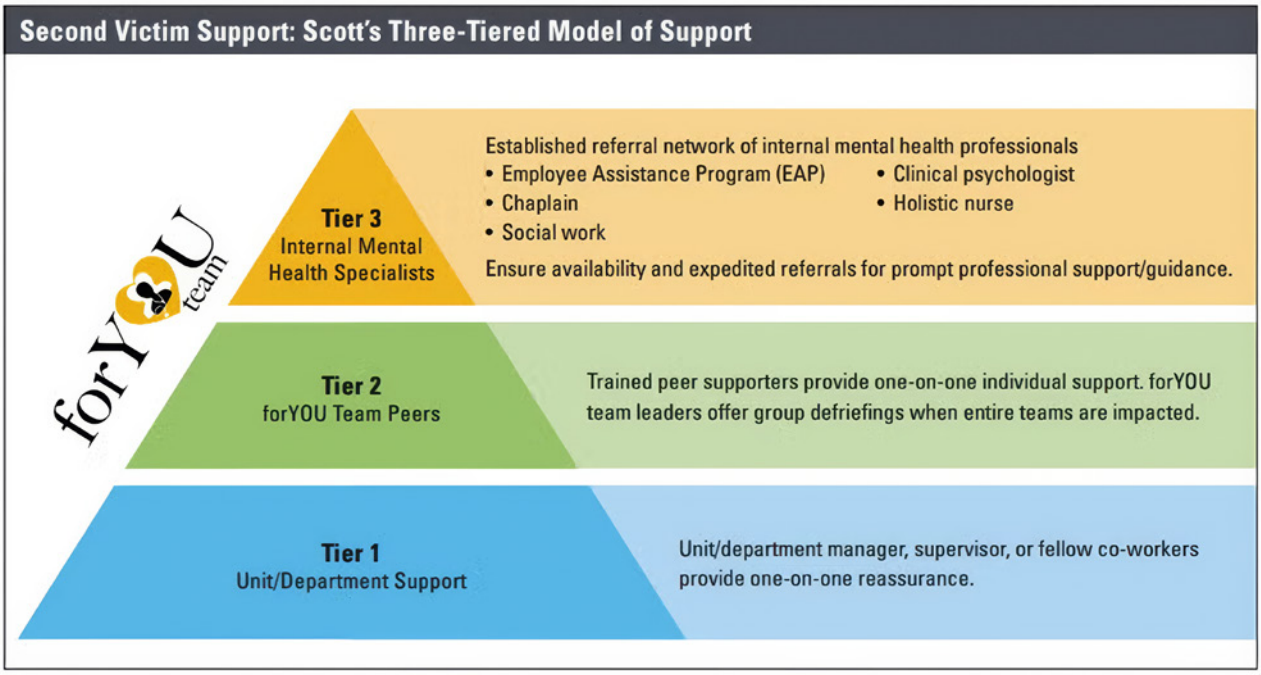
Second victim symptoms often emerge acutely following an adverse event but may evolve over time. Commonly described symptoms include:

- Emotional: guilt, shame, anxiety, sadness, anger, loss of confidence.
- Cognitive: self-doubt, intrusive memories, rumination, impaired concentration.
- Physical: insomnia, fatigue, appetite changes, palpitations.
- Behavioural: avoidance of similar cases, withdrawal, hypervigilance, defensive practice.

Insights from the second victim experience

The qualitative work of Scott et al. provides insight into how clinicians experience and process harm,[3] describing the second victim experience as unfolding across distinct phases, each requiring different types of support:

1. Chaos and accident response: the immediate, emotionally charged period where the provider realises the severity of the event and works to stabilise the patient.
2. Intrusive reflections: the provider repeatedly revisits the event, often experiencing physical or psychological distress and loss of confidence.
3. Restoring personal integrity: a phase focused on questioning "why" and attempting to reconcile one's role in the event. Searching for reassurance and rebuilding trust.



Adapted from Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Hahn-Cover, K., Epperly, K., Phillips, E., and Hall,L.W. (2010) Caring for our Own: Deployment of a Second Victim Rapid Response System. The Joint Commission Journal on Quality and Patient Safety. 36(5):233-240.

4. Enduring the inquisition: the stressful process of formal reviews and questioning, which can induce fear regarding job security.
5. Obtaining emotional first aid: seeking support from peers, family or professionals.
6. Moving on: this phase results in either professional growth (thriving), continued work with lingering distress (surviving), or leaving the area/profession (dropping out). Without effective support, some clinicians develop burnout, depression, post-traumatic stress symptoms, or consider early retirement.

Support for staff

Internationally, structured programs such as the "forYOU" team model (see above) – originating from Scott's work – demonstrate how tiered support systems can be embedded within healthcare organisations.[4] These programs combine immediate local departmental/collegial support, access to trained peer support, and referral pathways for professional psychological care when needed.

Immediately after the event, clinicians require compassionate peer support, clear communication, and reassurance that they are not alone. At this "point of impact," silence, blame, or exclusion from discussions can be profoundly damaging. Over time, clinicians seek meaning-making and reassurance about their professional competence and integrity. Importantly, organisational responses that focus solely on investigation and accountability, without addressing emotional impact, may exacerbate harm.

A key finding from Scott et al. is that a colleague who listens, checks in and normalises emotional responses is often more valuable than formal counselling in the acute phase. However, peer support must be embedded within a broader system that allows psychological safety and destigmatises help-seeking.

In medicine, impacts of an adverse event may be amplified by professional culture. The expectation of technical excellence, emotional resilience and individual accountability can make it particularly difficult for clinicians to acknowledge vulnerability or seek help.

Organisational responsibility and just culture

A just culture framework recognises that most errors arise from system vulnerabilities rather than individual recklessness. Within such a culture, clinicians are treated with fairness and empathy, while accountability remains appropriate and proportionate. This approach aligns with anaesthesia's longstanding commitment to patient safety through systems thinking.

Healthcare organisations have ethical and practical responsibilities to:

- Acknowledge the emotional impact of adverse events on staff.
- Provide structured and timely second victim support pathways.
- Train leaders to recognise distress and respond with compassion.
- Ensure investigations are transparent, supportive, and learning-focused.

Implications for anaesthetists and trainees

Anaesthetists frequently encounter critical incidents, unexpected outcomes, and perioperative deaths. Trainees may be particularly vulnerable, balancing professional identity formation with exposure to high-stakes environments and assessment pressures.

Normalising conversations about second victim experiences should be part of departmental culture, morbidity and mortality meetings, and training curricula. Role modelling by senior clinicians – acknowledging fallibility, sharing experiences, and demonstrating help-seeking – can significantly reduce stigma.

Practical steps at a departmental level may include:

- Identifying trained peer supporters.
- Ensuring followup after critical incidents.
- Including wellbeing checkins alongside clinical debriefs.
- Signposting confidential supports through colleges and employers.

