ANZCA
FPM

Bulletin

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

SPRING 2026



"So just like that I was dying"

A FELLOW'S STORY

Exploring research

Nurturing the next generation of clinical researchers

Trainee profile

Finding purpose through representation

National Anaesthesia Day
16 October 2026



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

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

We're also using NAD to launch our new resources for patients on "Fasting before surgery," which includes guidance on what to do if they're taking GLP-1 medications or other peptides.

Visit our website for more information or email communications@anzca.edu.au. Join in the fun by using the hashtag #InSafeHands.

It's not too late to get involved!



ON THE COVER

Dr Steven Hocken was getting ready to sit his final exam when a colonoscopy changed everything. He tells his remarkable story of diagnosis, treatment and recovery on page 19.

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

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

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

Copyright
Copyright ©2026 by the Australian and New Zealand College of Anaesthetists, all rights reserved. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form, by any means without the prior written permission of the publisher. Please note that any views or opinions expressed in this publication are solely those of the author and do not necessarily represent those of ANZCA.
ISSN: 1038-0981 (print)
2206-5423 (online).

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

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

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

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

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

In this edition









4 President's message

6 CEO's message

8 Letters to the editor

11 ANZCA and FPM in the news

12 ANZCA and government

19 Dr Steven Hocken shares his story

22 Safety and quality

29 Sustainability

36 Faculty of Pain Medicine

45 Perioperative medicine

52 Continuing professional development

54 Training and education

62 Global development

66 Doctors' health and wellbeing

69 Anaesthesia history

71 Museum

72 Research

81 ANZCA Awards

82 ANZCA Library news

84 Obituary

AI and medicine: Holding on tight to what makes us doctors, and human



You can't get through an ANZCA meeting these days without reference to information technology (IT) or artificial intelligence (AI). Our people are screaming for more, better, faster. There is enthusiasm and a demand for pace from some of our brightest people.

Our people need and deserve IT that enables the work and is user friendly: Continuing professional development (CPD) platforms, trainee portfolios, behind the scenes admin portals that both work and don't make you want to throw your laptop across the room in frustration trying to access it.

We are prime targets for cyber criminals because we sit at the intersection of healthcare and education. The risk is not only the release of personal information like the Qantas data breach, but even more sensitive material such as upcoming exam questions or details of a trainee in difficulty.

Balancing ease of access against security is fundamental.

AI is the newer, shinier gizmo coming at us like a tsunami. It promises so much, and we are giddy with possibility about how it might make our work easier. But there is also plenty to worry about. Who owns the data we feed into it? Where does the data go? What happens if the company we use flicks the kill switch? How do we get our data back if we withdraw consent? What about bias, breaches, misinformation, and the financial and environmental costs of it all? What happens if there is another drought and we need to choose between drinking water and cooling data centres?

We're hearing worrying anecdotes. Here's one to make your blood run cold. An invitee sends an unannounced bot to attend an online meeting in their place. It arrives unnoticed, transcribes the discussion, and stays on to "listen" while confidential matters are raised. The transcript is then emailed to everyone.

This might seem like someone else's responsibility, but ask yourself: how secure is your department's morbidity and mortality meeting? Our lawyers now worry that privacy-breach claims will be the next frontier for personal injury litigation. Our IT experts can help with data security, but they aren't ever present.

A decade ago, Stephen Hawking said that AI would be either the best or the worst thing to ever happen to humanity, we did not yet know which. Bill Gates says AI could replace doctors within a decade. Elon Musk gives us a paltry five years before we're all made redundant by his robots. Predicting the future is hard, even if you are a genius or a billionaire.

The thing that worries me most is that AI might be quietly chipping away at our critical thinking. Is AI making us stupid and nudging us toward inappropriate shortcuts? Where is the line between helpful offloading of work and irretrievable atrophy?

Our trainee selection panels report that many applications for 2027 training positions now appear to have been AI-assisted. This is a dramatic shift from even a year ago. On the surface it appears to be an improvement. The applications are polished, the grammar is immaculate, the answers comprehensive.

