ANZCA
FPM

PS64 Position statement on environmental sustainability in anaesthesia and pain medicine practice 2026

Short title: Environmental sustainability

1. Purpose

The purpose of this statement is to:

1.1 Affirm ANZCA's commitment to the health benefits and improved wellbeing of addressing climate change and promoting environmental sustainability.

1.2 Serve as a resource for clinicians to promote environmentally sustainable practices in their workplace and health system.

1.3 Assist clinicians and healthcare facilities to integrate environmental sustainability and climate resilient practices in the delivery of safe, high quality patient care.[1]

2. Scope

This document is intended to apply to, but is not limited to, all clinicians practising anaesthesia, perioperative medicine, pain and hyperbaric medicine, as well as all healthcare facilities in which these services are provided.

3. Background

The healthcare sector is intrinsically linked with processes that emit pollutants into the air, water, and soil, creating a substantial ecological footprint and acting as a major contributor to anthropogenic climate change. To safeguard human health, clinical sustainability must be understood within the Planetary Boundaries Framework.[2] This scientific model defines a "safe operating space" for humanity across nine critical Earth life support systems, including climate change, freshwater integrity, and land-system change. Healthcare activities drive risks beyond these boundaries through carbon emissions, resource consumption, ozone depletion, plastic pollution, and freshwater ecotoxicity.

Carbon emissions originating from the healthcare sector constitute a significant portion of national totals:

- Australia: Estimated to contribute between 5% and 7% of national carbon emissions.
- New Zealand: Estimated to contribute 3.6% of national carbon emissions.
- United Kingdom: Approximately 5% of acute hospital carbon release is directly attributed to anaesthesia practices, highlighting the unique role of the specialty in mitigation.

Threats to planetary health and the breach of global ecological boundaries disrupt stable climate systems and environments, impacting human health outcomes. Environmental degradation and climate shifts place an inequitable burden on population groups with increased adaptation challenges including:

- Infants, children and the elderly.
- Indigenous populations in Australia (Aboriginal and Torres Strait Islander peoples) and Aotearoa New Zealand (Māori), and those within the Pacific region.
- Communities in low-lying geographical areas.
- Individuals experiencing socio-economic challenges or pre-existing medical conditions.

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- Future generations, who will bear the most severe impacts of current ecological transgressions despite bearing no responsibility for them.

As described in the background paper PS64BP, sustainability action can result in many co-benefits such as improved health and reduced health costs, reduced fossil fuel use, improved energy security, less air pollution, mitigation of rising temperatures, less waste, and increased green spaces. Redesigning infrastructure and introducing innovative, sustainable models of care, using new technologies, and judicious use of resources can lead to better patient care. Sustainable healthcare can therefore reduce financial costs and waste whilst providing high-quality care and improving health.

4. Principles

4.1 All consideration of environmentally sustainable practice must occur in the context of optimal patient care, including minimising unnecessary interventions and overtreatment.

4.2 Environmental sustainability is an area of new and rapidly emerging evidence and technology, which should be frequently appraised and implemented when effective.

4.3 The role of the clinician in environmental sustainability is multifactorial, including:

4.3.1 direct responsibility for environmental sustainability in clinical decision making

4.3.2 advocacy

4.3.3 education

4.3.4 research

5. Medications

5.1 Nitrous oxide

5.1.1 When used, N_2O can represent the greatest emissions of any component of an anaesthetic. Avoiding or reducing clinical N_2O use where possible will significantly reduce the greenhouse gas emissions of an anaesthetic. When it is necessary to use N_2O, using the lowest possible fresh gas flow and the shortest duration will reduce its negative impact.

5.1.2 N_2O has been demonstrated to leak in considerable amounts (up to 75-99%) from the centralised pressurised medical gas pipeline systems (MGPS).

5.1.2.1 Avoiding installation of new N_2O MGPS, decommissioning existing N_2O MGPS, and utilising point of care cylinder supply where N_2O is required for clinical use will substantially reduce associated emissions.

5.1.2.2 Clinicians can reduce healthcare emissions by advocating for their hospital to return to cylinder supply of N_2O for clinical use in operating theatres and other areas. This approach is endorsed by ANZCA and other international anaesthetic organisations. Full use of cylinder contents will reduce the residual volumes returned to suppliers and the associated emissions of this wastage.