Moving forward: from recognition to action

Recognition of second victim syndrome represents an important shift in healthcare culture, but recognition alone is insufficient. For anaesthetists, whose professional ethos emphasises vigilance, responsibility, and patient safety, caring for colleagues after adverse events is both a moral and professional imperative.

Supporting second victims does not detract from accountability or patient-centred care. Rather, it strengthens systems, fosters trust, and enables learning. As the evidence base grows – supported by international collaborations such as European Researchers Network Working on Second Victims (ERNST)[5] – there is an opportunity for colleges, healthcare organisations, and departments to embed second victim support as a standard component of safe, compassionate practice. Second victim support is a patient safety intervention: clinicians who are supported are better able to recover, learn, and continue to provide high-quality care.

Ultimately, how we care for clinicians after harm occurs speaks volumes about who we are as a profession.

References

1. Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. BMJ. 2000 Mar 18;320(7237):726-7. doi: 10.1136/bmj.320.7237.726. PMID: 10720336; PMCID: PMC1117748.
2. Sachs C, Wheaton N. Second Victim Syndrome. StatPearls. Updated June 20, 2023.
3. Scott SD, Hirschinger LE, Cox KR, et al. Care at the point of impact: insights into the second victim experience. J Healthc Risk Manag. 2016;35(4):6–13.
4. https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou
5. European Researchers Network Working on Second Victims (ERNST). https://cost-ernst.eu/about

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 995 262 in Australia or 0800 459 020 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 or visit our website.

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/

For Māori

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

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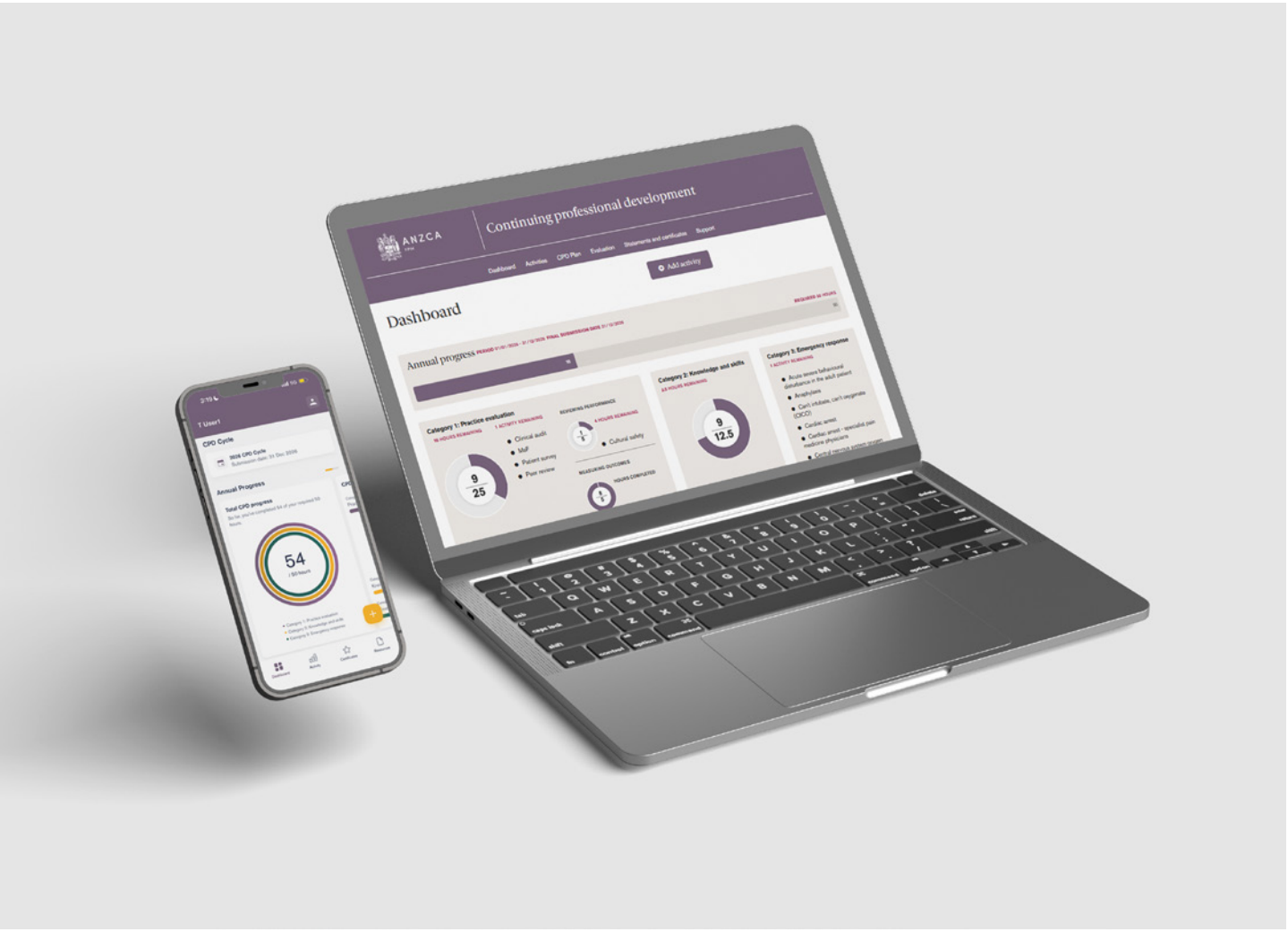
New CAPE requirements for CPD



You will now be immersed in your Continuing Professional Development (CPD) for 2026 and will have noticed CAPE requirements appearing on your CPD dashboard.

CAPE CPD is not about superheroes, stylish fashion or windy headlands, it is an acronym for four domains:

- Culturally safe practice.
- Addressing inequity.
- Professionalism
- Ethical practice.

Colleagues in a "signal group" recently debated how the hours would appear and if they inadvertently double up if two domains are assigned. The answer is no.

All four domains need to be covered in the annual cycle, and one activity may cover off more than one domain. For example, a cultural safety course may cover both culturally safe practice and addressing inequity. The activity would need both "C" plus "A" ticked when entering the course on the CPD dashboard.

Most fellows are a living example of the CAPE framework in their daily work as empathic doctors who show respect and understanding to patients and families from diverse backgrounds who are dealing with illness.

Completing a critical reflection in a quiet moment at the end of a complicated day can serve many purposes. Structured, deep examination of professional actions can lead to improved outcomes through life-long learning. Thinking about what worked, what didn't work and why, is part of a reflective practice. It is also part of CPD and can be entered on your dashboard.

RESOURCES

CPD resources to help us meet program requirements are easily accessible in the ANZCA and FPM Library Guides. The relaunched CPD resources hub had 52,440 views in 2025, with a surge in December, outperforming everything else in quarter four. There were more than 9000 views in December alone (up 111 per cent for the year).

