ANZCA
FPM

Bulletin

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

SUMMER 2025

ANZCA trainees are flying high

Substance use disorder
Supporting practitioners' return to work

2026 research grants
Funding for decompression sickness, heart surgery infection and frontline stress

ON THE COVER

Dr Max Margalit, retrieval registrar with CareFlight NT, goes through his paces during a training session in Darwin. (Supplied)

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 President-Elect Dr Tanya Selak observed the primary earlier this year. She reflects on how things have and haven't changed.

22 Trauma-informed care

ANZCA has been working on guidelines that focus on caring for patients who have experienced trauma.

Transitions and challenges

Janus: Roman god of beginnings, endings, gates, and transitions

"It is perhaps the end of the beginning"
– Winston Churchill

As we barrel towards January (named after Janus) we have current and future transitions. ANZCA has a new chief executive officer (CEO) with the retirement of our longstanding and outstanding CEO Nigel Fidgeon. Succeeding Nigel is Dr Lance Emerson PhD who has a long history with member-based organisations, as well as government. Like any institution in good standing ANZCA needs evolution not revolution.

Other transitions will occur in May after the ANZCA Annual Scientific Meeting with a new president, vice president, dean of FPM, and some new committee chairs and committee members. While these changes will lead to changes in style, the content will continue to be guided by our strategic plan in the best interests of clinical care, public health, and workforce wellbeing.

A major concern and challenge across ANZCA are the sudden unexpected deaths, some due to suicide, of fellows, trainees, specialist international medical graduates (SIMGs) and rural generalists.

We are working on this challenge in several ways. At its December meeting ANZCA Council approved a guideline for departments managing sudden death for release in early 2026: *Guidance on the management of a suicide or unexpected death within an anaesthesia or pain service* and the highly relevant *PG48* guideline: *Administrative management of substance use disorder*.

We are also seeking advice from external experts about whether we are outliers in frequency of death by suicide and identifiable precipitators. However, because we often have limited information, we refer to these tragic deaths as sudden and unexpected.

ANZCA often becomes aware of sudden unexpected deaths through informal networks. We then aim to work through the relevant head of department and regional or national (NZ) committee chairs to ensure that we can adequately support those affected. The co-chairs of the ANZCA Trainee Committee have been great partners in helping to inform and support trainees. With social media and other e-links, news of these deaths spreads quickly and we aim to balance privacy, particularly for the loved ones and others close to those who have died, with information about which hospital is affected. I recognise we don't always get that right but we try to do our best often with limited information.

Many in Australia will have seen media commentary on out-of-pocket costs for non-GP specialist care including anaesthesia care. Australian Health Minister Mark Butler has made it clear that limiting these costs is a major priority for the federal government, which includes possible punitive action against those found to be undertaking "extreme" billing; yet to be defined. ANZCA will work closely with the Australian Society of Anaesthetists on this, but we recognise that some extreme billing by a small number of fellows is very hard to defend in the absence of exceptional circumstances.

We have established the Chapter of Perioperative Medicine (ChPOM) with a board as a committee of ANZCA Council and multidisciplinary education and policy committees of the board. We have appointed Dr Jill Van Acker as Director of Professional Affairs for POM and now have the first graduates of the post-fellowship course in POM.

I think we have reached a Churchillian "end of the beginning". I met the many of the first POM course graduates at the POM SIG meeting in Wellington (see page 51). I was reassured that they think the course with its emphasis on health services adds to the POM component of their FANZCA training. They also commented that the course led them to work with other specialists (for example, rehabilitation specialists) who they had rarely encountered.

As part of the end of the beginning we have re-named the POM framework (also known as the nephron) as the Australian and NZ Perioperative Patient Pathway (below). ANZCA continues to be among the world leaders in POM (to quote a high profile American) but like all trail blazers we often have to be adaptable, creative, and have a bit of "making it up as we go along".

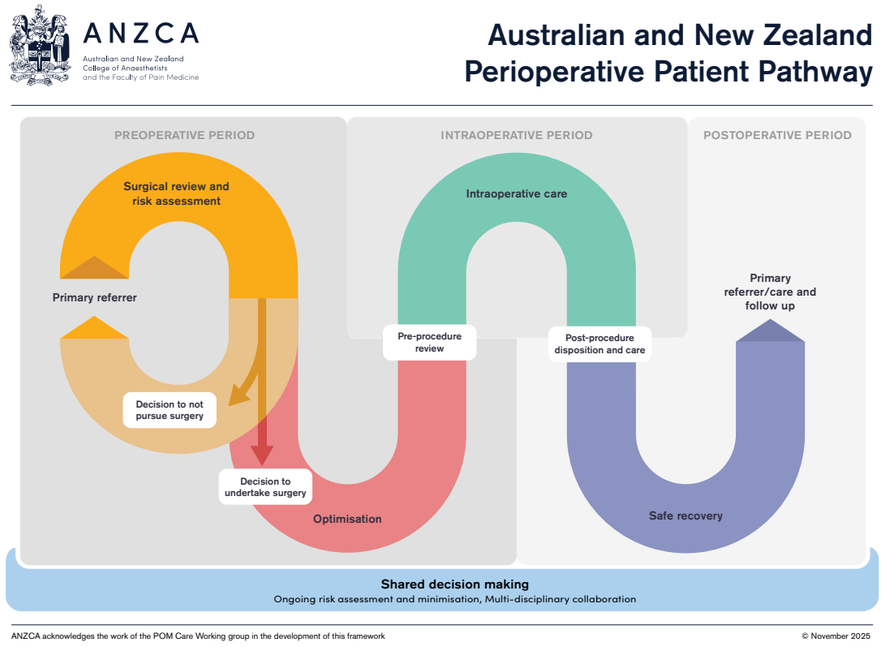
I wish all fellows, trainees, SIMGs, and staff of ANZCA a happy and safe summer.

Professor Dave Story
ANZCA President

**For help and support, the ANZCA Doctor's Support line number in Australia is 1300 995 262 and 0800 459 020 in New Zealand, identify yourself as an ANZCA fellow, trainee or SIMG, or visit the ANZCA Doctor's Support Program on the ANZCA website for further information.*

ABOVE

ANZCA President Professor Dave Story with many of the first POM course graduates at the POM SIG meeting in Wellington.



My last message

This is my final message as ANZCA CEO – in fact by the time this edition of the *ANZCA Bulletin* is published I'll have left this wonderful organisation to embark on the next chapter of my life.

I began at ANZCA in October 2019, oblivious as we all were, to the fact that we would be entering a completely different world ravaged by the effects of COVID-19 in less than six months.

We made an early decision in mid-March 2020 for staff to work from home. It is amusing to look back at my Autumn *Bulletin* message that year where I said we anticipated getting back into the office on 1 May 2020.

Two years later after several lockdowns across all Australian regions and New Zealand, staff eventually returned to our offices, although work patterns have changed and even now, nearly all staff work from home for one or more days each week, one of COVID-19's many legacies.

One of the other more obvious changes since those days is the prevalence of Zoom meetings. This has been both a positive and a negative. On the one hand, online meetings are more convenient for attendees and less costly for the college, but on the other, spontaneity and the camaraderie that comes with face-to-face interactions can sometimes go missing.

The COVID years resulted in great initiatives and work-arounds for the college as we worked hard to ensure the safety of everyone (developing PPE guidelines, curating credible information on the pandemic) and running online scientific meetings and events, in particular the ANZCA Annual Scientific Meeting which goes from strength to strength. And then of course communicating all the changes.

Our IT team did a spectacular job of bringing forward the set-up of Zoom for all staff – all done remotely – and managing to continue with exams in an environment of travel restrictions were significant technical feats of which I'm very proud.

Of course, externally things have changed markedly in the past six years with changes in leadership both in Australia and New Zealand and internationally and divisive conflicts around the world.

I have certainly noticed a decline in civility and an increase in "keyboard warriors" sometimes criticising the college and its people, an unfair burden carried by our leaders who devote hours and hours of their own time to making the college better and anaesthesia, pain medicine and perioperative medicine stronger and safer.

I'm very proud to have been told on more than one occasion that ANZCA is a leader amongst the colleges. This can be put down to excellent leadership at board and committee level, and also within an incredibly talented staff.

We have played a leading role on the Council of Presidents of Medical Colleges (CPMC) and have been a strong voice to government in relation to workforce issues in Australia and New Zealand and ongoing sector reform.

There has been a steady increase in the number of consultations along with greater advocacy for our professions.

We have committed to fostering a culture of diversity, equity, and inclusion and have developed two important documents in the Indigenous space, the Reconciliation Action Plan and Te Tiriti o Waitangi roadmap and action plan reflecting our commitment to Aboriginal, Torres Strait Islander and Māori trainees, fellows and patients.

The establishment of the Chapter of Perioperative Medicine and the development of the ANZCA Course in Perioperative Medicine have been a highlight as well as the development of the advanced certificate in Rural Generalist Anaesthesia.

We have had some significant technical uplifts over the past few years including a website refresh and platform upgrade and of course the more recent launch of MyPortfolio to replace the legacy training portfolio system.

I'm proud to be leaving the college in a strong financial position and as a trusted, vibrant organisation that strives for the highest standards and best patient outcomes.

Finally, I'd like to welcome Lance Emerson with whom I have been able to spend two weeks "handing over". I can already see that the college will be in good hands under his stewardship.

Nigel Fidgeon
(Former) ANZCA Chief Executive Officer

Nominate your next leaders

KNOW SOMEONE WHO WOULD MAKE A GREAT ANZCA COUNCILLOR?

We invite fellows to nominate for three vacancies (councillors) on ANZCA Council.

We are also looking to appoint a new fellow councillor in 2026. If you're an active ANZCA or FPM fellow within three years of admission, you're eligible to nominate for the new fellow position on council. The new fellow councillor is appointed for a two-year term and commences following the ANZCA AGM in the year they're elected.

Nominations for councillors and the new fellow councillor should be submitted to the ANZCA CEO (ceo@anzca.edu.au) by 5pm (AEDT) on Friday 30 January 2026.

Each nomination form must be signed by two active fellows of the college, as well as by the nominee.

If the number of councillor nominations exceeds three, a 2026 ANZCA Council election will take place from Monday 9 February to Friday 6 March 2026, via an electronic ballot. Similarly, a new fellow councillor election will take place over the same period if we receive more than one new fellow councillor nomination.

We'll announce the results of the ballot at the 2026 ANZCA Annual General Meeting (AGM) which will be held on Monday 4 May 2026 during the ANZCA Annual Scientific Meeting in Auckland.

The councillor and new fellow councillor nomination form can be found on the ANZCA website.

FPM BOARD PROCEEDS TO ELECTION

The faculty received three nominations for two elected vacancies on the 2026 FPM Board so will proceed to an election between Saturday 31 January to Monday 16 February 2026, via an electronic ballot.

Further details on the FPM Board election process including answers to FAQs, forms and guidelines can be found here.

We'll announce results of the election at the FPM Annual Business Meeting held on Sunday 3 May during the 2026 ANZCA Annual Scientific Meeting in Auckland.

UPCOMING AUSTRALIAN REGIONAL AND NEW ZEALAND COMMITTEE ELECTIONS

The next elections for the ANZCA and FPM Australian regional committees and the ANZCA New Zealand National Committee (NZNC) are scheduled for March/April 2026.

We'll invite eligible fellows to submit nominations in February 2026 and will hold an electronic election if the number of nominations received exceeds the number of vacancies for each.

ANZCA Council will confirm the appointment of office bearers, committee chairs and membership nominations of the Australian ANZCA committees at the ANZCA New Council Meeting on 22 May 2026 and will also note the appointment of membership of the NZNC.

For FPM committees, the FPM Board will confirm the appointment of office bearers, committee chairs and membership nominations at the FPM New Board Meeting on 7 May 2026.

2027 ANZCA TRAINEE COMMITTEE ELECTIONS

The 2027 ANZCA Trainee Committee elections will be held in October/November 2026.

The results of the elections will be sent to the Education Executive Management Committee (EEMC) for ratification.

The chairs of the Australian and New Zealand trainee committees make up membership of the ANZCA Trainee Committee.

UPDATE YOUR DETAILS TO VOTE

We encourage you to vote in these elections. Please ensure your preferred email address is up to date on the MyANZCA Portal.

To avoid your voting keys going to spam folders, please add noreply@electionrunner.com to your safe sender list.

Participating in ANZCA and FPM elections is one of the best ways to have your say on the future of your college. For everything you need to know about standing for election, endorsing a colleague's nomination, or simply casting your vote, head to the elections page on our website.

YOUR HANDY GUIDE TO KEY NOMINATION AND ELECTION DATES

Election	Nomination period	Election period	Official announcement date
ANZCA Council	Monday 15 December 2025 to Friday 30 January 2026	Monday 9 February 2026 to Friday 6 March 2026	Monday 4 May 2026 at ANZCA Annual General Meeting
ANZCA new fellow election	Monday 15 December 2025 to Friday 30 January 2026	Monday 9 February 2026 to Friday 6 March 2026	Monday 4 May 2026 at ANZCA Annual General Meeting
FPM Board	Wednesday 29 October 2025 to Wednesday 12 November 2025	Saturday 31 January 2026 to Monday 16 February	Sunday 3 May 2026 at the FPM Annual Business Meeting
ANZCA Australian regional committees	Monday 2 February 2026 to Friday 27 February 2026	Monday 16 March 2026 to Friday 17 April 2026	Friday 22 May 2026 at ANZCA New Council Meeting
ANZCA New Zealand National Committee	Monday 2 February 2026 to Friday 27 February 2026	Monday 16 March 2026 to Friday 17 April 2026	Friday 22 May 2026 at ANZCA New Council Meeting
FPM Australian regional committees	Monday 2 February 2026 to Friday 27 February 2026	Monday 16 March 2026 to Friday 17 April 2026	Thursday 7 May 2026 at FPM New Board Meeting
FPM New Zealand national committee	Monday 8 February 2027 to Friday 5 March 2027	Monday 15 March 2027 to Friday 9 April 2027	Mid-May 2027
ANZCA trainee committee	Friday 3 to 24 October 2025	Friday 7 to 21 November 2025	Mid December 2025

ANZCA
FPM

Make sure you're not missing out on important information!

Keep your details up to date on the MyANZCA portal. We use the information on your MyANZCA profile for all of our official communications, including:

Exam updates · Events and courses · Committee vacancies
Safety alerts · Hospital rotations · Research opportunities

So please take a few minutes to check your personal details. It's easy to do, and ensures you won't miss out on important information.

1. Log into anzca.edu.au/portal
2. Click "Update my contact details"
3. Ensure your details are up-to-date and click "save".

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.

Letter to the editor

EARLY RETIREMENT

I read with interest the various specialist colleges' objections to the Government's Workforce Strategy, yet many appear to overlook one of the major contributors to our current workforce shortage: early retirement.

In discussions with colleagues, it is clear that a significant number are choosing to retire early – taking with them an enormous reservoir of clinical experience. A commonly cited factor in these conversations is the increasingly onerous CPD requirements imposed by AHPRA. For those unfamiliar, CPD requirements are now all-or-nothing. There is no longer a step-down registration category, and part-time practitioners are not offered a pro-rata or reduced CPD option.

Former Medical Board of Australia Chair Dr Anne Tonkin has been quoted as saying, "I would always want my doctor to be up to date," and "Our CPD is evidence-based." The Medical Board frequently cites studies to support this, yet a closer reading reveals that their only conclusion is simply that active learning is more effective than passive learning.

However, when considering your own doctor, would you prefer your eye block performed by someone who has completed more than 10,000 blocks, or by someone meticulously up to date in neuroanaesthesia who has only performed a handful of blocks?

During COVID, thousands of recently retired doctors sought to volunteer for vaccinations, contact tracing, and other essential work. AHPRA required them to obtain full registration – complete with a full application, CV, references, full fees, and full CPD compliance. Unsurprisingly, only a small number proceeded. This represented a substantial and unnecessary loss of valuable expertise. Many comparable countries maintain a reserve register of newly retired doctors for precisely such emergencies.

If all specialist colleges united to advocate for the reinstatement of a step-down registration category and pro-rata CPD requirements, many more specialists would remain in the workforce. This would help address current shortages and reduce the need for government intervention in specialist recognition.

Dr Jeff James MBBS FANZCA
New South Wales

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

New MOU with Hong Kong

ANZCA has renewed its Memorandum of Understanding (MoU) with the Hong Kong College of Anaesthesiologists (HKCA) at a formal signing ceremony at the November HKCA annual scientific meeting.

Research, education and partnerships across anaesthesia and pain are at the heart of the MoU which reinforces the strong collaboration and sharing of knowledge that has existed between the Colleges for many years and builds on new activities and opportunities.

The MOU was signed on 22 November by ANZCA President-Elect Dr Tanya Selak and HKCA President Dr CHEE Yee Eot.

Australian Indigenous doctors meet for annual conference

ANZCA was a silver sponsor of the 2025 Australian Indigenous Doctors' Association (AIDA) conference held on Gadigal land in November.

This year's conference brought together Aboriginal and Torres Strait Islander medical students, pre-vocational doctors, specialists, health professionals and allies to explore the central theme "Evoking Sovereignty, Honouring Country, Nurturing Community".

Across the three-day program, delegates engaged with key focus areas including empowering Indigenous voices and advocating for social justice and equity; caring for Country and strengthening environmental stewardship; building courageous collaborations for thriving communities; and harmonising mind, body and spirit. These themes were woven throughout plenaries, panel discussions, and workshops, creating a space for reflection, connection, and action.

ANZCA was strongly represented throughout the conference. Aboriginal and Torres Strait Islander fellows Dr Sharon McGregor, Dr Angus McNally, Dr Paul Mills and Dr Gene Slockee, with allies Associate Professor Susie Lord and ANZCA President-elect Dr Tanya Selak fielded questions, shared personal experiences, and offered practical guidance, motivating many attendees to consider a future within our specialty.

The ANZCA booth in the trade hall served as a central space for conversation, drawing interest from students and doctors seeking information about training pathways and the support available for Aboriginal and Torres Strait Islander trainees.

A highlight of the conference was the ANZCA "Growing our fellows" session, where prospective trainees continued the conversation with our fellows about anaesthesia as a career and had the opportunity to try their hand at nasal intubation.

ANZCA also congratulates Dr Slockee on receiving his framed hand painted AIDA stethoscope at the gala dinner to celebrate the achievement of becoming an anaesthesia fellow.

Beyond the conference the Indigenous Health Committee continues to work to grow and support the Aboriginal and Torres Strait Islander anaesthesia workforce through initiatives such as sponsorship packages for pre-vocational doctors to attend the ANZCA Annual Scientific Meeting; the Career Navigator program – an Australia-wide network of Aboriginal and Torres Strait Islander fellows, senior trainees and allies united to support prospective Aboriginal and Torres Strait Islander trainees; and our partnership with AIDA through the Specialist Trainee Support Program.

ABOVE FROM LEFT

ANZCA fellows Dr Angus McNally and Dr Gene Slockee at the ANZCA booth.

Medical students and pre-vocational doctors try their hand at nasal intubation with Dr Gene Slockee

FANZCA steps down from prestigious journal role

Professor Andrew Davidson has stepped down as editor-in-chief of the international journal *Pediatric Anesthesia* after nine years.

Professor Davidson is a senior staff anaesthetist at the Royal Children's Hospital in Melbourne, head of anaesthesia research at the Murdoch Children's Research Institute and a professor in the departments of paediatrics and critical care, University of Melbourne. He is also the medical director of the Melbourne Children's Trials Centre, chair of the Melbourne Academic Centre for Health Clinical Trials sub-committee, and past chair of the ANZCA Clinical Trials Network.

He trained in anaesthesia in Melbourne, Nottingham, Rotterdam and Boston. He has received a Diploma of Biostatistics and Epidemiology and Doctor of Medicine from the University of Melbourne and is a fellow of the Australian Academy of Health and Medical Science.

He first joined *Pediatric Anesthesia's* editorial boards in 2005. He was the first Australian anaesthetist to be an editor-in-chief of an international journal apart from *Anaesthesia and Intensive Care*.

During his tenure the journal steadily grew in reputation for high quality publications. As editor- in-chief Professor Davidson ensured the journal had greater diversity in terms of gender and geography, had regular podcasts and a social media presence.

He also established a successful fellowship program within the journal to mentor and train future reviewers and editors.

"A journal's success is not due to the editor-in-chief but mainly due to motivated, fair and talented editors and reviewers," he says.

Professor Davidson says his greatest enjoyment came from building an international team that included the world's best academic paediatric anaesthetists, including many ANZCA fellows.

Stepping down from *Pediatic Anesthesia* will allow Professor Davidson to focus more on his recent promotion as deputy editor-in-chief of *Anesthesiology*.

ANZCA and government

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

ANZCA leads debate on workforce issues

AUSTRALIA

Working with Queensland Health on regional workforce issues

Further meetings with Queensland Health have occurred following ANZCA's successful advocacy earlier in the year to implement an additional five advanced training positions.

This started a positive ongoing dialogue with the government, where the initial increase in trainee numbers was seen as a broader phased approach looking at training numbers across the state and longer-term planning solutions.

As part of this workforce planning Queensland Health's initial priority is regional workforce requirements. ANZCA and key Queensland fellows and the Queensland Directors of Anaesthesia Group met with Queensland Health again in early October to discuss potential approaches to improve workforce supports in regional sites.

ANZCA presented a snapshot of workforce suggestions for improvement covering immediate (0-3 months), medium (3-12 months) and long-term (1-3 years) options. A large component of the conversation covered a process that could support the rapid mobilisation of staff to support regional areas. This is intended to be an ongoing process with the government.

ANZCA also attended a Queensland Health Workforce Engagement Forum for the development of their Systemwide Health Workforce Plan. The plan is a strategic initiative by the Queensland Government to address and manage the state's health workforce, aiming to ensure there are enough doctors, nurses, and paramedics to meet the needs of the public, including meeting the government's commitment to grow the Queensland Health workforce by 46,000 FTE by 2032. The new workforce plan will be released in 2026.

As part of this planning, the government has undertaken a health workforce analysis, resulting in a Workforce Gap Analysis – Part A (system view) and Part B (professional lens). Further information is available from the Queensland Government website.

Rural workforce focus

The month of October included various rural workforce focused conferences and report releases. Globally, many countries grapple with geographical imbalances in the distribution of their health workforce. Australia and New Zealand are no exception in facing issues surrounding equitable access to health services.

ANZCA staff attended two rural focused conferences to further embed our focus and knowledge in this important health workforce area.

- The **Rural Medicine Australia conference**, hosted by the Australian College of Rural and Remote Medicine (ACRRM) and Rural Doctors Association of Australia (RDAA), held this year in Perth comprised four days of education sessions, case studies, professional development, and networking and connections.

  The conference was once again a great opportunity to meet with rural health professionals and policy makers to explore current rural health initiatives and opportunities being undertaken across the country. Highlights of the program included presentations regarding adapting training models for the rural and remote workforce (Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)), working/training relationships for consultant specialists and rural GPs/ generalists, why geographical narcissism skews interest in rural medical carers, and discussing the most effective methods of communication between supervisors and trainees.

  Associate Professor Deb Wilson FANZCA also provided a review and future development of the Advanced Certificate in Rural Generalist Anaesthesia (RGA), a joint initiative of ANZCA, Royal Australian College of General Practitioners (RACGP) and ACRRM to deliver the education, training, and assessment of rural general practitioners and rural generalists providing anaesthesia services in rural locations.

  The Faculty of Pain Medicine also presented a poster about bringing specialist pain medicine training to rural Australia with a focus on expanded accreditation.

- The **10th Rural and Remote Health Scientific Symposium** hosted by the National Rural Health Alliance (NRHA) in Alice Springs, brought together rural and remote health researchers, practitioners, policymakers, and community leaders. Concurrent sessions over two days spanned workforce, models of care, health outcomes, mental health, Indigenous health, oral health, aged care, digital innovation, climate impacts, and disability focused topics.

  Addresses were provided from the Hon Emma McBride MP (federal government Assistant Minister for Rural and Regional Health), Associate Professor Geoff Argus (Deputy Rural Health Commissioner for Allied Health), Professor Michael Kidd (Australia's Chief Medical Officer for the Department of Health and Aged Care), and others.

The NRHA also recently released their report on "The Forgotten Health Spend: A Report on the Expenditure Deficit in Rural Australia". The report provides an updated analysis of government health expenditure and access across rural, regional and remote Australia and revealed that non-urban Australians received $8.35 billion less than their urban counterparts equating to $1090.47 less spent on a rural person compared to someone living in a city each year.

The gap is most pronounced in remote areas (Monash Modified Model 5–7), where per capita expenditure is now $4701 lower than in metropolitan areas. The report underscores that while targeted programs improve access in some regions, systemic issues such as service shortages, workforce challenges, and limited infrastructure continue to drive inequity, pointing to the need for coordinated, regionally tailored solutions. The report is available from www.ruralhealth.org.au/the-forgotten-health-spend-report/.

NEW ZEALAND

Government

Health reform continues apace with the government approving a two-agency approach for the procurement of medical devices. Under the new arrangement, Pharmac will lead procurement of devices that have a direct therapeutic impact on patients, while Health NZ will focus on high-volume devices that can be standardised across hospitals and integrated with hospital infrastructure.

Cabinet approved several policy decisions on the *Medical Products Bill* including continuing to allow direct-to-consumer advertising of prescription medicines, regulation which NZ shares only with the US. The bill is being drafted in the wake of the government's precipitate repeal of the *Therapeutics Products Act 2023*, which had been the culmination of many attempts to replace the 40-year-old *Medicines Act 1981*. The bill will be introduced to parliament in 2026 and come into effect around 2030.

Increased powers for the Minister of Health to direct workforce regulators and new planning and reporting requirements setting up a "streamlined process" for reviewing decisions made by regulators are foreshadowed in amendments to the *Health Practitioners Competence Assurance Act 2003*.

Te Akla Whai Ora Māori Health Authority

The High Court has reserved its decision in a landmark case over the Crown's disestablishment of Te Aka Whai Ora, the Māori Health Authority, last year. Proposed changes to the legislation established the Authority and the Iwi Māori Partnership Boards reporting directly to Health New Zealand.

Reports

Twenty-seven years after the landmark report on "The Social, Cultural and Economic Determinants of Health in New Zealand", the Public Health Advisory Committee has published a new report on the factors influencing health status outside of healthcare in Aotearoa New Zealand. "Determining our future" reviews progress since 2000. It affirms health equity as a key goal for the health system, discusses future challenges to health, including climate change AI and digital technologies, and recommends a number of cross government actions to assure health and wellbeing for all.

The latest report in the Association of Salaried Medical Specialists' (ASMS') health funding series "Managed Decline: The Health of New Zealand 2011 to 2024" shows an overall decline in the health of adult New Zealanders, primarily in the under 65 age group, at an estimated economic cost of between $2.5 and $3.5 billion.

Mega strike

About 100,000 employees across the public sector, including doctors, nurses, and teachers, participated in a national "mega strike" in October, demanding better pay, safer staffing levels, and improved working conditions. Earlier, Health Minister Simeon Brown had provoked an angry response from senior doctors when he accused them of "crossing an ethical line" and "putting politics before patients" by taking industrial action. Doctors claimed that the key driver for strike action was "a government that is deaf to what is really going on with our health workforce".

ANZCA actions

Open letter – ANZCA, along with other medical colleges and health organisations, signed an open letter sent to all Members of Parliament, protesting the passing of the hugely contentious *Regulatory Standards Bill* which attracted 166,300 submissions, 98.7% (156,882 submissions) of which were opposed to the bill. More egregiously, the Finance and Expenditure committee deemed only 1317 submissions (0.8%) to be "substantive" (containing "detail or unique arguments") and gave no information as to which submissions they took cognizance of. The letter stated that "when medical colleges independently submit similar evidence-based on clinical research, it reflects professional consensus rooted in shared clinical evidence. This should reinforce the evidence, not dismiss it."

Te Tiriti o Waitangi Action Plan – ANZCA's Te Tiriti o Waitangi Action Plan 2025-2028 was approved by ANZCA Council in September. Membership of OraTaiao, the NZ Climate and Health Council, and the Public Health Association of New Zealand are among several "deliverables" underway that demonstrate ANZCA's advocacy and support for health equity.

Faculty of Pain Medicine (FPM) New Zealand – FPM NZ chair Dr Charlotte Hill and co-chair Dr Paul Vroegop have initiated a meeting with several consumer health advocacy groups to explore a collaborative approach to advocating for a national Chronic Pain Strategy and nationally consistent services across Aotearoa.

SUBMISSIONS AND CORRESPONDENCE

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

Australia

- Australian Commission on Safety and Quality in Health Care (ACSQHC) – Revision of the Australian Open Disclosure Framework
- ACSQHC – The foundations of high-quality care: A national model for clinical governance
- Austraian Medical Council (AMC) / National Health Practitioner Ombudsman (NHPO) / Miller Blue Group – Structured learning: guidance to support the Model Standards for Specialist Medical College Accreditation of Training Settings
- AMC / NHPO / Miller Blue Group – Measuring supervision: Guidance to support the Model Standards for Specialist Medical College Accreditation of Training Settings
- Therapeutic Guidelines – Next revision of the Pain and Analgesia and Diabetes guidelines
- ACSQHC – Emergency Laparotomy Clinical Care Standards
- NHPO – Preliminary findings and recommendations in Part 2 of the Processes for Progress review

New Zealand

- Health NZ | Te Whatu Ora – Draft Guidelines to manage secondary employment – conflicts of interest
- Te Kaunihera |Medical Council of New Zealand – Regulating doctors performing cosmetic procedures
- PHARMAC | Te Pātaka Whaioranga – Draft 2025/26 Tender
- Accident Compensation Corporation (ACC) – Draft AI policy for ACC-registered health providers
- Ministry of Health | Manatū Hauora – Registered Nurse prescriber medicines list
- Ministry of Health | Manatū Hauora on the Pharmacist prescriber medicines list
- Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand – Draft Statement on Using AI for patient care
- Te Kaunihera Tapuhi o Aotearoa |Nursing Council of New Zealand – Registered Nurse Prescriber and Nurse Practitioner copes of practice and education standards
- ANZCA also provided feedback to Te Whatu Ora on draft principles for registrars' training in private settings, in response to the significant increase in outsourcing elective surgery to private hospitals.
- The college endorsed the Council of Medical Colleges |Te Kaunihera o Nga Kareti Rata o Aotearoa submission on the proposed new Code of conduct for public servants.

How we celebrated #NAD25

Fellows and trainees from more than 70 hospitals across Australia and New Zealand celebrated ANZCA's National Anaesthesia Day on 16 October by setting up displays with posters and anaesthesia simulation demonstrations.

In addition to the posters of college councillors produced by ANZCA, hospitals also used our National Anaesthesia Day templates to create posters of themselves at work including Bowral and Hornsby Ku-Ring-Gai Hospital who created more than 30 different posters of fellows and trainees.