5.1.3 New technologies for capture and destruction of exhaled N_2O are increasingly being considered. They are not currently effective in the presence of inhalational anaesthetic agents, though may be appropriate for use in other clinical areas such as the birthing suite.

5.2 Inhalational anaesthesia agents

5.2.1 The contribution of inhalational anaesthetic agents to climate change on the global scale is small although anaesthetists are able to make decisions at work that impact the carbon footprint from an anaesthetic.

5.2.2 Inhalational anaesthetic agents absorb and re-radiate infrared in the atmosphere, acting as greenhouse gases (GHG). The effect of each agent is dependent on its absorption of infrared radiation that would otherwise leave the Earth's lower atmosphere, the amount used, and its atmospheric lifetime. Nitrous oxide (N_2O) and some volatile anaesthetics also contribute to the destruction of atmospheric ozone.

5.2.3 As they are used in clinical practice, desflurane and N_2O have a high intrinsic impact on global warming which is at least ten-fold greater than sevoflurane and isoflurane.

5.2.4 The breakdown products of sevoflurane and desflurane are known to persist and accumulate in the environment with no known degradation pathways.

5.2.5 Clinicians can reduce their impact on the environment by

- Minimising fresh gas flow when using volatile anaesthesia, by utilising low fresh gas flow techniques where clinically appropriate (<0.5L/min) and using automated end-tidal volatile delivery where available.
- Using agents that have a lower impact on the environment, in particular avoiding the use of N_2O and desflurane.
- Using techniques to minimise the impact of general anaesthetic agents, such as regional anaesthesia.
- Using total intravenous anaesthesia (TIVA) where clinically appropriate.
- Using optimal fresh gas flows when using TIVA, which will depend on local factors, and using the lowest FiO2 that is clinically appropriate.

Such considerations must always be in the context of achieving optimal patient outcomes, for every individual case.

5.3 Sustainable prescribing practices

Prescribing practices have a clinical safety and environmental impact. Consideration should be given to:

5.3.1 the appropriate indication for use.

5.3.2 the route of administration, as formulations such as intravenous (IV) (eg paracetamol), sublingual (eg buprenorphine) and transdermal (eg fentanyl) have a much higher cost and environmental impact than oral preparations.

5.3.3 prescribing appropriate quantities for discharge, to improve patient safety (eg opioids), reduce waste, and reduce environmental pollution due to disposal of medications at home.

5.3.4 appropriate patient education for responsible disposal of excess medications to prevent ecological contamination.

5.3.5 appropriate deprescribing to address overtreatment, reduce waste and the ecological impacts of pharmaceutical supply.

5.3.6 the use of non-pharmacological strategies such as the use of heat or ice, relaxation or mindfulness techniques, distraction, or other physical or psychological strategies to reduce medication use in both acute and chronic pain settings.

6. Waste

6.1 Reducing material waste in anaesthesia

Operating rooms generate 20-30% of total hospital waste; 20-25% of total operating room waste comes from anaesthesia services specifically. Anaesthesia systems should be designed to provide safe, effective patient care while minimising unnecessary waste. Waste can be minimised by (in descending order of size of impact):

1. finding ways to generate less material waste.
2. purchasing lower environmental impact products.
3. recycling and reducing the environmental impact of waste disposal.

6.2 Generating less material waste

6.2.1 Anaesthetists should avoid unnecessary use of non-sterile gloves and should follow the principles of 5 Moments for Hand Hygiene during patient care, to improve hand hygiene compliance, reduce iatrogenic infections, and reduce carbon emissions and waste.

6.2.2 As the pre-emptive preparation of drugs and consumables for emergency use increases waste and increases the risk of error and contamination, anaesthetists should reserve this practice for cases considered higher risk. Pre-filled syringes may provide both financial and environmental benefits, as well as enhance safety.

6.2.3 Dedicated operating theatre footwear and freshly laundered lint free hats should be encouraged, to reduce waste. Theatre attire should meet standards set out in *PG28 Guideline on infection control in anaesthesia*.

6.2.4 Reusable drapes and gowns (both sterile and non-sterile) should be advocated for, as the environmental impact is lower when compared to disposable alternatives.

6.2.5 Pre-formulated packs such as dressing packs and CVC insertion packs should contain only the required products, to avoid unnecessary cost and waste.