Uploading CPD activities "as you go" is a pragmatic approach to ensuring a smooth verification process if audited by ANZCA or the regulators. December can be more about spending time with family and friends when CPD hours are completed and evidence uploaded earlier in the year.

The library resources were accessed most frequently in 2025 through web browsers Chrome/Chrome mobile (49.2 per cent) and Safari/Safari mobile (29 per cent). The CPD mobile app is part of this data and delivers us a helpful tool to assist quick CPD activity uploads, and easy documentation. The app is free to members of ANZCA and FPM. College librarian, John Prentice, reported that ANZCA Library Guides broke through the 350,000 milestone (up another 13 per cent), showing the value of our curated resources.

Our statistics show cultural safety leads the frequency of library searches as progress continues in the evolution of ANZCA resources to guide fellows in their cultural safety journey. A culturally safe health practice requires the ongoing critical reflection of health practitioners' knowledge, skills, attitudes, practicing behaviours and an awareness of existing power differentials. The Geoffrey Kaye Museum of Anaesthetic History is another useful resource[1] and Veronica Dominiak, our museum curator can provide direction for members curious to explore cultural safety materials in the collection.

Self-reflection, peer collaboration and performance feedback are where the eyes of the regulators are focused in the context of strengthened CPD. The ANZCA and FPM CPD Program has always held these practice evaluation standards as integral to a highly functioning fellow who performs at their best.

A focus on expansion of resources to enable our rural colleagues to better access practice evaluation tools online is evolving. The private practice hub[2] has commercial vendors which provide some of these tools, however fellows should be aware ANZCA and FPM do not endorse these vendors and fellows use them at their own discretion.

An environmental audit (category one) is possible using the ANZCA environmental sustainability network (ESN) guideline[3]. Government is calling for collaborative action by medical colleges in environmentally sustainable and climate resilient healthcare[4]. The ESN resources are another area members can explore for CPD activities which align with this collaboration.

The three most accessed library special interest group (SIG) guides were wellbeing, airway management and obstetric anaesthesia. Interestingly Wellbeing SIG views surge in the winter months of June and July. The wellbeing question in the CPD plan is a genuine prompt to consider educational activities over the annual cycle which enhances wellbeing learning, synergistic with the Latin 'medice cura de ipsum' (physician heal thyself) which requires us to look after ourselves to best care for others. Thank you to all the wellbeing champions in our profession.

CPD PLAN REVISION

We have heard the fellowship voice, and we will be revising the style of the CPD plan to improve clarity, create better prompts and guide fellows to educational activities which suit their academic interests. Some of the ANZCA Annual Scientific Meeting (ASM) activities will continue to auto populate to your CPD dashboard.

As Australian and New Zealand anaesthetists we continue to show the value of our dedication and high standards of training in a globalised environment. Last year there were more than 7000 CPD participants who were 99.42 per cent compliant and 100 per cent of audit participants passed.

The CPD team at ANZCA work hard to help us meet compliance requirements and combined with the CPD Committee, strive to keep our specialty reflective of ANZCA and FPM's strategic goals.

CPD is an extension of our training years and program completion provides assurance to our communities that we are always endeavoring to bring our best selves to their health journey.

Dr Debra Devonshire, FANZCA
Chair, ANZCA and FPM CPD Committee

References and links

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4. https://www.safetyandquality.gov.au/sites/default/files/2024-09/Joint-Statement-Working-together-to-achieve-sustainable-high-quality-health-care-in-a-changing-climate.PDF

Research

Grant leads to $NZ5 million for breast cancer

An ANZCA Foundation grant for a study led by FANZCA Dr Marta Seretny has led to a New Zealand Health Research Council (HRC) grant of $NZ5 million to improve survival for symptomatic breast cancer patients, starting with Māori women.

Dr Seretny, a specialist anaesthetist at Auckland City Hospital, received the foundation grant of $A60,222 in 2023 for the qualitative research project "Prehabilitation needs of patients with breast cancer".

Half of all women with 'symptomatic' breast cancer (BC) in New Zealand are diagnosed outside the national screening program, and Māori women with symptomatic BC face a 37 per cent greater mortality risk than non-Māori women. The HRC-funded project will develop and test a model of care called "Breast Cancer Whiri" in Auckland and the Waikato, which aims to improve survival, starting with Māori women.

BC Whiri's approach will include fixing gaps in access to timely and holistic care, integrating best practice cancer care including a whānau-based approach, formalised care plans, and prehabilitation. The research team, which includes Dr Seretny, is co-directed by medical oncologist and Māori health specialist Associate Professor George Laking, and Health NZ's Māori Health Directorate Chief Medical Officer Dr Nina Scott, will study effects of BC Whiri on cancer biology, health outcomes, and whānau wellbeing, with a goal of national implementation.

BC Whiri will have universal value to improve health outcomes across all populations.

Dr Seretny said, "The data we gathered during the ANZCA (Foundation) funded project was integral to the success of the HRC programme grant application. Hanna Van Waart (my research group co lead) and I are immensely grateful for the support".

NEW WORKING GROUPS FOR STRATEGY AND GRANT ASSESSMENT

The ANZCA Research Committee has established two new working groups to identify and implement opportunities to improve efficiency, effectiveness, equity, and impact of the foundation-supported medical research program.

The Grant Assessments Working Group is focusing on making the grant assessment process more time efficient for applicants, reviewers, staff, and expert volunteer committee members, improving equity of assessment, and increasing emphasis on the potential impact of funded projects in the application, review, and assessment process.

The Strategy, Priorities and Improvement working group is re-examining the strategic objectives of the research program, the extent to which they are being achieved, and their alignment with the ANZCA mission.

FOUNDATION RECEPTION AT THE AUCKLAND ASM

The ANZCA Foundation reception will be held once again in 2026, during the ANZCA Annual Scientific Meeting (ASM) at the New Zealand International Convention Centre (NZICC).

The event will be from 6.30-8.30pm on Sunday 3 May, in the NZICC's Wellesley Gallery. The annual ANZCA Foundation-named research awards presentation will be conducted by incoming ANZCA Research Committee chair, ANZCA councillor Associate Professor Stuart Marshall, while ANZCA President Professor David Story will deliver a summary keynote address on "Academic anaesthesia: strategic directions, threats, and impact".

THANK YOU TO RECENT DONORS

The foundation once again thanks all our very generous donors, including all those who gave so generously around the Christmas and New Year season.

We again received several donations. As our donors know so well, these regular gifts make it possible for us to continue our level of support for research and health equity projects led by our FANZCAs, FFPMANZCAs and trainees, which consistently make strong contributions to the advancement of science and evidence-based practice within the specialties.

7 TELETHON TRUST GRANT APPLICATIONS

Despite several previous successes, the foundation was advised in late December that its applications for three proposed studies in paediatric anaesthesia lodged with the 7 Telethon Trust in Western Australia were unfortunately all unsuccessful.