And yet our selection panels are worried: the AI answers don't get to the heart of the question, the candidates all sound the same – robotic with the humanity ironed out.

Rather than helping our future colleagues showcase what makes them brilliantly unique, AI may be inadvertently hiding exactly the thing selection panels are trying to find. It will surprise no one that everyone has an opinion on what to do about this, including "don't worry, the AI will get better". Even informal preliminary discussion around whether we should issue guidance around AI use for trainee selection (tutorials on AI prompting anyone?) produces vigorous debate.

There are bigger, existential questions.

Who benefits now and in the future from AI? Who will be worse off? What will happen to society if many jobs cease to exist? ANZCA's advocacy on role substitution argues for medically-led multidisciplinary care over non-medical leads. But maybe this question is already historical.

Instead of doctor versus non-doctor, the question now might be why bother with a human at all. Humans are flawed and messy and expensive and unpredictable. Wouldn't it be easier, faster, more accurate to bypass us and just go straight to the bots?

No matter how hard we try, we can't out-compute AI. As George Washington says in the musical *Hamilton* during the Battle of Brooklyn: "We are outgunned, outmanned, outnumbered, outplanned, we gotta make an all-out stand".

Whether we realise it or not, whether we like it or not, we are scrutinised constantly at work – by patients, families, colleagues, health systems. We are actors on a stage, with an audience watching our every move. Every interaction counts, big and small, good and bad. Trust builds slowly and can vanish in an instant. We need to prove our worth now more than ever. The days when people deferred to us simply because we were doctors are long gone. Being trusted with someone's care remains an extraordinary privilege, no matter the technology. Patients have choices.

We need to retain a laser-sharp focus on what our patients of the future will want and need. What makes us better than the robots and the industry that seeks to replace us? We can and should control what we can control.

In the end, it is our humanness that sets us apart.

We must treasure our patients and their families and provide them excellent care. We must be kind to each other, whether senior or junior, whether doctor or not. We must nurture our own hearts and minds to arrive ready to contribute. Even this may not be enough, but it is all we have. As Aaron Burr says in *Hamilton*: "I am the one thing in life I can control".

On your behalf, we engage experts to help us navigate the technical aspects of these issues. We have had a chief information officer (Shubha Sridhar) and an Information and Communications Technology Governance Committee (ICTGC) for only the past three years – we owe Shubha and her team our thanks and patience while they work through the massive IT projects we have asked them to deliver, while patiently and methodically untangling our legacy systems.

Like anaesthesia, IT might look simple on the outside, but in fact there are layers of code and interdependencies and spreadsheets and asks across the college that are not visible to us.

Acknowledging the new AI world, we have just approved a new Data and AI Sub-committee to keep pace with opportunity, minimise risk, and help us move forward while we hold onto what makes us doctors and humans. Thanks to ICTGC chair Associate Professor Stu Marshall for leading us through this uncharted territory.

Dr Tanya Selak
ANZCA President

Strength in joint advocacy approach with other colleges



One of the most important roles ANZCA performs on behalf of its fellows, trainees and specialist international graduates (SIMGs), is advocacy.

Much of this work occurs behind the scenes, helping to ensure the voices of specialist anaesthetists, specialist pain medicine physicians and perioperative medicine (POM) practitioners are heard when governments, regulators and health services make decisions that affect clinical practice, training and patient care.

Over recent months, we have continued to advocate strongly on issues that matter to fellows: A sustainable specialist workforce, high-quality training, environmentally responsible healthcare and equitable access to services. At a time when health systems across Australia and New Zealand face increasing pressures, our role as a trusted and evidence-based advocate has never been more important.

CPMC AT ANZCA HOUSE

Much of our advocacy work is undertaken through our involvement with the Council of Presidents of Medical Colleges (CPMC).

In September, I was proud to host CPMC at ANZCA House in Melbourne for two days with ANZCA President Dr Tanya Selak. The CEOs and presidents of all the specialist medical colleges address the issues of most importance to our fellows, trainees and SIMGs.