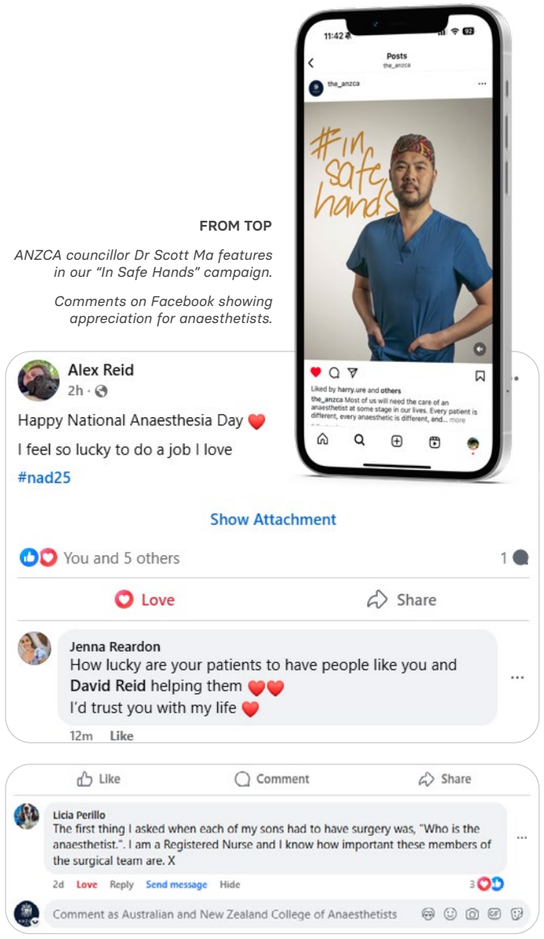
Several hospitals posted images on social media including Armadale (WA), Bankstown (NSW), Central Queensland Hospital & Health Service (Qld), QEII (Qld), Wollongong (NSW), Werribee Mercy Hospital (Vic), Queen Elizabeth Hospital (SA), Canberra Hospital (ACT), South West Healthcare (Vic), Hornsby Ku-Ring-Gai Hospital (NSW), Horsham (Vic), Bowral (NSW) and in New Zealand Middlemore, Auckland, Wellington and Whangerei.

The ANZCA "In safe hands" campaign featured ANZCA councillors individually recording videos and being photographed.

We created posters, animations of their handwriting ("In safe hands"), videos and animated images for social media, a website homepage banner, compilation videos, te reo Māori posters and even a cake featuring the president for a staff celebration at ANZCA House.

We featured four "Ask your anaesthetist" compilation videos in response to "How do you reassure patients?"; "How do you explain what an anaesthetist does?"; "What makes a good anaesthetist?" and "What keeps you passionate about anaesthesia?"

We also videoed ANZCA President-Elect Dr Tanya Selak for a video on how to pronounce "anaesthetist" and shared it on social media.



FROM TOP

ANZCA councillor Dr Scott Ma features in our "In Safe Hands" campaign.

Comments on Facebook showing appreciation for anaesthetists.

DIGITAL AND MAINSTREAM MEDIA

Media coverage activated by our media manager included ANZCA councillor Associate Professor Paul Lee-Archer being interviewed for a 10-minute segment on ABC Radio's Drive Program in Brisbane based on our "New tool helps children to recover safely after surgery" media release (as well as "National Anaesthesia Day spotlights the specialty").

Radio "grabs" relating to A/Prof Lee-Archer's research were broadcast on more than 100 Australian radio stations in metropolitan, rural and regional cities as diverse as Dubbo, Bundaberg, Bendigo, Bathurst, Brisbane, Albany, Bairnsdale, Darwin, Hobart, Lismore, Rockhampton, Wollongong, Toowoomba and Wauchope.

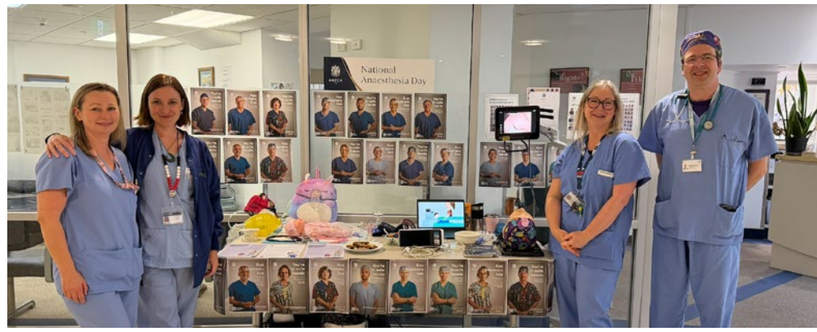
Dr Chris Ball, honorary curator at the Geoffrey Kaye Museum of Anaesthetic History was interviewed on ABC Radio Melbourne's *Evenings* program by host David Astle on Monday 20 October about the specialty and NAD in a 20-minute segment.

On Facebook, the campaign collateral curated by our digital team has had more than 90,000 views which continues to grow. The week following NAD, the most popular video had nearly 13,000 views and 121 interactions. Nearly 80 per cent of views were from non-followers, indicating that the videos reached the wider community.

On Instagram, our "In safe hands" collateral had nearly 50,000 views and 780 likes by deadline. On average, 63 per cent of those views were from non-followers. The content has had more than 980 interactions (this includes likes, shares, saves and comments) and has been shared nearly 120 times. Since the start of the campaign our Instagram account has grown by more than 125 followers, with a peak number of people following us on 16 October.

On LinkedIn, the collateral has had 16,791 impressions and 1051 clicks.

On Bluesky, the individual councillor videos/animations had 135 engagements, with 20 new followers during the campaign.



CLOCKWISE FROM TOP

#NAD2025 in South West Healthcare, Whangārei Hospital, Auckland City Hospital, Central Queensland Hospital & Health Service, ANZCA House, Sunshine Coast Health, Wellington Regional Hospital and Ipswich Hospital.

Returning to work: Supporting anaesthetists through substance use disorder

ANZCA has revised its guideline on substance use disorder in practitioners. A new professional document has been developed with collaborative advice by multidisciplinary experts. *PG48* is for use in all anaesthesia departments and anaesthesia practices in Australia and New Zealand. The latest guideline builds on the work of the Wellbeing Special Interest Group (SIG), who first published on substance use disorder as the Welfare of Anaesthetists SIG in 1996 with a subsequent revision in 2016.

When anaesthetist Dr Genevieve Goulding first encountered colleagues struggling with substance use as a young registrar she observed both the devastating consequences as well as the possibility of recovery. One colleague never worked in anaesthesia again. Another, with proper support, returned to a successful career.

Those two very different scenarios underpin the development of ANZCA's *Professional Document PG48: Guideline on the administrative management of substance use disorder in medical practitioners in anaesthesia and pain medicine 2025*.

"Every department will face this problem at some stage," Dr Goulding, a former ANZCA president says.

"But whenever it happens, people are often unsure about what to do. It's concerning, and there hasn't been an easily accessible, up-to-date document to guide them."

PG48, now in post-pilot review, aims to fill that gap by providing clear, compassionate, and practical guidance for heads of department, senior anaesthetists, and hospital administrators on how to manage these situations effectively and ethically. Dr Goulding, who played a leading role in the Welfare of Anaesthetists SIG as co-founder and former chair, led the document development group for the guideline.

Dr Goulding explains how, until now, departments of anaesthesia relied on a 1990s-era resource, *The Auckland Substance Abuse Protocol*, developed by New Zealand FANZCA Dr Robert Fry and colleagues within the then Welfare SIG. That document served its purpose but focused narrowly on the detection and immediate management of anaesthetists found to be abusing drugs in the workplace. It did not address the complex steps involved in helping affected colleagues return to practice.

"We wanted something that was accessible, contemporary, and multidisciplinary," Dr Goulding tells the *ANZCA Bulletin*.

"But not only that. Emerging evidence from overseas suggests that with good multidisciplinary management, successful return to work rates of up to 75 per cent can be achieved. This is in the setting of large doctors' health programs.

Unfortunately, such programs do not exist in our countries but I still believe we can do better than we have in the past.

"Substance use disorder is not just about detection. It's about prevention, early recognition, and, crucially, safe reintegration into the workforce. And it's about treating people with the respect and care you would afford anyone with a medical illness."

To that end, the document development group brought together anaesthetists, physicians and psychiatrists with expertise in drug and alcohol addiction, a medical administrator and a representative from the Medical Board of Australia. Their aim was to produce a balanced, practical framework reflecting both clinical insight and the realities of regulation and hospital governance.

One of *PG48's* central messages is that substance use disorder is a disease of the brain – a recognised medical condition under the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* – not a moral weakness.

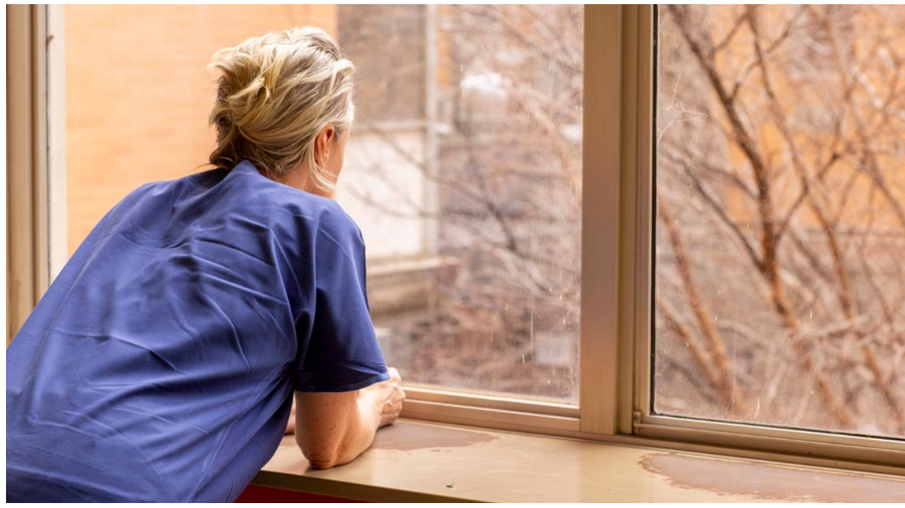
"Practitioners shouldn't be punished for having a disease," Dr Goulding says. "We don't punish people for having a heart attack or diabetes. Yet substance use still carries a huge stigma, especially in medicine."

That stigma, she explains, often prevents affected doctors from seeking help early. Many fear being judged, ostracised, or reported. Yet without timely intervention, anaesthetists who misuse potent anaesthetic agents face an extraordinarily high risk of harm.

"Anaesthesia medicine-related substance use disorder – what we call *AMRSUD* – is a particularly dangerous subset," she explains. "It involves drugs of very high potency and rapid tolerance. Relapse carries a mortality rate of around 40 per cent for some agents like propofol. If any other condition carried that risk, there'd be an outcry."

There are no collated figures on how many Australian or New Zealand anaesthetists are affected. Dr Goulding has spent the past decade trying to obtain de-identified information from medical regulators, coroners, and health departments — without success.

"We don't know how big the problem is, because not every case is reported to a medical board or regulator"



"The only information we have is retrospective and anecdotal," she says.

"We don't know how big the problem is, because not every case is reported to a medical board or regulator. Some doctors are quietly sent away to 'get better'. Others can be charged with theft for taking drugs from hospital stocks. There's no consistent approach."

The lack of reliable data, she says, reinforces the importance of *PG48* as a structured framework: "If we can't quantify the problem, the least we can do is ensure that every department has a plan to deal with it properly when it arises."

Although originally conceived as a guideline for *AMRSUD*, the working group soon realised the need for a broader remit. "The psychiatrists in the group said, 'This is just the tip of the iceberg,'" Dr Goulding recalls. "Departments are dealing not only with substance issues but also with distressed or burnt-out practitioners who may have behavioural, emotional, or chronic pain problems."

PG48 therefore outlines graded responses — from the early "cup of coffee" conversation with a colleague who seems stressed or irritable, through to managing a practitioner found unconscious at work.

"It's about early recognition, compassionate engagement, and timely support," Dr Goulding says.

"Not every problem is a drug problem. But every problem deserves a thoughtful response."

Dr Goulding emphasises that *PG48* is not designed for individual clinicians to self-manage, nor is it primarily a clinical treatment guide.

"It's a non-therapeutic management framework for department directors and hospital administrators – the people who actually have to make decisions when a problem arises."

Heads of anaesthesia departments are central to that process. They are often the first to notice concerning behaviour or hear reports from colleagues. They are also responsible for patient safety, departmental culture, and the welfare of their staff.

"Having this document at their fingertips means they can act quickly, appropriately, and consistently," she says. "It helps them know when to seek advice, when to involve administration or the regulator, and how to support the practitioner back to work."

Dr Goulding believes *PG48* should be circulated widely to every anaesthesia department across Australia and New Zealand.

"It's no good sitting quietly on a website. Directors and senior staff need to read it, discuss it, and know what's in it before they need it."

One of the most difficult aspects of managing anaesthetists with substance use disorder, Dr Goulding says, is the differing frameworks between public and private hospitals.

"Half of all anaesthesia in Australia is delivered in private hospitals," she notes. "But private hospitals often deal with these situations very differently. Because anaesthetists are contracted rather than employed, there's often less obligation for follow-up or structured support."

In many cases, she says, private hospitals simply ask the anaesthetist to "voluntarily withdraw privileges" – effectively removing them from the roster without any ongoing contact or rehabilitation plan. "They'll say, 'Go and get yourself sorted out,' and that's it. No supervision, no cover, no communication with colleagues. It's a hands-off approach."

By contrast, public hospitals – though often constrained by human resources departments and regulatory processes – are more likely to facilitate formal rehabilitation and return-to-work programs. "That's why public hospital departments are so important in this process," she says. "They have the infrastructure, the supervision capacity, and the willingness to provide structured pathways back to practice."

She points to the example of Cairns anaesthetist Dr Emile Kurukchi who spoke about his recovery and successful return to public practice at the 2025 ANZCA Annual Scientific Meeting in Cairns. Dr Goulding says his recovery and successful return to public practice were achieved through a carefully managed collaboration between the Cairns

"Substance use disorder is not just about detection. It's about prevention, early recognition, and, crucially, safe reintegration into the workforce"

Hospital's anaesthetic department, hospital administration, the medical board, and treating practitioners. "It was an excellent model of how it can work when everyone cooperates," Dr Goulding says. "But it took enormous effort and goodwill.

"Strong anaesthetic leadership is required, in collaboration with medical administrators and treating practitioners. Returning to work is a co-ordinated process that takes time and effort."

PG48 provides detailed guidance on the rehabilitation and return-to-work process — an area that has previously lacked clarity. The guideline emphasises graded, supervised re-entry, transparent communication, and collaboration between the practitioner, their treating team, the department, and the regulator.

"It's not just about getting someone back to work," Dr Goulding says. "It's about ensuring they are supported, supervised, and safe — for themselves, their colleagues, and their patients."

For anaesthetists with *AMRSUD*, she cautions, returning to private solo practice is often unrealistic. "You can't give an anaesthetic without access to dangerous drugs. Without close supervision, it's simply not safe. Most practitioners need a period of one-on-one supervision before they can even consider independent work."

Rehabilitation also requires long-term monitoring and an understanding that relapse can occur. "Substance use disorder is a chronic, relapsing disease," she says. "Like alcoholism, it can be controlled but not cured. Practitioners need insight, and departments need to be prepared to act swiftly and supportively if problems recur."

"It should be noted that not every anaesthetist or pain physician with substance use disorder can successfully return to work with guidance from treating specialists. A decision may need to be made for return to other medical or non-clinical work."

A key message of *PG48* is the need for departmental cultures that balance confidentiality, accountability, and compassion. "Directors must control gossip, maintain confidentiality, and protect both staff and patients," Dr Goulding says. "But they also need to create an environment where people can seek help without fear."

She highlights organisations such as *Doctors in Recovery*, a voluntary peer-support group modelled on Alcoholics Anonymous but tailored for medical professionals, including anaesthetists. "Peer connection is incredibly powerful," she says. "People in recovery often say it's lifesaving."

Ultimately, *PG48* seeks to normalise the idea that doctors — including anaesthetists — can become unwell and need help. "We have to stop pretending it can't happen to us," Dr Goulding says. "It can happen to anyone. And when it does, we owe our colleagues the same care and respect we give our patients."

The process of developing *PG48* took about a year, from planning meetings in mid-2024 to the completion of the pilot version for stakeholder feedback.

The Medical Board of Australia has already provided detailed feedback, much of which was incorporated into the final draft. "They've been very supportive," Dr Goulding says. "But we still need engagement from hospital executives, health departments, and other medical colleges."

She believes ANZCA is leading the way. "As far as I know, no other medical college has a document like this," she says. "It's something our specialty should be proud of."

Dr Goulding hopes that widespread dissemination of *PG48* will equip departments to respond swiftly, safely, and compassionately when problems arise – and that it will help shift attitudes across the profession.

"This document is about awareness, consistency, and humanity," she says. "It recognises that anaesthetists are people first. They can get sick, they can recover, and with the right structures in place, they can return to being valued members of our community."

As *PG48* becomes embedded within ANZCA's professional documents framework, Dr Goulding hopes it will become a living resource — not just a policy file but a catalyst for culture change.

"Ultimately, this is about safeguarding patients and supporting colleagues," she says. "If we can do that better, more consistently, and with more compassion, then PG48 will have done its job."

Carolyn Jones
Media Manager, ANZCA

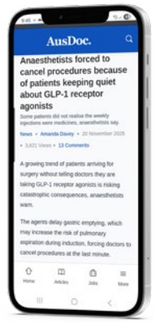
PG48 Guideline on the administrative management of substance use disorder in medical practitioners in anaesthesia and pain medicine 2025 is available to view and download on the ANZCA website.

ABOVE

Dr Genevieve Goulding.

Media coverage

GASTRIC EMPTYING



ANZCA President Professor Dave Story was interviewed for an *AusDoc* article on 20 November that highlighted a growing trend of patients arriving for surgery without telling doctors they are taking GLP-1 receptor agonists.

Professor Story said patients were risking catastrophic consequences by failing to disclose they are taking Ozempic type drugs such as semaglutide.

He said anaesthetists had reported near misses where use of GLP-1 receptor agonists had only become clear at the last moment despite the risk of serious consequences.

SAFE SEDATION

ANZCA President Professor Dave Story was interviewed for an ABC online article on 5 November about sedation and elderly patients.

Professor Story notes that where a patient's needs are "very complex" the advice is that anaesthetists are consulted.

"We are the principal experts in safe sedation," Professor Story said.

FPM SPRING MEETING

Faculty dean Dr Dilip Kapur was interviewed for a 10-minute segment about the FPM Spring Meeting and the shortage of specialist pain medicine physicians on ABC Radio Perth's *Drive* program on 23 October.

Dr Kapur joined host Gary Adshead to talk about the growing burden of chronic pain and the shortage of pain specialists in Western Australia.

"Around one in five people live with chronic pain – that's about 600,000 people – yet there are only 42 active pain specialists in the state of Western Australia. For 600,000 people, eight full-time public specialists…you can imagine there will be waiting lists," Dr Kapur said.

NATIONAL ANAESTHESIA DAY

Dr Chris Ball, honorary curator at the Geoffrey Kaye Museum of Anaesthetic History was interviewed for a 20-minute segment on ABC Radio Melbourne's *Evenings* program by host David Astle on Monday 20 October about the specialty and National Anaesthesia Day.

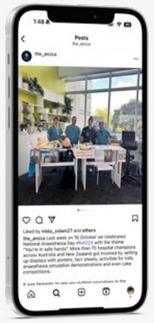
We issued two media releases for the #Insafehands campaign: "National Anaesthesia Day spotlights the specialty" and "New tool helps children to recover safely after surgery" about a joint Australian/US research project that has developed a new checklist to help children recover after surgery. The Australian arm of the study was led by ANZCA Councillor Associate Professor Paul Lee-Archer who recorded audio 'grabs' about the project for news broadcasts across Australia.

The grabs were broadcast on more than 100 radio stations in metropolitan, rural and regional cities as diverse as Dubbo, Bundaberg, Bendigo, Bathurst, Brisbane, Albany, Bairnsdale, Darwin, Hobart, Lismore, Rockhampton, Wollongong, Toowoomba and Wauchope.

ABC Radio Brisbane's *Drive* program host Ellen Fanning interviewed A/Prof Lee-Archer on her program in a 10 minute segment.

"What a wonderful contribution you have made," the host told A/Prof Lee-Archer.

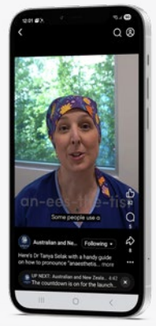
What we're talking about online



One of the most popular posts on Facebook (based on views) in October was an interview with FANZCA Dr Mark Priestley for National Anaesthesia Day. The post received 18,362 views and reached 16,646 people.

On Instagram, the most popular post (based on views) was a wrap up post of National Anaesthesia Day. This received 6373 views and 141 interactions.

Other top stories across our social media channels, based on views and engagement, were mostly related to NAD. Overall, our NAD content had high views and engagement but some highlights were:



- ANZCA President-Elect Dr Tanya Selak on how to pronounce "anaesthetist".
- How do you explain what an anaesthetist does compilation video.
- President Professor Dave Story's animated image.
- Councillor Dr Debra Devonshire's interview snippet video.
- Councillor Dr Sarah Nicolson's interview snippet video.
- New ANZCA CEO Dr Lance Emerson announcement (LinkedIn).

Towards trauma-informed care

This article introduces the concept of trauma-informed care (TIC) and agreed key definitions as they relate to ANZCA.

The application of trauma-informed principles not only supports but it is arguably fundamental to the purpose of the college – to serve our communities by leading high-quality care in anaesthesia, perioperative medicine and pain medicine, optimising health and reducing the burden of pain.

While trauma is often thought of as a physical harm or injury, it is now recognised as including significant psychological or emotional injury.

TIC is more than respectful care. Trauma-informed approaches shift the focus of care from "What's wrong with you?" to "What happened to you?" and in doing so enables the provision of safety (physical and psychological), trustworthiness, peer support, collaboration, empowerment of voice and choice, and recognition of culture, history, race and gender issues.

These are the fundamental principles of trauma-informed care.

TIC is relevant to the core business and practice of anaesthetists, specialist pain medicine physicians and perioperative medicine practitioners, because patients consciously and subconsciously bring their lived experience of trauma or traumatic events into each healthcare encounter.

WHY IS TIC BEING INTRODUCED NOW?

The intersection of important dialogues has driven an imperative for ANZCA to map a path towards embedding TIC as an everyday part of practice in its sphere of influence.

1. During 2023, a number of ANZCA fellows raised a range of aligned perspectives on several key issues: the pervasiveness of trauma and its adverse impact as a safety and quality concern, culturally unsafe practices and the ongoing trauma they cause, and the need for adjustments in clinical practice to address both historical and ongoing medical trauma. These diverse but similarly aligned perspectives were also shared by other medical colleges.
2. The college's initiatives in response to changing community recognition of the importance of cultural safety for Aboriginal, Torres Strait Islander, Māori and Pasifika peoples; the effects of racism, complex trauma of abuse and domestic violence; and trauma associated with marginalisation and systemic inequity of diversity including gender and neuro-developmental diversity.

ANZCA

Trauma-Informed Care (TIC) definitions background paper 2025

1. Introduction

The Australian and New Zealand College of Anaesthetists' purpose is to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, optimising health and reducing the burden of pain. Underpinning this purpose are the principles that:

(a) Health is a state of physical, mental and social wellbeing and not merely the absence of disease or infirmity.

(b) The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition[1].

While trauma is often thought of as a physical harm or injury, trauma is now recognised to include significant psychological or emotional injury[2]. The college seeks to define "trauma", "trauma-informed care" and the qualities of a "trauma-informed organisation". Common definitions relevant to anaesthetists, specialist pain medicine physicians, and specialist doctors who provide perioperative medicine services, form the first phase in our development of underlying principles around trauma-informed care which will be promoted and embedded into college wide activities and functions.

Trauma is a widespread, harmful and costly public health problem. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. The need to address trauma is increasingly viewed as an important component of effective health care and health service delivery[2]. Anaesthetists and specialist pain medicine physicians care for many patients who consciously or subconsciously bring their lived experience of trauma or traumatic events into healthcare interactions. These include consultations, procedures and periprocedural processes. An awareness of trauma-informed care practice and principles can potentially improve patient engagement, treatment adherence, and health outcomes, as well as improve patient, and clinician, health and wellbeing.

Many patients with trauma have difficulty maintaining trusting open relationships with a clinician. For patients, a trauma-informed care approach offers the opportunity to engage more fully in their health care, by developing a trusting relationship with their clinician, and improve long-term health outcomes.

Beyond the clinical relationship, trauma-informed principles stand to help our college, its fellows, trainees and specialist international medical graduates (SIMGs) navigate employment legislation governing the workplace. In 2024, the Commonwealth government introduced changes to Work Health and Safety (WHS) laws in order to minimise harm at work. These changes included managing psychosocial hazards at work[4]. The Work Health and Safety Code of Practice (2024)[5] identifies 17 psychosocial hazards. Among them is 'Traumatic events or materials' – witnessing, investigating or being exposed to traumatic events or material is considered a workplace psychosocial hazard. State jurisdictions across Australia and New Zealand have adopted these

3. In 2024, the Australian Government introduced changes to the Work Health and Safety (WHS) Act to minimise harm from psychosocial hazards at work. Legislation, enacted slightly differently in each state, but with the same intent, identifies 17 psychosocial hazards. Among them is "traumatic events or materials" – witnessing, investigating or being exposed to traumatic events or material is considered a workplace psychosocial hazard. The practice of anaesthesia, perioperative medicine and pain medicine is directed at managing the adverse effects of trauma – physical, surgical and pain-related experiences of trauma that affect analgesia needs, ongoing and chronic pain, and the trajectory of recovery; and in both the planned and emergent context, managing the sequelae of preceding traumatic experiences. During everyday work, our fellows, trainees and SIMGs are all at risk of being adversely affected by trauma.
4. Importantly, despite a potentially traumatising experience, long-lasting adverse effects of trauma do not always follow. Recent years have seen the emergence of programs to educate and disseminate skills useful to mitigate the effects of procedural anxiety and to prevent trauma arising from procedural and related experiences.

Application of trauma-informed principles stand to help our college, fellows, trainees and SIMGs navigate the paradigm of complex intersecting issues, WHS legislation and emerging skills education.

Our background paper, "Trauma-Informed Care (TIC) definitions background paper 2025" that accompanies "Trauma-Informed Care (TIC) definitions 2025" outlines widely accepted principles of TIC and describes in greater detail what ANZCA seeks to achieve by becoming a trauma-informed organisation and how this aligns with our college's strategic goals and purpose.

TOWARD TIC – A SHARED MENTAL MODEL WITH AGREED DEFINITIONS

The college formed a Trauma-Informed Care Working Group (TICWG) to progress TIC, its membership drawn from across a diversity of practice in Australia and New Zealand.

From analysis of published definitions and differing perspectives, it became clear that to progress a college-led TIC approach it would be necessary to achieve a shared mental model of *trauma*, *trauma-informed care* and that of a *trauma-informed organisation*.

It was important to achieve workable and consistent interpretation of these fundamentals for practical application, research and scientific perspectives, clinical and non-clinical practice, and internal and external organisational engagement.

A collaborative response to stakeholder feedback finalised common definitions of these three key terms. They are published in the paper "Trauma-Informed Care (TIC) definitions 2025" and are available on our website.

OUR NEXT STEPS

I am grateful for the work of the TICWG who demonstrated the value of collaboration, contributing their thoughts toward shared understanding.

I hope the group will remain engaged as we take the next steps. Over the next 12 months we will develop a roadmap towards embedding TIC in usual practice as individuals, teaching TIC, and for ANZCA and FPM to become a leading trauma-informed organisation.

Dr Poranee Buttery, FANZCA
Chair, Trauma-Informed Care Working Group

Self matters

Make work better with occupational wellbeing

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

This column by Dr Amber Chisholm examines positive work environments.

Dr Chisholm is an anaesthetist focused on improving the work lives of healthcare professionals in New Zealand.

She is the perioperative wellbeing lead at Level 8 at Te Toka Tumai Auckland and believes that small incremental changes add up to lasting organisational change.

Dr Jo Sinclair, FANZCA

**Dr Sinclair's opinions are her own and do not necessarily reflect those of ANZCA or Health NZ.*

MAKE WORK BETTER: OCCUPATIONAL WELLBEING

How do we make our workplace an environment we all thrive in? I asked myself a year ago, kicking off a year of trying very very hard to find out.

I was not the first to ask this – Epicurus opened his happiness school 2500 years earlier. I attended an updated version of this school (with fewer fruit baskets) – the Stanford Chief Wellness Officer (CWO) course – and began a diploma in positive psychology.

The answer Epicurus came up with was to live in a state of "eudaimonia" – to live with a sense of meaning and fulfillment, that comes from work mastery, purpose and connection.

He's right, well done, but er... how?

Stanford's CWO course provides a roadmap for how to start:

1. Build a strategy

This is a high-level, long-term approach to achieving goals, one that doesn't change year by year, created in collaboration with your team.

2. Build structure

- Be prepared to use the "reasonably priced car" – resources you already can access in your work unit. Work with what you have rather than what you dream of.
- Ruthlessly prioritise and decide what you are doing and *not* doing.
- Adopt the Trojan mouse approach: try lots of little projects, they add up over time.
- And get off the horse when it dies – abandon what isn't working and focus on the small wins that work.

3. Build teams

Humans thrive on connection; the best teams foster a sense of belonging and collaboration. You need a compelling team identity: established shared norms and values, promotion of shared experiences, and team rituals. The All Blacks do a haka for themselves, not for the crowd.

4. Invest in social capital

To make an organisation succeed you also need social capital – how people connect. The currencies of social capital are trust and teamwork. So how you lead *and* how you participate is contagious.

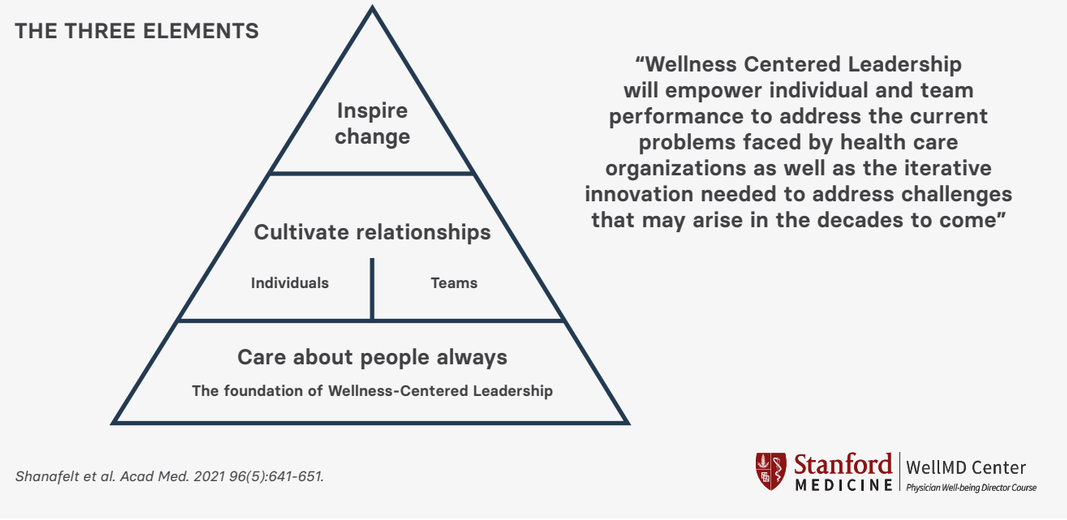
5. Emotional contagion

Sigal Barsade, an organisational psychologist, has conducted many studies to investigate how emotions spread within groups and how this affects teamwork, decision-making and performance.

Emotions are contagious. Team members unconsciously mimic facial expressions, tone and posture, leading to shared emotional states. Leaders play a pivotal role in shaping team emotion, and their mood significantly amplifies ripple effects.

So use humor, gratitude and small rituals to trigger positive ripple effects and leverage emotional contagion to enhance staff morale and, in turn, patient outcomes.