6.2.6 Managing stock volumes of drugs and consumables to minimise wastage of expired and outdated stock can reduce costs, waste, and carbon emissions.

6.2.7 Some items no longer appropriate for healthcare use can be reused in non-healthcare settings. It may be appropriate for some items to be used in medical education, or provision of veterinary care. Donation of expired items or unused equipment to developing nations must be carefully considered under the WHO guidance on Medical Device Donations with regards to ethics and ongoing maintenance of items. Care should be taken to seek institutional approval, and consider any risks associated with donation.

6.3 Purchasing lower environmental impact products

6.3.1 Switching from disposables to well-designed reusable equipment can significantly reduce waste, cut carbon emissions, lower costs, and enhance system resilience.

6.3.2 Reusable drug trays, blood pressure cuffs, pulse oximeters, face masks, LMAs and laryngoscope blades can all be safely reused provided appropriate disinfection (such as wipe down or wash cycle in CSSD depending on the item) occurs between uses.

6.3.3 When washing or sterilization by CSSD is required, the carbon savings of reusable versus single use equipment will depend on the local energy source. With increases in renewable energy in Australia and Aotearoa New Zealand, the environmental impact of reusable equipment continues to improve.

6.3.4 Remanufactured items may be considered for purchase where they meet relevant standards.

6.4 Recycling and reducing the environmental impact of waste disposal

6.4.1 Recycling

Recycling programs can reduce operating theatre waste disposal costs by up to 60% and should be present in all facilities that have access to them. However, it should be recognised that recycling is less effective in reducing environmental harm from waste than reducing waste generation and choosing lower impact products, due to energy expenditure and secondary waste production.

Plastic recycling has significant limitations: it is frequently accompanied by microplastic and toxin production, recycling streams are not available in all regions, and contaminated plastics may not be acceptable to waste management companies.

Recycling streams which may be of value when available include:

- Paper and cardboard
- Blue surgical/equipment wrapping
- Polyvinyl chloride (PVC), polypropylene and polyethylene
- Metals, including stainless steel (i.e. single use metal instruments), copper (i.e. diathermy cables), and aluminium (i.e. nose-strips on Hudson masks, packaging of sutures)
- Glass, including drug vials when bespoke repurposing schemes exist, as drugs remain present in only small amounts. Tempered glass ampoules are not currently recyclable in Australia or New Zealand as they are made from borosilicate glass, which requires higher incineration temperatures to manufacture and recycle than standard glass
- Medication blister packs
- Batteries
- Fluorescent light bulbs
- Electronics, within e-recycling programs

6.4.2 Waste disposal

Ensuring that items are disposed of correctly into clinical, pharmaceutical or sharps waste streams will result in energy and financial savings.

6.4.2.1 Clinical waste is for items contaminated by body fluids (such as blood, serum, plasma, pleural, amniotic, pericardial, peritoneal, synovial and cerebrospinal fluids and all biological fluids visibly contaminated with blood) or that have had contact with a patient suspected of having a communicable disease. Note that faeces, urine, vomit, sputum, or meconium from patients not suspected of having a communicable disease are not clinical waste and should be disposed of in the general waste stream.

6.4.2.2 Pharmaceutical waste is for unused pharmaceutical agents, and is treated prior to disposal, to mitigate the effects of the pharmaceutical agents on the environment and minimise the opportunity for diversion.

6.4.2.3 Sharps waste is for any items capable of cutting or penetrating the skin. Of note, this does not include tempered glass vials or plastic syringes. Where dedicated recycling waste streams are not available, empty tempered glass vials or syringes should be placed in the general waste stream. Sharps waste management varies between jurisdictions: it may be crushed or macerated with or without treatment or incinerated to render pharmaceutical waste inert. When not incinerated, pharmaceutical waste disposed of in this stream can contaminate the environment and should be disposed of in a dedicated pharmaceutical waste stream.

7. Green procurement principles

Decarbonisation of healthcare, and reducing waste generated through external supply chains, is essential to achieving environmentally sustainable anaesthetic practice.

Environmental considerations should be embedded in purchasing and tendering decisions alongside safety, clinical effectiveness, durability, and cost.

Procurement decisions should take a whole-of-life approach and should align with circular economy principles to reduce waste production and pollution, and to circulate products and materials at their highest value.