CPMC provides all colleges with access to senior decision-makers in addition to our own approaches to government on issues including workforce planning, training, regulation and healthcare reform. Mark Butler, Australia's Minister for Health and Ageing attended and we discussed, among other issues, the important role of specialist medical colleges in maintaining system quality and safety, appropriate funding for public outpatient clinics to ensure consumer access to specialist care, and the role of SIMGs in meeting system demand.

By working collectively with other specialist colleges, we are able to be part of a strong, collaborative voice on discussions that directly affect fellows' and trainees' professional lives.

A range of shared strategic and operational priorities across the colleges was discussed including funding for training posts, employment challenges, supervision capacity, private sector training opportunities, college governance and the future strategy and direction of CPMC.

ADDRESSING WORKFORCE

Dr Selak and College of Intensive Care Medicine President Associate Professor Priya Nair gave a presentation at CPMC on the recently launched Dual Training Recognition Process.

This process, which reduces the time it takes to complete both the anaesthesia and intensive care training programs, is a great example of college collaboration that will have a very positive impact on care provision in rural and regional areas.

The maldistribution of our workforce and increasing service demands are among the most significant challenges facing our professions.

ANZCA continues to advocate for a greater involvement of specialist colleges in workforce planning. We argue that our expertise in training standards, workforce distribution and service delivery should make us central to policy development.

SPECIALIST FEES

We have also been actively involved in discussions about the access and affordability of specialist care and specialist fees, an area that is clearly a focus for Mark Butler.

At CPMC, Minister Butler noted the current parliamentary inquiry into affordability and access, forthcoming legislation relating to the Medical Costs Finder website and three consultations on specialist affordability.

For the first time, at least on the public record to my knowledge, the minister acknowledged access to public outpatient specialist services was an important part of the broader problem of specialist access and affordability and would be raised at the upcoming health ministers meeting.

SUSTAINABILITY

Protecting the environment is essential to protecting human health. One area where ANZCA can be justifiably proud of its leadership is environmental sustainability. Through the Environmental Sustainability Network (ESN) led by ANZCA, we have continued our push to reduce healthcare emissions associated with nitrous oxide.

ESN continues to build momentum for decommissioning reticulated nitrous oxide systems. On behalf of ESN I wrote to all health department secretaries seeking their commitment to this important process.

With positive responses from these jurisdictions, the Australian federal government has since invited ANZCA to collaborate with the Australian Centre for Disease Control on implementation and emissions measurement through the State and Territory Climate and Health Working Group. ANZCA is the only specialist college represented on this group, testament to the strong role of ESN and our commitment to environmental sustainability.

PERIOPERATIVE MEDICINE

We have also continued to promote the value of perioperative medicine and multidisciplinary models of care to Australian (federal and state) and New Zealand governments and other stakeholders, ensuring they understand the opportunities for improving patient outcomes, improving healthcare efficiency and reducing long-term health system costs.

Underlying all of this work is the expertise and commitment of our fellows and the POM Board, supported by a dedicated staff working towards the development of a strong value proposition for perioperative medicine to help in our advocacy efforts.

ANZCA VOLUNTEERS

Finally, ANZCA's influence with governments, regulators and healthcare leaders depends on the goodwill, expertise and generosity of fellows to contribute through committees, networks, consultations and advocacy activities.

We are in the process of developing a fellowship engagement framework to provide for more flexible, inclusive and clearly defined opportunities for fellows to contribute. Our recent fellow volunteer survey received about 1500 responses with findings expected in early October to inform volunteer engagement and workforce planning.

Measuring volunteerism is critical to understanding the scale of your contribution and ensuring this volunteerism is supported, recognised and sustained. Thank you so much to those of you who responded.

Ultimately, effective advocacy helps create the conditions that allow you to do what you do best – deliver outstanding care to patients and communities across Australia and New Zealand.

Lance Emerson
ANZCA Chief Executive Officer

Letters to the editor

CONTROVERSIES SURROUNDING PERIOPERATIVE METHADONE ADMINISTRATION

A recent *Anesthesiology* Clinical Focus Review[1] has re-examined the effectiveness and concerns regarding the perioperative administration of methadone to provide effective and prolonged analgesia in a wide range of surgeries.