6. Wellness-centered leadership[1]

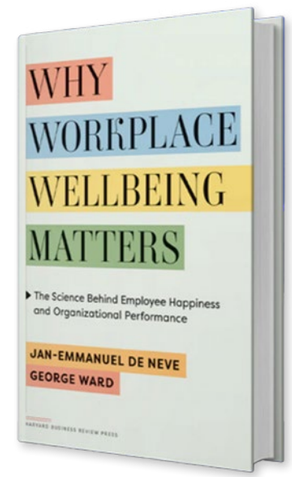


6. Belonging

This concept is explained in the book *Why Workplace Well Being Matters*:

"When you break down that sense of belonging, it's essentially people feeling like they belong and are treated as human beings in their organisation; that they have friends at work; that they feel like they know what the impact of their role is within the organisation; and how they impact others within the organisation.

"All of these things come together in a sense of a culture of belonging, and you cannot underestimate the importance of that. In the HR space, it's often said that people don't quit their jobs; they leave their managers or they leave their teams."[2]



Our values in action

See me for who I am
When my team understands who I am, and where I come from, I feel accepted

My voice counts
When I know my voice is heard I feel a valued part of the team

Thank you goes a long way
When I'm thanked it motivates me to keep doing great work

Be kind to each other
When I'm respected, I'm happier in the workplace

I have your back
As a team we support each other and lend a helping hand when it's needed

I am part of a team
I give more of myself when we work together as one big whānau

Throughout the year, Dr Lucy Hone's three secrets of resilient people kept popping back into my head as shorthand:[3]

– Resilient people get that shit happens (adversity doesn't discriminate).

– Resilient people are good at choosing where they put their attention.

– Resilient people ask themselves, "Is what I'm doing helping or harming me?"

Or – if you are going to get into a spiral, it may as well be upwards.

Having a strong feeling of purpose means we feel that our work is contributing to society and improving the lives of others. In turn, this supports ongoing learning, innovation and creativity. And in health this equates to better outcomes for the people we care for.

Is "not burned out" our highest goal? Stanford WellMD defines professional fulfilment as "happiness or meaningfulness, self-worth, self-efficacy and satisfaction at work".

The values of my workplace (above), Te Toka Tumai, resonate. If we all keep nudging around the edges, we can make work better for all of us.

Every day, in as many ways as I can, I'm trying to build our own eudaimonia. With less wine. Epicurus was very keen on that too.

Dr Amber Chisholm, FANZCA
Specialist Anaesthetist
Auckland City Hospital

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1. Shanafelt et al. Academic Medicine 96:641
2. Why Workplace Wellbeing Matters Jan-Emmanuel De Neve, George Ward
3. Dr Lucy Hone: https://www.drlucyhone.com/

Free ANZCA Doctors' Support Program

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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:

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- 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.

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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/

Safety and quality

We are the foremost authority on anaesthesia, pain medicine, and perioperative medicine in Australia and New Zealand, respected by governments and the healthcare sector to provide expert advice that ensures the safety of our patients.

Queensland obstetric anaesthesia database ensures quality assurance

The Queensland Anaesthesia Benchmarking System (ABS) is a large scale, statewide database facilitating quality improvement and research in obstetric anaesthesia and has been collating data since 2018.[1]

Initiated by Dr Guy Godsall of the Sunshine Coast University Hospital and curated by the Healthcare Improvement Unit of Clinical Excellence Queensland, the database has 29 contributing public hospital institutions. Under ethical approval, we have detailed clinical information relating to more than 49,000 cases of labour analgesia and more than 52,000 cases of caesarean delivery anaesthesia. Anaesthetists entering details at the point of clinical care are integral to the success of the project.

Each hospital has access to its own site-specific data, allowing audit of practice and patient reported outcomes. Anaesthesia trainees and specialists can access their individual personal case series, allowing completion of scholar role projects and meeting annual continuing professional development requirements.

In a joint project with Mater Health Services in Brisbane (an institution that doesn't contribute to the database), we demonstrated factors associated with general anaesthesia for caesarean delivery in 35,227 cases across Queensland.[2] Urgency of delivery and presence of a mental health condition were significantly associated with primary general anaesthesia. Conversion to general anaesthesia was more likely in those having Category 1 caesarean, postpartum haemorrhage, extremes of body mass index and those with a mental health condition. Women with a body mass index ≥ 40 kg/m^2 were more likely to reside in remote or very remote locations.

In a project limited to sites contributing to the ABS, we evaluated changes in practice for post-caesarean analgesia, between 2019 and 2022 in 27,867 patients.[3] We used control charts to demonstrate an increase in the use of the gold standard, neuraxial long-acting opioid (Figure 1) and a decrease in the use of oral slow-release oxycodone (Figure 2). At the same time, the use of tramadol and buprenorphine increased. These findings were significant, given the publication by ANZCA in 2023 of *PS41(G) Position statement on acute pain management*,[4] which recommends against the routine use of slow-release opioid for acute pain. Importantly, we had high overall rates of patient satisfaction. Those receiving neuraxial long-acting opioid had higher rates of satisfaction, but the use of slow-release oral oxycodone did not influence patient satisfaction.

Figure 1. Control chart showing the proportion of patients administered neuraxial opioid in 25,531 patients having neuraxial anaesthesia. Monthly values shown as black dots, solid line is the mean, dashed lines show upper confidence limit and lower confidence limit.

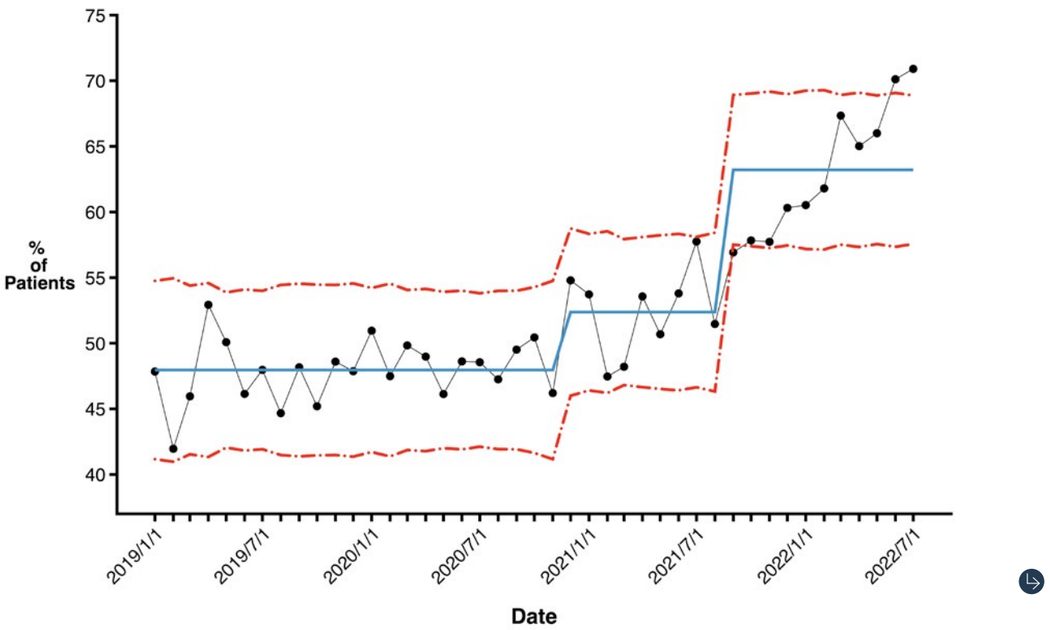
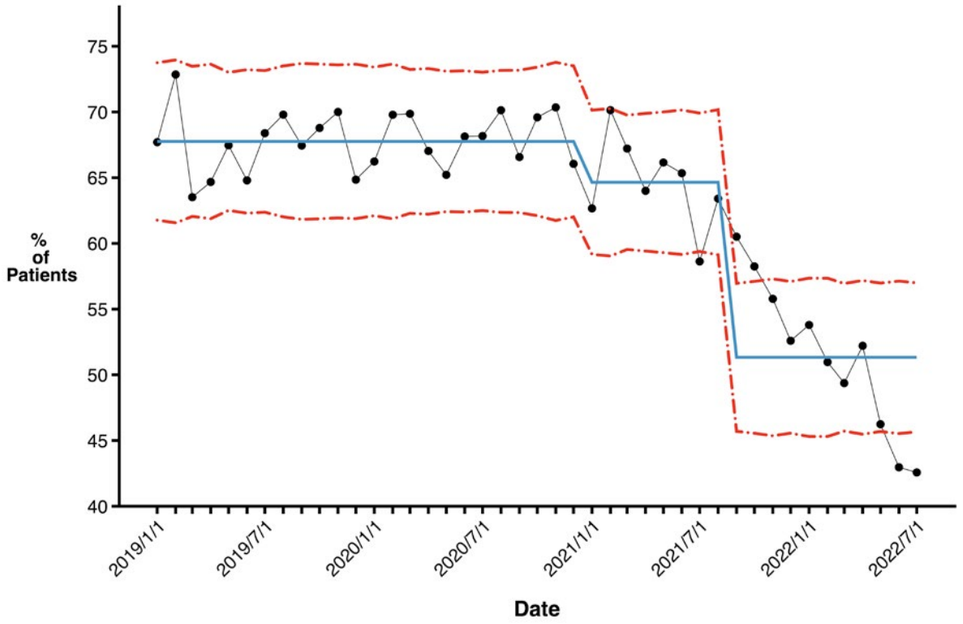


Figure 2. Control charts for all patients showing the proportion of patients administered postoperative slow release oxycodone. Monthly values shown as black dots, solid line is the mean, dashed lines show upper confidence limit and lower confidence limit.



The ABS represents a collaboration between anaesthetists providing clinical care and digital health experts of the Healthcare Improvement Unit, working together to ensure ongoing audit and quality improvement at an individual, institution and statewide level.

Next steps include finalising statewide reporting dashboards to compare outcomes between institutions, with data presented in funnel plots and control charts. We'll identify and target anaesthesia practices with large and unnecessary practice variation, to provide clinical practice guidance and ensure widespread high-quality care to mothers and babies in Queensland.

Professor Victoria Eley, FANZCA
Royal Brisbane and Women's Hospital
Co-chair, Queensland ABS Obstetrics Steering Committee

Dr Guy Godsall, FANZCA
Sunshine Coast University Hospital
Co-chair, Queensland ABS Obstetrics Steering Committee

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WebAIRS

Peripheral infiltration and extravasation – what can we learn from webAIRS reports?

Secure intravenous (IV) access is fundamental to anaesthesia. As anaesthetists, we develop and maintain IV skills through high procedural volume, ultrasound-guided techniques, and experience matching cannula size and site to patient and procedure. While most peripheral IV failures cause little or no harm, under-reporting is likely.[1]

Definitions[2]

Infiltration: Leakage of IV fluids or medications into surrounding tissue.

Extravasation: Infiltration involving a vesicant – an agent capable of causing significant tissue injury when leaking from a vein.

Vasopressors are the most common potential vesicant we administer as a part of anaesthesia. All calcium salts, hypertonic glucose and potassium, and mannitol are also included in the high-risk category as vesicants. Thiopentone with a pH of 10 to 11 is very high risk, although not now a routine agent.

With over 13, 000 case reports, webAIRS provides a unique opportunity to transform anaesthetists' experiences into practical insights. This review examines 136 reports of peripheral IV failure; detailed results are forthcoming.

CASE ONE

An elderly woman with significant cardiac disease and difficult IV access (DIVA) presented for elective surgery. Induction through a large-bore arm IV resulted in loss of consciousness but no muscle relaxant effect. Mask ventilation proved difficult, and airway instrumentation was impossible due to preserved muscle tone. The IV appeared patent but was replaced; the new line also "ran freely". Despite further pressors, hypotension ensued. Stability was restored after adrenaline infusion commenced on a new IV.

Comment: Mobile subcutaneous tissue may mask infiltration; a longer cannula may reduce dislodgement risk. Despite extravasation of adrenaline, there was no report of tissue injury.

CASE TWO

A child undergoing elbow relocation lost consciousness after IV induction, but rocuronium appeared ineffective. The IV site looked normal and flushed easily. A second IV was placed and the repeat rocuronium dose was effective. The original site was mildly tender. The child was observed in the high-dependency unit overnight; no delayed re-curarisation occurred.

Comment: Uncertainty over relaxant reabsorption was common in these cases. Rocuronium has a pH as low as 3.8 and is classified as a vesicant as a result. Acidic vesicants are better buffered by tissue than alkaline.

CASE THREE

A high body mass index (BMI) patient with DIVA underwent elective surgery. An ultrasound-guided antecubital fossa (ACF) IV ran freely by gravity, yet propofol (20 mL) caused no effect apart from a delayed ache. After re-siting the IV, anaesthesia proceeded uneventfully. The next day, the patient experienced arm pain and bruising which persisted for two weeks.

Comment: Gravity flow may falsely reassure patency; deep ultrasound-guided lines can delay visible infiltration signs.

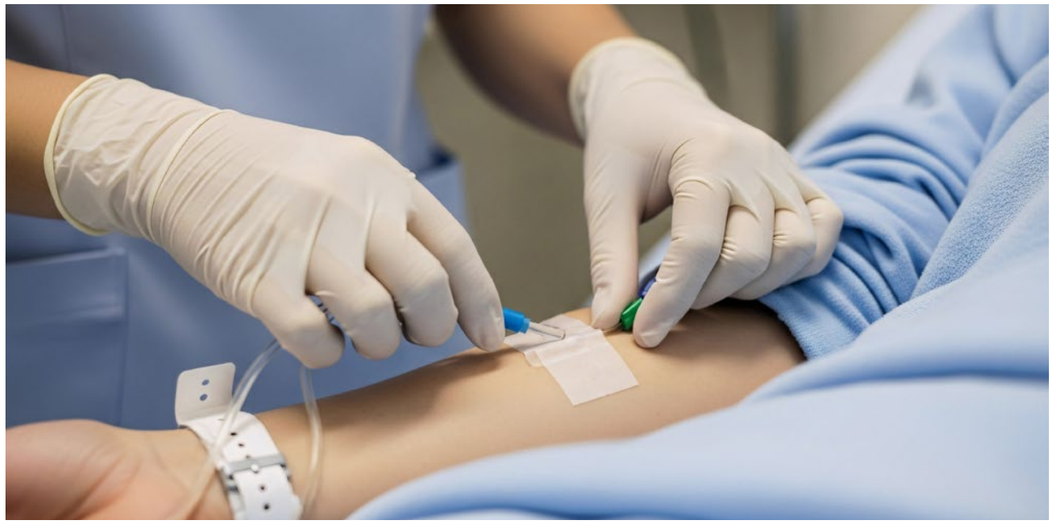
CASE FOUR

A woman with an ultrasound-guided IV placed prior to theatre underwent total intravenous anaesthesia (TIVA). Rising bispectral index (BIS) and blood pressure prompted conversion to sevoflurane. At case end, upper arm swelling indicated propofol extravasation. The following day, arm pain worsened, with mild bruising but no signs of infection or thrombosis. Symptoms persisted for two weeks, limiting function. A diagnosis of basilic vein thrombosis occurred the next day.

Comment: Limited visibility under drapes may delay recognition of IV failure. Propofol infiltration reports have described prolonged discomfort.

RISK FACTORS FOR IV FAILURE AND INFILTRATION

Patient factors include extremes of age, steroid use, impaired venous return, and hormonal effects on tissue.[2-4] Diminished pain perception under anaesthesia delays recognition. Technical factors include proximal puncture sites, large bore cannulae, joint proximity, high-pressure or prolonged infusions, and obscured visual access. Many anaesthetic contexts combine these risks; vigilance and experience remain key mitigators. The future may include biosensors for early infiltration detection.



VESICANT INJURY RISK

High-risk vesicants include chemotherapy agents, vasopressors, solutions with extreme pH (< 5 or > 8), and high osmolarity (>600 mOsm/L).

In webAIRS, vasopressor extravasation is the most frequently reported high-risk vesicant. Encouragingly, no permanent tissue harm has been reported. Recommended management includes saline washout and/or phentolamine infiltration depending on severity.

Two reports queried IV paracetamol infiltration risk due to mannitol as an excipient; modern formulations have physiological osmolality (~300 mOsm/L) and rarely cause tissue injury.

RECOGNISING IV FAILURE

Many infiltrated lines still infused freely by gravity and appeared patent initially. Early signs included unexplained drug ineffectiveness (for example, absent relaxation), pain or swelling (often delayed) delayed local discomfort or swelling, and signs of light anaesthesia.

Recognition may be delayed when local anaesthetic flush masks discomfort; deep veins or mobile subcutaneous tissue conceal infiltration; or ultrasound-guided IVs are placed too deep to assess visually from the skin's surface.

ANAESTHETIC DRUG INFILTRATION

Subcutaneous depot absorption varies with tissue perfusion and drug properties (charge, lipid solubility, molecular weight).

Propofol: Several cases reported delayed emergence after infiltration, though all resolved without requiring prolonged monitoring. Pain at injection site was common, lasting up to two weeks. Propofol's lipid carrier releases bradykinin, causing vasodilation and inflammation.[5] Histological studies classify propofol as an irritant, not a vesicant;[6] however, reports of tissue injury has been described, leading to it being classified in clinical guidelines as a medium-risk vesicant.[7] Mild redness, warmth, or pain is self-limiting; cool compresses (18-20°C) may aid comfort and recovery over warm compresses.

Muscle relaxants: Rocuronium was the only neuromuscular blocker in extravasation reports. Absent effect at induction led to re-dosing via new IV, followed by prolonged block at emergence. Anaesthetists used quantitative monitoring and sugammadex, and variable duration of additional monitoring; no re-curarisation occurred.

Literature confirms delayed peak effect (≈20 minutes) after extravasation, with unpredictable variability. Recommendations include cautious re-dosing of relaxants once IV reliability is confirmed, and four to five hours of post-anaesthesia care unit monitoring with neuromuscular assessment postoperatively.[8,9]

MANAGEMENT OF SIGNIFICANT EXTRAVASATION

The National Infusion and Vascular Access Society (NIVAS) guidance is clear: **"Act fast – lost time is lost tissue."**[2]

Prompt recognition and structured management can prevent severe injury. Even non-vesicant infiltrations under pressure can cause compartment syndrome requiring urgent action.

KEY CLINICAL RESOURCES

Royal Children's Hospital Melbourne – concise, stepwise approach.

NIVAS Clinical Practice Guidelines – comprehensive, available via the QR code.

SIMPLIFIED MANAGEMENT

Always consult a thorough reference.

1. Stop infusion immediately; do not flush or remove cannula.
2. Attempt aspiration via existing IV.
3. Assess injury grade and vesicant risk.
4. Consider saline washout, reversal agents (phentolamine/hyaluronidase), elevation, and temperature-specific compresses.
5. Mark and photograph affected area.
6. Initiate referrals and ongoing monitoring.

CONCLUSION

Peripheral infiltration and extravasation remain under-recognised yet preventable complications in anaesthetic practice. Insights from webAIRS reinforce the need for vigilance when expected drug responses are absent. Increasing surgical draping and patient positioning can obscure IV sites, further heightening risk.

Rapid recognition and adherence to structured management protocols can mitigate harm and preserve tissue integrity.

Dr Phillip Quinn FANZCA

Dr Sarah Wongseelashote FANZCA FCICM

The ANZTADC Case Report Writing Group

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Safety alerts

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

Recent alert:

- Propofol pump software error (20 August 2025)

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A herenga waka is a physical place where waka are anchored at a safe harbour or resting point. The herenga waka reflects a space of connection and safety for voyaging waka. The hospital is a welcoming space where individuals come and go as needed. Patients arrive seeking care and healing, families offer love and support, and healthcare professionals dedicate themselves to guiding others through their journeys. This ebb and flow reflects the dynamic nature of a herenga waka, symbolising the continuity of life and the interconnectedness of those who pass through its doors.

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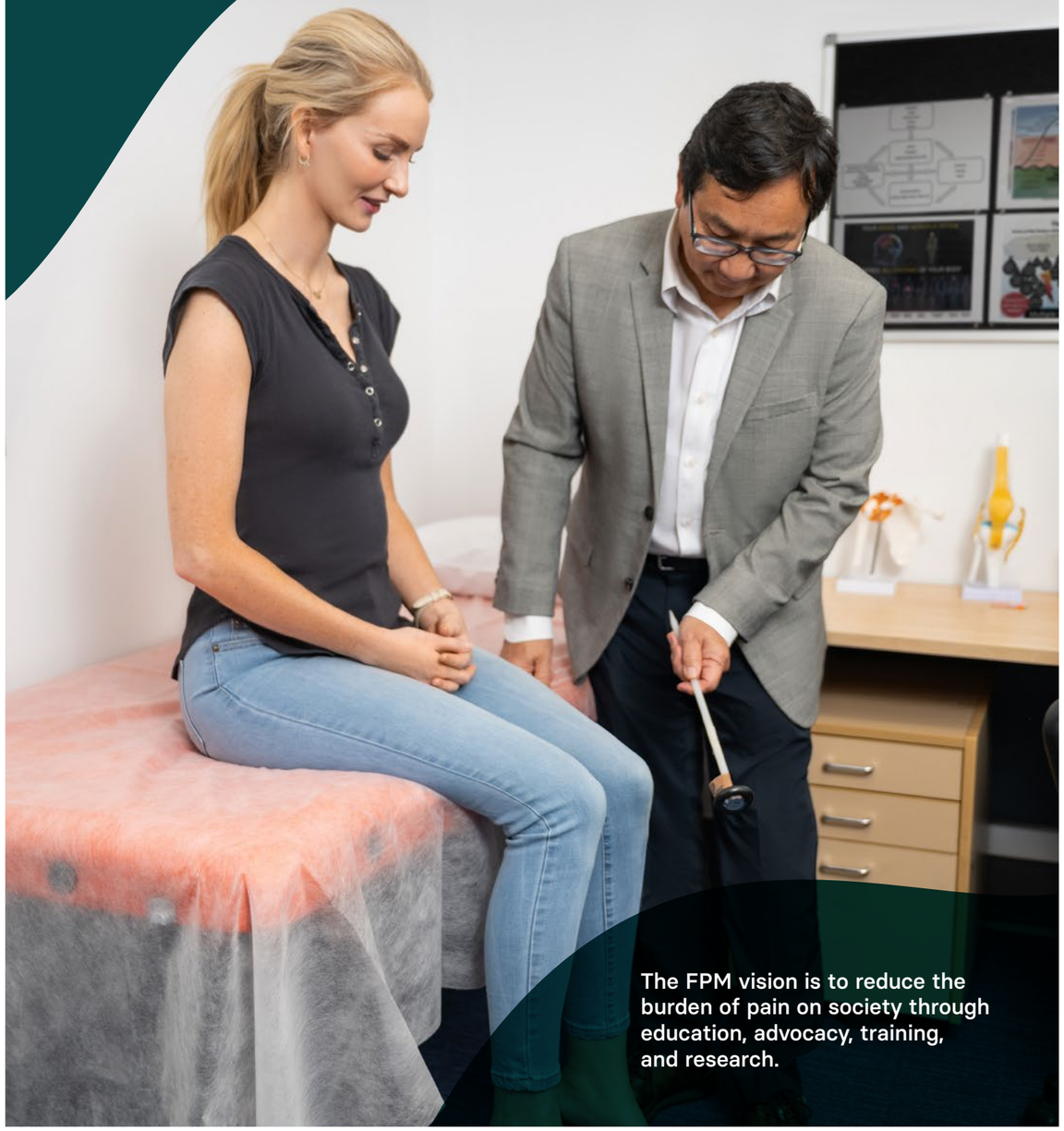
Faculty of Pain Medicine



Medicinal cannabis prescribing at odds with good practice in pain medicine

The first truism of pain medicine is that chronic pain presentations are complex. This has guided the Faculty of Pain Medicine (FPM) from its inception: our training and practice frameworks emphasise much more than biological, interventional or pharmacological interpretations. Yet time and again, the field is confronted with treatments promoted as simple answers to complex problems. The opioid crisis remains the most salient recent example of where such thinking can lead.

A similar pattern has emerged in the contemporary medicinal cannabis environment in Australia. The political pressure to facilitate access preceded, and ultimately overshadowed, the clinical evidence. The analgesic effect of cannabinoids in chronic non-cancer pain is small, and the adverse effect burden is not trivial. Rigorous meta-analyses conducted both before and after legal pathways were introduced have consistently confirmed this. Were cannabis a novel pharmaceutical seeking Therapeutic Goods Administration approval today, the available evidence would be unlikely to support widespread prescribing for chronic pain.

Despite this, prescribing has expanded at extraordinary speed. By early 2024, more than one million Australians had been supplied medicinal cannabis products, up from fewer than 20,000 in 2019. The model driving this expansion is now familiar: high-volume telehealth clinics offering rapid access to THC-dominant flower and oils following extremely brief consultations, sometimes without any direct interaction with the prescriber. The workflow is optimised for throughput, not clinical diligence. In significant parts of the sector, the structures of medical care have been repurposed to resemble retail systems.

The parallels with the "pill mill" phenomenon of the opioid era are difficult to ignore. Investigations and regulatory data show prescribers issuing cannabis scripts at volumes that cannot be reconciled with adequate medical assessment. One prescriber was reported to have written more than 17,000 cannabis scripts over six months: effectively one script every few minutes of a full working day. These are not isolated anomalies; they are consistent with a business model in which the script is the principal product.

What is new, however, is the demographic pattern of use. Prescriptions for high-THC smokeable flower products have increased sharply among men aged 18–31. This is a demographic that does not reflect the epidemiology of chronic pain, which is more common in older populations and more frequently in women. It does, however, correspond closely with the demographic profile of recreational cannabis users. The shift is difficult to interpret as anything other than the emergence of a *de facto* recreational access pathway under the banner of medicine.

The clinical governance concerns are substantial. In many of these high-volume models, assessment is cursory, often limited to patient-entered questionnaires or brief telephone calls; documentation is template-driven and offers little evidence of clinical reasoning; real-time prescription monitoring is inconsistently checked; follow-up is perfunctory or automated, with no structured evaluation of benefit; "trials" of treatment continue indefinitely without functional goals or exit criteria.

These are not minor variations in practice style; they represent departures from foundational principles of safe prescribing. Moreover, several services both prescribe and directly facilitate supply of the products they recommend, creating clear conflicts of interest. The clinical judgement of prescribers cannot be assumed to remain insulated from commercial incentives when access, dispensing, and repeat sales are structurally intertwined. Declaring these interests is not sufficient to neutralise them.

Advertising practices also warrant scrutiny. A core safeguard of therapeutic goods regulation is the prohibition on promoting prescription-only and unapproved medicines directly to the public. Such practice is prohibited in both Australia and New Zealand. Yet social media channels, online referral networks, and targeted marketing to veterans and chronic pain sufferers have become common tools of business growth in this sector. Patients frequently report encountering cannabis not through clinical recommendation, but through online promotion. The line between "information" and inducement is being breached as a matter of routine.

For pain medicine specialists, the result is a familiar clinical dilemma. Patients often present already using, or seeking access to, cannabis compounds. Some perceive benefit; others report worsened mood, anxiety, cognitive fog, or paradoxical pain sensitivity. The task of the specialist is not to dismiss patient experience, but to situate it within evidence-based models of pain care. In many cases, the most clinically responsible approach is to explain the limitations of cannabis as an analgesic, to review functional outcomes carefully, and to guide tapering when harms outweigh benefits.

Where medicinal cannabis is used, it should be approached as a structured therapeutic trial with clear functional goals, measured benefit, and explicit exit criteria. This is no different from the approach taken with other medications of uncertain benefit and known risk. Continuation without demonstrated improvement in pain-related function is not justified and exposes patients to cost, dependency risk, and potential psychiatric harm.

Some clinicians express discomfort in challenging cannabis use because of fears of appearing paternalistic, moralising, or aligned with prohibitionist rhetoric. However, this is not a debate about personal freedom or cultural attitudes to cannabis. It is a question of clinical standards, professional ethics, and patient safety. Any model of care that prioritises access and convenience above careful assessment, continuity, and evidence-based management is incompatible with good practice in pain medicine.

The scale of the current problem suggests that professional leadership is required. Regulatory activity is increasing, but enforcement alone will not shift culture. As a faculty we have the capacity and the responsibility to articulate clear expectations: that prescribing must be clinically justified; that conflicts of interest must be actively avoided, not merely disclosed; that advertising must not target vulnerable patients; and that cannabis, if used, must be guided by structured review and cessation rules.

We have learned, at great cost, what happens when the profession fails to speak plainly in the face of commercial momentum and seductive therapeutic narratives. We should not repeat that lesson. The high-volume, low-supervision model of medicinal cannabis prescribing is not compatible with safe, ethical pain care. It should be recognised as such and called out whenever encountered.

Dr Dilip Kapur
Dean, Faculty of Pain Medicine

News update


FPM examiners.

EXAMINATION CHANGES IN THE FPM TRAINING PROGRAM

Over recent years, the faculty has progressed an assessment review of the training program. A roadmap to renew the assessment tools has been created to ensure they are aligned with contemporary medical education approaches.

Introduction of the Foundations MCQ examination

In 2026, structural changes will be introduced to the faculty examinations as part of this review. A new Foundations multiple choice question (MCQ) examination will be introduced, designed to be completed within three to nine months of starting training.

The examination will assess core knowledge across the curriculum early in the training period. This early assessment will help identify trainees who may benefit from additional support, allowing time for targeted learning and successful program completion.

The MCQ format was selected as it enables broad assessment across the curriculum.

The Foundations MCQ examination will be:

- Computer-based (using the platform currently used for the written section of the fellowship examination).
- Three hours long.
- 150 questions (a mix of basic and applied knowledge).

In 2026, the exam will be offered twice, in June and October, at designated test centres in Brisbane, Sydney, Melbourne and Perth. If sufficient candidate numbers are present in other regions, additional centres may be considered.

Trainees will be eligible to sit the Foundations MCQ examination after completing at least three months full-time equivalent of pain medicine training. Their supervisor of training (SOT) must confirm readiness to sit the exam, with a checklist available to support this decision-making process.

A recommended reading list has been prepared for trainees preparing for the examination. Units are encouraged to advise their new trainees in 2025 to attend the Orientation to Pain Medicine Course (28 February – 1 March 2026) to learn more about the new process.

Changes to the fellowship examination

With the introduction of the Foundations MCQ examination, the written component of the fellowship examination will be retired.

From 2026, the fellowship examination will comprise:

- Four objective structured clinical examination (OSCE) stations.
- Four structured viva voce examination stations.

A pass in the Foundations MCQ examination will be a prerequisite to sit the fellowship examination. As a transitional arrangement, trainees who passed the written section of the fellowship examination before 2026 are exempt from sitting the new Foundations MCQ exam.

To support the implementation of this new format, sessions will be offered for trainees, supervisors and examiners.

For more information, please refer to the FPM exams webpage and the FPM training handbook.

Dr Aarathi Vaska
Chair, FPM Examination Committee

Dr Donald Johnson
Foundations MCQ Working Group

2025 FPM FELLOWSHIP EXAMINATION

Thirty-nine candidates sat the oral section of the fellowship examination on 15 November, following the written exam on 11 September 2025. The oral examination was held at the new Australian Medical Council Test Centre.

The faculty acknowledges the examiners' contributions to the delivery of the examination and the support offered by supervisors and fellows in preparing candidates.

Dr Ben Low was recognised as the meritorious candidate.