Life cycle analyses and other transparent environmental information should be used to inform procurement where available, to avoid unintentionally switching to a product that causes more harm to the environment.

- Anaesthetists can actively engage in hospital procurement processes to ensure the environmental impact of products is considered in purchasing decisions.
- Anaesthetists can advocate for improved environmental disclosure by suppliers.

8. Beneficial care

Clinicians have a role in ensuring all healthcare encounters provide value to the patient, including advocating for macro (government) and meso (organisation and professional colleges) strategies to remove low value and harmful healthcare from systems.

8.1 Anaesthetists should be involved in pre-operative planning for patients with complexity with the aim of optimising health outcomes, avoiding late cancellations due to incomplete pre-assessment, and avoiding unnecessary or inappropriate procedures

8.2 Anaesthetists should collaborate with procedural colleagues to audit patient outcomes to detect any patterns of healthcare provision not resulting in patient benefit, specifically considering futility in these efforts

8.3 Clinic appointments should be offered via telehealth to patients when clinically appropriate, as this reduces travel-related carbon emissions and can improve the patient experience

8.4 Clinicians should ensure that all diagnostic investigations ordered are evidence-based, targeted, and performed only when results are likely to influence perioperative management or patient outcomes.

8.5 Routine laboratory testing and cardiovascular or respiratory investigations are not recommended for asymptomatic patients undergoing low-risk surgery in the absence of clinical indications.

8.6 Anaesthetists and pain medicine practitioners should advocate for systems which enable sharing of results and information to prevent duplication of investigations.

9. Infection prevention and control

Infection prevention and control practices should incorporate environmental sustainability principles while maintaining patient safety. Anaesthetists should align practice with existing ANZCA infection control guidance (PG28), applying sustainability considerations where evidence supports equivalence in safety and effectiveness.

Examples include:

- Appropriate use of alcohol-based hand rubs including surgical scrub with alcohol-based hand rubs.
- Disposable or reusable anaesthetic breathing circuits can be reused for up to 7 days provided appropriate precautions and processes are in place, including the use of bacterial filters and inspection after each use for contamination.
- Avoidance of routine sterile gown use for uncomplicated single shot neuraxial anaesthesia.
- Use of reusable surgical drapes and gowns when facilities exist to launder and sterilise to manufacturing guidelines.

10. Building design and infrastructure

Anaesthetists can play a key role by advocating for infrastructure planning that aligns clinical excellence with environmental responsibility.

Infrastructure decisions for new builds or refurbishment represent a major opportunity to reduce emissions, improve resource efficiency, and enhance staff and patient wellbeing. Sustainable infrastructure also

reduces operational costs, builds resilience to climate change, and supports continuity of care during extreme weather events.

Planning of future healthcare facilities should adopt an integrated, whole-of-life design approach, consistent with sustainable design frameworks.

Retrofitting existing facilities can deliver immediate gains in environmental performance and often has a significantly lower carbon footprint than a new build.

- Installing flow restrictors and water-efficient fittings and motion-sensitive taps to reduce water wastage.
- Energy efficiency upgrades - facilities should aim for NABERS energy ratings of 4.5 stars or higher or NZGBC 5 Green Star certification, especially for all new health facility buildings.
- N_2O medical gas pipeline systems should be decommissioned or truncated to essential limbs only.
- Optimisation of heating, ventilation and air conditioning (HVAC) settings, including appropriate out-of-hours setback modes, optimisation of temperature settings, minimisation of unnecessary door openings, and deactivation of anaesthesia gas scavenging systems when not in use. HVAC settings must comply with local policy and engineering governance to ensure patient safety.
- Waste stream optimisation requires spatial design to support effective segregation, including clear signage and bin placement in clinical and non-clinical areas. Infrastructure upgrades should also ensure sterilisation capacity supports the shift toward reusable equipment.
- Digital infrastructure should support sustainable clinical operations through electronic health records, telehealth capability, ePrescribing and remote monitoring systems, reducing paper use and travel-related emissions.
- sustainability noticeboards and data dashboards, that track and report on sustainability quality improvement projects, can promote shared ownership and accountability for environmental performance.

11. Travel

Employee commute and business-related air travel contribute significantly to the greenhouse gas emissions of the healthcare system. Reducing travel-related emissions can provide considerable health and environmental co-benefits, including improved air quality, reduced road congestion, and health benefits of active transport.