The high degree of uncertainty and low success rates associated with applications for research funding, a reality researchers deal with on a regular basis, again highlights the importance of the foundation's generous regular private donors, and the regular support they provide.

More funding is always needed to expand the high-quality work being delivered, and to support the development of new and emerging investigators, so please continue or consider supporting this work through the ANZCA Foundation.

ANZCA research – the outcomes

Over many years, ANZCA has allocated $A1.5 million or more every year for research in anaesthesia, pain medicine, and perioperative medicine. In this third report of our ongoing series, we bring you results from three more 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 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 health system.

In this issue we feature studies led by FANZCA clinician researchers based in Queensland, which has emerged in recent years as a leading centre for academic anaesthesia and pain medicine. These studies have been published in leading peer-reviewed journals, presented at major scientific meetings, or in most cases, both.

HIGH-FLOW NASAL OXYGEN A SECOND OPTION FOR TUBELESS AIRWAY PAEDIATRIC SURGERY

High-flow oxygen for children's airway surgery: a randomised controlled trial protocol (HAMSTER)

Associate Professor Susan Humphreys from the University of Queensland and Queensland Children's Hospital, and her team received a project grant in 2020 for this study and reported on the findings and outcomes in 2023. Her research team included Professor Andreas Schibler, Queensland Children's Hospital; Professor Andrew Davidson and Dr Ben Hallett, Royal Children's Hospital, Melbourne; Associate Professor Justin Skowno, The Children's Hospital at Westmead; and Associate Professor Kristen Gibbons, Paediatric Critical Care Research Group, Mater Research.

$A63,000

In a recent review of the anaesthesia care of children undergoing airway surgery at Queensland Children's Hospital, the team found that 34 per cent of children experienced low intra-procedural oxygen levels one or more times, and 23 per cent of surgeries were interrupted to correct oxygen levels. The hypoxemia common during upper airway surgery, and resulting interruption of procedure for rescue oxygenation, can potentially compromise patient safety, prolong the procedure, increase anaesthetic exposure, and affect the success of the surgery.

Before this study, however, no rigorous large-scale evaluation of any oxygenation method to reduce such anaesthetic complications had ever been undertaken. The team's recent studies had demonstrated that the "high-flow" nasal oxygenation method is a safe and effective alternative technique for oxygen delivery in infants and children with abnormal airways. However, there was no evidence for whether the traditional "low-flow nasal oxygen" (up to 6L/min), or "high flow nasal oxygen" (warm and humidified oxygen, weight-determined and breathing-adjusted) method was superior in reducing hypoxemic events.

This multicentre randomised trial aimed to compare the proportion of rescue oxygenation attempts to manage hypoxemia during anaesthesia for upper airway surgery between the high-flow and low-flow techniques, in infants and children undergoing elective tubeless upper airway surgery. The secondary objective was to demonstrate if high-flow reduces severity of hypoxaemia, incidence of adverse cardiorespiratory events, and unexpected paediatric intensive care unit (PICU) admissions.

Both objectives targeted potential to improve safety outcomes for these children.

The results showed no differences in the proportion of rescue oxygenation attempts, severity of hypoxaemia, or unplanned PICU admissions, between the two techniques. Nevertheless, they showed that high-flow was non-inferior to low-flow, offering a second option for oxygenation during tubeless airway surgery. At recruitment sites, there has been increased use of total intravenous anaesthesia as a maintenance of anaesthesia technique, and more confidence in using high-flow oxygen. Clinically it is favoured by surgical colleagues as a minimally invasive and easy to learn technique for paediatric anaesthetists.

CANDIDATE REVERSAL AGENTS – A NEW LEVEL OF TESTING

Lennard Travers Professorship: Discovering anaesthesia recovery treatments (DART): A super-resolution microscopy approach to uncovering reversal agents

Professor Andre van Zundert at The University of Queensland's Queensland Brain Institute and Royal Brisbane and Women's Hospital received the 2023 ANZCA Lennard Travers Professorship and grant to conduct this study. His team included Professor Bruno van Swinderen, a world expert in using Drosophila as a model organism to study the effects of sleep and anaesthesia.

$A69,687

There are currently no reversal agents for expediting recovery time after general anaesthesia, partly due to lack of knowledge of anaesthetic mechanisms, especially presynaptic. The team found common general anaesthetics such as propofol impair neurotransmission, likely by impairing mobility of presynaptic proteins like syntaxin1A and munc-18. They sought to investigate whether non-anaesthetic propofol analogues (for example, , 2,4-diisopropylphenol) could counteract its presynaptic effects, and to develop a platform to test candidate reversal agents, as a paradigm for future screening a wide range of potential agents. Finding agents that could overturn presynaptic effects of common drugs like propofol would be candidates for further clinical trials, towards improving control of general anaesthesia and recovery outcomes, in vulnerable patient populations likely to be affected by exposure to general anaesthetics.

A platform was developed to test potential reversal agents at a level never tested before, investigating presynaptic functions like presynaptic protein dynamics and neurotransmission. Although the final datasets were underpowered due to optimisation, the team concluded 2,4-diisopropylphenol is unlikely as a promising reversal agent. While neurotransmission readouts were promising, single-molecule imaging experiments suggested the analogue does not counteract propofol. The team aims to finalise this dataset with a sample size of around 10 cells per experiment to achieve a definitive conclusion.

In experiments to test potential reversal agents in live nematode worms, and assess effects on behaviour and survival, 2,4-diisopropylphenol caused their rapid demise. This useful assay was then adopted as a test of potential toxicity. Further experiments using the same cell platform and live animal screening found other propofol analogues that do not kill the nematodes, while also seeming to rescue the presynaptic readouts. These will form the basis for the next ANZCA project report.

This first study developed an efficient, cost-effective live animal test for toxicity. Although finding 2,4-diisopropylphenol kills nematode worms was disappointing, it paved the way for effectively screening these drugs before clinical trials. Considerable effort was made to optimise both presynaptic assays. Sample sizes remained low, but the data did indicate 2,4-diisopropylphenol is unlikely to overturn the effect of propofol on presynaptic function – the project's central question.

Trials for discovering alternative presynaptic drugs are ongoing, focussing on fluorinated analogues of propofol. These appear much more promising, with excellent outcomes, and form the basis of the team's second ANZCA Foundation-funded project. The fluorinated propofol analogues tested so far do not kill nematode worms, and the same approaches reported here are therefore being taken to screen these new candidate reversal agents.