It concludes that perioperative methadone administration "provides multiple benefits over standard opioids for various surgeries and that intraoperative methadone should be strongly considered in place of other opioids as part of routine multimodal analgesic strategies."

This and similar publications prompted a recent article in the *ANZCA Bulletin*[2] highlighting caution and concerns in methadone administration in opioid-naive patients and references ANZCA's *PS41* guidelines and related publications from advisory and regulatory organisations to support their conclusions.

Such promulgated guidelines are crucial for the safe and prudent administration of methadone in this setting. Subsequent correspondence[3] in the *ANZCA Bulletin* questions whether methadone use for perioperative analgesia carries greater risks than other opioids and also, the grouping of methadone with regular long-acting opioids, for example, modified or slow-release opioid formulations.

A recent ADVANCE (Anaesthesia discussion, views and contemporary evidence) educational session[4] on this topic attracted 750 anaesthetic, surgical, pain and other medical and nursing participants, indicating interest in perioperative methadone use in Australia and New Zealand.

The grouping of methadone with modified release opioid formulations makes sense and is entirely appropriate from the opioid pharmacodynamic perspective in the promulgated guidelines, but is totally incorrect from the pharmacokinetic perspective and requires some qualification.

Such guidelines provide crucial educational impact and clinical direction and I suggest the message is not as clear as it might be, which can exacerbate confusion regarding methadone use perioperatively.

Specifically, the variability in blood opioid concentrations at a particular dose are almost at the opposite ends of the pharmacokinetic spectrum. With modified release opioid formulations, the variability relates to differences and unpredictability in dissolution rates (that is, the rate at which the opioid dissolves from the patented technology that each company uses in its modified release formulation)[5] and the subsequent inherent interpatient variability in absorption rates which is significant.

In contrast, variability in methadone blood concentration relates to its metabolism as it is administered intravenously perioperatively, so absorption is not an issue. Morphine clearance from the body is high following absorption as there are large amounts of hepatic Cytochrome P_{450} isoforms and conjugating enzymes predominantly in the liver responsible for its metabolism and elimination whereas methadone clearance is low and defined as capacity limited – that is, depending on the absolute amounts of various Cytochrome P_{450} isoforms.


Caution needed with intraoperative methadone use in opioid-naive patients

For every intubation. Even the strange ones.

This means that concomitantly administered drugs can inhibit (that is, metabolised by the same Cytochrome P_{450} isoforms) or stimulate methadone clearance by inducing these same isoforms. Methadone has a rapid distribution phase and effect site concentrations promptly equilibrate with blood concentrations, with the effect site equilibration half-life similar to that of fentanyl and sufentanil[6].

An understanding of these issues may aid in the more rational use of methadone perioperatively. Thus, if an anaesthetist is satisfied that it is appropriate to transfer the patient to the ward, it is indeed true that that blood methadone concentration will continue to fall and associated respiratory and central nervous system (CNS) effects should not increase.

Of course, the pharmacodynamic effects associated with perioperative methadone administration cannot be considered in isolation and can have a profound effect in the ward if other CNS or respiratory depressants are administered in that setting.

This is why education and full disclosure to everybody involved in the postoperative care of such patients is mandatory and the importance of, inter alia, ANZCA's *PS41* guidelines.

Dr Geoffrey Gourlay, PhD, FFPMANZCA
Willunga, South Australia

References

1. Xie J, Pan SJ and Anderson TA.(2025) A Comprehensive Update on Intraoperative Methadone Use. Anesthesiology 143: 710-736.
2. Hollington I, Weiss A, Caution needed with intraoperative methadone use in opioid-naive patients, ANZCA Bulletin Spring 2025, pp30-31
3. Barnes R. Disagreement over intraoperative methadone risk. ANZCA Bulletin Autumn 2026, p8
4. "Sleeping with a Friend or Enemy? The Methadone Debate." ADVANCE (Anaesthesia Discussion, Views and Contemporary Evidence); 27 Oct 2025; Virtual national educational meeting, Australia. Available from: https://www.advanceanaesthesia.com.au/
5. Gourlay GK. (1998) Sustain Relief of Chronic Pain: Pharmacokinetics of SR Morphine. Clin. Pharmacokin. 35: 173-190.
6. Kharasch ED. (2011) Intraoperative Methadone: Rediscovery, Reappraisal and Reinvigoration. Anesth. Analg. 112: 13-16.