The candidates who successfully completed the fellowship examination are:

New South Wales	Dr Pedro Bernardino Campos Dr Jon Larach Dr Aidan McParland Dr Joel Parrey Dr Joshua Sandy Dr Amit Sequeira Dr Fatemeh Shooshtari Dr Kal Lim Yacoub
Queensland	Dr Oluwatosin Adeyemi Dr Craig Kennedy Dr Ben Low Dr Reza Modarres
South Australia	Dr Harshpreet Ghataura
Tasmania	Dr Mohammad Jabbarpour Associate Professor Nicolaas Terblanche
Victoria	Dr Dora Alexiou Dr Frank Buchanan Dr Pratima Majhi Dr Harrison Mihailidis Dr Aws Salih Dr Songmei Wu
Western Australia	Dr Paige Bavich Dr Lucy Dempster Dr Laura Prates Vitoria Dr Khurram Aziz Shah
New Zealand	Dr Chinmay Pandit Dr Sheela Perumal
Hong Kong	Dr Tiffany Cheung Dr Katherine Ka Yan Leung Dr Janice Liu Dr Daniel Liu Dr Alex Wong

The Examination Committee and Panel of Examiners would like to congratulate Dr Malcolm Hogg on his retirement as an examiner and thank him for his service.

NEW FELLOWS

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

Dr Maleeka Khullar, FRANZCP FFPMANZCA (Vic)

Dr Amit Sequeira, DNB Anaesthesia, FFPMANZCA (NSW)

Dr Reza Modarres, FRACGP FFPMANZCA (Qld)

We congratulate the following doctors on their admission to FPM fellowship through completion of the SIMG pathway:

Dr James F Wilson, FANZCA FFPMANZCA (Tas)

Dr Hoi Wang Ivan Wong, FRCA FFPMANZCA (Vic)

Treating the whole pain patient: FPM's 2025 Spring Meeting

This year's Faculty of Pain Medicine Spring Meeting was held in Fremantle, Western Australia, on Whadjuk Noongar country.

Spanning three days at the Esplanade Hotel by Rydges from 24–26 October, the meeting was attended by more than 135 delegates from Australia, New Zealand, Hong Kong and Singapore.

Ahead of the weekend program, the faculty hosted emergency response workshops, a supervisors of training workshop and the regional and national committee forum.

The forum brought together board members, committee representatives and college staff to share advocacy priorities, address common challenges and build stronger connections across the faculty.

The meeting explored the theme "Treating the whole pain patient," with sessions examining how multidisciplinary and biopsychosocial approaches can improve patient wellbeing and shape best practice in pain medicine.

Presentations spanned psychology, psychiatry, rehabilitation, palliative care and more, alongside discussion of emerging treatments such as ketamine infusion, scrambler therapy, topical medications and naltrexone.

Delegates also enjoyed opportunities to connect at social events, including welcome reception drinks at the Esplanade Hotel and a dinner at the WA Maritime Museum.

Reflecting on the meeting's theme, FPM Dean Dr Dilip Kapur drew on his experience working with First Nations communities, as featured in the 2025 Spring *Bulletin*.

"Yarning reminds us that effective care begins, not with interrogation, but with relationship," he said.

"As health professionals, and as the Faculty of Pain Medicine, we remind you that care and healing occur in contexts shaped by people's connection to place, identity and story."

A consistent message throughout the meeting was the need to continue advocating for pain medicine as a specialty.

Dr Irina Hollington's advice to "be the squeaky wheel" captured this, reinforcing the importance of advocating for our profession, for our patients and for the multidisciplinary approach that underpins effective pain care.

We would like to thank all speakers, session chairs, sponsors, exhibitors, delegates and college staff whose contributions ensured a successful meeting from start to finish.

Dr David Holthouse and **Professor Michael Veltman**
2025 FPM Spring Meeting Co-convenors

ABOVE FROM LEFT

From left: Associate Professor David Sommerfield, Dr Megan Dodd and Associate Professor Philip Finch.

Participants of the FPM regional and national committee forum.

Reflecting on the flexible accreditation pathways project

ABOVE FROM TOP

From left: Dr Kiran Tippur, Dr Greg Henderson, Dr Matthew Bryant, Dr Mahboubeh Adinehzadeh and Dr Suran Dhanapala at Grampians Health Ballarat.

From left: Dr Hima Venugopal, Dr Parul Sareen and Dr Anand Natarajan.

As the pilot for flexible accreditation pathways for pain medicine draws to a close this year, we reflect on its achievements in expanding training opportunities beyond the big cities.

Last year we kicked off the project by bringing together more than 70 pain medicine fellows, trainees, and colleagues from several other specialist medical colleges to participate in stakeholder consultations. From these consultations, combined with evidence in the literature, four key opportunities emerged for the development of flexible accreditation pathways: harnessing flexibility through telehealth, training networks, supervision and scope of practice.

The need to explore this space is twofold. Without local pain medicine training opportunities, regional doctors need to relocate to complete their training, and without local pain specialists, patients often have no choice but to travel long distances or forgo treatment altogether.

FPM Dean Dr Dilip Kapur is the board sponsor for this project, supporting the faculty and units involved and continuing to advocate for regional training and communities. As a pain specialist providing care to local patients in Port Lincoln and the Lower Eyre Peninsula, Dr Kapur sees first-hand the impact of local services and hopes this project will be a catalyst for other regional units applying for accreditation.

As of this year, we have visited two regional units through the pilot, and two additional units are currently being supported through the accreditation process. With most of our accredited pain medicine training sites anchored in our major cities, these visits represent an exciting step forward for regional pain medicine training.

Grampians Health Ballarat in Victoria was visited earlier this year and was the first regional unit in several years to be accredited for end-to-end pain medicine training. Our accreditation team also visited Mackay Base Hospital in Queensland.

Ballarat's Director of Anaesthesia, Pain and Perioperative Services, Dr Greg Henderson, said the pilot gave the unit confidence to apply for accreditation – something that can seem challenging in some regional contexts.

"The pilot was key to this unit applying for accreditation … it meant we knew there were flexibility options around the use of remote sites in the Grampians Health network and telehealth where required."

The accreditation team comprised Dr Mahboubeh Adinehzadeh and Dr Matthew Bryant, who reflected on the Ballarat experience:

"They have committed to train pain medicine registrars, having learned from their exemplar, networked anaesthetics regional training program … [they have] determined that a multidisciplinary pain clinic is a priority."

RIGHT

Dr Susan Cartwright with her two greyhounds in Tamworth, NSW.

Mackay Base Hospital's pain unit has grown over the years, supported initially as a satellite site of Townsville University Hospital, and recently recruited another pain specialist. Local pain specialist and anaesthetist, Dr Anand Natarajan, said:

"The faculty's offering of flexible accreditation meant a lot to us … it was why we decided to apply for accreditation at this point of time. It gives us an insight into the importance that the faculty has given regional centres in delivering pain relief to [regional] Australia."

Dr Melissa Viney, who along with Dr Hima Venugopal was part of the accreditation team that recently visited Mackay, said regional accreditation gives the faculty a practical way to strengthen local training capacity.

"It allows the faculty to help new units develop evidence-based, multidisciplinary approaches to managing pain … and promotes equity of access across regional, rural and remote communities."

Expanding accreditation is a step toward addressing rural workforce shortages in pain medicine as part of a multifaceted approach. In pain medicine, where we have a smaller fellowship relative to most specialties, challenges can be profound. This pilot has demonstrated that through collaboration and engagement, there is potential to incrementally grow the number of accredited regional pain units and broaden the kinds of opportunities available to prospective trainees.

The FPM Board and ANZCA are committed to growing and supporting our regional and rural fellowship, as articulated in the ANZCA 2026-2028 strategic plan. Lessons from this project will help inform our accreditation process as it evolves over the coming years.

Thank you to all our fellows, trainees and units involved, from the early consultations to the project working group, accreditation teams and committee, and regional fellows who participated in interviews and filming. We also acknowledge the regional units who stepped forward to engage with this pilot.

This work was made possible with the Australian government's support through the flexible approach to training in expanded settings (FATES) funding, which aims to grow regional specialist workforce supply in order to better meet the needs of regional communities.

ANZCA and FPM CPD program updates for 2026

Following development of the new ANZCA strategic plan, the ANZCA and FPM Continuing Professional Development (CPD) Committee aims to expand and strengthen participants' lifelong learning in anaesthesia, pain medicine, and perioperative medicine. We seek to encourage fellowship interest beyond compliance through improved engagement with learning which is relevant, effective, and evidence based.

The CPD program is aligned with promoting *Good medical practice: a code of conduct for doctors in Australia*[1], which outlines medical practice that is culturally safe, addresses health equity, and is professional and ethical.

In synergy with this code, from January 2026, CAPE – a framework of four key principles: culturally safe practice, addressing health inequities, professionalism, and ethics – will be integrated into the CPD program. This also meets our CPD homes accreditation requirement.

Culturally safe practice emphasises the importance of understanding and respecting the cultural backgrounds and beliefs of patients, ensuring healthcare is provided in a way that is sensitive and appropriate for everyone. It will be familiar following cultural safety activities implemented into the CPD program as a stand-alone mandatory activity since 2023.

Addressing health inequities focuses on recognising and addressing the social determinants of health that can lead to disparities in health outcomes for different population groups.

Professionalism for health practitioners includes expected standards of behaviour, conduct, and ethical decision-making. Ethics encompasses the moral codes that guide healthcare practice, including issues like confidentiality, informed consent, and professional boundaries. An ANZCA guide, developed in 2017 and revised in 2023, *Supporting Professionalism and Performance*[2] is an extremely useful resource which further describes these concepts.

WHAT DOES THIS MEAN FOR YOU?

There are no additional CPD hours required however you will need to allocate an A, P or E to at least one of your activities in a CPD cycle. This is a regulatory requirement. The culturally safe practice requirement remains the same.

Library CPD program resource guides[3] will be published and your CPD portfolio and app will be updated to assist you in recording these activities.

The CPD committee plans to provide a wider range of emergency response activities in 2026 to assist you in meeting the mandatory requirement to complete one emergency response activity per CPD cycle.

We aspire for CPD to be a positive learning experience that allows us to deliver considered care to patients and communities and build resilient structures in healthcare.

The CPD committee strives to understand the needs of our fellows and CPD participants and continues to evolve to meet those needs.

We are working with you and for you and we appreciate the bidirectional conversations with interested fellows and CPD participants.

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

References

1. See https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
2. See ANZCA-Professionalism-Performance-Guide_2024.pdf
3. See ANZCA & FPM CPD Program resources https://libguides.anzca.edu.au/CPD

New emergency response activity added to CPD

ANZCA's continuing professional development (CPD) activities have a new cardiovascular perfusion crisis addition. The FANZCA behind the development, Dr David D'Silva, explains more here.

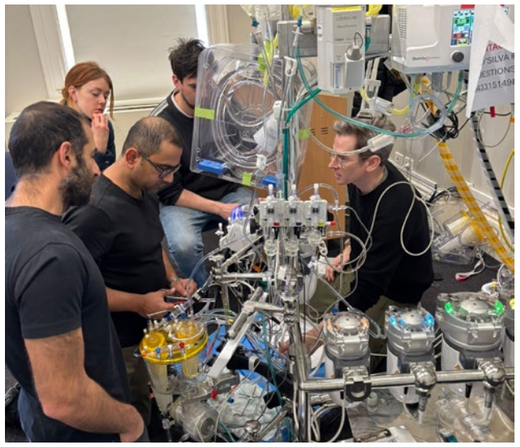
The first cardiovascular perfusion crisis emergency response (ER) activities have now been delivered in Australia, marking an important milestone for anaesthetists engaged in the care of patients requiring extracorporeal support.

Fellows have long played a central role in the development, governance, and delivery of cardiopulmonary bypass (CPB), extracorporeal membrane oxygenation (ECMO) and cardiothoracic resuscitation across Australia and New Zealand. The introduction of this new ER activity provides structured, simulation-based exposure to a rapidly expanding area of practice and supports capability building across the wider anaesthesia community.

The activity is open to all anaesthetists. FANZCAs provide a significant proportion of cardiovascular perfusion services, ranging from CPB to ECMO initiation, ongoing management, and retrieval. In centres operating a medical perfusion model, two independently functioning FANZCAs work synergistically to provide the highest level of perioperative care, where both anaesthesia and perfusion medical expertise are provided by practitioners trained in both. This model allows for redundancy and flexibility to manage crises and conundrums available during complex procedures.

Perfusion crises are uncommon but time critical. Deterioration can be rapid, and effective management requires expert technical skills, structured communication, and coordinated teamwork. The emergency response activity directly addresses the four major perfusion crises defined in the ANZCA guideline – oxygenator failure, arterial pump failure, boot line rupture, and air embolism – and provides hands-on rehearsal of crisis recognition, decision-making, equipment troubleshooting, and leadership behaviours.

While originally developed to support core skills maintenance for medical perfusionists, the relevance of these scenarios now extends far beyond cardiothoracic anaesthesia. ECMO has become increasingly integrated into advanced life support protocols, retrieval medicine, and emergency resuscitation. This means that non-specialist anaesthetists may increasingly find themselves involved in ECMO-assisted cardiac arrest management, structural heart rescue, and time-critical support of patients requiring extracorporeal therapies. Familiarity with perfusion equipment, circuit behaviour, and crisis algorithms is therefore an emerging competency for the broader fellowship.



A recent workshop (above) at Royal Prince Alfred Hospital in Sydney exemplified the multidisciplinary nature of the activity. Participants and faculty included anaesthetists, surgeons, intensivists, nurses, and clinical perfusionists. Teams worked through realistic high-fidelity simulations using heart–lung machines, ECMO systems, task trainers, and crisis-specific equipment. Scenarios emphasised leadership, communication, cognitive load management, and the practical realities of troubleshooting highly specialised devices under pressure. Feedback was uniformly positive. Medical perfusionists valued the opportunity for hands-on crisis rehearsal, while cardiac anaesthetists highlighted the benefit of deepening their understanding of perfusion workflows, cognitive aids, and circuit physiology.

Importantly, the activity provides a structured, ANZCA-recognised pathway to consolidate skills in a high-stakes, low-frequency domain. It supports hospitals, private groups, and training departments seeking to strengthen shared mental models, improve crisis performance, and enhance patient safety in an era of increasingly complex cardiovascular intervention.

The development of this emergency response activity has been a multi-year process, and I would like to acknowledge the collaboration, expertise and support of the ANZCA CPD team. Their guidance has been instrumental in establishing a robust framework to support providers, facilitators, and participants as this activity is rolled out across Australia and New Zealand.

Dr David D'Silva, FANZCA
President, Australasian Society of Medical Perfusion

**For further information, or for those interested in setting up a workshop, Dr D'Silva can be contacted at doctor@dsilvadavid.com*

ANZCA's top flight trainees take to the skies

When Dr Cristy Rowe's alarm sounds in the early hours of a Darwin morning, she's never quite sure what the day will bring. Within minutes she could be airborne – heading hundreds of kilometres across the Northern Territory to retrieve a critically ill patient from a remote community or hospital.

"It might be a ventilated septic patient from Katherine Hospital, or someone who has suffered a head injury in a motor vehicle accident," she says.

"You can be preparing for one thing and then find the job completely changes when you arrive. You just need to adapt quickly."

For Dr Rowe, a provisional fellow in anaesthesia who previously worked as an intensive care unit (ICU) nurse, that ability to stay calm and think clearly under pressure comes naturally.

"Anaesthesia teaches you to make decisions in high-stakes environments," she says. "That translates directly to retrieval medicine."

Dr Rowe is one of two ANZCA trainees currently working as registrars with CareFlight NT, the aeromedical retrieval service based in Darwin. Alongside fellow registrar Dr Max Margalit, she is spending six months with the service as part of her final year of anaesthesia training.

Both doctors say the experience has been one of the most challenging and rewarding of their careers.

Dr Rowe, from Narrabri in regional NSW, completed her postgraduate medical training after an early career as a nurse in Sydney, Brisbane and with the Australian Army. She began her anaesthesia training at Canberra Hospital and moved to Royal Darwin Hospital for her provisional fellowship year. Drawn to the mix of procedural and cognitive skills in anaesthesia, she saw the CareFlight placement as an ideal way to test herself outside the theatre environment.

"Anaesthesia gives you such a strong foundation in airway management, resuscitation, and critical care physiology," she says.

"Out here, you use all of that but you're also operating with limited resources, often in very small teams. It really develops your adaptability and your non-technical skills."

That adaptability can be crucial. A typical shift may involve several flights to retrieve multiple patients based on clinical need, all while the logistics team and pilots are balancing factors such as flight hours and weather conditions.

"Some of my first shifts were transferring cardiac patients to Adelaide," Dr Rowe recalls.

"Because Royal Darwin Hospital doesn't have cardiac surgery theatres, those transfers are routine. Other days you might be flying to a remote community clinic with a two-year-old in respiratory distress or retrieving a patient with seizures who needs intubation before transport."

Her anaesthetic skills – airway management, sedation, and vascular access – are used daily. "You might be sedating a patient for transport, managing a ventilator in flight, or stabilising someone with limited equipment. It's the same principles as anaesthesia, just in a completely different environment."

For Dr Margalit, who is training at St George Hospital in Sydney, the decision to apply for CareFlight came after hearing about a colleague's experience.

"A friend a few years above me had done the term during a year away from hospital training and said it was incredible," he says. "My wife and I had always wanted to spend time in the Northern Territory, so this was similarly the perfect opportunity."

Now in his first year of advanced anaesthesia training, Dr Margalit began with CareFlight in August after taking some time to travel and recharge.

"It's been a complete change of pace," he says. "You go from the comforts of theatre to being on a football field in 38-degree heat, intubating a patient out of the side of a helicopter, while coordinating with a pilot, a nurse, and the retrieval consultant on the phone. It's challenging, but it's exactly the kind of experience that makes you a better clinician."

CareFlight's retrieval teams usually comprise just two clinicians – a doctor and a highly skilled flight nurse – working alongside the pilots or helicopter crew.

"You can't press a buzzer and call for help," Dr Margalit says.

"So the induction training is very rigorous. There's a huge focus on simulation, planning and minimising human error. It's about making sure you can safely manage those uncommon but high-acuity situations."

That preparation is essential for the diverse range of missions CareFlight undertakes.

"Recently we flew with a neonatologist to a very remote Aboriginal community, Lajamanu, where a woman had delivered a premature baby," he recalls.

"We intubated the baby, stabilised them in a transport cot and flew back to the neonatal ICU in Darwin. The whole mission took about nine hours."

He says the small-team environment brings out a different side of anaesthesia training.

"You rely heavily on teamwork, communication, and situational awareness. The flight nurses are phenomenal – most are also trained midwives – and the pilots are incredibly professional. Everyone has to trust each other completely."

ANZCA trainees Dr Cristy Rowe and Dr Max Margalit on site at CareFlightNT in Darwin.

LEFT

Dr Cristy Rowe getting ready for her first search and rescue mission with CareFlightNT.

Both registrars note the unique professional mix within the Darwin base. Registrars rotate through from anaesthesia, emergency medicine and intensive care, and the retrieval consultants hail from those same disciplines.

"That's one of the real benefits," says Dr Rowe.

"You're constantly learning from people with different skill sets. The emergency department (ED) doctors are brilliant at managing undifferentiated critical illness; the ICU people have incredible troubleshooting skills. You get exposure to how each specialty approaches complex patients."

Dr Margalit agrees: "It's very educational seeing how an ED physician might run a cardiac arrest compared with how we'd do it in theatre. You learn a broader, more nuanced approach."

Life in Darwin brings its own challenges. Both doctors relocated for the placement and quickly discovered the city's competitive rental market.

"Finding accommodation was an adventure in itself," Dr Rowe recalls.

"But once you're here, the community and the lifestyle are fantastic. It's an amazing part of Australia to live in for a while."

CareFlight operates on a monthly roster, with shifts ranging from 12-hour day or night duties to 24-hour on-call, and jet shifts for interstate transfers. The interstate retrievals, often to Adelaide for cardiac patients, can be marathon days.

"An Adelaide return might be 11 or 12 hours," says Dr Margalit. "You leave early morning and you're back late at night, sometimes with a return patient on board."

The registrars also undertake regular education and simulation days at the Darwin base, reinforcing the clinical and procedural skills needed for such diverse retrievals.

Both Dr Rowe and Dr Margalit encourage other ANZCA trainees to consider a CareFlight rotation if the opportunity arises.

"It's a really valuable addition to anaesthesia training," says Dr Rowe.

"You develop your non-technical skills – leadership, decision-making, communication – in a way you just can't replicate in theatre. You also gain experience managing a huge variety of medical conditions."

Dr Margalit agrees: "It broadens your perspective enormously. The training and supervision are excellent, and you get to work in one of the most interesting clinical environments in the country. It's a great way to challenge yourself and grow as a clinician."

He also notes the cultural learning that comes with working in the Territory.

"Many of our patients are from remote Aboriginal communities. Understanding the social and cultural context is essential. The patients are incredibly resilient, and it's a privilege to be able to help in such a direct way."

For those interested in applying, both recommend getting in touch with CareFlight well in advance. The organisation recruits twice a year, in February and August, and runs a comprehensive induction program that includes aviation safety and helicopter underwater escape training (HUET).

Associate Professor James Hooper is the Medical Director of CareFlight NT. He says entry into a CareFlight NT rotation is competitive with the organisation requiring a good level of fitness and resilience.

"Our doctors may be required to undertake a range of relatively strenuous activity such as winching in to a patient, delivering advanced critical care, and then extracting the patient back into a hovering helicopter" he explains.

"We employ the very best senior trainees in the critical care specialties. Our induction program is three weeks long and covers a wide range of topics from aviation physiology, pre-hospital trauma, and multiple simulations before moving on to aviation training. Our flight doctors are trained as crew members on our KingAir B200 turboprop aircraft, AW139 helicopters and Gulfstream G150 jets. Part of this training includes helicopter winch insertion and patient extraction, and HUET."

A/Prof Hooper arrived in Darwin in 2017 for a registrar term with CareFlight. After becoming hooked on aeromedical retrieval, he completed ANZCA training (having already undertaken some anaesthesia training in London) at Royal Darwin Hospital and the Princess Alexandra Hospital in Brisbane, before moving through various roles at CareFlight to become the CareFlight NT Medical Director.

He divides his time between CareFlight NT, and Royal Darwin and Palmerston Hospitals, where he is a consultant in the department of anaesthesia and the hyperbaric unit. Away from clinical medicine he is a Clinical Associate Professor at Charles Darwin University.

"Undertaking a rotation at CareFlight NT further develops our trainees' skills in delivering advanced critical care in really challenging environments," A/Prof Hooper says.

"Providing expert medical care in often undifferentiated patients in a remote community or on a roadside in brutally hot and humid conditions is very different from the operating theatre. The rotation really develops a trainee's ability to deal with the unexpected, be resourceful, work in an austere environment and 'think outside the box'. This training and experience, in my view, makes one a better doctor and anaesthetist."

"In addition to trainees, we also employ FANZCAs, FACEMs and FCICMs as Medical Retrieval Consultants (MRCs). Our MRCs provide 24/7 critical care advice and retrieval oversight for the Top End of the NT."

When their CareFlight terms finish early next year, Dr Rowe and Dr Margalit will return to hospital training – Dr Margalit to Sydney to complete his advanced training at St George Hospital, and Dr Rowe to Royal Darwin Hospital to finish her provisional fellowship. But both say they hope to maintain a connection with retrieval work.

"I'd love to keep doing casual retrieval shifts," says Dr Rowe.

"It keeps your critical care and crisis management skills sharp, and it's such meaningful work."

Dr Margalit agrees. "There's nothing quite like it. You're flying over the Territory with this amazing team, helping people who might otherwise have no access to advanced care. It's an unforgettable experience, and one that definitely makes you a better anaesthetist."

CareFlight is a national organisation, with a heavy presence in NSW where it operates various aeromedical retrieval operations. Trainees and consultants are also employed on these operations. Further information is available at https://careflight.org/about/careers/clinical/

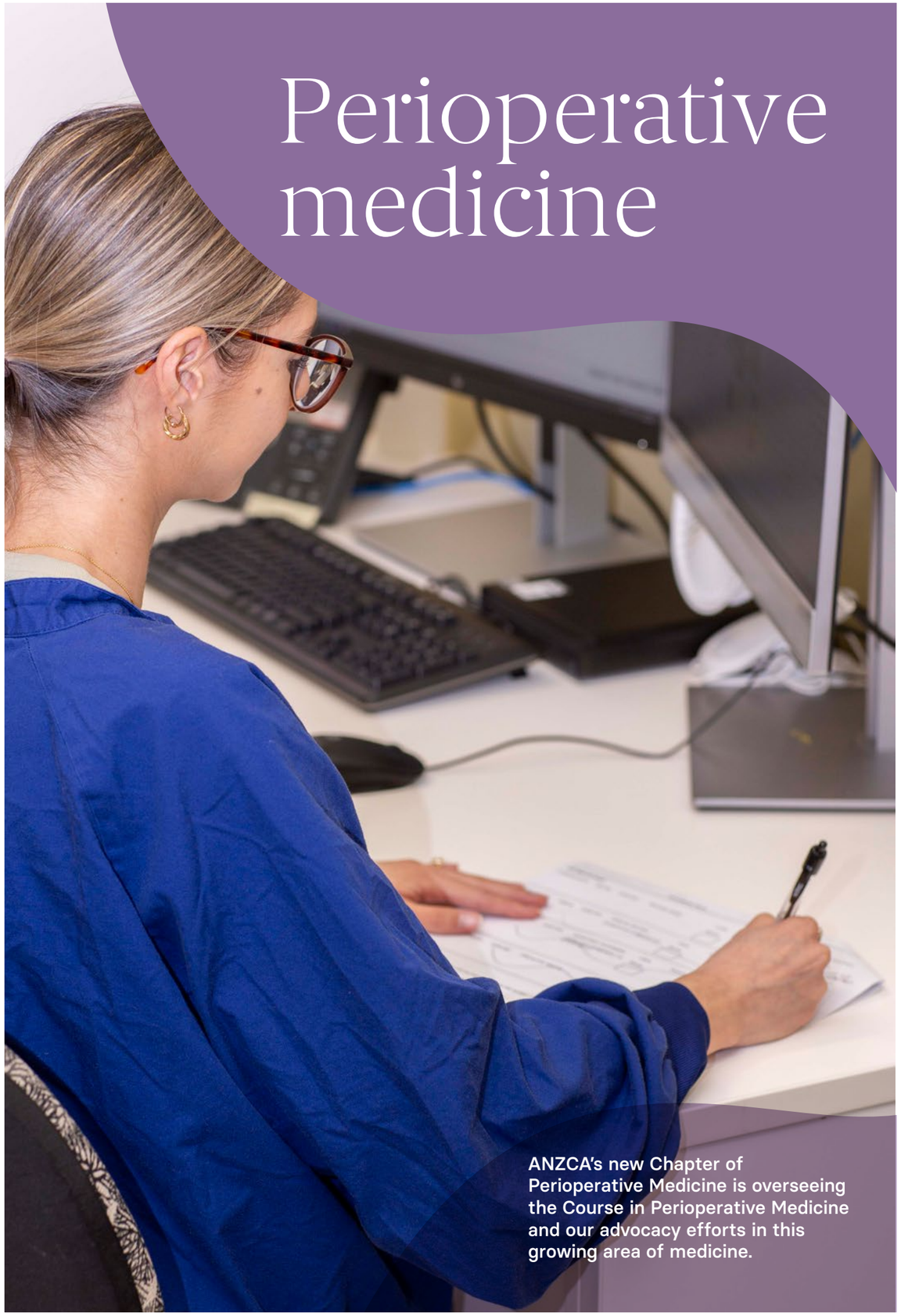
**A/Prof Hooper will be speaking about pre-hospital and retrieval medicine in the "Top End" of Australia at the 2026 ANZCA Annual Scientific Meeting in Auckland on 3 May.*

Carolyn Jones
Media Manager, ANZCA

RIGHT

ANZCA President Professor Dave Story visited CareFlight NT's Darwin base earlier this year.

Perioperative medicine



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

College forges ahead with more POM milestones

Just 12 months ago we launched our Chapter of Perioperative Medicine at the 2024 Perioperative Medicine Special Interest Group (POM SIG) meeting in Melbourne.

How far we've come!

Now 17 participants have completed the course (two physicians and the remainder anaesthetists). This brings the number of graduates of the chapter (GChPOM) up to 786.

At this year's POM SIG meeting in Wellington we recognised 10 new graduates who were attending – seven completed the course in 2024 and one in 2025 and the remaining two were awarded their GChPOM via the recognition pathway.

While I hear some FANZCAs questioning the value of the perioperative medicine certification ("Aren't we all perioperative physicians?") the growing number of our members who have done the course see POM as an enhancement of their anaesthesia practice.

The course is largely for those who want to broaden their health services work, particularly through multidisciplinary teams for the entire perioperative patient pathway.

This year we have also established the chapter's two committees, the Advocacy and Policy Committee and the Education and Assessment Committee.

While it is important to enjoy these milestones, there is still much work to do.

We are building on the number of hospitals who can provide the course. We now have 33 hospitals across Australia and New Zealand where participants can complete the course after Palmerston North Hospital in New Zealand and Queensland's Sunshine Coast Hospital and Royal Brisbane and Women's Hospital (commencing 2026) joined our growing network.

We are refining course content and making improvements. For example, from 2026, separate workshops will no longer be a requirement for completion of individual units of study. Instead, the workshops will be distilled into a single workshop and held once a year in the lead-up to the POM SIG meeting held each year in November. We hope this will be more convenient for participants.

We have also revised the POM supervisor training program, combining online pre-work with interactive in-person sessions. The first workshop took place on 3 November at the Royal Brisbane and Women's Hospital and was attended by 34 graduates from general practice, anaesthesia, medicine, and intensive care.

The perioperative care pathway diagram (fondly referred to as the "nephron") has been relabelled the Australian and New Zealand Perioperative Patient Pathway (ANZPPP). The thinking behind this is to establish the pathway globally as an Australian and New Zealand initiative.

We are having conversations with fellows from other colleges and craft groups to ensure our work is relevant to them.

Last month's POM SIG meeting in Wellington had general practitioners, surgeons, physicians, intensivists, nurses and physiotherapists as well as anaesthetists participating, reflecting the true multidisciplinary nature of POM.

Of our graduates most are fellows of ANZCA (480) as well as the Faculty of Pain Medicine (two). There are 166 fellows of the Royal Australasian College of Physicians, 81 fellows of the College of Intensive Care Medicine, 16 fellows of the Royal Australasian College of Surgeons, 29 fellows of the GP colleges (RACGP/RNZCGP/ACRRM) and another 13 from other specialty groups and overseas luminaries in POM.

The theme of the 2026 ANZCA Annual Scientific Meeting (ASM) in Auckland is "Herenga waka, herenga tāngata: From home to home" which is particularly pertinent to one of the guiding principles of POM "From the contemplation of surgery to optimal outcomes".

In November the chapter hosted its first webinar with plans for more in 2026 based on what our graduates have told us when we surveyed them earlier this year. We are also looking to embed perioperative medicine in our professional documents and promote the benefits and awareness of perioperative medicine to governments and through the health sector.

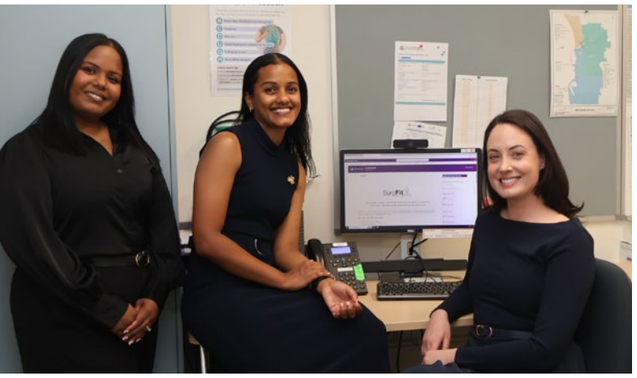
Finally I'd like to congratulate Dr David Mogg, a final year College of Intensive Care Medicine trainee from Queensland and Dr Bernadette White FANZCA, from Victoria, who are the first Alan and Kate Gibson Fellowship recipients and will complete the course in 2026.