Clinicians are encouraged to:

- Utilise teleconferencing and virtual attendance to reduce travel for non-clinical activities. When air travel is required, consider that business and first-class tickets can have 2.6–4.3 times the carbon footprint of an economy ticket.
- Utilise work-from-home arrangements during non-clinical time when feasible.
- Use telehealth for consultations where clinically appropriate, reducing the need for patients to travel - particularly benefitting those in rural and remote areas.
- Use and promote active modes of transport (walking, cycling) and public transport over private vehicle use.
- Advocate for organisational support of virtual meeting infrastructure, flexible working arrangements and the provision of end-of-trip facilities to encourage active transport.

The main source of carbon emissions from medical conferences is due to participant travel. Guidance for conference organisers is available in Zotova et al.'s checklist[3] (2020) and the sustainable conference guide produced by the Doctors for the Environment Australia. Hybrid, localised and carefully designed events can substantially reduce the impact. Clinicians should employ careful thought and optimisation of their travel to reduce distance flown, combining trips to minimise flights, and considering the class of travel to minimise emissions.

12. Advocacy

Anaesthetists, perioperative and pain medicine physicians are well positioned to advocate for both local and system-wide solutions. As problem-solvers and leaders, they may encourage their health services, colleagues and colleges to make better decisions with respect to the environment, the climate, and public health.

Clinicians may advocate at many levels, including:

- Within the operating theatre environment
- At local, hospital and statewide environmental committees
- In development of policy and governance related to climate mitigation and adaptation within health organisations and infrastructure
- With trainees in developing an understanding of more environmentally responsible anaesthesia, perioperative and pain medicine practice
- Within their professional representative bodies, which should also support clinicians in their advocacy roles.

13. Environmental sustainability knowledge

13.1 Research

There are significant gaps in knowledge relating to environmental sustainability in healthcare. Anaesthetists should engage in research which furthers understanding of how to safely and effectively decarbonize the healthcare system.

Supporting and funding audit and research in the environmental impact of clinical anaesthesia, perioperative medicine and pain medicine will continue to assist in improving and rethinking methods of environmental sustainability.

Robust research will empower clinicians to spread proven sustainable practices and speed up the transition to climate neutral healthcare.

13.2 Quality improvement

Anaesthetists, perioperative and pain medicine physicians should lead and contribute to quality improvement programs which aim to deliver sustainable healthcare services and to reduce harm from their environmental impacts.

Clinicians can use the principles of Sustainability in Quality Improvement (SusQI) to incorporate environmental, social and economic costs of healthcare in the existing quality improvement framework.

ANZCA Environmental Sustainability Audit Tool is available to assist departments and practitioners to develop and maintain sustainable practices in their working environment.

13.3 Education

Departments should appoint a sustainability lead, who is involved with quality improvement and education.

The curriculum for anaesthesia and pain medicine trainees and junior doctors involved in anaesthesia, pain medicine and perioperative medicine should integrate:

- Education and specific guidance in environmentally responsible clinical practices, waste mitigation and mitigation of healthcare impacts on the environment.
- Mapping the effects of climate change on individual organ systems and overall health outcomes.
- Extrapolation of these effects to surgical and anaesthetic practice and access to timely and safe perioperative care.

- Planetary health is identified as a key theme in the 2025 Australian Medical Council's Review of Standards for Specialist Medical Programs which will inform future joint AMC/MCNZ accreditation standard and should be considered in reviewing the ANZCA, FPM, ChPOM and DHM curricula for training.
- Resources concisely detailing evidence-based environmentally responsible clinical practice should be developed and made readily available to practising anaesthetists, SPMPs and perioperative physicians.

Environmental sustainability should be integrated into CPD programs of anaesthesia, pain and perioperative medicine specialists throughout their career.

This document is accompanied by a background paper (PS64BP) which provides more detailed information regarding the rationale and interpretation of the Statement.

References

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Further reading

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Related ANZCA documents

The following Professional Documents should be interpreted in light of this document:

PG07 Guideline on pre-anaesthesia consultation and patient preparation

PG28 Guideline on infection control in anaesthesia

PS40 Position statement on the relationship between fellows, trainees, graduates and the healthcare industry

PG51(A) Guideline for the safe management and use of medications in anaesthesia

PS62 Position statement on cultural competence and cultural safety

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the college's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

While ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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