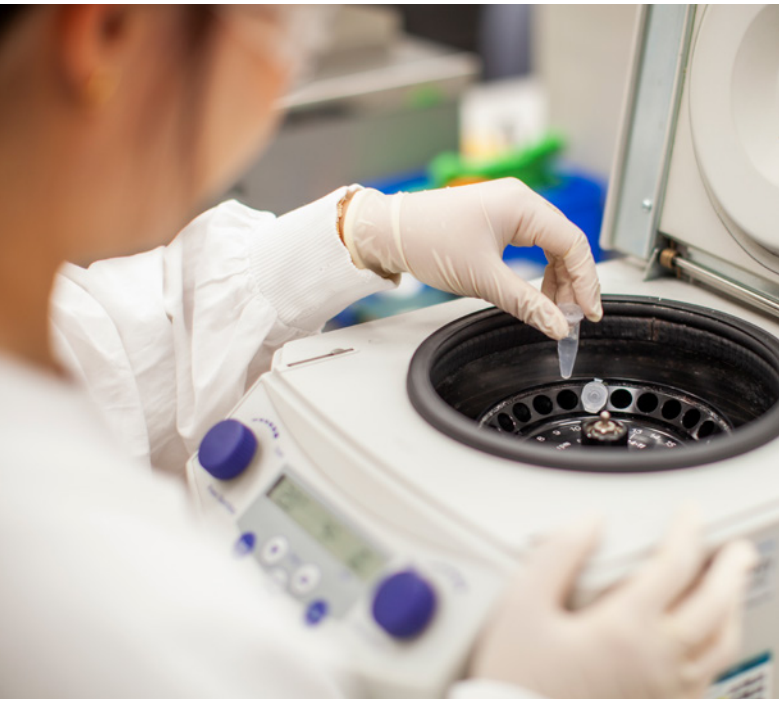
KETAMINE AND DEXMEDETOMIDINE COULD BE EFFECTIVELY NEBULIZED

Comparative pharmacokinetics (PK) of nebulised and intravenous ketamine and dexmedetomidine in ventilated patients

Dr Julie Lee, The Royal Brisbane and Women's Hospital, received the ANZCA Foundation's Robin Smallwood Bequest in 2022 for this study, and provided a final report in 2023. Her team included Dr Jayesh Dhanani, Associate Professor Victoria Eley, and Professor Jason Roberts.

$A66,165

Inadequate clinical effect and significant side effects associated with conventional administration of sedative and analgesic agents indicate a need for investigating novel drug delivery. Sub-optimal analgesia and sedation in intensive care causes adverse patient outcomes including impaired sleep in 46 per cent, reduced quality of life, impaired mobility, hospital and or intensive care pain-related readmission costs



equating to $A1869 per event, and 30 per cent and three per cent incidences of neurological side-effects and respiratory events respectively. Dexmedetomidine and ketamine have sedative-analgesic properties, and intravenous administration is commonly used for both but is associated with low blood pressure and heart rate, and excessive sedation.

Both drugs have previously been used safely, but due to unique advantages of administration via the lung, nebulisation may result in more favourable blood concentrations for safety and clinical effectiveness. Side effects are likely to be minimised, as high peak concentrations following intravenous administration are avoided.

However, lack of clinical data on nebulised ketamine and dexmedetomidine limits ability to select appropriate doses for appropriate clinical effects. For this study, mechanical ventilation in the intensive care unit provided the ideal setting to safely evaluate drug delivery systems. Defining lung dose prior to clinical studies is essential, and it was determined that a comparative plasma study of nebulised versus intravenous ketamine and dexmedetomidine would allow the dose equivalency for the intravenous and nebulised administration routes to be derived. The data could then be used to generate dosing guidelines for clinical trials in diverse patient groups.

The study found that with mechanical ventilation, ketamine and dexmedetomidine can both be effectively nebulised. They both achieved optimal aerosol characteristics, achieving a mean fine particle dose of 30 per cent and bioavailability of 29 per cent (ketamine) and mean fine particle dose of 28 per cent and bioavailability of 35 per cent (dexmedetomidine).

Detailed population pharmacokinetic modelling is now under way and will inform future clinical trials. Dose calculation in the design of these trials will need to account for the effective bioavailability of the nebulised delivery route. The final population pharmacokinetic modelling will further inform a dosing schedule.

Preliminary comparative pharmacokinetic data suggest lower peak and wider area under the curve, indicating the potential for its use for effective analgesia. Following these results, a phase III pilot feasibility randomised controlled crossover trial with nebulised dexmedetomidine for pain management in burn injury dressing changes has been completed, and a feasibility and plasma pharmacokinetic study of nebulised ketamine in non-ventilated post-operative and trauma patients, as well as in cardiac surgery patients, has commenced. This will lead to a large randomised controlled trial in the future.

For information on key publications, presentations, and implementation of ANZCA Foundation-funded study outcomes, 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.

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Strengthening the clinical trials pipeline

The ANZCA Clinical Trials Network (CTN) is operating in one of the most challenging research environments in its three-decade history. National funding success rates are declining. Medical Research Future Fund (MRFF) allocations are not being fully disbursed as intended. Downturn in actively recruiting clinical trials is reducing per-patient income streams that many departments rely on to support research coordinators.

At the same time, regulatory complexity is increasing and trial designs are becoming more sophisticated. These structural pressures are being felt in departments across Australia and Aotearoa New Zealand, where emerging investigators face lower odds of funding success, and research coordinator roles are under growing strain, with job security no longer assured in many departments.

Overlaying these pressures is a fundamental shift in how funding applications are assessed. Scientific merit remains essential, but it is no longer sufficient on its own. At Australia's National Health and Medical Research Council, reforms to the Clinical Trials and Cohort Studies scheme now allocate 20 per cent of the overall application score to consumer and community involvement, with consumers embedded directly in peer review.

Applications are assessed not only for methodological strength but for the authenticity of partnership and the credibility of implementation plans. The Health Research Council of New Zealand requires all applicants to address Māori health advancement, demonstrating how research contributes to improving Māori health and reducing inequities, even where Māori are not the primary study population. Within this funding model, proposals that demonstrate genuine partnership consistent with Te Tiriti o Waitangi principles are significantly more competitive.

Against this landscape, strengthening the pipeline from emerging investigator research idea, to funded, practice-changing trial has become a clear strategic priority for the CTN.

The network has recognised that reliance on single-grant income is no longer sustainable and that structured mentorship, research coordinator workforce capacity, rigorous peer review infrastructure and authentic consumer and Indigenous partnership must be embedded.

The CTN Strategic Research Workshop remains central to these efforts. It functions as a structured pre-submission review forum, convening investigators, methodologists, statisticians and research coordinators to interrogate feasibility, refine methodology and strengthen protocols before grant submissions.

The workshop is also a fabulous opportunity for novice and emerging researchers to rub shoulders with experienced clinical trialists and research leaders. This occurs not only during the formal sessions, but also over dinner, drinks, and the fun social activities held throughout the workshop.

"It is surreal to think that our team has obtained such a large amount of funding with a registrar and emerging career researcher at the helm – I think it is a testament to how the CTN is embracing and supporting the next generation."

Dr Luke Perry, researcher and anaesthesia trainee

FROM CONCEPT TO NATIONAL FUNDING

The trajectory of the pulmonary artery catheters in low-risk cardiac surgery (PUMA) trial illustrates how this model operates in practice. In 2021, at a fully virtual CTN strategic research workshop, Dr Luke Perry presented the PUMA pilot as a registrar seeking structured peer review, where he received peer-review feedback.