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

ABOVE

ANZCA's newest Chapter of Perioperative Medicine graduates with their certificates at this year's POM SIG meeting in Wellington.

WA hospital leads the way in surgical prehab model



At Fiona Stanley Hospital in Perth, a new approach to surgical prehabilitation is transforming patient outcomes and the perioperative journey.

SurgFit is a hospital-wide prehabilitation program developed by the Department of Anaesthesia, Pain and Perioperative Medicine and supported by the hospital's Innovation Hub. It began as a modest initiative for patients undergoing major upper gastrointestinal and colorectal procedures.

Today, SurgFit has grown into a fully integrated, opt-out digital program spanning multiple surgical specialties, with early data suggesting significant improvements in patient readiness, postoperative recovery, and system-wide efficiency.

The origins of SurgFit were grounded in a simple but powerful idea: that patients waiting for elective surgery could use that time to improve their physical and psychological resilience.

Historically, patients arrived at their operation with variable levels of preparation, and opportunities for prehabilitation were often missed due to resource limitations.

SurgFit aimed to change this, harnessing digital platforms and automated referral pathways to ensure patients were identified early and supported comprehensively from the start.

From the outset, the program was designed with accessibility and sustainability in mind. By linking elective wait list procedure codes directly to the hospital's patient administration system, eligible patients are automatically enrolled into SurgFit as part of their surgical journey.

This opt-out model reduces barriers to engagement and ensures that those who stand to benefit most are not overlooked. Once enrolled, patients complete an initial health questionnaire that assesses parameters such as frailty, nutritional risk, lifestyle factors, and significant comorbidities. Based on these responses, tailored referrals are generated to allied health professionals, including physiotherapy, dietetics, psychology, and pharmacy.

By recruiting patients early in their surgical journey, we can take advantage of that potentially long wait-time before surgery, well before they reach the anaesthesia pre-admission clinic.

The health questionnaire is automatically uploaded onto the patient's medical record so that all multidisciplinary clinicians can access those details immediately, resulting in reduced nursing administration costs and time.

Education is another cornerstone of SurgFit. Patients are invited to attend peer-led SurgFit schools, which provide evidence-based education in a supportive group environment.

The sessions combine video content, practical demonstrations, and interactive questions and answers, covering topics such as nutrition, exercise, breathing techniques, and pain management. This model has proved both scalable and effective, with high registration rates and very low "did not attend" levels. This follows significant marketing of the service and a change in management strategy to highlight what the service provides, further developed with consumer engagement.

Patients consistently report increased confidence in their ability to actively participate in their recovery. The clinical impact of SurgFit has been significant.

Consultant anaesthetist Dr Paris Dove reflects on the impact the program has had on patients.

"Through the program, participants build agency and an increased sense of belonging – which is extremely powerful. This then lifts patient engagement and their internal motivation, not only for the benefit of their own mental and physical health perioperatively, but for sustained healthy behaviours in the longer term."

PATIENT STORIES BRING DATA TO LIFE

Lois, a patient who participated in SurgFit before her major surgery, describes the experience as pivotal in her recovery.

She notes that learning simple breathing and exercise strategies, alongside feeling psychologically prepared for surgery, gave her confidence at a time that could otherwise have been overwhelming.

She attributes her smooth recovery and shorter length of stay to the preparation she received through the program.

ABOVE

Fiona Stanley Hospital's SurgFit team, from left: Trisha Govender (nurse co-ordinator), Dr Leena Nagappan (anaesthetist and SurgFit clinical lead), Dr Marie Timlin (perioperative anaesthesia fellow).

Not only are patients better prepared physically and psychologically, but the cohesive nature of SurgFit has fostered a stronger sense of teamwork across disciplines. Pharmacy, nursing, allied health, and surgical staff now share consistent language and goals, streamlining communication and reducing variation in practice. Geriatric physicians provide expertise at the point where surgery is contemplated and can offer interventions throughout – including discharge planning after surgery.

Consultant gerontologist Dr Afsana Habib reflects, "SurgFit has been a great addition to the geriatric clinics by providing consolidated prehabilitation and education which has demonstrated improved postoperative outcomes."

The program's design also builds on the success of other pathway-based initiatives at Fiona Stanley Hospital, such as enhanced recovery after surgery protocols and multidisciplinary respiratory bundles such as the aCOUGH initiative which encourages simple breathing practices patients can implement to reduce their risk of respiratory complications.

The program has consistently exceeded weighted activity unit targets, achieved high engagement metrics, and was recently nominated for a state health award. Its scalability was further demonstrated by its expansion to Rockingham Hospital, where it has been successfully implemented with minimal adaptation.

The future direction of SurgFit is both ambitious and grounded in patient-centred innovation. Work is underway to develop digital education modules for specific surgical cohorts, integrate wearable technology to monitor activity, and strengthen routine reporting of outcomes to ensure the program remains clinically meaningful and measurable. A strong focus on health equity is also emerging, with translated resources and culturally tailored support being developed to improve accessibility for culturally and linguistically diverse patients.

The South Metropolitan Health Service has recently been awarded a targeted call grant to enhance and validate the SurgFit Digital Companion, recognising its potential to deliver scalable perioperative support across the system. This AI-enabled platform guides patients throughout their surgical journey, offering personalised information, reminders, and progress tracking. By tailoring support in real time, SurgFit aims to empower patients to play an active role in improving their surgical outcomes.

The SurgFit program exemplifies how innovation, collaboration, and digital integration can reshape perioperative care.

By meeting patients early, supporting them with education and allied health input, and creating a shared language across the surgical pathway, Fiona Stanley Hospital has set a new benchmark for surgical prehabilitation in Australia.

The early outcomes are compelling, but perhaps more importantly, the program has created a platform for ongoing improvement and expansion. As the program matures, it is poised not only to continue improving patient outcomes but also to contribute valuable insights to the broader perioperative community.

For patients, the impact is clear: less anxiety, smoother recovery, and a stronger sense of agency in their care.

For clinicians, SurgFit offers a structured, evidence-based framework that enhances teamwork and optimises outcomes. And for the health system, it provides a scalable, sustainable model that can be adapted across settings.

The journey of SurgFit is still unfolding, but already it stands as a powerful example of how perioperative medicine can innovate to meet the challenges of modern healthcare. The lessons learned here – about digital integration, multidisciplinary collaboration, and the power of patient education – are ones that can resonate far beyond Fiona Stanley Hospital.

Dr Leena Nagappan, FANZCA
Dr Marie Timlin, Anaesthesia trainee
Fiona Stanley Fremantle Hospitals Group

ABOVE

Staff from Fiona Stanley Hospital's Department of Anaesthesia and Perioperative Medicine.

Research

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

Research grants for 2026

It was great to see an increase in applications this year. We received 56 applications for new studies across anaesthesia, pain medicine, and perioperative medicine, up from 50 last year.

The Research Committee has awarded funding of more than $A1.6 million from the ANZCA Foundation for 2026 research grants: the Academic Enhancement Grant, 17 new project grants, five second-year project grants, one novice investigator grant, the Patrons Emerging Investigator Grant, two Professional Practice Research Grants, the Skantha Vallipuram ANZCA Research Scholarship, and an allocation for Clinical Trial Network pilot grants.

Twenty-eight teams will be supported in 2026. Their important research will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong, and is a vital part of ANZCA's continuous advancement of safe, evidence-based patient care in anaesthesia, intensive care, perioperative medicine and pain medicine, through high-quality medical research and its translation and implementation within clinical practice.

The foundation is very appreciative of the generosity of all its donors and supporters, especially the regular giving of our patrons, and those who provide named research awards, bequests, and major grants: Mrs Rowena and Mrs Victoria Cole, Mrs Indi Mackay, the late Dr Robin Smallwood, the late Dr John Boyd Craig, the estates of the late Dr Nerida Dilworth and Dr Elaine Lillian Kluver, Dr Stanley Tay, Dr Peter Lowe, Mrs Asoka Vallipuram, Mrs Jan Russell and the Medibank Community Fund.

Professor Britta Regli-von Ungern-Sternberg
Chair, ANZCA Research Committee

Mr Rob Packer
General Manager, ANZCA Foundation

NAMED RESEARCH AWARDS

Harry Daly Research Award

Established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1981. The award may be made in any of the college's research grant categories provided the project is judged to be of sufficient merit. The award is made each year to the grant ranked most highly by the ANZCA Research Committee.

Understanding sex-specific infection risks after cardiac surgery: The CALIPSO multi-omic study

A new research project led by Dr Chris Bain from Alfred Health and Monash University is a groundbreaking investigation into why female patients face a higher risk of infection after cardiac surgery compared with males.

Cardiac surgery is the most common major surgical procedure performed in Australia, yet alarmingly up to 15 per cent of patients develop serious infections in the months following their operation. Notably, infection risks are not uniform. Females not only experience infections more often but are infected by different bacterial profiles than males. Despite clear sex-specific differences, infection prevention and post-operative care are currently standardised for all patients.

This research project entitled "Multi-omic analysis to investigate sex-specific differences in the microbiome-host interaction after cardiac surgery," seeks to uncover biological mechanisms behind these disparities. This will examine how immune responses and the gut microbiome (the diverse community of bacteria in the digestive system) interact differently in male and female patients after surgery, and whether these differences can predict infection risk within 90 days.

The study draws on the CALIPSO (Duration of Cardiac Antimicrobial ProphyLaxIS Outcomes Study) trial, a large ANZCA Clinical Trials Network endorsed study that is evaluating the optimal duration of antibiotic use after cardiac surgery. Leveraging CALIPSO's existing infrastructure, ethical approvals, consumer support and patient recruitment has made possible the collection of gut bacterial samples and immune cells from patients before and after surgery. The research team will conduct a "multi-omic" analysis, integrating detailed information on gene activity related to immune function with data on the gut microbiome.

The project brings together a multidisciplinary team of experts in clinical trials, perioperative genomics, infection prevention, and computational biology.

Ultimately, the CALIPSO multi-omic study aims to identify biological markers that distinguish infection susceptibility between sexes, paving the way for precision-based infection prevention strategies in cardiac surgery. This novel approach moves beyond current risk models that do not account for sex-specific differences.

By linking high-quality clinical trials and advanced molecular analysis, this project represents a vital step towards Precision Gender Medicine, ensuring that both female and male patients receive care informed by their unique biological response to surgery.

Dr Chris Bain, Professor Trisha Peel, Professor Paul Myles Alfred Health and Monash University, Melbourne, Associate Professor Stefan Dieleman, Westmead Hospital, Western Sydney University, NSW, Dr Kiymet Bozaoglu, Murdoch Children's Research Institute, University of Melbourne, Associate Professor Mark Ziemann, Burnet Institute, Melbourne, Dr Brian Forde, Institute of Molecular Biosciences, The University of Queensland.

$A69,500

The Russell Cole Memorial ANZCA Research Award

Established following a generous ongoing commitment to the ANZCA Research Foundation from Mrs Ann Cole, in memory of the late Dr Russell Cole, to support a highly ranked pain-related research grant.

Proof-of-concept translation study for a biosensor-based blood test to enhance chronic pain diagnosis and treatment.

Chronic pain affects one in five people globally, incurring significant costs and presenting complex challenges in diagnosis and treatment. Current diagnostic methods rely heavily on subjective self-reporting, which can be inaccurate and ineffective, especially in non-verbal populations. The lack of objective diagnostic tools complicates treatment, often leading to ineffective therapies and potential opioid-related issues.

The investigators aim to develop a novel blood test as a human pain biomarker tool to enhance the diagnosis and treatment of chronic pain at the Flinders Medical Centre Pain Main Management Unit and the Pain and Sensory Cell Biology Laboratory at Flinders University. The study seeks to translate a preclinical biosensor device, capable of discriminating between chronic pain conditions in animal models, to human patients in clinical settings.

If successful, this research could improve the accuracy of chronic pain diagnosis and treatment by providing an objective measure of pain to complement subjective patient reports, enabling more accurate assessment of pain severity and type, and guiding precise analgesic requirements. This innovative approach is targeted at significantly improving patient outcomes across diverse populations of chronic pain patients with complex pain subtypes.

Dr Porhan Kang, Pain Management Unit, Dr Amelia Searle, Flinders Medical Centre, Dr Dusan Matusica, Flinders Health and Medical Research Institute, Professor Rainer Haberberger, University of Adelaide, South Australia.

$A68,329

John Boyd Craig Research Award

Established following generous donations from Dr John Boyd Craig to the ANZCA Foundation to support pain-related research by fellows.

A personalised anti-inflammatory nutrition study for chronic pain (PANTRY): A pilot randomised controlled trial

Diet is an important modifiable risk factor for chronic disease. Recent evidence shows that dietary interventions can improve chronic pain intensity and quality of life. However, precise mechanisms are not well understood.

PANTRY is a pilot randomised controlled trial, testing a personalised anti-inflammatory nutrition intervention in adults attending a multidisciplinary chronic pain service. The anti-inflammatory intervention will involve behavioural change to improve diet quality, by decreasing consumption of highly processed foods and food or drink with added sugars and increasing consumption of unprocessed or minimally processed whole foods, including fruit and vegetables. The control group will be encouraged to continue eating as usual. Financial support will be provided for purchase of recommended foods in the intervention group and usual foods in the control group. The intervention has potential to reduce inflammation and pain intensity, and to improve quality of life. If the intervention is successful, there is the possibility of translation to models of care across the pain management sector.

The planned PANTRY trial is part of Dr Hayes' PhD, "A study of nutrition to reduce inflammation in chronic pain".

Dr Chris Hayes, Dr Katherine Brain, Dr Hema Rajappa, Ms Laura Bruggink, Hunter Integrated Pain Service, Newcastle, Dr Bronwyn Berthon, Professor Lisa Wood, The University of Newcastle, NSW.

$A32,834

Robin Smallwood Bequest

Established following a generous bequest from the late Dr Robin Smallwood to support a highly ranked grant in anaesthesia, intensive care or pain medicine.

Reconciling pre- and postsynaptic effects of general anaesthesia in a mouse model

General anaesthetics produce loss of consciousness by acting on multiple mechanisms in parallel. These mechanisms can be broadly separated into pre- and postsynaptic effects, involving protein targets on either side of chemical synapses in the brain. Post-synaptic targets include inhibitory ion channels such as GABA(A) receptors. Specific GABA(A) receptor mutations have been engineered in mice that block this postsynaptic effect. On the other hand, pre-synaptic mechanisms of general anaesthesia are less understood. There is however also a way to potentially block the presynaptic effects of anaesthetics: expressing a truncated version of a protein called syntaxin1A has been found to produce anaesthesia resistance across a range of systems, including nematodes, flies, and rodent neuronal cultures. However, this presynaptic manipulation has never been tested in a live mouse model.

In this project, we will engineer a mouse expressing the mutant protein and test whether this produces a level of resistance to general anaesthetics. Further, we anticipate that a GABA(A)-syntaxin1A double-mutant mouse should be highly resistant across a range of anaesthesia endpoints. This project will disambiguate the relative contribution of these distinct target mechanisms of general anaesthesia, and in this way inform the design of effective reversal agents to help expedite recovery.

Professor André Van Zundert, Associate Professor Michelle Roets, Royal Brisbane and Women's Hospital, The University of Queensland, Brisbane, Queensland.

$A70,000

The Elaine Lillian Kluver ANZCA Research Award

Established following a generous gift to the ANZCA Research Foundation from the estate of the late Dr Elaine Kluver to support a highly ranked pain-related research grant.

Plasma concentrations and outcomes of an optimised intraoperative lidocaine infusion regimen in patients with obesity.

Perioperative lidocaine infusions have demonstrated benefits for improving analgesia and recovery after laparoscopic abdominal surgery. In patients with obesity, using multi-modal and non-opioid adjuncts such as lidocaine infusion, may reduce opioid-related complications. However, there are inconsistencies with lidocaine infusions dosing regimens with concerns for safety and efficacy, particularly when using a weight-based protocol in patients with obesity. Optimising the dosing of lidocaine is important to balance the risk-benefit profile and ultimately improve outcomes of this increasing surgical population.

Our previous research demonstrated that current lidocaine infusions are likely to achieve sub-therapeutic concentrations in patients with obesity. Using pharmacokinetic analysis and dosing simulations, we developed an infusion regimen that more optimally achieves (simulated) plasma concentrations within the therapeutic and non-toxic range. This new study will prospectively evaluate our optimised lidocaine infusion for safety and efficacy in patients with obesity undergoing elective laparoscopic abdominal surgery at the Royal Brisbane and Women's Hospital. Pharmacokinetic analysis will determine if this infusion achieves targeted therapeutic plasma concentrations without high peak concentrations. We will also evaluate important patient-focused outcome measures, including pain scores, post-operative recovery and length of stay. If safe and effective, the proposed regimen will be evaluated in a randomised controlled trial.

Dr Angela Tognolini, Professor Victoria Eley, The Royal Brisbane and Women's Hospital, Professor Jason Roberts, The University of Queensland Centre for Clinical Research, Brisbane.

$A90,000 (includes scholarship)

Skantha Vallipuram ANZCA Research Scholarship

Set up by Skantha Vallipuram's family as a memorial to assist fellows or trainees to help establish their research careers.

Density spectral array, can it add a layer of safety against inadvertent disconnection in total intravenous anaesthesia?

In Australia in 2023-24, almost 200,000 elective surgeries involving patients aged 65 or older were performed in public hospitals. But older people worry about the safety and outcomes of anaesthesia, as deep anaesthesia may have a lasting impact on brain function. A new study led by Dr Boules at the Royal Brisbane and Women's Hospital aims to evaluate the role of Density Spectral Array (DSA) in addition to Bispectral (BIS) index in depth of anaesthesia monitoring in patients older than 65 years. Previous literature has demonstrated that BIS can underperforms in older adults. DSA provides more detailed real-time visual data on brain activity, helping anaesthetists tailor drug delivery more accurately. The study seeks to determine if DSA can improve the detection of inadequate anaesthesia, providing more confidence in depth of anaesthesia monitoring to inform better anaesthesia titration.

By enhancing monitoring techniques, this research aims to promote safer, more effective anaesthesia practices, especially during Total Intravenous Anaesthesia (TIVA). Results could lead to improved patient safety, shorter hospital stays, and better overall experiences for older Australians undergoing surgery. The findings can inform clinical guidelines, supporting anaesthetists in delivering precise and personalised care for this vulnerable population.

Dr Michael Boules, The Royal Brisbane and Women's Hospital; PhD Supervisors: Professor Victoria Eley, Professor Andre van Zundert, Professor Alison Mudge, The Royal Brisbane and Women's Hospital, Queensland.

$A20,000

Patricia Mackay ANZCA Research Award

Established following a generous donation to the ANZCA Foundation from Mrs Indi Mackay, to support a highly ranked grant that aligns with Dr Patricia Mackay's known special interests in quality and safety in patient outcomes and the related identification and reduction of adverse events.

SEALION: A study on the effectiveness of additional oxygenation in little children during intubation using oxygenation delivered by nasal cannula

Even for experienced paediatric anaesthetists' tracheal intubation, in neonates, is technically challenging with repeated intubations causing trauma and increasing the risk of failure. Neonates are particularly prone to hypoxaemia, with desaturation occurring rapidly following the cessation of spontaneous or assisted respiration.
This international multicentre, prospective, single blinded, randomised control trial will recruit neonates, aged up to 52 weeks post conceptual age, requiring intubation in theatre. A total of 240 neonates, 120 assigned to either the intervention or control group, will be recruited. The intervention group will receive 1L/kg/min of oxygen delivered via nasal cannula during the apnoeic phase of tracheal intubation, while the control group will not receive supplemental oxygen during their intubation (current standard practice). The use of a VL will be standard across both groups.

This study aims to investigate the effects of apnoeic oxygenation in neonates during intubation. The primary outcome and hypothesis are that supplemental oxygenation and the standardised use of a VL, will improve the first intubation success rate reducing both desaturations (< 90 per cent) and bradycardia (< 100bpm) in neonates, less than 52-weeks post conceptual age.

Associate Professor Neil Hauser, Perth Children's Hospital, Western Australia, Dr Vinicius C Quintao, University of São Paulo, Brazil, Associate Professor Arash Afshari, Copenhagen University Hospital, Denmark.

$A70,000

ANZCA Innovation and Technology Research Award

Established following generous donations to the ANZCA Foundation from Dr Stanley Tay, a foundation Governor Patron, to support a highly ranked research study that involves the innovative use or development of technology.

AI and large language models generating positive paediatric anaesthesia trial outcomes (ALLIGATOR)

This project aims to assess the feasibility and safety of using large language models (LLMs) to assist clinicians in the care of paediatric patients in the perioperative setting. We will investigate the ability of LLMs to classify and predict the incidence of perioperative complications from pre-operative textual data. This includes perioperative respiratory adverse events (PRAE defined as major adverse events such as laryngospasm or bronchospasm and minor adverse events such as severe persistent coughing, desaturation, airway obstruction, stridor), pain, nausea and vomiting and other complications from multi-modal input.

We hypothesise that LLMs will be able to perform automatic classification and prediction of perioperative paediatric adverse events using preoperative information from the digital medical record.

Dr Liam O'Doherty, Dr Harry Smallbone, Perth Children's Hospital, Associate Professor Wei Liu, The University of Western Australia.

$A70,000

W. John Russell ANZCA Research Award

Established following a generous donation to the ANZCA Foundation from Mrs Jan Russell to support a highly ranked grant that aligns with Dr Russell's area of special interests in engineering and equipment in anaesthesia, perioperative or pain medicine or related to patient safety, teaching or clinical pharmacology.

Identifying EEG biomarkers that predict postoperative delirium in older adults undergoing anaesthesia and surgery

Postoperative delirium (POD) is the most common postoperative complication in older adults undergoing surgery, with an estimated incidence of 15-25 per cent for all inpatient procedures. POD is associated with increased mortality, an increased risk of discharge to institutional care and long-term cognitive decline. Whilst 30 – 40 per cent of cases of POD are thought to be preventable, identifying those at greatest risk remains a significant challenge.

Acute delirium is associated with identifiable changes on the electroencephalogram (EEG), including changes in brain connectivity. Reductions in brain connectivity have also been proposed as the neurophysiological basis of a delirium-vulnerable brain phenotype. Anaesthesia and surgery have been described as a 'stress-test' for the brain, and a vulnerable brain phenotype may become more apparent under general anaesthesia.

The aim of this project is to identify EEG-derived biomarkers that are associated with the subsequent development of POD. We will utilise multi-channel EEG collection and analysis of spatio-temporal brain dynamics to develop biomarkers that we hypothesise will outperform current POD risk stratification methods. It is hoped that such analyses will not only provide a clinically useful marker of brain vulnerability and POD risk, but will also further our understanding of the pathophysiology of POD.

Dr Steven McGuigan, Dr Andre Peterson, Professor David Scott, St Vincent's Hospital, Melbourne, Professor Jamie Sleigh, Waikato Clinical School, University of Auckland, New Zealand.

$A70,000

Provisional/New Fellow Research Award

Established following a generous donation from retired anaesthetist Professor Barry Baker, former ANZCA Dean of Education, and former Nuffield Professor of Anaesthetics, University of Sydney, to the ANZCA Foundation to support a highly ranked novice investigator.

PROFESSIONAL PRACTICE RESEARCH GRANT

GOPRO Trial: A stepped-wedge cluster randomised trial of goal-directed neuromuscular block monitoring and management

Residual neuromuscular blockade after general anaesthesia contributes to adverse patient outcomes and increased healthcare costs. Using objective (quantitative) neuromuscular monitoring to guide and confirm appropriate reversal prior to tracheal extubation is strongly recommended. However, uptake of this evidence-based practice is very poor.

The goal-directed objective paralysis reversal outcomes (GOPRO) trial is a multi-centre, batched stepped-wedge cluster randomised trial comparing routine practice with a goal-directed approach that combines objective neuromuscular monitoring and pharmacological reversal to achieve a train-of-four ratio ≥ 0.9. As a hybrid effectiveness-implementation trial, the GOPRO trial will not only evaluate the clinical intervention, but also the implementation strategies for promoting its uptake into clinical practice.

Implementation science is critical to bridging the evidence-to-practice gap in anaesthesia and perioperative medicine. By addressing individual, organisational and system-level barriers, the GOPRO trial aims to engage clinicians as key drivers of change and achieve sustainable adoption of evidence-based practices to improve patient safety in the real world.

This trial will form part of Dr Sophie Liang's PhD at the University of Sydney, which focuses on improving the translation and implementation of research evidence in anaesthesia and perioperative medicine. She is also supported by a National Health and Medical Research Council (NHMRC) Postgraduate Scholarship.

Dr Sophie Liang, Dr Brenton Sanderson, Westmead Hospital, Dr Mitchell Sarkies, Professor Melissa Baysari, Dr Kristy Robledo, University of Sydney, Dr Oya Gumuskaya, Western Sydney University, Dr Ben Olesnicky, Royal North Shore Hospital, Associate Professor Justin Skowno, Children's Hospital at Westmead, Professor Paul Stewart, Australian National University, Dr Wade Weigel, University of North Carolina, USA.

$A89,906 (includes scholarship)

ACADEMIC ENHANCEMENT GRANT

Exploring the impact of pre-dive exercise and microparticles on venous gas emboli formation after diving

Decompression sickness (DCS) is caused by bubble formation from dissolved gas after ascent from a compressed gas dive. Bubbles appearing in the venous blood (venous gas emboli – VGE) and arriving in the right heart can be detected and quantified using transthoracic echo. A recent landmark study unexpectedly revealed markedly variable VGE numbers across multiple dives performed by the same divers despite performing identical dives. Explanatory hypotheses include an influence of variations in pre-dive physical activity and variations in numbers of gas containing microparticles that may form during the dive and act as nuclei for bubble formation after ascent. Forty subjects will complete five standardised hyperbaric chamber dives. Three of these dives will not be preceded by exercise, while the other two will be preceded by controlled periods of brisk walking or cycling. Blood samples for assays of microparticles will be taken prior to decompression. Serial echocardiography exams for VGE assay will be undertaken after surfacing.

These interventions will allow us to confirm the observation of intraindividual variability in VGE formation despite performing identical dives, evaluate the effect of different forms of pre-dive exercise, and determine whether microparticle formation at depth influences VGE formation after surfacing.

Professor Simon Mitchell, The University of Auckland, New Zealand.

$A99,622

NOVICE INVESTIGATOR GRANT

Remote monitoring for patients discharged home after cancer surgery

Timely discharge from hospital is a key priority and performance indicator for both patients and their treating teams. On the other hand, premature discharge can mean that complications such as blood clots or infection go unnoticed and result in delayed recovery or hospital readmission. A solution may be sending patients home with wearable devices that monitor basic physiological parameters such as heart rate, blood pressure, oxygen levels and temperature. There are medical-grade wireless blood pressure cuffs, pulse oximeters and infrared thermometers as well as commercial smartwatches that perform these functions and could securely share data with the patients' healthcare teams after discharge. This should enable earlier detection of deterioration and support safer, faster recovery.

This pilot study aims to test the feasibility and utility of wearable monitoring for patients recovering from major cancer surgery in their homes. 20 adult patients will be provided with medical devices to record their vital signs for seven days post-discharge; a subgroup will also wear smartwatches. At the end of the monitoring period, participants will complete a short questionnaire.

Feasibility will be confirmed by collecting at least 80 per cent of daily vital sign data and achieving an 80% questionnaire completion rate. Patient satisfaction and usability scores will also be examined to determine acceptability. If successful, the findings will inform a larger study to evaluate whether wearables enhance recovery, reduce readmissions and promote patient confidence following surgery.

Dr Harriet Beevor, Peter MacCallum Cancer Centre, Melbourne.

$A19,687

PATRONS EMERGING INVESTIGATOR GRANT

Investigating the impact of the glucagon-like peptide-1 receptor agonist semaglutide on the gastric pacemaker

GLP-1 receptor agonists have emerged as important medications to treat obesity, as well as a range of obesity-related cardiovascular and metabolic conditions. An unintended consequence for patients taking these drugs is the observation that they may still have a full stomach when they come for anaesthesia, despite following a recommended six hour fast. Pulmonary aspiration by regurgitation of stomach contents is a leading cause of anaesthetic-related harm. In a normal stomach, emptying is partially coordinated by slow electrical waves initiated from a dominant pacemaker site -*the gastric pacemaker.* Abnormal, chaotic, slow-wave electrical activity has been connected to stomach motility disorders including gastroparesis where the stomach muscle is paralysed or very weak. Erythromycin is a common antibiotic which is suggested as potentially helping the stomach empty before anaesthesia. We will use a pig model to undertake high-resolution electrical signal mapping of pigs taking the GLP-1 receptor agonist semaglutide (Ozempic or Wegovy), to see how it impacts the gastric pacemaker and stomach electrophysiology and then how erythromycin counters these changes.

Dr Kate Goldstone, Dr Amy Gaskell, Dr Nicola Whittle, Waikato Hospital, Professor Leo Cheng, Auckland Bioengineering Institute, Dr Logan Voss Health New Zealand Waikato Hospital.

$A70,000

PROFESSIONAL PRACTICE RESEARCH GRANT

Unmasking stress in anaesthetists: Assessing heart rate variability and job demands

Anaesthetists operate in high-stress, high-risk settings, where sustained occupational stress can result in serious physical and psychological health issues. Such stress not only jeopardises practitioners' wellbeing but can also adversely affect patient care, organisational performance, and healthcare resource management. This proposed multi-site study will systematically investigate occupational stress among anaesthetists by examining workplace factors including job demand, control, support, conflict, and recognition. Notably, the study will emphasise the innovative use of readily available wearable technology to objectively measure heart rate variability (HRV), a physiological indicator of how the body responds to stress. Unlike traditional laboratory-based ECG approaches, leveraging consumer-grade wearables enables continuous, real-world monitoring of HRV alongside sleep and activity patterns. This novel methodology allows the collection of objective stress data in actual work and non-work environments, enriching the study's mixed methods design comprising quantitative surveys and qualitative interviews/workshops. By triangulating data from subjective and objective sources, the research aims to produce reliable, actionable insights into stressors affecting anaesthetists and to inform evidence-based interventions to mitigate burnout and psychological distress.

Dr Neil Paterson, Associate Professor Paul Lee-Archer, Queensland Children's Hospital, Dr Laura Ferris, The University of Queensland, Professor Stewart Trost, School of Human Movement and Nutrition Sciences, The University of Queensland.

$A69,584

Applicants for future Professional Practice Research grants are encouraged to contact the PPRN Executive (research @anzca.edu.au) if they have any questions regarding their application or would like mentorship prior to the grant submission date.

PROJECT GRANTS

Determining the relationship between perioperative neuronal injury and one year cognition

Deleterious brain changes occur 10-20 years before dementia manifests, representing an "at risk" period for intervention. Major surgery has already been shown to be associated with accelerated cognitive decline, however it is not yet clear whether biomarkers associated with acute postoperative delirium are, in turn, associated with cognitive decline. The present study will establish associations in dynamic plasma concentrations of neurofilament light (an axonal protein that is considered the leading biomarker of neuronal injury) at the time of surgery with change in cognition at one-year.

New scientific knowledge determining the association of acute brain injury biomarkers with one-year cognition that will focus the development of interventions to protect brain health.

Dr Neil Pillinger, Professor Rob Sanders, Dr Tom Payne, University of Sydney and Royal Prince Alfred Hospital, NSW, Associate Professor Lis Evered, St Vincent's Hospital, Melbourne, Ms Kaitlin Kramer, Royal Prince Alfred Hospital, Dr Ben Moran, Gosford Hospital, NSW.

$A70,000

Pre-planned sub-studies of the SNaPP multi-centre randomised controlled trial

The SNaPP Study recently concluded recruitment, randomising 3,500 patients across 44 metropolitan, regional and private hospitals in Australia, Aotearoa New Zealand and Hong Kong. Patients aged ≥40 years having abdominal and thoracic surgery were randomised to neostigmine or sugammadex reversal of neuromuscular blockade, with primary outcome the incidence of death and new lung complications up to hospital discharge (or postoperative day seven if still in hospital). Results of the main trial will be published early in 2026.

This grant will support sub-studies investigating issues that are important to patients. The PONV sub-study will determine whether neostigmine is associated with more nausea and vomiting than sugammadex, so that it can be avoided in patients who are at high risk, potentially improving length of stay, resource allocation, cost, and quality of life. The Frailty sub-study will examine whether frailty and other factors, such as older age and lung disease, increase the risk of lung complications after surgery. The Follow-up sub-study will look at the effect of the reversal agents and postoperative lung complications on survival one year after surgery.

Associate Professor Jai Darvall, Professor Kate Leslie, Royal Melbourne Hospital and the University of Melbourne, Professor Matthew Chan, Chinese University of Hong Kong, Dr Peter Xiang, Auckland District Health Board, New Zealand, Associate Professor Sabine Braat, The University of Melbourne.

$A69,820

Associate Professor Paul Gray

Leveraging crosstalk to mitigate opioid induced ventilatory impairment

Opioid-induced ventilatory impairment (OIVI) remains a persistent and potentially life-threatening complication in the perioperative setting. Despite their efficacy in managing post-operative pain, opioids continue to pose a significant respiratory risk – one that contributes to avoidable morbidity, prolonged hospital stay, and, in severe cases, death. With over 14,000 estimated cases of OIVI annually in Australia alone, the burden is substantial.

This project investigates a novel neuropharmacological strategy to mitigate OIVI without compromising analgesia. It builds on the discovery that ventilatory suppression arises primarily from mu-opioid receptor activation in the pre-Bötzinger complex – distinct from the sites mediating analgesia.

We aim to leverage "crosstalk" between G-protein-coupled receptors by activating orexin-2 receptors in the brainstem to reverse opioid-induced respiratory depression. Central to this strategy is ALKS 2680, a selective orexin-2 receptor agonist currently in late-phase clinical development for narcolepsy. Through electrophysiological and behavioural studies in mice, we will evaluate its capacity to restore ventilatory drive in the presence of opioids.

If successful, this work will provide a mechanistic and translational foundation for clinical trials, potentially leading to safer postoperative opioid prescribing with reduced risk of OIVI.

Associate Professor Paul Gray, Tess Cramond Pain and Research Centre, Associate Professor Sebastian Furness, Dr Farhad Dehkhoda, The University of Queensland.

$A70,000

Associate Professor Tim Coulson

Amino acid infusion to improve renal outcomes after pulmonary organ transplantation (AIRPORT Study)

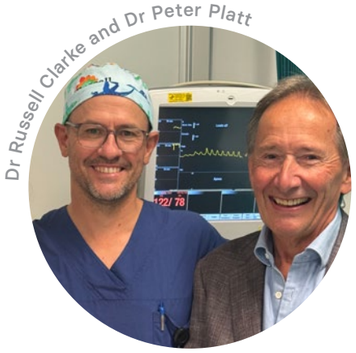
Acute kidney injury (AKI) occurs in up to two-thirds of patients after lung transplantation, and renal replacement therapy is required in 10%. Amino acid infusion has been shown to reduce AKI in cardiac surgical patients. No trial of amino acid infusion has taken place in lung transplant. The AIRPORT study will determine feasibility of a larger definitive trial and investigate efficacy using markers of kidney function. We will include all adult patients undergoing lung transplantation surgery. Patients will be randomised to either a blinded balanced amino acid infusion (Synthamin 17 10%) or placebo (balanced crystalloid solution), started after induction of anaesthesia and continued for 72 hours. Feasibility outcomes will include consent rate, protocol compliance and confirmation of consumer engagement endpoints. Efficacy outcomes will include urinary neutrophil gelatinase associated lipocalin (NGAL), GFR, Cystatin C and urinary albumin:creatinine ratio.

A finding of feasibility and efficacy will lead to the design and funding application for a larger and definitive study in lung transplantation investigating patient centred outcomes.

Associate Professor Tim Coulson, Professor Glen Westall, Professor David Pilcher, Professor Silvana Marasco, The Alfred Hospital, Melbourne.

$A64,955

Dr Russell Clarke and Dr Peter Platt



IRIS (increasing rate infusion system) study

Perioperative anaphylaxis remains a leading cause of anaesthesia-related morbidity. When skin testing is inconclusive, drug provocation testing (challenge) is often required to prove drug safety. Standard constant-rate infusions can unintentionally deliver excess dose between the moment a reaction is biologically triggered and the moment it is recognised.

This randomised, doubleblind trial at Sir Charles Gairdner Hospital's Perioperative Challenge Clinic tests whether IRIS – a nonlinear, exponentially increasing test-dose delivered via a novel dualchamber syringe and infusion pump – reduces the total dose at reaction recognition versus constant infusion. Secondary outcomes include reaction severity, duration and feasibility of routine use. Target recruitment is n=40 over 24 months, with intention-to-treat analysis and DSMB oversight.

IRIS is a singleuse, fully-automated Australian device listed on the ARTG. It leverages the parallel log–dose–response of immediate hypersensitivity – dose ratios for equal severity are approximately constant across patients – to create orderofmagnitude spacing early in the infusion and cut excess dose if a reaction emerges. If effective, IRIS could lessen severe reactions, ICU admissions and surgical cancellations while fitting existing infusion workflows, particularly in scenarios previously suited to test dosing. ANZCTR: ACTRN12624001002572.

Dr Peter Platt, Dr Russell Clarke, Sir Charles Gairdner Hospital, Western Australia.

$A40,350

Associate Professor Michal Kluger

Preoperative prediction of chronic postsurgical pain with functional impairment in a New Zealand tertiary referral centre

This study investigates ways to accurately predict chronic postsurgical pain (CPSP), a common, costly and often burdensome complication after surgery. Current prediction models lack precision, limiting the ability to prevent CPSP through targeted care. The research will validate a new electronic preoperative questionnaire, combined with information from electronic health records (EHRs), to measure functionally significant CPSP at three and 12 months post-surgery. Over six months, approximately 6000 patients undergoing planned surgery at Health NZ – Waitematā in Auckland will participate. The questionnaire will assess known CPSP risk factors, including pre-existing pain, medication use, and psychological well-being. Demographic and medical history data will also be extracted from EHRs. Participants will complete follow-up 2 surveys to measure CPSP and its interference with daily functioning (CPSP-F). The study will determine CPSP and CPSP-F prevalence across a wide range of surgery types and use both traditional statistical methods and Machine Learning to test predictive model accuracy.

By identifying high-risk patients early, the findings aim to support timely, cost-effective, and targeted interventions, improving recovery outcomes, preventing chronic pain development, and optimizing healthcare resource allocation for those most likely to benefit with an existing perioperative medicine model of care.

Associate Professor Michal Kluger, Associate Professor David Rice, Dr Daniel Chiang, Dr Chen Kai Jin, Health New Zealand Waitematā-Te Whatu Ora, Auckland, Dr Nico Magni, Associate Professor Mangor Pedersen, Auckland University of Technology, New Zealand.

$A69,944

Myocardial protective effect of pre-operative melatonin following CABG surgery: A randomised controlled trial

Cardiovascular disease remains the leading global cause of death, with reperfusion injury continuing to limit the benefits of restoring blood flow after ischemia. Experimental evidence suggests melatonin can mitigate reperfusion injury through its antioxidant and anti-inflammatory properties, yet human data remain limited. Given melatonin's excellent safety profile, affordability, and accessibility, this study aims to evaluate its potential cardioprotective role during ischemia–reperfusion (I/R) injury in cardiac surgery.

This multicentre, prospective, randomized, double-blind, placebo-controlled phase 2 trial will assess the effect of a once-off, sublingual preoperative dose of melatonin in patients undergoing elective coronary artery bypass grafting (CABG) at Sir Charles Gairdner and Fiona Stanley Hospitals. Participants (aged 18-90 years) will be randomized to placebo, low-dose (10 mg), or high-dose melatonin (30 mg).

The primary aim is to determine whether preoperative melatonin reduces myocardial injury, measured by high-sensitivity troponin T (hsTnT) levels. Secondary aims include evaluating melatonin pharmacokinetics, anti-inflammatory effects (via C-reactive protein), and dose–response relationships between melatonin levels, inflammation, and cardiac injury.

Blood samples for melatonin, hsTnT, and CRP will be collected preoperatively (to establish baseline values), intraoperatively, and at 6, 12, and 24 hours postoperatively. This study may support melatonin as a simple, safe, and low-cost cardioprotective adjunct.

Dr Marli Smit, Dr Dale Currigan, Sir Charles Gairdner Hospital, Western Australia.

$A12,153

Effect of sugammadex on serum concentrations of levonorgestrel in women who take oral contraceptives – a multicentre RCT

The primary aim of this study is to determine and compare changes in plasma concentration of levonorgestrel after sugammadex (intervention) or neostigmine (control).

There are no published studies on exogenous hormone changes in relation to sugammadex administration in women who take hormonal contraception. This study will determine if sugammadex or neostigmine affects the serum concentration of levonorgestrel – Australia's most common hormonal contraceptive listed on the Pharmaceutical Benefits Scheme. It will also determine if ovulation has occurred in the post-operative period for a sub-group of participants, which would indicate contraceptive failure.

Serum concentrations of levonorgestrel may be reduced after exposure to sugammadex to a degree that risks contraceptive failure and unintended pregnancy in female patients.

The information generated from this research project will produce scientific evidence to address the current global concerns about contraception efficacy after sugammadex administration. If a significant change in plasma hormone concentrations does not exist, then this will provide clinicians with the confidence to use this drug in young females without fear of a threat to contraception and unintended pregnancy and is a step closer to gender equality in health.

This study is part of a PhD for Dr Tamblyn Devoy through the University of Wollongong, NSW, Australia.

Dr Tamblyn Devoy, Associate Professor Natalie Smith, Wollongong Hospital, NSW.

$A61,150

Heart rate variability for the objective measurement of stress and anxiety in caregivers and their children undergoing surgery – an observational study (Pulse Star)

Anaesthesia can be a stressful time for children. Perioperative anxiety increases the risk of emergence delirium, post-operative behaviour changes and poor compliance with future episodes of healthcare.

Caregivers often accompany their child to theatre to reduce the child's anxiety, however if the caregiver is feeling stressed and anxious themselves, it can make the child feel worse.

One problem that is holding back successful research in this area is how to effectively measure the stress and anxiety levels for both the child and the caregiver.

Currently we rely on skilled observers to rate anxiety, but this is labour intensive, subjective and inconsistent. One promising solution is to use heart rate variability which can be used to measure someone's general level of stress and also moments of increased stress.

Previously it was necessary to do a formal ECG to determine heart rate variability and this made the measurement impractical in many clinical situations. Now, it is possible to obtain accurate ECG data with a sensor worn on the wrist, arm or chest.

This study aims to show the feasibility, acceptability and clinical utility of heart rate variability measured using a wearable device in children and their caregivers at induction of anaesthesia.

Associate Professor Paul Lee-Archer, Queensland Children's Hospital, Dr Karin Plummer, Griffith University, Gold Coast, Professor Stewart Trost, School of Human Movement and Nutrition Sciences, University of Queensland.

$A70,000

All of these ANZCA research grants are funded by the foundation. If you would like to donate to support this important work, please scan the QR code.

Grant review process

On behalf of the college, the ANZCA Research Committee thanks all reviewers who reviewed one and in many cases several grant applications for your invaluable contributions to the peer-review process. A full list of reviewers can be found on the ANZCA website.

Much effort continues to be made to ensure that the process is as fair and rigorous as possible. Each year ANZCA Research Committee members consider the grant applications and select three reviewers for each grant, based on their relevant expertise. One reviewer, a member of the committee, is appointed "spokesperson", while the other two are from outside the committee. These reviewers include expert researchers from anaesthesia, perioperative medicine, pain medicine, and other disciplines as required and include reviewers from overseas. The reviewer comments are sent back to the researcher applicants and the spokesperson then collates the information into a synopsis with an overall score. Each application is then discussed in detail by the whole committee during a day-long face-to-face meeting, with the final scores determined by the averages of ballot scores (out of seven) from each committee member, provided via a fully blinded electronic voting system to minimise bias.

Conflicts of interest are declared and recorded, and members of the committee are excluded from discussion and scoring of any applications for which they have conflicts. The presence of Mr Andrew Brookes, our community representative, and his long experience in ethics committees, medical research grants, and corporate governance adds an extra safeguard.

Finally, funding is allocated to the proposed projects considered to be of "fundable" quality in descending order of the final averaged committee member scores, within the limits of the funds available. The success rate consistently averages over 40 per cent, significantly higher than most other grant programs. Inevitably, in any competitive process some applicants are unsuccessful. As with most grant programs, feedback is not provided to any applicant after the committee has finalised its decisions, except to novice investigators. However, detailed feedback on applications is formally provided during the review process through reviewers' comments to applicants, which reflect most of the factors that will influence committee decisions. Most committee members have themselves experienced many unsuccessful applications to ANZCA and other granting agencies and recognise the disappointment felt when a submission is unsuccessful. However, unsuccessful applications also help applicants to develop grant writing skills for future success, and perhaps it is this persistent pursuit of continual improvement that most characterises all ANZCA grant applicants. The Research Committee recognises the significant time and effort involved in grant writing, extends its thanks and encouragement to all applicants, and strongly encourages all fellows and trainees considering applications to apply for the 2027 grants round which opened on 1 December 2025.

Every year committee members, reviewers and ANZCA staff continue to work to maintain and improve our high-quality research grant process.

During 2025, the committee reviewed the grant quantums to appropriately reflect the cost of conducting research, allowing for cost inflation, the first review since 2012. With council approval, the project grants, professional practice research grants and the Lennard Travers and Douglas Joseph Professorships maximums will increase to $90,000. Second year grant funding and scholarship funding will be discontinued and the latter replaced with up to A$5000 tied funding. This additional funding is available for chief investigator A if enrolled in a higher degree to attend an ANZCA ASM. This tied funding will be automatically made available to the successful applicant of the Patrons Emerging Investigator grant to attend an ANZCA ASM.

The committee believes this will provide a more equitable grant program for all applicants.

The contribution of committee members and reviewers are often made in their own time. We would like to express our sincere thanks to all of them, and to the council, president, and CEO of ANZCA for their ongoing commitment to research led by our fellows and trainees, as a vital contribution to continuous improvement and excellence in quality, safety and patient outcomes.

This will be my last report as chair of the Research Committee. I will be stepping down at the end of January 2026 after nearly 13 years as a member of the committee. I feel privileged to have been able to work alongside my wonderful colleagues from the research committee, driving change to improve the grant process, particularly supporting emerging researchers and bringing change to the college's research agenda. Being the chair of the Research Committee for the last three years has been a rewarding experience, and it is wonderful to see the important and diverse work the college has continued to support, helping to provide safe and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. A new chair will be formally appointed by ANZCA Council in December.

Professor Britta Regli-Von Ungern-Sternberg, Chair

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Research grants for 2027

FOUNDATION GRANTS ARE NOW OPEN

Information for applicants

During 2025, the Research Committee reviewed the grant quantum to appropriately reflect the cost of conducting research, allowing for cost inflation, the first review since 2012. The Research Committee believes this will provide a more equitable grant program for all applicants.

Following council approval, the following changes have been made:

- The quantum for project grants, professional practice research grants and the Lennard Travers and Douglas Joseph Professorships has increased to $90,000.
- Second-year grant funding has been discontinued.
- Scholarship funding, except for the Skantha Vallipuram ANZCA Research Scholarship, has been discontinued and has been replaced with tied funding of up to A$5,000. This additional funding is available for chief investigator A (CIA) if enrolled in a higher degree to attend an ANZCA ASM to present on their project and for networking/mentoring.
- The quantum for the Patrons Emerging Investigator grant is now A$50,000, and the successful applicant will also receive tied funding of up to A$5,000 to assist the emerging investigator to attend an ANZCA ASM to present on their project and for networking/mentoring.

ANZCA FOUNDATION GRANTS PROGRAM

Applications are invited from fellows and registered trainees of ANZCA and FPM for the following research grants and awards for projects related to anaesthesia, perioperative medicine, or pain medicine.

Grants available for 2027:

- **Academic Enhancement Grant**
  This grant aims to foster the advancement of these academic disciplines, and help establish, enhance or sustain a research program. All chief investigators must be fellows of ANZCA and/or FPM with an academic appointment.
- **Lennard Travers Professorship**
  This is a prestigious award to support a fellow to work in an area of their choosing towards the advancement of knowledge in a nominated area of anaesthesia.
- **Project Grants**
  These grants support specific research projects proposed by fellows and trainees.
- **Professional Practice Research Grants (including simulation and education)**
  These grants support high quality research to provide evidence for effective, efficient, safe and equitable professional practices in anaesthesia, perioperative and pain medicine for patients, organisations and staff and include the areas of education, simulation, strategies for translating and implementing evidence into clinical practice and the ANZCA roles in practice.
  Applicants are encouraged to contact the PPRN Executive (research@anzca.edu.au) if they have any questions regarding their application or would like mentorship prior to the submission date.

To find out more about the Professional Practice Research Grants, scan the QR code

- **Novice Investigator Grants**
  Early applications from novice investigators are invited by 14 January 2026 for mentoring during the application process. Further details are available on the website.
- **ANZCA Patrons Emerging Investigators Grant**
  A dedicated grant to support emerging researchers transitioning from the novice investigator grant level. The grant is named in honour of the foundation patrons who are high-level donors to research.
- **Environment and Sustainability Research Grant**
  This grant is the initiative of a group of anaesthetists and the foundation to encourage and support research exploring the environmental impact of anaesthesia and related products and activities.
- **Skantha Vallipuram ANZCA Research Scholarship**
  This scholarship has been established by the family of Dr Vallipuram, FANZCA FFPMANZCA to support a fellow or trainee enrolled in a higher research degree and assist in establishing their research career.

Full details of the ANZCA grants program and each of the grant categories with the relevant application forms and guides for applicants are available on the college website. Further resources for applicants can be found in the ANZCA library research hub.

The closing date for all grant applications is 5pm AEDT 1 April 2026.

For further information, please email Susan Collins, Research and Administration Coordinator at research@anzca.edu.au

ANZCA FOUNDATION HONORARY NAMED RESEARCH AWARDS FOR 2027

Russell Cole Memorial ANZCA Research Award
Robin Smallwood Bequest
Elaine Lillian Kluver ANZCA Research Award
John Boyd Craig Research Award
Patricia Mackay Memorial ANZCA Research Award
The W. John Russell ANZCA Research Award
The ANZCA Innovation and Technology Research Award
Darcy Price Regional Anaesthesia Award

Thank you to all foundation donors

The ANZCA Foundation is grateful to its patrons, bequestors, and generous donors for assisting the vital work of fellows and trainees in research in anaesthesia, pain medicine and perioperative medicine, Aboriginal, Māori and Torres Strait Islander health, and in global health development.

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Reports on funded research findings continue

Our series of summary reports on new findings from the ANZCA Foundation and donor-funded research projects continues in this issue of the *ANZCA Bulletin* on page 74, supplementing the announcements of new studies to be funded from 2026.

The reports will continue to feature "world-firsts", and highly relevant outcomes for clinical practice. References to publications from each study, in leading peer-reviewed journals, will be available via the QR code link to the research outcomes page in the foundation section of the ANZCA website, and full publications are available from the ANZCA Library.

This second in the series of reports continues to highlight advances and benefits delivered by our fellows and trainees through the foundation's support for research, and to promote awareness of peer-reviewed literature in the areas around these studies.

SUCCESSFUL ARRC FUNDING APPLICATION

The foundation was delighted to be advised by the Medibank Better Health Research Hub in November that its application for $A95,000 lodged in September has been successful. The grant is for a project to support multi-site implementation of Advanced Recovery Room Care (ARRC), a proven perioperative model of care led by Professor Guy Ludbrook from Royal Adelaide Hospital, or similar models.

The model was associated with a 35 per cent reduction in postoperative complications among medium risk patients enrolled in Professor Ludbrook's previous ANZCA Foundation-funded single site study at Royal Adelaide Hospital, and since implementation as standard care at that site, an actual reduction of 50 per cent. This was also associated with reductions in length of stay, unplanned intensive care unit admissions, and mortality.

The project will provide online resources and network support for the many hospitals across Australia and internationally now considering or actively seeking to implement this model of extended recovery room care.

By proactively supporting and securing funding for this research implementation project, this collaboration between the ANZCA Foundation, Professor Ludbrook, and the Medibank Community Fund Research Hub advances the ANZCA Foundation's and ANZCA Research Committee's goal of promoting and supporting research translation and implementation into clinical practice, as per the ANZCA research strategy.

CHANNEL SEVEN TELETHON TRUST GRANT APPLICATIONS

It is expected that the foundation will be advised in late December of the outcomes of its applications for three proposed studies in paediatric anaesthesia lodged with the Channel Seven Telethon Trust in Western Australia.

2025/26 RESEARCH GRANTS ROUND

The annual all-day face-to-face grants meeting of the ANZCA Research Committee was completed in September, assessing 56 funding applications received for studies to commence in 2026. All applicants have been advised of the outcomes, with the successful applicants' proposed studies outlined in the research section of this issue.

The foundation looks forward to reporting on the outcomes of all of these studies upon their completion and publication.

RESEARCH LITERATURE SUPPORT FOR FELLOWS AND TRAINEES

The ANZCA Foundation, ANZCA Research Committee, and ANZCA Clinical Trials Network medical research program continue to ensure that the national and international body of scientific literature and evidence available to support excellence in clinical practice includes a significant contribution from ANZCA and FPM fellow and trainee clinician investigator-led studies.

This, in turn, ensures that the literature includes a strong and diverse component of knowledge and evidence sourced from high-quality research that has involved Australian and New Zealand patients, hospitals, and universities, with findings valid for local contexts.

This also includes many Australian, New Zealand, and Hong Kong arms of international multicentre randomised clinical trials, the sources of "gold-standard" evidence, often facilitated by early foundation-funded exploratory and feasibility studies.

The published outcomes of these foundation-supported studies, as well as the national and international scientific literature, are all easily available to all ANZCA and FPM fellows and trainees via the ANZCA Library, especially the online research hub and the ANZCA Institutional Research Repository (AIRR), as a major benefit of fellowship.

From basic science and exploration to multicentre trials, spanning a wide range of craft groups, sub-specialties, and patient cohorts across anaesthesia, pain medicine and perioperative medicine, the foundation is pleased to be able to contribute to making sure the literature is accessible, locally valid, and up to date.

We particularly thank all ANZCA Foundation donors for helping make this possible, for the benefit of our fellows, trainees, and ultimately all patients who receive care in our specialties.

Please continue to or consider supporting the work we support through the ANZCA Foundation, and we wish you all a safe, healthy and relaxing Christmas and New Year.

ANZCA research – the outcomes

OUTCOMES AND IMPACTS OF RECENT FOUNDATION-FUNDED RESEARCH

Over many years, ANZCA has allocated $A1.5 million or more each year for research in anaesthesia, pain medicine, and perioperative medicine. In this second report of this ongoing series, we bring you results from more research projects supported by grants funded through ANZCA Foundation investment earnings, donor gifts, 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 healthcare specialists and professionals to continually improve clinical practice and patient outcomes within our health system.

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

NEW UNDERSTANDINGS OF RESPONSES TO SPEAKING OUT IN THEATRE

Speaking up in the operating room: a grounded theory study

In 2023, Professor Jennifer Weller and Dr Tanisha Jowsey from the University of Auckland, and Professor Sandy Garden of Wellington Regional Hospital in New Zealand, reported on the outcomes of the ANZCA Foundation Project Grant they received in 2019 for this study.

$A68,635

Speaking up with concerns is an important issue for patient safety. Team members must feel safe to voice concerns, suggestions, or questions. This continuing problem contributes to a high proportion of unintended patient harm.

While efforts to help staff speak up against hierarchy gradients or professional boundaries are worthwhile, the investigators proposed that clinical leaders have a responsibility to create an environment where staff can speak freely, confident that they will be listened to respectfully.

This study began a clinical program aimed initially at understanding why clinical leaders might react negatively when staff speak up, and subsequently at using new understandings to develop and evaluate interventions to help leaders create environments where all team members have a voice and are actively involved in their patients' care and safety.

Interviews and focus groups were conducted with surgeons, anaesthetists, nurses, and anaesthetic technicians in operating theatres across New Zealand. With data from 79 participants, the team conceptualised three phases in the speaking up interaction: 1) content of speaker message and delivery tone; 2) message interpretation through receiver filters including personal fallibility and leadership beliefs, respect for the speaker, understanding the challenges of speaking up, and personal cultural and professional communication norms; and 3) the receiver's response and its effects on the speaker, observing operating theatre staff, and patient care.

The research led to an in depth understanding of the basis of responses to being spoken up to. The findings led to the development of a grounded theory, model-based, new critical reflection questionnaire, which is now being used in a communications workshop on "giving the team a voice".

The workshop is being incorporated into the instructor training course in New Zealand's NetworkZ national multidisciplinary simulation-based team training intervention, reflecting a pathway from research to translation, and then to implementation into clinical environments.

The potential implications are that ultimately, the findings will play an influential role in effecting change in the culture of healthcare workplaces towards ones of respect and inclusion.

ENDOSCOPY PATIENTS COMMONLY DEHYDRATED AND HYPOTENSIVE BEFORE PROCEDURE

Fluid status after bowel preparation for colonoscopy: objective assessment and relationship to hypotension under sedation

Dr Megan Allen and Professor Kate Leslie from Royal Melbourne Hospital received a project grant from the ANZCA Foundation through the ANZCA Research Committee for this study on the unknown relationship between hypotension and dehydration in these procedures in 2017, and reported on the final outcomes in 2023.

$A54,938

Hypotension is a common problem during sedation for endoscopy, but whether this is due to dehydration (from fasting, bowel preparation, or both), or to the sedative medications, was unknown. This study planned to use advanced technology, heart ultrasound, and a specialised finger probe to measure if patients were dehydrated before their procedures. Both were used in the same patients to determine the suitability of the easier finger probe method for future patients, when cardiac ultrasound is unavailable. A secondary aim was to investigate whether patients who were dehydrated before the procedure were more likely to have intra-procedural hypotension, and any differences in their recovery.

Patients undergoing elective lower intestinal endoscopy were found to commonly be dehydrated before their procedure on cardiac ultrasound. The technologies used to assess dehydration were inconsistent, and use of the finger probe when cardiac ultrasound is unavailable could not be recommended. After sedation, blood pressure commonly became lower than at baseline, and this reached a clinically important level for a significant minority of patients. Dehydrated patients were more likely to have clinically important hypotension during their procedure. Strategies to reduce dehydration in colonoscopy patients and optimising hypotension prevention during their procedure are important future research targets.

This research found that there was no reliable, readily available technology to determine patient dehydration when cardiac ultrasound is unavailable. However, understanding the commonality of pre-procedural dehydration and significantly low intra-procedural blood pressure can prepare anaesthetists to better care for patients. ANZCA recently updated pre-procedure fasting guidelines which may assist future patients. The research increased understanding of the patient experience and increased knowledge vital for preventing future patient harm.

DISCOVERY OF RNAS IN CEREBROSPINAL FLUID LINKED TO PAIN

Exosomal miRNAs in cerebrospinal fluid as objective descriptors of pain states

In 2018 the foundation's John Boyd Craig ANZCA Research Award for pain medicine was awarded to Professor Paul Rolan at the University of Adelaide for this study, and the final report was received in 2024. The team included Dr Porhan Kang and Dr Michael Zenon, Flinders Medical Centre Adelaide; and Professor Rainer Haberberger and Dr Dusan Matusica, Flinders University, Adelaide.

$A70,066 over two years.

New treatments and ways to diagnose and target pain are urgently needed, as pain and chronic pain after injury and nerve damage affect many people's lives. Pain is perceived differently by individuals, and what causes severe pain for one might not for others. With pain affected by behaviour, expectation, and other psychological factors, it is very difficult to measure. Many treatments only work in a limited proportion of patients, necessitating multiple trials of drug therapy, which may be ineffective, yet expose patients to unwanted side effects.

A more objective way to measure pain would help health professionals to better diagnose and manage it.

In this research, completed in 2024, the team aimed to determine whether it is possible to find measurable markers for pain in samples of human cerebrospinal fluid (CSF). To do that, they isolated tiny vesicles from the cerebrospinal fluid, inside of which are very small molecules, RNAs, that might be linked specifically to pain.

After isolating RNAs from these vesicles, the team compared their diversity and composition between people with diabetes who suffered ongoing pain and those who did not. They found molecules that were present in the CSF of people with ongoing pain but absent in those without pain. In addition, they found that the structure of those molecules seemed to be different.

This is the first study to have ever found small RNAs in the cerebrospinal fluid that are linked to pain.

The investigators will now confirm these results, and use the information to develop a kit to make it easier to track pain progression in patients who suffer ongoing pain. This would be especially useful for patients who have an intrathecal pump exchanging anti-pain medication with CSF, as the exchanged CSF could be used for tests including the efficacy of medications.

FIRST EVALUATION OF A CLINICAL DECISION SUPPORT SYSTEM FOR MASSIVE TRANSFUSION

Computerised decision support to improve efficiency and outcomes of massive blood transfusion

Dr Brenton Sanderson of Westmead Hospital and Macquarie University, Sydney, secured an ANZCA Foundation Project Grant in 2020 for this study, and provided the final report in 2023. The research team included Professor Enrico Coiera, Macquarie University, Sydney; Professor Erica Wood, Monash University, Melbourne; Dr Lise Estcourt, John Radcliffe Hospital, Oxford UK; and Dr Jeremy Field, Westmead Hospital, NSW.

$A130,244 including scholarship.

Major bleeding can occur in surgical, trauma, obstetric, or critically ill patients, but remains difficult to manage, requiring significant hospital resources often urgently and unexpectedly.

Patients may require massive blood transfusion (MT), and recent studies show 30-day mortality at more than 20 per cent, related to blood loss, underlying causes, or complications. Studies show that MT requires a time-critical, coordinated effort between front-line clinicians, haematologists, and hospital blood bank staff, working in separate environments to expedite complex transfusion support.

Most hospitals use a locally adapted MT Protocol (MTP) to determine roles, activities, blood products, quantities, laboratory investigation guidance, success markers for resuscitation, and continuing management specific to cause of bleeding. High quality process completion is associated with better patient outcomes, reduced blood resource requirements, and lower overall cost.

MT requires critical decisions on timing and blood product selection, often by staff resuscitating the patient, involving significant stress. Clinical decision support systems (CDS) developed to improve complex care, involving computerised evidence-based rules, algorithms and patient information, are shown to reduce blood transfused and complications in non-critical settings. However, before this research no studies had evaluated their efficacy in critical bleeding requiring MT.

This project aimed to enhance MT decision-making by developing and evaluating a CDS; identify quality indicators and processes for optimised MT decision-making; and to describe barriers and risks in these processes.

The team's systemic literature review of current MT measures research identified a lack of international consensus on optimal quality care measures. Significant variation in the quality indicators reported limited potential to guide future decision making. Pragmatic indicators that may represent high quality care were also identified for future investigation.

In a binational MT survey, anaesthetists reported that multiple simultaneous tasks and lack of equipment to measure patient's blood clotting potential limited their subjective performance the most. A majority supported future use of a CDS for MT.