In 2022, he secured an ANZCA Foundation project grant to conduct the pilot study and obtained CTN endorsement. The pilot findings were subsequently presented at the CTN Late Breaking Trials session at the 2025 ANZCA Annual Scientific Meeting.

With continued mentorship from senior investigators including Associate Professor Lachlan Miles and the late Professor Rinaldo Bellomo, and collaboration with colleagues at the Victorian Heart Hospital, the team secured $A3.7 million through the MRFF Clinical Trials Activity Initiative to conduct a definitive, world-first international trial comparing pulmonary artery catheters with less invasive central venous catheters in low-risk cardiac surgery.

The application achieved an impact score of 6.85 out of 7, the highest ranked in its funding round, reflecting not only scientific rigour but the authentic patient co-design that was embedded from inception, with guidance from cardiac surgery survivor and researcher Paige Druce from the CTN office.

The progression from workshop presentation to pilot funding, endorsement and major national grant exemplifies the structured framework the CTN uses to strengthen the trial pipeline and support the career development of emerging investigators.

This approach is also reflected in the delirium prevention pilot led by Professor Robert Sanders and presented by co-investigator Dr Benjamin Moran at the 2025 CTN workshop. Following expert peer review, the team secured $800,000 through the MRFF Clinical Trials Activity Initiative for a multicentre, double-blind pilot enrolling 120 patients aged 60

years and over. The study will evaluate pragmatic strategies including celecoxib use, avoidance of peri-induction midazolam and EEG-guided depth of anaesthesia, generating data to inform a subsequent large-scale platform trial.

SUSTAINING EXCELLENCE IN A CONSTRAINED ENVIRONMENT

These achievements are occurring alongside major network milestones. In 2025, three decades after the CTN first began recruitment, enrolment was completed for SNaPP, ROCKet, TRIGS and MASTERSTROKE. The *Journal of the American Medical Association* published the results of the CLIP-II trial, led by Professor Michael Reade, which showed that although cryopreserved platelets are safe in adult cardiac surgery, they are less effective than standard liquid-stored platelets for routine bleeding control.

The 2025 Strategic Research Workshop was the largest in CTN history, with a record number of proposals presented by both emerging and established investigators, representing the strongest program of new concepts seen in the past decade. In New Zealand, PROMPT-O_2, led by Dr Daniel Frei, secured major funding from the Health Research Council of New Zealand in 2025, further strengthening the binational pipeline.

The CTN will celebrate these achievements at the upcoming ANZCA Annual Scientific Meeting, where first-hand results from SNaPP, ITACS and TRIGS will be presented by Professor Kate Leslie AO and Professor Paul Myles. Together, these milestones demonstrate the CTN's proven ability to deliver major trials while building the resilience required for future challenges.

The current funding climate demands strategic adaptation. By strengthening core infrastructure, formalising mentorship pathways and embedding authentic partnership, the CTN is equipping the next generation of triallists to compete effectively within this increasingly complex environment, while building the capacity required to sustain anaesthesia, perioperative and pain medicine research over the coming decade.

ABOVE

From left: Dr Daniel Frei, Professor Trisha Peel, Dr Lisa Higgins and Professor Steve Webb discussing the future of platform trials at the 2025 CTN workshop in Adelaide.

New for 2026: DynaMed and AccessWorldMed

DYNAMED

Following a successful trial with private practice fellows in 2025, ANZCA now provides ongoing access to *DynaMed* for all fellows and trainees. *DynaMed* is an evidence-based clinical decision support tool – similar to UpToDate – that is updated daily through systematic surveillance of more than 500 medical journals, ensuring information remains current and reliable.

Users can quickly access condition summaries that cover overviews, diagnosis, management and links to relevant guidelines and resources. Specialty filtered alerts, including anaesthesia and pain management, highlight recent topic updates. The platform also offers an A–Z list of drugs, a drug interactions calculator and other medical calculators.

Signed-in users can claim CME/CPD credits after reviewing content. *DynaMed* is available via web browsers and a mobile app.

Moving forward, it is planned to incorporate relevant ANZCA professional documents and guidelines into the evidence.

To get started, check out the DynaMed guide – https://libguides.anzca.edu.au/dynamed.

ACCESSWORLDMED

ANZCA Library has begun a new subscription to *AccessWorldMed*, a platform offering locally relevant clinical and educational resources. It includes the latest edition of *Westmead's Anaesthetic Manual*, the Australian-focused *Clinical Cases in Rural and Indigenous Health*, and *Murtagh's General Practice*.

AccessWorldMed content is also accessible via the McGraw Hill Access app. With an Access profile, users can save content to favourites, create collections, track their history and view content offline.

Log into AccessWorldMed using your college ID and password to get started. For more information on the Access by McGraw Hill app, see the guide – https://libguides.anzca.edu.au/apps/accessmgh.

MORE JOURNALS AND MORE OPEN ACCESS PUBLISHING

ANZCA has joined two new Read & Publish (R&P) agreements in 2026: with Taylor & Francis and Wiley. Negotiated through the Victorian Health Library Consortium (VHLC), these agreements enable ANZCA-affiliated authors throughout Australia and New Zealand to publish open access (OA) in eligible journals with no-cost article processing charges (APCs).

The other chief benefit of the R&P agreements is access to a much wider range of Taylor & Francis and Wiley journals than previously available, strengthening ANZCA's support for clinical practice, research and education – and all within the library's existing subscriptions budget.

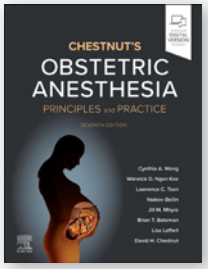
In total, the deals provide R&P access to more than 1,800 new titles and include such diverse journals as the *ANZ Journal of Surgery, Anaesthesia Reports, Prehospital Emergency Care, Allergy and Synapse,* in addition to such existing journals as *MJA, Anaesthesia, Pediatric Anesthesia, Emergency Medicine Australasia, European Journal of Pain* and *Medical Teacher.*

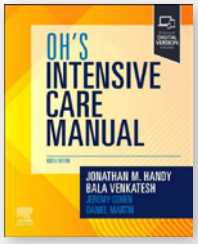
These two new agreements build on ANZCA's existing R&P deal with Springer, now in its second year, further expanding the college's commitment to sustainable open access publishing.

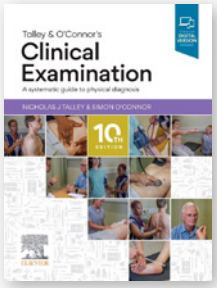
More information, including ANZCA's open access strategy and details of all three read and publish agreements, is available via the ANZCA Library open access publishing guide –https://libguides.anzca.edu.au/OA-publishing/.

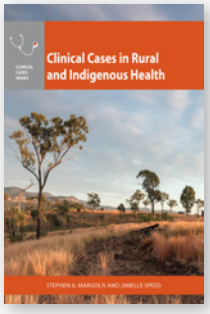
Latest books

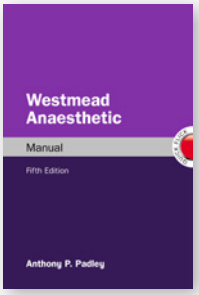
For the latest updates and a complete list of new titles check out the library news page: libguides.anzca.edu.au/news











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Stewart Thomas Bath

1943 – 2026

Stewart Bath was born in 1943 in Ipswich, Queensland and after finishing school studied medicine at the University of Melbourne, graduating in 1966.

After graduation he worked as a resident medical officer at Launceston General Hospital, spending four months of his second year in anaesthesia and intensive care.

With an interest in anaesthesia as a career, he first worked as a registrar in Perth, then the Royal Melbourne Hospital, and finished with six months at each of the Royal Women's and Royal Children's Hospitals.

On obtaining his fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (FFARACS) in 1971 he was offered a staff specialist position at the Royal Children's Hospital by then director John Stocks. Looking to find another direction in his anaesthesia career, and distressed by John Stocks' death, Stewart decided to return to Tasmania in 1977.

In his two years as a staff specialist at Launceston General Hospital, Stewart upgraded the safety of obstetric and paediatric anaesthesia to "big city" standards. He then became a visiting medical officer in what was a patchwork of private facilities. This included the (then not uncommon) practice of bringing his own anaesthetic equipment and nurse to ear, nose and throat and dental offices to anaesthetise for minor procedures – hence making day treatment an option when public facilities were not available and private hospitals unaffordable to many.

During this period he was a member of the Tasmanian Regional Committee of the Faculty of Anaesthetists, and was chair from 1982-85. With this position and his background knowledge, he made it his mission to bring the practice of private anaesthesia in Northern Tasmania up to the level found in the public hospitals. His successors give tribute to his legacy that set up a culture of equipment, monitoring, and protocols that prioritised safety in surgery and endoscopy at the private hospitals.

In 1988 Stewart was elected to the board of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (RACS) and in 1992 that board founded the Australian and New Zealand College of Anaesthetists (ANZCA). Stewart recalled the then president of RACS made the comment "all children do grow up"!

On 7 February 1992, faculty dean Peter Livingstone was allocated fellowship certificate number one and Stewart, fellowship certificate number two of the fledgling college.

In 2017, Stewart and fellow Tasmanian Mike Hodgson (the second ANZCA president) were guests of honour at the state's 'Tasmania and the twenty-fifth anniversary of ANZCA' conference. Launceston, of course, figuring large in that history being the location of the first anaesthetic in Australia given by William Russ Pugh in 1847, and the location of the first independent Annual Scientific Meeting of ANZCA in 1994, of which Stewart was on the organising committee.

Gentle and much loved, both in and out of the operating theatre, Stewart Bath was a wellspring of wisdom based on his great experience and common sense. His quiet persona concealed his skill in the nuances of anaesthetic practice: what could and could not be done safely with a particular patient, in a particular location, and with a particular surgeon's skill or mood!

Beyond the summits of medical practice, Stewart was held in high and warm regard throughout the local community. He and his wife Jillian were also enthusiastic participants in the activities of the Northern Tasmanian Alpine Club, providing leadership skill and friendships on the Tasmanian ski fields.

However, ill health meant Stewart had to retire in 2007, earlier than planned, moving to Canberra to be nearer his children and grandchildren.

In retirement he continued his hobbies of photography and gardening, growing much admired roses and Meyer lemons in the retirement village.

He is survived by his wife Jillian, children Andrew and Louise, and grandchildren.

Dr Colin Chilvers AM FANZCA (retired), Launceston
Dr Lachlan Doughty FANZCA (retired), Launceston
Dr Jillian Bath MBBS, Canberra

Roger Alan Capps AM (Military)

1944 – 2026

Roger Alan Capps, 81, a beloved husband, father, grandfather and colleague, passed away peacefully on 12 January 2026. Roger was born on 8 November 1944 at Calvary Hospital, North Adelaide. The youngest of three boys, he grew up in Glandore and was educated at Blackforest Primary and Marion High Schools. Roger entered Adelaide medical school in 1962 and graduated in 1968.

After he completed his residency at the Queen Elizabeth Hospital (QEH), Adelaide, he travelled to the UK twice as a ship's doctor. Roger obtained his surgical primary examination in 1970 at the Royal College of Surgeons. He returned to the QEH in 1971 as a surgical registrar and later transferred to the Royal Adelaide Hospital (RAH) where he met his future wife, Helene. They married in 1972 and had five children: Nigel, Philip, James, Timothy and Sally, and now have six grandchildren.

Roger couldn't see a future in surgery so he changed to anaesthesia in 1973. The primary examination for anaesthesia and surgery was not only reciprocal at this time but also reciprocal between Britain and Australia.

Roger was a valuable and highly respected member of the department of anaesthesia and hyperbaric medicine at the RAH. He joined the staff there as a consultant in 1977, also working in the intensive care unit during the time when intensive care medicine was an evolving medical specialty. He retired from the RAH in 2014 after 37 years of outstanding service and continued doing anaesthesia locums until full clinical retirement in 2020.

Roger joined the Australian Defence Force (ADF) in 1976 and saw distinguished service for more than 30 years before retiring from it in 2009. He was mainly responsible for the incorporation of the early management of severe trauma course into the ADF and was the ADF's representative on the Australian Resuscitation Council for six years. He was the Surgeon General's consultant in anaesthesia and resuscitation and saw active service in the first Gulf War, Rwanda, East Timor, Bougainville and Malaysia, and as a veteran he marched annually on Anzac Day.

Roger was appointed a Member of the Order of Australia (AM – Military) in the 2000 Queen's Birthday Honours List for "exceptional service to the Australian Defence Force as a Consultant in Anaesthetics and Resuscitation, and as the Principal Reserve Medical Officer (SA and NT)."

Roger was a man of many talents and passions; he loved tennis and baseball. He remained a central figure in the South Australian baseball community until his passing, and continued to present the Capps medallion to the best A Grade player in South Australia following the death of his father in 1982. He became a pilot in the 1970s.

He worked on more than 22 Australian F1 motor races as the resuscitation doctor in the main chase vehicle and later became the chief medical officer for the Clipsal motor races in Adelaide.

In 2001 he became the Assistant Surgeon General ADF and at the same time promoted to Air Commodore in the Royal Australian Air Force (RAAF).

In 2002 Roger was part of the emergency medical response sent to Darwin for the retrieval of the victims of the Bali bombings, and in 2005 he was also part of the civilian medical team sent to Banda Aceh by the Australian government in response to the 2004 Boxing Day tsunami.