A prototype MT CDS was then developed using best-practice evidence-based software development, involving clinical staff, and several opportunities were identified to improve MT efficiency and efficacy. The prototype, "MTP Assistant", was evaluated in a randomised simulation trial using a simulated bleeding patient compared to current best practice. MTP Assistant improved decision efficiency, with similar efficacy, while reducing clinical team cognitive load.

These outcomes also support the potential to use a decision support approach in other emergency scenarios associated with high cognitive load.

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

CONTACT AND SUPPORT

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

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CTN drives rural and regional participation in clinical trials

The ANZCA Clinical Trials Network (CTN) successfully implemented the Australian Teletrials Program (ATP), a national initiative funded through the Medical Research Future Fund (MRFF) that expands clinical trial access for rural and regional patients.

Based on a hub-and-spoke model, the program enables established sites with resources and expertise to mentor and support regional hospitals, building on local capability and broadening patient participation in research.

In South Australia, this approach built on a long-standing collaboration between Flinders Medical Centre, an experienced CTN site, and Mt Gambier Hospital, a regional hospital keen to develop local research activity. The Flinders team, including research nurse Louise de Prinse and senior consultant Dr Mervyn Atkinson, worked closely with Mt Gambier clinicians and FANZCAs Dr Nicole Forbes-Olivier and Dr Cecile van der Westhuizen, anaesthetic registrar Dr Henry Shaw, research co-ordinator Jane Fuller, Charlotte Goess from the ATP and strong support from the Flinders research governance office.

Through feasibility assessments, business case support, site visits, and regular Zoom meetings, both teams, supported by the South Australian ATP and the Sugammadex, Neostigmine and Postoperative Pulmonary Complications (SNaPP) trial teams, built confidence and capability to recruit to the SNaPP study locally.

Through mentorship and hands-on support, the Mt Gambier team gained valuable research experience in Good Clinical Practice (GCP) training, ethics and governance submissions, and patient screening, consent, and recruitment. Although they joined near the conclusion of the SNaPP study, their involvement laid the groundwork for future participation in CTN-endorsed trials.

At the same time, the collaboration between the Alfred Hospital in Victoria and Royal Darwin Hospital in the Northern Territory advanced the TRITON study, further strengthening rural and regional engagement through the ATP. The successful implementation of the ATP now sets a benchmark for embedding rural and regional participation into future trial protocols, ensuring the hub-and-spoke model is incorporated from the outset.

This milestone reflects months of coordinated effort across the CTN office, trial teams, the Australian Clinical Trials Alliance, ethics committees, trial sponsors, and ATP collaborators nationwide, who worked together to overcome governance and operational barriers and establish a sustainable framework for participation.

Involving rural and regional patients in clinical trials improves follow-up, early complication detection, and engagement with healthcare, while fostering a culture of evidence-based practice.

Hospitals benefit from a strengthened culture of research excellence, clinicians gain opportunities for professional development, and the healthcare system as a whole stands to benefit from improved outcomes and more generalisable research.

Expanding trials into rural and regional areas enables research to be embedded in daily care, driving real-world translation and measurable health and economic gains.

With nearly 30 per cent of Australians living in rural and regional areas, this initiative represents a critical step towards equity, inclusion, and impact in perioperative medicine research.

FROM TOP

Flinders team, from left: Louise de Prinse and Dr Mervyn Atkinson.

Mt Gambier team from left: Jane Fuller - Research co-ordinator, Dr Cecile van der Westhuizen - FANZCA, Dr Henry Shaw- anaesthetic registrar, Dr Nicole Forbes-Olivier - FANZCA.

Harnessing the power of mentorship in research

Dr Matthew Bright, a cardiac anaesthetist at Brisbane's Prince Charles Hospital, is the inaugural recipient of the ANZCA Clinical Trials Network's Emerging Investigator Prize for his study examining personalised blood pressure management during cardiac surgery (*WAVELET-II: Individualised haemodynamic optimisation informed by the lower limit of cerebral autoregulation during PEARS (Personalised External Aortic Root Support) surgery*). The prize, supported by the ANZCA Foundation, recognises early career researchers in anaesthesia, pain medicine, and perioperative medicine, fostering innovation and academic excellence.

Dr Matthew Bright's fascination with research began in high school when he couldn't wait to participate in summer school lab projects at Sydney's Prince of Wales Hospital.

His enthusiasm for research was first fostered during his undergraduate honours degree in science and then when he moved to Melbourne to complete a medical degree. After deciding to specialise in anaesthesia he then moved to Brisbane where, in addition to his clinical work, he's now completing a PhD at the University of Queensland.

Dr Bright (left) is quick to credit the mentors who have guided him since his student days. After his early introduction to lab-based science, he was encouraged to pursue medicine to combine clinical and research skills. During his medical degree at the University of Melbourne he received crucial advice from FANZCA Professor Alicia Dennis: focus first on training, then return to research when the time is right.

The move to Brisbane brought new connections – FANZCAs Professor Victoria Eley and, later, his PhD supervisor Associate Professor Jonathon Fanning and Associate Professor David Highton – all of whom helped foster his research skills and introduced him to the ANZCA Clinical Trials Network (CTN).

"Victoria Eley told me early on that your hardest research project is your first one," he recalls.

"She was right. Each time you go through the process, it gets a little easier. I definitely wouldn't have made it this far without the support of mentors who guided me through the hurdles."

Dr Bright's PEARS study explores how brain monitoring can be used to individualise blood pressure management during surgery.

"The aim is to make surgery safer by personalising or individualising blood pressure targets using brain monitoring," he says.

"Everyone has a different threshold for maintaining adequate blood flow to the brain. If we can determine that limit for each patient in real time, we can reduce the risk of postoperative complications such as confusion or kidney dysfunction."

Dr Bright explains how PEARS surgery is used to reinforce dilated aortas in mostly young patients with connective-tissue disorders. It requires a period of profoundly low blood pressure, offering a natural setting to study cerebral autoregulation.

"It's a really elegant operation," he says.

"Instead of replacing the valve, surgeons fit a sort of compression sleeve around the aorta. It spares the patient from cardiopulmonary bypass and lets them keep their native valve."

Dr Bright's award is the first significant research accolade he's received from ANZCA and the CTN.

"The emerging investigator stream is a new initiative, and it's been fantastic to see the college creating opportunities to encourage junior investigators to get involved."

The new award, introduced at the 2025 ANZCA CTN Strategic Research Workshop at Glenelg in August, is designed to foster early career researchers and provide structured mentoring and development sessions alongside presentations and workshops. For Dr Bright, who had attended the previous year's CTN meeting and was a convenor of this year's new and emerging investigators' stream, the format was both practical and inspiring.

"There were mentoring sessions, introductions to basic statistics, and the opportunity to present potential projects that could one day lead to randomised clinical trials," he explains.

With ethics and governance approval now complete, recruitment for his PEARS study's 40-50 patients will begin early next year at Prince Charles Hospital.

"It's an exciting step," he says. "We're hoping this work will ultimately contribute to developing a real-time monitor to help clinicians target blood pressure more precisely during surgery."

Now, as a fellow balancing clinical and research responsibilities, Dr Bright is mindful of paying forward the support he's received.

"For trainees who are interested in research, the best thing you can do is seek out mentors – at your hospital, through ANZCA meetings, or at CTN events. Just start a conversation. You don't need to begin by designing a multicentre trial; you can join an existing CTN study and learn from how it's done."

He believes that the culture of collaboration within the ANZCA CTN is key to sustaining innovation.

"There's incredible support within the network," he says.

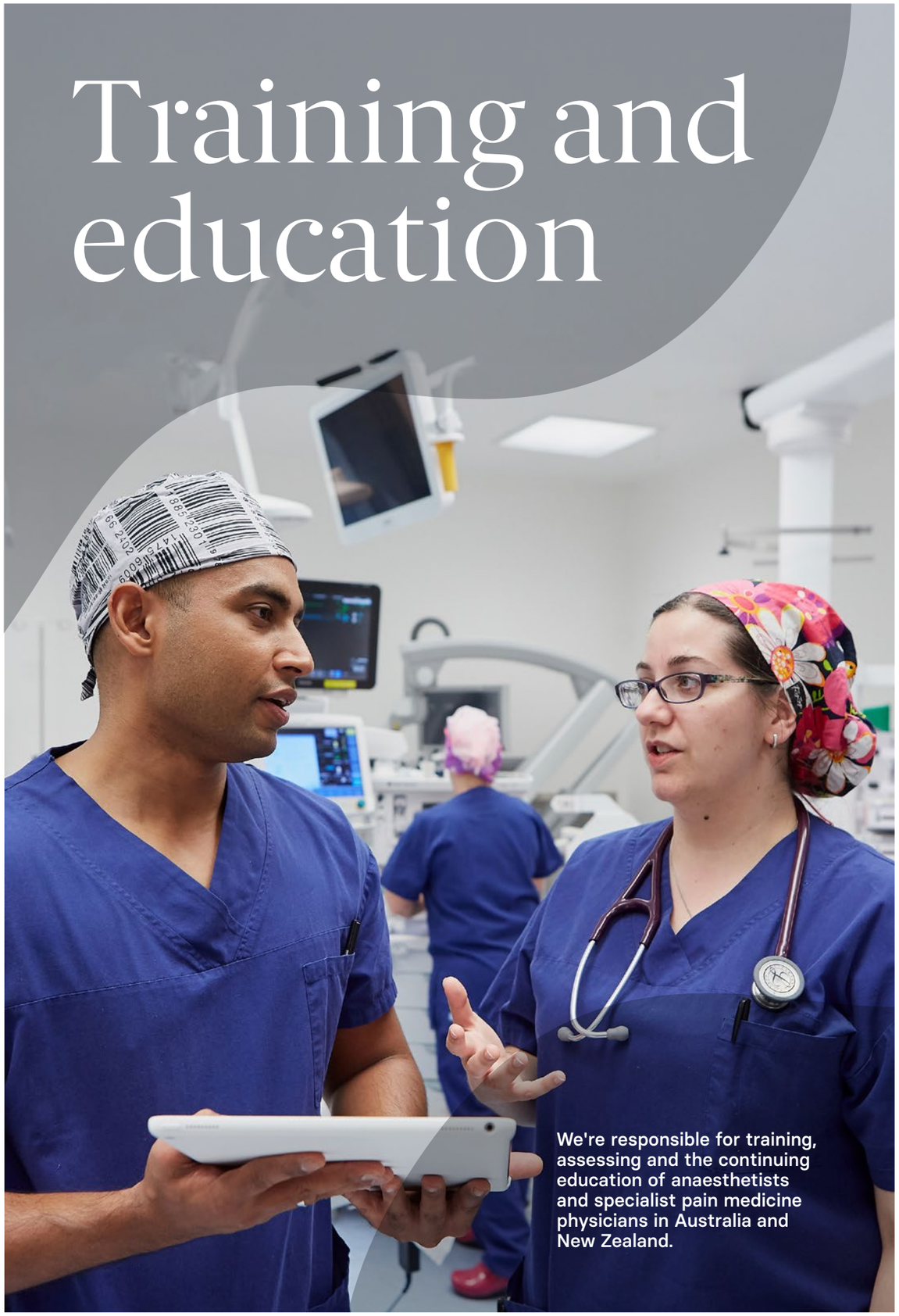
"Everyone is willing to help you succeed. For me, that's been the difference – having mentors who encouraged me to take that first step."

Carolyn Jones
Media Manager, ANZCA

ABOVE

View of The Prince Charles Hospital from drone, 2020. Image courtesy of Wikimedia Commons.

Training and education



Returning to the primary exam decades later

ANZCA President-Elect Dr Tanya Selak recently sat in on the primary exam in Brisbane as an observer. Here she shares her reflections.

Decades after my own primary exam viva – no longer a nervous trainee at ANZCA House in Melbourne with a heart rate of 170 bpm and rising nausea – I found myself in Brisbane as an observer. Over several days I sat in on sub-committee meetings, examiner workshops, and vivas to learn from the people at the heart of it all: examiners, ANZCA staff, invigilators, and the trainees themselves.

WHAT I LEARNED ABOUT THE PROCESS

I knew the exam was rigorous, heavily scrutinised and regulated. However, I hadn't appreciated the depth of thought that underpins every tiny detail. Many things are hotly debated: the font in short-answer questions (SAQs), the direction pencils face on the viva desk to support right and left-handed candidates, how to ease quarantine periods, and how to sensitively assist the estimated 10 per cent of candidates requesting special consideration. Every decision is made with laser sharp focus to best support candidates, their future patients, and the community.

The exam team listen carefully and acts on feedback. Recently when trainees raised concerns about fatigue during the written paper, evidence was reviewed and the order was changed – SAQs in the morning, multiple choice questions in the afternoon. There is constant refinement.

WHAT I LEARNED ABOUT THE EXAMINERS

Becoming an examiner is a serious, long-term commitment – typically 12 years, longer for those who continue as examiner assessors. Selection and induction are strict. Examiners I met were genuinely concerned for trainee welfare, career progression, and patient outcomes. Most have spent years teaching in their home hospitals, standing alongside trainees as they navigate the ups and downs of training. Some struggled with exams themselves. They all bring a unique lens to the role.

Detailed analyses of examiner scoring provide iterative individualised feedback to sustain fairness and consistency. Over three days I saw how much examiners cared about their own performance – not for ego, but because it affects candidates, our college, and the communities we serve.

I watched many examiner dyads at work. Their shared repertoire of techniques was striking: quiet reassurance ("I agree – don't worry, that's a small point"), gentle prompts ("take some water"), warm smiles. They were clearly well-trained and ready to go with (and redirect where necessary) candidates wherever their answers led.

Examiners are practising anaesthetists and ANZCA fellows drawn from across Australia and New Zealand: public, private, and mixed practice; regional and metropolitan; academic high-flyers and – unexpectedly – 'rock stars' (these are the examiners that perform in the viva celebration band that plays during the celebration at the end of the day. No one briefed me about this and I was entirely blown away as I wondered why the band looked so familiar!) Some run together in the mornings. Some, even senior ones, still have trouble sleeping the night before they examine. All are physiology and pharmacology gurus.

WHAT I LEARNED ABOUT THE CANDIDATES

Observers sit quietly behind candidates, mostly out of sight. From there, in my out of sight observer position, I was deeply impressed by the dignity and composure of our trainees. Everyone demonstrated intelligence, resilience, and adaptability as they answered questions. Even when nerves arose or questions became difficult for them, they kept going – thinking, reasoning, pushing forward.

When I sat my exam, our cohort were aged mostly in our 20s and we only had ourselves and work to look after. It was a different world and a different time. Many candidates are now older, more mature, and many bring with them the additional 'adulting' that life inevitably brings. I don't know who was juggling work and family and exams and a myriad of other commitments, but I know that this is now the norm, rather than a rarity. I also know I was so impressed. All the candidates are quite something.

I found myself silently cheering them on and beaming good vibes to them from my corner. At the post-exam celebration, seeing candidates relaxed and happy with their support crews was pure joy. Several sought out examiners to thank them for their kindness. It's hard to overstate how much a simple thank you was appreciated and how much this exemplified the professionalism and kindness of our profession that we all take pride in.

WHAT I LEARNED ABOUT THE EXAM ITSELF

Exam questions remain grounded in the fundamental sciences, and none were unfamiliar to me. I was pleasantly surprised when the answer to many questions popped into my head like a Pavlovian reflex: the contents of Hartmann's, total body water in a 70 kilogram adult, and cardiac action potentials. These fundamentals are as relevant now as ever. I'm told that some topics have been retired (so long, farewell, Wheatstone bridge).

A NEW TRADITION: DELAYING RESULTS, CELEBRATING TOGETHER

At the risk of showing my age, results were posted – on the wall – on the day of my viva. We gathered at ANZCA House in the evening, nervously waiting as a staff member taped up the list of successful candidates. For some, it was pure relief; for others, crushing disappointment. Tears and high emotion for both groups. Examiners told me they used to worry about candidates who didn't pass, especially those far from home and support networks; now distressed and perhaps alone in their hotel rooms or goodness knows where.

Today, with larger candidate numbers, results are released a week later. The wait can be excruciating but an unexpected benefit has emerged: post-exam celebrations where results don't define the night. Candidates, supporters, examiners, and staff gather to mark the completion of a major milestone. Some candidates even return on subsequent nights to cheer friends sitting later. Watching everyone laugh together – freed from the long haul of study – filled my cup. I feel privileged to have been able to bear witness to this and allowed this rare behind the scenes view of an intense, busy and important process where all groups were so generous and open with my questions.

GRATITUDE

Congratulations to all candidates, their families and friends; to supervisors of training, education officers, heads of department, and every anaesthetist who prepares and cares for candidates. I would be remiss to not thank the invigilators. They swept in like a squad of order and precision. Once they were in situ everyone knew it was business time.

My thanks to the candidates, examiners, and the exam team for allowing me to observe this pivotal, sensitive process. So much work, care, professionalism, and humanity underpin this exam. I am proud to be part of our college and our community.

Dr Tanya Selak, FANZCA
ANZCA President-Elect

ABOVE FROM TOP

Primary exam invigilators and ANZCA staff.

Primary exam band.

Successful candidates

Primary fellowship examination

2025.2 Exam

One hundred and seventy-five candidates successfully completed the primary fellowship examination:

AUSTRALIA

Australian Capital Territory
Naini Nishita Rao

New South Wales
Gunn Atkinson
Stephen William Bennie
Taylor James Blackstock
Christian John Brogan
Morgan Zane Burrows
Mark Teed Butorac
Andrew Garry Cahill
Eka Peng Cox
Douglas George Falconer
Ray Kaide Fang
Jeremy Thomas Glendinning
Felicity Leilia Colleen Goodes
Laura Jane Hailstone
Chengyi Han
Philippa Marjorie Haria-Ross
Angus James Edward Sautelle Hayes
Daniel James Hedger
Sung Mu Heo
Montana Paige Hoolahan
Dominic Edward Howell
Dustin Luke Jefferys
David Kang
Shobhana Katti
Nishta Kaushik
Matthew Liam Krauel
Luke Sze Yun Lau
Terence Zi-Long Luo
Matthew John McHugh
Christopher John Morris
Alfonse Le Huy Nguyen
Jamie Bankim Patel-Kerr
Mark Rafla
Murari Srivas Ramesh
Joshua Ray Richards
Rhys Johnathan Rahul Rodrigues
Michael Abraham Sawang
Praba Sekhar
Harriet Kate Semple
Anita Skaros
James Robert Alexander Taylor
Brendan Ashburn Kum-Loon Toy
Riya Wadhwa
Hannah Lily Wallder
Daniel Joseph White
Emma Hsu Cheng Williams
Xueli Celeste Yeo
Don Zhang
Jeffrey Zhou

Northern Territory
Rahil Stefanel De Silva
Alexander John Keen
Aydan Charles McGuirk
Kelvin John Muller

Queensland
Alexander Theodore Anderson
James Jia Ming Ang
Michelle Karen Ashford
Andrew William Bennie
Celeste Eileen Rachel Bloomfield
Homya Bolla
Tobeas James Brennan
Alexander Michael Bykersma
Kin Man Choi
Rory George Cole
Jack William Cooper
Lucy Elizabeth De Kantzow
James Leonard Devin
Jessica Rose Hayes
Nathan Tate Jeffery
Jenny Hanbi Kim
Ankita Maria Koshy
Ayano Kusakabe
Samuel Thomas Lawler
Alexander Ching Siong Lim
Chanida Limpatiyagorn
Michelle Guang Hong Liu
Sara Ikuyo Lock
Yanru Ma
Salih Ibn Mohamed
Sophie Moin
Pathmila Binu Navaratne
Leon Joel Rothberg
Ricky Singh
Monica Annie Smits
Derek Chen Yew Teo
Clare Merrett Vincent
Ainsley Kathryn Walsh
Andrew Thomas Yates
Yi Wen Yvonne Zhou
India Esther Zweng

South Australia
Adam Seth Kallmeyer
Kevin Kour
Jack David Loftus
Fergus William Lynch
Samuel Edward McCallum Paull
Thomas Adrian Smith
Liem Tran
Rachel Kate Van Hecke
Hao Zhang

Tasmania
Sasha Brill
Broden John Morgan
Emily Kate Murray
Vignesh Rajasundaram

Victoria
Alisha Baswa
Jackson Douglas Brown
Mark Andrew Brown
David Cappellari
Carmela Beatrice Anna Cosentino
Joshua Benjamin Cross
Ann Du
Reilly William Eddy
Alexander John Eggleston
Georgia Fox
Darragh Gallagher Chu
Victoria Anne Louise Garwood
Lee Ryan Graham
Amy Lauren Hatton
Bridget Elizabeth Jones
Alice Megan Kludass
Mayank Koppa
Evan Nicol Kumarakurusingham
Alex Adrian Kwong
Peter Le
Zhong Yang Li
Barton Alexander McPherson
Cameron Lachlan Williamson Morrice
Carrington James Morwood
Tuck Seng Ngun
My Thao Nguyen
Angus James Nicholson
Jason Jun Hao Ong
Samuel Keith Penfold
Sepideh Roshanaei
Stefan Xavier Saggese
Gabriel Jacob Segal
Declan Patrick Sela
Roshan John Selvaratnam
Claire Emma Thomas
Bradley Samuel Treloar
Thomas Lawrence Trengrove
Christopher John Wheeler
Peter James Williams

Western Australia
Alison Nicole Butt
Indra Danny
Rebecca Giudicatti
Brieana Claire Nolan
Kirby Anne Rex
Nicola Jia En Tan
Jason Wylde

NEW ZEALAND

Yasmin Ammar Al-Abid
Douglas William Buchan Allan
Jack Michael Sean Barrett
Diarmuid Chevalier-Riffard
Ting-An Anne Chiang
Matthew Cameron Codd
Lachlan Rapley Cooper
Joseph John Faithfull
Callum Milne Webster Forbes
Thomas James Hargreaves
Maria Agathe Josefine Hoefliger-Te Moni
Alice Julia Hunter
Pavly Emad Tawfeek Hanna Ibrahim
Nicola Jayne Kluger
Guy Bennett MacDiarmid
Stuart Richard Pike
Natalie Anna Ron
David Silley
Thomas John Barclay Sizeland
Angela Sun
Shu Leed Tan
Chris Wang
Luke John Weaver-Mikaere
Fiachra Pol Weiner
Teri Michael Mark Whiley
Guy Josef James Wisniewski
Caroline Anne Yuill

MERIT CERTIFICATES

Merit certificates were awarded to:
James Leonard Devin, Queensland
Bridget Elizabeth Jones, Victoria
Alexander John Keen, Northern Territory
Nicola Jayne Kluger, New Zealand
Mark Rafla, New South Wales
Thomas John Barclay Sizeland, New Zealand
Peter James Williams, Victoria

RIGHT
Court of Examiners for the Primary fellowship examination.

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended 31 December 2025 be awarded to:

Roshan John Selvaratnam, Victoria

"My journey in medicine started with completing a PhD in perinatal medicine and pursuing paediatric training. But it was not long before I realised that my passions and skills were better suited for a vocation in anaesthesia. I am now a first year trainee on the Eastern scheme in Victoria, working at Maroondah Hospital.

It was no light matter to undertake the ANZCA primary exam. How sweet it is to look back on this year – when I have now arrived at its final destination.

The lessons were hard, the burdens were heavy, and the perils that beset the way were many. I owe my success in this exam to my Christian faith, my beautiful wife April, my family, my study group, and the department of anaesthesia at Eastern Health and St Vincent's Hospital Melbourne.

I am now on vacation in Vietnam, where rest is no longer spoiled by an unrelenting drive to study – which makes it all the sweeter!"

Murari Srivas Ramesh, New South Wales

"I grew up in New Zealand and originally studied engineering, before moving to Sydney to study medicine. I'm now a registrar at Prince of Wales Hospital, where I've been lucky to work alongside a supportive and inspiring anaesthesia department.

Preparing for the primary was an intense and often overwhelming process, and I know I couldn't have made it through alone. I'm incredibly grateful to my friends and family who helped me not only persevere, but also preserve my sanity.

Now that the exam is behind me, I'm enjoying the novelty of having free time again. I'm looking forward to spending the coming months catching up with friends, getting outside more, and rediscovering hobbies that have been neglected along the way."

Final fellowship examination

2025.2 Exam

One hundred and sixty candidates successfully completed the final fellowship examination:

AUSTRALIA

Australian Capital Territory
Navid Aminian
A'ishah Bhadelia
Madelaine Elizabeth Collins Howard
Stephanie Louise Jones
Samantha Jane Lambe
Amery Ng Kai Xian
Mallikarjuna Reddy Ponnapa Reddy
Thomas Mulckey Yates

New South Wales
Ankit Ahluwalia
Kyrolos Assaad
Ashley Katherine Benn
Tarra Elizabeth Booth
James Roan Bulman
Joshua Avi Burman
Hugh William Gordon Carter
Benjamin Kum-Fung Chau
Elinor Jeanne Cripps
Richard Philip Davey
Jillian Ann De Coster
Timothy Peter Ellwood
Hakeem Shing Kam Ha
Kim Douglas Hanna
Adam Osman Joghee
Nitesh Kumar
Jonathan Michael Kuo
Steven Polis Lazar
Ann May Lee
Andrew Lin Luo
Ben Nelson Richard Maudlin
Leah Meron
Brendan James Miles
Michelle Wing Yan Miu
Conor Thomas Keeper Moylan
David Christopher Mulder
Jonathon Oliver Murtagh
Megan Oliver
Matthew James Palmer
Emily Charlotte Phizacklea
Andrew Thomas Shannon
Terence Brendan Chee Lun Sue
Nicholas Arvind Van Huizen
Jacob Henry van Tienen
Stephanie Alice Warner
Matthew Le-Gend Wong
Peggy Xie

Queensland
James Matthew Armston
Ganashyam Arunagiri
Brian Richard Beaver
Andrew Kevin Cook
Elliot James Duong
Ryan Nicholas Erskine
Damen Jeffrey Fagg
Lucy Evelyn Gebbett
Charles Hamish Grey
Samuel Sharif Hanafy
Christopher Michael Hewitt
Darragh Peter Hickey
Karen Joseph
Jessica Arna Lewkowicz
Zachary James Lovelady
Timothy Alan Mason
John Michael Parr
Abraham Petrus
Jack Peter Righton
Luke James Salmon
Yoni Shor
Jeremy Cheuk Kin Sin
San-Rene Tan
Stephanie Nathania Tan
Kate Alexandra Taylor
Tim Tran
Lalethadevi Velayutham
Kristen Anne Wadwell
Jacinta Louise Wynne

South Australia
Amy Jane Chapman
Cassandra Louise Driscoll
William John Emmerton
Matthew Douglas Fischer
Tristan Leigh Frank
Adrian Gasparini
Duncan Peter Hamilton
Susan Joanne Kelly
Kenny Kok Keong Lean
Brianna Adele Martin
Samuel Alexander McBride
Teodor Florin Mocioaca
Edwina Jane Stenner
Corinne Lee Tching Teh
Jessica Mary Walker

Tasmania
Rebecca Elizabeth Jameson
Natasha Christine Nilsen

Victoria
Imogen Louise Ackerly
Ryan David Francis Adams
Ahmad Al Helwani
Alastair John Anderson
Anna Mary Bakogianis
David Edric Barlow
Kavinay Narayan Chand
Kerry Karwai Chen
Luka Simun Cosic
Amranthir Singh Dhillon
Jarron Mitchell Dodds
Craig Leonard Fisher
Andrew Kirk Fordyce
Madeleine Xi Xian Hollitt
Seyed Soheil Hosseini
Claire Danielle Ishak
Ade Rizki Kurniawan
Joel McRae Lawrence
Christine Gayan Li
Charles Daniel McKay
Luke Alastair Perry
Carolina Radwan
Ashleigh Kate Rohde
Jeigh Merill Tiu
Kristen Mary Tuffin
Jared Bart Vurens Van Es
Benedict Wong
Tracey Wong
Harrison Yao

Western Australia
James David Charleson
Teegan Elise Hartwig
Tom Frederick Hickish
Julia Madelaine Inman
Vibhushan Manohar Manchanda
Jack William Perkins
Geoffrey David Ryan
Ariane Elyse Tioke
Claudia Kerry Nadia Toro
Anika Lauren Weightman
Laura Marguerite Wisniewski
Jessica Jun Yi Zheng

NEW ZEALAND

Harith Sinan Butrus Awrooj
Simone Jane Besseling
Jonathan Brian Lightley Blake
Laura Jayne Bond
Gabrielle Suzanna Britton
Thomas Ashwin Chima
Wojciech Mikolaj Chmiel
Ching-Wen Chou
Charlotte Michaela Dumble
Sarah Elizabeth Dwyer
Caleb Ngai-Hin Fung
Steven Joseph Greenblatt
Shona Seu-Yu Jian
Holly Anne Lorraine Johnstone
Christopher Mark King
Caroline Weiling Law
Liam John McAskie
Erin Mary McKergow
Ching Pui Denise So
Louise Alice Thomas
How-Shin Tsao
Kristyan Andrew Urlich
Antony Xie

SIMG EXAMINATION

Five candidates successfully completed the specialist international medical graduate examination:

Renuka Devawrat Buche, Western Australia

Jalil Makarem, Victoria

Muhammad Awais Qureshi, Western Australia

Kevin Teck Meng Tan, Western Australia

Menaga M. Vasu Dewan, Victoria

MERIT CERTIFICATES

Merit certificates were awarded to:
Steven Joseph Greenblatt, New Zealand
Luke Alastair Perry, Victoria
Geoffrey David Ryan, Western Australia

LEFT

Court of Examiners for the final fellowship examination.

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31 December 2025 be awarded to:

Jacob van Tienen, New South Wales

"I was born and raised in Launceston, Tasmania. My parents have been my most staunch supporters and I owe everything I've become to their sacrifices.

I completed my MBBS locally with my twin brother, Zac – the first in our family to go to university. Despite now being in different states, his identical sense of humour and healthy cynicism got me through some tough times. He was the first one I called with the news.

After graduating, my heart took me to NSW to be with my partner of now eight years, Peter. He, our dog Buddy, and the rainbow family we've since cultivated together have been pivotal in regulating my work-life balance and reminding me of what's important.

Huge thanks go to my study group, the Four Eyed FEx-ers (Ben, Josh and Kim).

We've surmounted both exams together and you've saved me from spiralling more times than I can count. Finally, to Westmead, my training hospital and other home, with whom I can share this success. I look forward to AT2 in 2026, continuing to learn from you!"

MyPortfolio launches, providing enhanced support for the anaesthesia training program

MyPortfolio has officially launched, marking the culmination of a year-long collaborative effort to deliver a modern, user-focused platform.

The journey started with a series of consultations involving supervisors of training (SOTs), assessors, and trainees, aimed at understanding what users appreciated about existing training systems and identifying areas for improvement. These early insights laid the foundation for a platform that reflects the needs and aspirations of the college. Council agreed to take a staged approach to delivering the new platform and agreed to prioritise the anaesthesia training program.

Throughout the build phase, there was a strong focus on stakeholder engagement. Committees were actively involved to ensure alignment with strategic goals, and members representing SOTs, trainees and directors of professional affairs were consulted regularly to provide their feedback and guidance. We held a series of workshops, drop-in sessions, and testing opportunities, inviting voices from across the college to shape the platform's development.

Testing was a critical component of the project's success. The process was structured, beginning with technical testing, where AI bots played a key role in identifying bugs quickly and efficiently. This allowed developers to focus on delivering a high-quality build with speed and precision.