Upon reflection, Roger remarked that his career highlight was being selected as an RAAF aeromedical consultant to accompany the remaining World War I veterans on the seventy-fifth anniversary return to Gallipoli in 1990 and similarly to the western front in France and Belgium in 1993. He also said that his greatest honour was the reception of the Chief of Airforce Commendation in 2010.

I first met Roger in 1971 when I was a final year medical student at the QEH. Our paths crossed many times and in 1990 I ended up sharing an office with him. There was a lot of banter, Roger being a Crows supporter and me a one-eyed Port supporter. It has been a sad task but a privilege to document the significant contributions Roger made to anaesthesia, hyperbaric medicine, aeromedical retrieval in South Australia and to his contribution to military medicine through his role in the ADF.

We extend our heartfelt condolences to Helene, his loving wife, and their children and grandchildren.

Dr Chris Acott AM
Retired anaesthetist

Peter John Lawrence

1948 – 2026

Peter was in the first cohort of ANZCA specialists to be awarded his intensive care unit (ICU) qualification which was run by ANZCA before the establishment of an intensive care medicine college.

After studying for his anaesthesia fellowship first in the UK, he completed his Australian fellowship in Sydney. He studied for his ICU fellowship at St Vincent's Hospital under the supervision of Bob Wright. On completion of his ICU training, he became the director of intensive care at Concord Hospital in 1981. He retired from this role in 1997. Following this, he continued for several years in combined anaesthesia and ICU specialist practice at Concord and in private hospitals.

For much of his practising life he participated in a one in two on call roster for ICU. ICU was a new specialty, and the cohort of patients included major burns, neurosurgery, thoracic surgery, trauma and complex post-surgical cases. Resuscitation of patients, especially from emergency, was also often managed by the intensive care unit.

Peter was a pioneer for spontaneous respiration in the ICU. Patients were all intubated using a blind nasal technique under local anaesthetic and then managed in a minimally sedated state. For major facial and airway burns, this conferred extra safety in the event of accidental extubation. Patients could mobilise around the unit and were encouraged to sit in chairs to optimise respiratory function.

Pain management with local anaesthetic techniques and intrathecal narcotics were also encouraged which was not the usual practice in many other intensive care units at the time. Management of burns patients was also shared between the burns unit and intensive care.

Peter was an outstanding teacher to junior medical and nursing staff. He encouraged a team approach and showed great leadership. The ICU nursing course that he established is still running today.

He was an incredible intellect and had the rare talent of being able to apply knowledge in the acute clinical setting of the intensive care unit. Many anaesthetic and intensive care trainees will fondly remember Peter's role as a mentor and role model. He was a formidable leader who possessed a wonderful sense of humour, always maintaining the best interests of the staff, patients and their families.

Peter enjoyed bush walking, golf and time with his family. He had successfully retired to Port Macquarie before the recent neurological illness robbed him of his mobility.

He is survived by his wife, Mary, two sons and six grandchildren.

Dr Michael Amos, FANZCA
NSW

ANZCA
FPM

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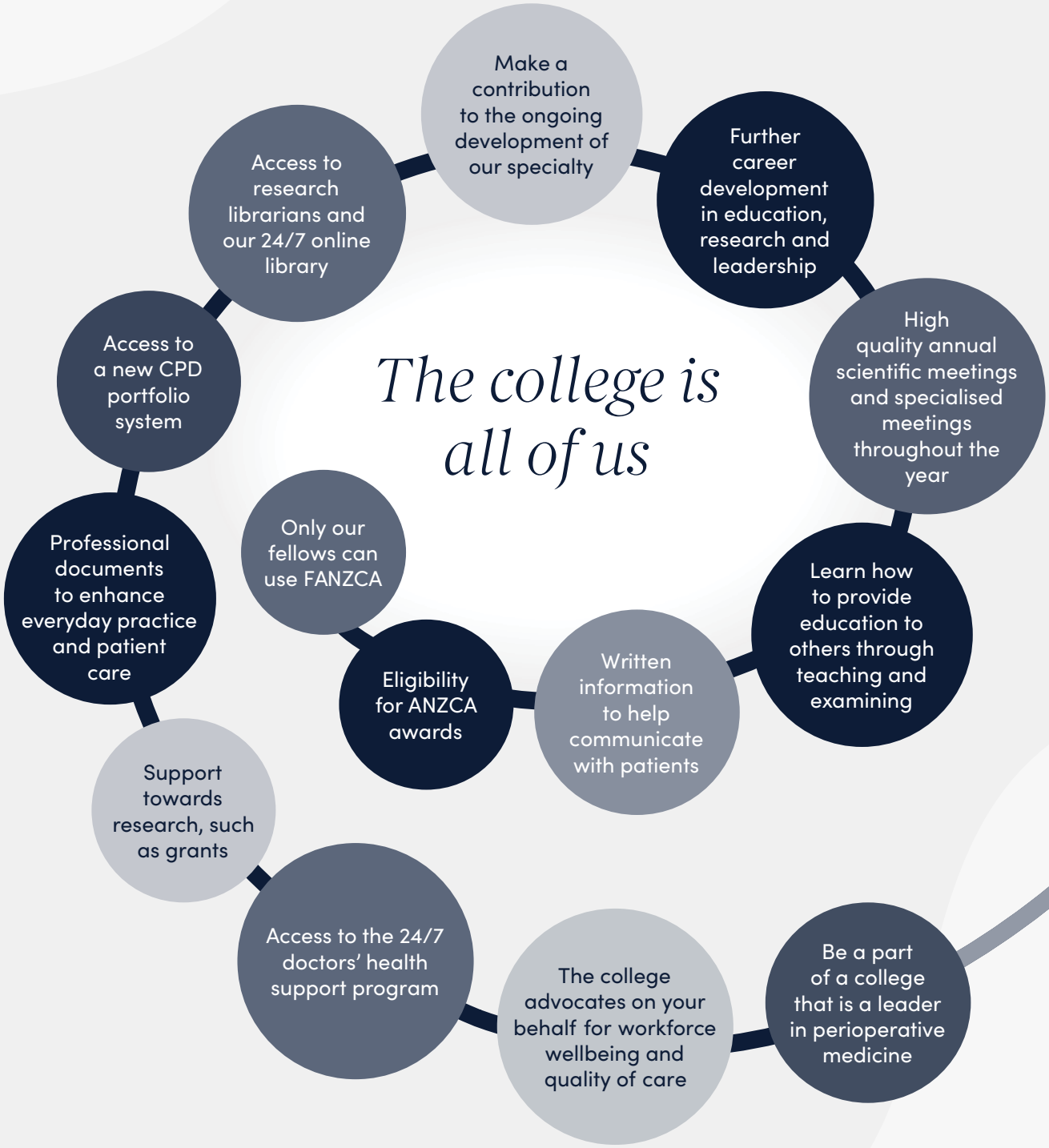
Benefits of fellowship



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