Next came business acceptance testing (BAT), where the training team played a pivotal role in validating MyPortfolio's processes against the previous training portfolio system (TPS). Their expertise ensured that the transition would be smooth and intuitive for end users. The final phase, user acceptance testing (UAT), was conducted with the Change Partner Network, a group of volunteers consisting of education officers, heads of department, SOTs, rotational supervisors and trainees who provided real-world feedback and helped fine-tune the platform before launch. Every piece of feedback has helped shape the final product.

Early feedback has been overwhelmingly positive, with users praising its intuitive interface, improved functionality, and responsiveness.

The team behind MyPortfolio extend heartfelt thanks to everyone who participated in the journey, from those who attended workshops and drop-in sessions, to the volunteers who gave their time to test and refine the platform. Their contributions have been instrumental in delivering a solution that reflects the needs of its users.

As MyPortfolio moves into its post-launch phase, the focus will shift to continuous improvement, user support, and gathering feedback to guide future enhancements. The successful launch stands as a testament to what can be achieved through collaboration, innovation, and a shared commitment to excellence.

ABOVE FROM LEFT

WA supervisors of training at their MyPortfolio training.

Tas supervisors of training at their MyPortfolio training.

Swapping Sheffield for South Australia

In this occasional series profiling ANZCA's specialist international medical graduates we talk to Adelaide-based anaesthetist Dr Zbynek Mathon-Rowe about why he moved to Australia.

When Dr Zbynek Mathon-Rowe and his wife Alexandra boarded a plane to Adelaide in late 2024, they were leaving behind not only the grey winters of Sheffield in the UK but also the familiar career landscape he had known for more than a decade.

It was, as he puts it, "a brave move" – one that has since brought new professional opportunities, a warmer climate, and a fresh lifestyle for their young family.

Born in the Czech Republic, Dr Mathon-Rowe completed medical school there before undertaking anaesthesia training and working as an anaesthetist in Ostrava. Early in his career, he set his sights on gaining international experience, moving to the UK to work in London and Eastbourne for three years. He then returned to Prague to complete his training, before once again heading to the UK – this time for a fellowship in regional anaesthesia in Nottingham.

That fellowship shaped his next chapter. From 2017 until the family's move to Australia, Dr Mathon-Rowe worked as a consultant in regional anaesthesia in Sheffield.

"Life was difficult in the UK with the weather, so we decided to move here," he says with a smile. "We'd never been to Australia before, but we were ready for an adventure."

The decision was not only personal but professional. Assessed as "partially comparable" by ANZCA, Dr Mathon-Rowe was required to complete a specialist international medical graduate (SIMG) performance assessment after 12 months of supervision. He began the process while still in the UK, finding it "fairly straightforward" to navigate.

When the time came to prepare for the assessment in Adelaide, he took no chances. With four children aged seven, four, three, and one at home, he checked into a hotel without his family for several days to focus entirely on study. The effort paid off – he recently completed the process successfully.

Securing a role in Adelaide was relatively smooth, and Dr Mathon-Rowe is now an anaesthetist at the Queen Elizabeth Hospital.

"My colleagues are very supportive, friendly, and approachable," he says. "It's probably the best place I have worked. It's a friendly environment and they make you feel very welcome."

"My colleagues are very supportive, friendly, and approachable... It's probably the best place I have worked."

In addition to his clinical work, Dr Mathon-Rowe is one of three anaesthetists at the hospital involved with the Australian and New Zealand Anaesthetic Allergy Group, testing patients for anaphylaxis allergies – an area of practice he finds particularly rewarding.

Beyond the hospital the family is embracing their new surroundings in one of Adelaide's beachside suburbs.

The children have settled into a local school and early learning centre, and weekends often feature trips to the beach.

"We love the lifestyle here," he says. "The sunshine makes such a difference – although the local drivers can be challenging!"

Looking back on the past year, Dr Mathon-Rowe reflects on the leap of faith that brought him halfway across the world.

"It was a big decision, but we're very happy we made it," he says.

"Australia feels like home now."

Carolyn Jones
Media Manager, ANZCA

ABOVE

Dr Mathon-Rowe with his wife Alexandra and their four children at Adelaide's Glenelg beach.

Simulation course held in Timor-Leste

Paediatric anaesthetists Dr Nilru Vitharana and Dr Melissa Chin write about their experience in Timor-Leste as part of an ANZCA 2024 Health Equity Projects Fund grant that enabled them to deliver a simulation emergency course in the capital Dili.

Timor-Leste lies a short 55-minute flight from the Australian mainland, just enough time to put on your seatbelts and admire the Timor Sea before you land in the capital Dili.

The health outcomes however couldn't be starker for one of our nearest neighbours. In the 22 years since Timor gained independence and became the first new sovereign state of the twenty first t century, there is much that has been achieved, and much more to achieve. Under five mortality sits at 48 per 1000 live births - of all World Health Organization (WHO) reporting countries, this sits in the highest 30 in the world for mortality. In comparison, Australia's under five mortality is 3.8 per 1000 live births. In Timor Leste neonatal mortality sits at 22 per 1000 live births compared with two in Australia,

The Pacific Paediatric Anaesthetic Insitu Teams Course (Pacific PAINTs) has been running in the Pacific for the last few years, having first been hosted in Fiji in 2022. The course uses simulation to develop clinical and non-technical skills in managing paediatric emergencies in low resource settings. In 2024, we facilitate the course at Guido Valadares National Hospital in Dili.

Over the course of a week in the colourful tropical grounds of the hospital, participants navigated some of the challenging typical emergencies of paediatric anaesthesia. The course covered topics and simulations including the critically ill deteriorating paediatric patient, sepsis, trauma, anaphylaxis, burns and difficult airway management. Feedback from participants continues to be highly rated. Every participant noted that they had increased clinical knowledge and skills, increased confidence in working in and leading teams in crisis management, and increased confidence in management paediatric anaesthesia emergencies.

It was particularly heartwarming to see former junior registrars of the Fiji National University Training program, now practising as early career consultants and emerging leaders in their home country. It's a proud moment for any consultant to see their registrars complete training – but even more so knowing that in a country with only a small handful of consultant anaesthetists, every registrar trained is going to make such an impactful difference to their country's future.

As the anaesthesia service develops and expands, continued support from educational programs such as this is very much valued by our colleagues in the Pacific.

It was eye-opening to realise during the anaphylaxis workshop, that adrenaline (a WHO listed essential medicine) is not always readily available to Timorese anaesthesia providers in remote locations. The eagerness to learn and soak up knowledge from participants was particularly notable as many remote nurse anaesthetists had to travel for very long distances to get to the course, as there is little

in the way of ongoing paediatric anaesthesia support and education for these providers who are often isolated in their region of practice. The course provided not only knowledge, but also much needed morale and social networking between participants.

We would like to acknowledge our appreciation for the support for the course provided by Dr Fernanda de Silva and Dr Maria Piedade who helped with translation, Dr Colombianos da Silva, head of department who facilitated logistics and organisation of the course, and the clinical director and hospital management of Guide Valadares National Hospital for supporting the course.

In addition, we would like to thank Lisa Meehan, secretary at The Children's Hospital Westmead for her support over the years for this project.

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

Dr Melissa Chin, FANZCA
Anaesthetist, The Children's Hospital at Westmead

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

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

ABOVE

From left, Dr Nilru Vitharana and Dr Fernanda de Silva facilitating a simulation.

Building resuscitation capacity in Papua New Guinea

In September 2025, a small team travelled to Port Moresby to deliver Advanced Life Support (ALS) training in Port Moresby. This program (above) marked a new chapter in resuscitation education for the country, building directly on the enormous success of the Basic Life Support (BLS) initiative launched the previous year.

The aim of the ALS course was not simply to deliver training, but to establish a sustainable instructor network that would empower local clinicians to lead future courses. To achieve this, the program was carefully adapted to the realities of clinical practice in Port Moresby General Hospital, with strong emphasis on contextualisation, local ownership, and building teaching capacity.

The four-day program was designed with a staged approach. The first two days focused on refreshing core ALS principles while running a train the trainer program for a group of experienced PNG BLS instructors.

The second two days were dedicated to practice and ownership: the newly trained instructors organised and taught the ALS PNG course for participants, with Australian facilitators stepping back into supporting and mentoring roles.

A further boost to sustainability was the donation of a resuscitation mannequin called Annie by Rosa Fung and the Institute of Academic Surgery, Royal Prince Alfred Hospital. This donation will enable ongoing simulation-based teaching at Port Moresby General Hospital.

The results of the first ALS course in PNG were remarkable:

- Eight new ALS instructors were trained and mentored through the program.
- Sixteen new participants successfully completed ALS training under the leadership of the new instructors.

The program established a pathway for ongoing ALS training within PNG — led by local clinicians, for local clinicians.

This ALS program did not emerge in isolation. It was built on the foundation created by last year's BLS course, which has already reshaped resuscitation culture at Port Moresby General Hospital, where we trained 13 BLS instructors.

Over the following 12 months, this team, led by Dr Keno Temo, has gone on to deliver BLS training to more than 650 hospital staff.

- Nurses are now taking the initiative in emergencies, starting CPR without hesitation.
- Early recognition and immediate response are saving lives.
- Resuscitation has become a true team effort, rather than an action deferred until a doctor arrives.

This cultural shift has created a lot of enthusiasm, and the ALS program was the natural next step, providing advanced knowledge and structured algorithms to complement the BLS foundation.

The mannequin donation, combined with the instructor network will help to run further courses. The model established is one of capacity building, with local instructors empowered to lead, adapt, and grow the program according to the evolving needs of their health system.

The success of the BLS and ALS programs might also open the door to wider expansion across PNG. Resources allowing, the instructor group will be able to deliver repeat ALS courses at Port Moresby General Hospital and, eventually, extend training to other centres in PNG.

With eight new ALS instructors, sixteen ALS-trained participants, and a thriving BLS instructor network that has already trained more than 650 staff, the future of resuscitation training in PNG is bright.

Dr Yasmin Endlich, FANZCA
Chair, ANZCA Global Development Committee

2026 grants announced

The ANZCA Health Equity Projects Fund supports college activities in global development, Indigenous health and other health equity projects.

It is a competitive grant process open to all ANZCA and FPM fellows, for projects that support the aims and activities of the Indigenous Health Committee, Global Development Committee and other health equity priorities of the college. Since commencing in 2019, funding has been provided for 52 projects.

2026 RECIPIENTS

Aboriginal and Torres Strait Islander health projects

First Nations ACORN (Anaesthesia Consumer Research Network) - planning study
Dr Edith Waugh

The Anaesthetic Story – development of patient videos in language
Dr Penny Stewart and Dr Jacob Koshy

GLOBAL DEVELOPMENT PROJECTS

Anaesthetic teaching in Timor Leste
Dr Megan Walmsley

Essential pain management training in Solomon Islands
Dr Moira Rush

Essential pain management training in Timor Leste
Dr Megan Walmsley

Inspire through clinical teaching course for Pacific anaesthesia trainees and Fiji National University (FNU) staff
Dr Elizabeth Hall

Leading emergencies in anaesthesia in the Pacific (LEAP) Course: Leading emergencies in anaesthesia in Papua New Guinea
Dr Mark Trembath

Safer anaesthesia from education (SAFE) paediatrics and obstetrics in Wewak, Papua New Guinea
Dr Anna Loughnan

Safer anaesthesia from education (SAFE) paediatrics and obstetrics in the Pacific Islands
Dr Yasmin Endlich

ABOVE

Timor Group photo: Facilitators and participants in the grounds of the Guido Valadares National Hospital in Dili, Timor-Leste.

Anaesthetists meet at the home of Hobbiton

From hobbit holes to high acuity areas, perioperative medicine to proffered papers, this year's Aotearoa NZ Anaesthesia Annual Scientific Meeting (ASM) had something for everyone.

Hosted in the upper North Island city of Hamilton, the meeting drew attendees from both sides of the Tasman and further afield for three days of lectures, workshops, and social events.

The program featured keynote speakers from two of the world's most prestigious universities.

Stanford University's Professor Fred Mihm spoke on stellate ganglion blockades as well as awake flexible scope intubation for the physiologically difficult airway.

His fellow keynote, the University of Oxford's Professor Bruce Biccard, discussed improving patient care across Africa, and weighed up clinical importance versus statistical significance.

ANZCA invited speaker, Dr Mark Hamilton, offered his thoughts on risk stratification from the perspective of a surgeon, as well as the challenges he faces working in the Northern Territory.

Beyond clinical settings, Dr Hamish Wright gave an account of his winter spent at the South Pole, while Dr Chris Jephcott's presentation "Walking through fire" recounted he and his family's personal journey following a house fire.

A highlight of the meeting was the debate session, with the future of high stakes examinations within ANZCA and the use of research grants to fund large trials in anaesthesia and perioperative medicine up for discussion.

The meeting also shared global perspectives, with sessions on anaesthesia delivery and development in central Africa, heart missions in Fiji, scoliosis surgery in Cambodia and an update on anaesthesia in the Pacific.

Closer to home, Dr Te Aro Moxon spoke on cultural safety and competence.

ANZCA President Professor Dave Story presented the meeting awards, announced by Dr Lisa Barneto, chair of the Aotearoa New Zealand Anaesthesia Education Committee (ANZAEC).

The John Ritchie Prize was awarded to Associate Professor Ross Kennedy, Dr Sarah Tomlinson won the ANZCA Trainee Prize, the ASM Poster Prize went to Dr Megan Briscoe, while Dr Wai Yan Bettina Fung was highly commended.

This year's Alan Merry Oration was given by Professor Jamie Sleigh, reflecting on his career in anaesthesia.

For many, one of the event highlights was the meeting dinner, hosted this year in the unique setting of Hobbiton, the movie set where Sir Peter Jackson's *The Lord of the Rings* and *The Hobbit* trilogies were filmed.

More than $NZ4000 was raised for the meeting's official charity partner, Rainbow Place, which provides free, specialist nursing support for children and young people living with advanced or life-limiting conditions.

Reon Suddaby
Senior Communications Advisor – New Zealand, ANZCA

CLOCKWISE FROM TOP

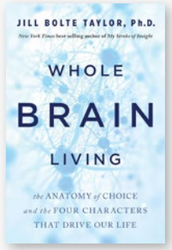
Professor Fred Mihm, from Stanford University, was one of the keynote speakers at the Aotearoa NZ Anaesthesia ASM.

ANZCA President Professor Dave Story presents Dr Sarah Tomlinson with the ANZCA Trainee Prize.

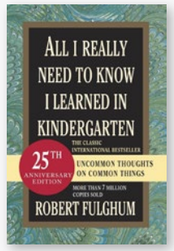
Meeting delegates enjoyed the chance to tour the Hobbiton movie site.

Library news – summer reads

The ANZCA library team recently attended a conference keynote speech on bibliotherapy – the concept of reading as a reflective practice of care. Inspired by Dr Susan McLaine of Bibliotherapy Australia, we have selected some restorative and uplifting books to brighten your summer days. All available through the ANZCA library!

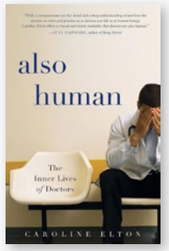


A Harvard neuroanatomist lost language and memory to a stroke but discovered a world of peace in her right hemisphere. Learn how to tap into that same power every day.

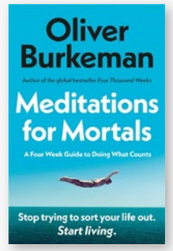


"Beautiful, quirky and funny stories that shine a light on life in a humble, gentle and enjoyable way. It reminds us of what it's like to be human."
– Dr Susan McLaine

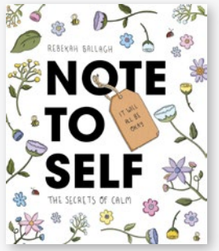
Dr Timoti Te Moke endured a horrific childhood of beatings and abuse, then gang life and stints in prison, and became a doctor at the age of 56 and is a staunch advocate for Māori.



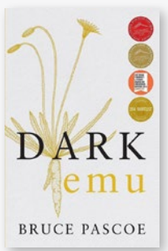
A groundbreaking examination of the pain, pressure and joy of medical work by a psychologist known as the "doctor's doctor".



A profound yet entertaining crash course in living more fully by embracing "imperfectionism" – are you game enough to give it a go?



An inspirational personal development book including helpful tips and illustrations to aid with anxiety, overthinking and depression.



"Essential reading for anyone who wants to understand what Australia once was, or what it might yet be if we heed the lessons of long and sophisticated human occupation." – 2016 NSW Premier's Literary Awards judges.

Books for the littlest patients

Stories that make anaesthesia less mysterious – and a little more friendly – for kids.

Contact the library: | +61 3 9093 4967 | library@anzca.edu.au | anzca.edu.au/library

Basil Rockcliffe Hutchinson

1933 – 2025

One of New Zealand's renowned anaesthetists of the recent era, Basil Hutchinson, died aged 91 in April this year, after a few years of slow decline in his health.

He was not only known for his work at ANZCA and the New Zealand Society of Anaesthetists (NZSA) but also for his meticulous anaesthetics, his records of all 21,000-plus anaesthetics he ever administered, his detailed historical research including a detailed bibliography of all published New Zealand anaesthesia-related articles, his personal diaries from age 13 for 70 years, his model railways and Meccano, and his general good nature, friendship and ability to compose appropriate songs to expand the joy of a good anaesthesia party. Examples include his renditions of *Scoline Bill* with its many anaesthetic allusions, and his playing of songs on a plastic endotracheal tube as if it were a flute!

Basil attended King's College in Auckland 1946-51, where he thrived academically and greatly enjoyed cricket, rugby, running and boxing. Holidays were spent at the family "bach" at Kawakawa Bay messing about in the family launch MV Minotaur, where Basil in typical style kept meticulous logs.

In 1959 Basil graduated in medicine from the University of Otago, where he delighted in the Capping Show, plays, and the Knox College Vintage Bicycle Race which he instituted. He married Diana Simmers in 1959.

He did his house surgeon years at Gore, in the South Island, then moved to Palmerston North (1962-63) where the legendary anaesthesia director Dick Rawstron became his most important mentor. Basil claimed that his introduction to anaesthesia coincided with the modernisation of New Zealand anaesthesia with the "introduction of relaxants, tracheal intubation and halothane".

He moved to Dunedin as a physiology demonstrator/lecturer at Otago University (1964) and as a visiting anaesthetist to the Dunedin Hospital, and finally to Auckland and Green Lane Hospitals (1965). He moved to the Royal Children's Hospital in Melbourne in 1966 and obtained his fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons. During his time there his second child (Richard) drowned, aged almost three. He had two other children, Josie (born 1961) and Martin (born 1967).

In 1967 he returned to Auckland and Green Lane Hospitals and eventually became the departmental chair at Green Lane (1987-89) where he also worked in intensive care. He also worked at the Mangere Dental Centre in Auckland. He retired from anaesthesia practice in 1997, at age 64.

After Diana died in 2014, Basil married Linley Kennett in 2016, a great support to him during his last decade.

Basil was awarded the NZSA's Meritorious Services Award (1988) for his 20 years of history articles in each edition of the NZSA newsletter, and was made a life member of NZSA in 2000. The New Zealand Anaesthetic Technicians' Society (NZATS) named their Trainee Anaesthetic Technicians' Award after him, acknowledging his involvement in their formation and his ongoing support.

From 1975-78 Basil was the chair of the Faculty of Anaesthetists New Zealand Regional Committee, and in 1978 he was elected to the faculty board and served until 1982. He then became the faculty's assistant historian for New Zealand (assisting Dr Gwen Wilson in Australia), and subsequently the faculty archivist for New Zealand. He was a final examiner and was awarded the Faculty of Anaesthetists Medal in 1990.

One of Basil's most intense passions was his extensive model railway track under the house in Auckland, where he spent many happy hours delighting visitors with a demonstration of the numerous trains. He was also a long-time member of the Glenbrook Vintage Railway at Waiuku, helping with restoring engines. One of Basil's history articles combined his railway enthusiasm and his professional interests: *"Ambulance and Hospital Trains" appeared* in the rather obscure *New Zealand Railway Observer.*[1]

Basil's most valuable historical contributions were his bibliographies.[2-6] He also co-edited the history of the NZSA,[7] and was a valued resource in New Zealand on historical anaesthesia matters.

His daughter recalled at his funeral that "he brought much joy to life, and was kind, hard-working, wise, and creative with a wonderful sense of humour". Basil Hutchinson will be sorely missed by many, and particularly by the New Zealand anaesthesia community.

Kua hinga he tōtara i te wao nui a Tāne (*a totara has fallen in the great forest of Tane*).

AB Baker AM
Emeritus Professor, University of Sydney

Thanks to Basil's family for help with this obituary. Photograph courtesy of the Hutchinson family.

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Christopher Adam Haug

1991 – 2024

It is with great sadness that we mark the passing of Christopher Adam Haug, our only child, and much-loved son. Chris was born in Saskatoon, Canada on 5 July 1991 and moved with his parents to New Zealand in 1998.

He excelled in school and was awarded the "Proxime Accessit" at John McGlashan College (Dunedin) in 2008. Chris was always fascinated and intrigued by science, and had a soft spot for rescue cats. He volunteered and worked part-time as a science communicator at Tūhura Otago Museum.

Chris received offers to study dentistry and medicine at the University of Otago but decided in favour of medicine, completing his MB ChB in 2014, with Dean's commendations. Chris started emergency department (ED) training in 2017 and switched to anaesthesia in 2023. He planned to complete the remaining ED requirements in 2026 to become a consultant, followed by a few months of travels, before switching back to anaesthesia, in his pursuit of the double specialty.

Chris was always busy, completing with distinction a postgraduate diploma in travel medicine, among others. His interests were broad. He enjoyed reading about history or watching foreign movies.

In his spare time, Chris loved the outdoors, exploring after work the surrounding nature reserves. He has hiked more challenging tracks, such as the Copland Pass Crossing and the Dusky Track, and further afield climbed Kilimanjaro and Aconcagua. Many of his longtime friends forgave Chris for being woken very early on tramps, giving enough time to scramble up a mountain and not miss a sunrise.

We are very proud of all our son's achievements, and a legacy of many lifelong friends, whom we thank for their support. Chris, you've made our lives and the lives of people around you more vibrant and so much better.

Professor Alfred A. Haug and **Bozena Misiewicz-Haug**

I knew Chris long before he became a doctor and our relationship started when I was in primary school. After a brief hiatus overseas, Chris and his family returned to New Zealand, and we promptly resumed our friendship as though nothing had changed; destined to be lifelong friends. Growing up with Chris was like running life on 2.0x speed (a trend which later translated into lectures or even movies) as he possessed a potent combination of relentless curiosity and boundless energy. These were traits that transcended medicine and encompassed art, music, architecture and the outdoors.

Eventually I also ended up in medicine, despite strong discouragement from Chris at the time. He was lost, trudging through his second house officer year before landing in emergency medicine which reignited his interest in medicine. It suited him well, but after many years in Wellington, he needed a change of scene and he moved north to Whangarei, where he got his first taste of anaesthesia.

As if emergency medicine training was not enough, he threw himself headlong into anaesthesia training. He was able to hone his focus onto one patient, a far cry from the chaos of the emergency department, and a refreshing change of pace.

Curiously, I never worked with him as a colleague, and my path diverged into general and then respiratory medicine. But I always relished the thought of running a busy ED overnight with him, or that he would arrive to intubate my flailing respiratory patient. There is no doubt that he treated his patients with kindness, and that his passing has shown me that his colleagues held him in great esteem also.

Chris possessed a vigour for life that left an indelible mark on me as he did on many others. He will be sorely missed, and the world just seems a little less colourful without him.

Dr Markus Ho, Respiratory registrar
Middlemore Hospital

Chris took easily to anaesthesia. He threw himself at work with the same tireless enthusiasm and adventurous spirit that defined the rest of his life. It had taken three attempts to get on the training program and he was determined to make up time. He was highly organised, had exceptional practical skills and worked at a pace that few could match. The recurring feedback that he should "slow down" merely reflected our inability to keep pace rather than any recklessness on his part. He wasn't handicapped by a fear of failure but wasn't accepting of it either. He held himself to a very high standard and cared deeply about his patients.

He was an excellent student and was well prepared for his upcoming part 1 exam. I have no doubt he would have done well, and the success of his comrades was in no small part due to his contribution to their study group.

Chris's energy and sense of humour would have made him an excellent colleague and I would have enjoyed working with him again. Nevertheless, we are very grateful for the time that we had with him and the memories he has given us. The pace of life in the department is certainly slower in his absence!

Dr Duncan JM Brown FANZCA, Supervisor of training
Taranaki Hospital

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James Edward Clive Twentyman

1931 – 2025

Dr James Edward Clive Twentyman, anaesthetist and long-serving member of the medical profession, passed away peacefully at the age of 94. His career spanned several decades and continents, marked by quiet dedication, clinical skill and a deep sense of service.

Born in Yorkshire, England, Dr Twentyman was the only child of a family with strong engineering roots. His early years were shaped by the loss of his father to pneumonia when he was just four, and by a close relationship with his mother, whom he described as a peacemaker. He inherited both her gentle nature and the intellectual curiosity of his grandfathers – one a marine engineer and managing director of a large shipbuilding company in Shanghai, the other a steel industry manager in Darlington.

Educated at Harrow School, London, he thrived in its broad academic environment. He developed lifelong interests in motor cars, sailing, skiing, and mechanical design. At age six, he declared his intention to become a doctor, a goal he pursued at Trinity College, Cambridge. His studies were interrupted by national service, during which he served as a young officer in Nigeria. This experience broadened his perspective and enriched his clinical training upon his return.

After qualifying in medicine, Dr Twentyman began his career as a houseman at University College Hospital, London. Following his marriage in 1960 to Leonore, a nurse he met on a ski trip in Austria, they moved to Sydney, where he established a general practice.

Together they built a home and raised two children in Caringbah on the shores of Sydney Harbour. Despite the idyllic setting, he found general practice professionally limiting and returned to London in 1968 to specialise in anaesthesia.

He qualified as an anaesthetist at age 39 and accepted a position at the Vrije Universiteit Hospital in the Netherlands. After a brief tenure, he returned to Australia and joined the anaesthesia department at Sir Charles Gairdner Hospital in Perth. He later became a member of the Perth Anaesthetic Group, where he practised privately alongside many of Perth's leading surgeons.

Dr Twentyman found his professional home in Perth. He developed a strong reputation for skill and reliability, ultimately specialising in neurological anaesthesia. He was known for his calm demeanour and meticulous approach, particularly during complex craniotomies that lasted up to 18 hours. His work contributed significantly to patient outcomes and earned him the respect of colleagues across multiple specialties.

Outside of medicine, he embraced the natural beauty of Western Australia. He enjoyed fishing and sailing, often accompanied by his children. He was a patient teacher, sharing his knowledge and wide-ranging interests in the arts and natural sciences.

In 1980, Dr Twentyman first visited Alderney, a delightful small island in the Channel Islands, where he was invited to take over the local general practice. He declined at the time, later accepting a final full-time anaesthesia post, eventually becoming head of anaesthesia in Taif, Saudi Arabia. There, he specialised in neonatal anaesthesia, with special interest in the particular precision required in caring for newborns. His time in Saudi Arabia included rare encounters with royalty, accompanying the King as his medical detail on desert expeditions and overseas medical visits.

In 1989 Dr Twentyman retired to Alderney where he remained active in the local medical community. He contributed to the Island Medical Centre, the Mignot Hospital, and served as chairman of the Connaught board, overseeing the building of a new care home. He also oversaw the ambulance service and was a trustee of Alderney Cancer Relief. He was a respected figure in village life, known for his caring concern, generosity, wisdom, and gentle humour.

In retirement, he cultivated a passion for gardening, cooking and entertaining, sharing these joys with family and friends. In his final decade, he became the devoted carer for his wife during her dementia, a role he fulfilled with quiet heroism until age 90. Despite increasing physical challenges, he remained intellectually sharp and active, engaging with contemporary issues, science, and faith.

A lifelong believer in God as the architect of life, Dr Twentyman found renewed spiritual depth in his final years. He embraced the Christian hope of resurrection and found joy in church fellowship and theological reflection. His faith became a source of strength and peace, guiding him through his final chapter with much grace.

Dr Twentyman is fondly remembered by many as a lovely gentleman: a man of quiet strength, clinical excellence, and enduring kindness. His legacy lives on in the lives he touched as a physician, colleague, friend, and father.

Compiled by his daughter, Catherine Meijer-Twentyman, B. Sc (Hons), founder and director of the Yayasan Mulia Hati Foundation in Indonesia, which engages in livelihoods training for poverty relief among disadvantaged communities in Tobasa, North Sumatra and West Aceh.

Mohandas Kattayat

1951 – 2025

On 20th October 2025, the anaesthesia fraternity of Malaysia mourned the loss of one of its pillars, a distinguished and beloved member of our community.

Dato Dr Mohandas Kattayat graduated as a doctor from the University of Madras, India in 1974. He first worked as a house officer and then as an anaesthesia resident at the Jawarharlal Institute in Pondicherry, India from 1975 to 1980, obtaining his diploma in anaesthesiology in 1978. In 1980, he moved to Malaysia, working as a specialist anaesthetist at Muar General Hospital, then as a consultant anaesthesiologist at Johor Bahru General Hospital, Melaka General Hospital and Kuala Lumpur General Hospital (HKL). While working at HKL he obtained the FFARCS (Australia) in 1985 and was awarded the FANZCA in 1993. He then moved together with the whole cardiothoracic team to the National Heart Institute when it was opened in 1992.

For his subspecialty training, he worked as a fellow in cardiothoracic anaesthesia and intensive care at the Brompton Hospital in London in 1987. He was one of the very few cardiothoracic anaesthesiologists who underwent medical perfusionist training, which he did at St Vincent's Hospital in Sydney in 1995.

Always a leader in the medical field, Dato Mohandas was very involved in the training of anaesthesiologists. In fact, he was made an associate faculty member of the American Heart Association in Emergency Cardiac Care in 1986 and he set up the standard and guidelines for cardiopulmonary resuscitation (CPR) in the country. He was even given an award and a grant of USD$5000 by the Laerdal Foundation in Norway in 1986 for his input in the design of the CPR mannequin which we use to teach cardiopulmonary resuscitation to this day.

He was instrumental in designing and setting up the operating theatres and intensive care units of three major hospitals in the country – the National Heart Institute in 1992, Gleneagles Kuala Lumpur in 1996, and Prince Court Medical Centre in 2006.

In the 1980s a medical team comprising of Dato Dr Mohandas, cardiologist Dato Dr. Zainal, a nurse and a medical assistant, Mr Siva, were asked to escort the Sultan of Terengganu to the San Francisco Mayo Clinic for a coronary angioplasty. One day before their departure Dato Mohandas led the team in setting up a mini ICU in the first-class section of a Malaysia Airlines plane. The 20-hour flight was not easy; however, under the guidance of Dato Dr Mohandas and the team, the Sultan of Terengganu was in good hands as they landed in San Francisco and handed the sultan over to the Mayo Clinic team.

In 2013 he was awarded the title "Darjah Indera Mahkota Pahang" (DIMP) by the Sultan of Pahang, which carried the title "Dato" (equivalent to Knight or Sir), for his contributions to medicine in Malaysia.

Whenever we had any trouble with our anaesthetic equipment in the operating theatre or ICU, the first person we would call would not be the biomedical team but Dato Mohandas, and he would very frequently troubleshoot and solve the problem for us. In fact, his nickname in the OT was "MacGyver of the OT" after the popular television series in the 1980s.

As we mourn the loss of someone who has contributed so much to the field of anaesthesia, let us also remember to celebrate all his accomplishments and hope that all his achievements will not be forgotten by his students, peers and the community.

Dr Anselm Suresh Rao
Consultant Anaesthesiologist,
Gleneagles Kuala Lumpur, Malaysia

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