AWARENESS WITH TIVA/AIR ANAESTHETICS

I am troubled by the ongoing spate of awareness associated with the TIVA/Air model of anaesthesia.

Rome burns, whilst Nero fiddles.

Primum non nocere is implicit in every medical interaction that anaesthetists undertake.

And yet I am dismayed by the unabated cases of awareness that continue to occur at Morbidity and Mortality meetings that I attend, and by reading emails from hospital craft group leads, with the repetitive theme of patient awareness that has occurred with TIVA/Air anaesthetics.

This is unacceptable.

There is a very simple immediate remedy to nullify the repeated theme of equipment or cannulation failure associated with awareness with TIVA/Air anaesthetics, or, at the very least significantly ameliorate this awareness, but inexplicably and with flaky prejudicial data this is ignored.

Nitrous Oxide is a tried and tested supreme anaesthetic adjunct with no significant downside, anaesthetically or environmentally.[1-3] Purported increased incidence of PONV is "near eliminated by the use of anti nausea prophylaxis".[4] This should be administered routinely with every anaesthetic.

It is a magnificent insurance policy against awareness, and in fine tuning anaesthesia, especially in this era of steadily rising obesity.

We are all environmentally aware and concerned, but the Real Politik of this often gets lost with misguided spirited enthusiasm.

I despair in theatre when I look around at the gigantic tonnage of landfill generated every day, with single use ... everything; including at a hospital that I attend, which is purportedly green, single use laryngoscopes, Magill forceps, scissors and artery forceps and plastic single use anaesthetic trays.

Whilst there is much discussion by rightly concerned anaesthetists about greening anaesthesia and theatre, barring the culling of the low hanging fruit of Desflurane and Nitrous Oxide, it seems very apparent to me that very little has changed; and unsurprisingly, with the stranglehold that the Infection Control departments have on the theatres.

The easy pickings low fruit is all but removed, engendering feel good factor amongst the protagonists, but the big picture and the difficult propositions with far more environmental consequence are bypassed ... and awareness continues to be an unacceptable, ongoing, technique specific issue.

It is the delivery of Nitrous Oxide that is the real problem[5]; this is fixable, and the bedevilling of Desflurane is championed by anaesthetists masquerading as amateur climatologists, and not supported by those who are renowned experts in this field.[6]

The TIVA mantra of essential ability to observe the delivery of TIVA from pump to circulation is often not possible, as increasingly surgeons mandate arms to be tucked in by the sides during surgery.

BIS and Entropy are not fail proof.

Whatever it takes, this ongoing awareness issue, reflated to a specific anaesthetic technique must be stopped.

The answer lies before us, but inexplicably continues to be ignored.

Dr Stuart Skyrme-Jones, FRCA(Eng), FANZCA
Victoria

References

1. Tian H et al. A comprehensive quantification of global nitrous oxide sources and sinks.
2. Nature 2020;586:248-56
3. Gadani H and Vyas A. Anaesthetic gases and global warming: Potentials,prevention and future anaesthesia. Anaesth Essays Res 2011;5(1) 5-10
4. Schwilden H and Schutter J. 200 years of nitrous oxide -and the end of an era? Anaesthesiologist, Intensvid Notfam Schmerz 2001;26(10)640
5. Severe nausea and vomiting in the evaluation of nitrous oxide in the gas mixture for Anaesthesia 11 trial. Myles et al. Anaesthesiology Vol 124;(5) 2016
6. Smith E and Mitchell C The importance of tackling leaks in nitrous oxide pipes. ANZCA Bulletin Autumn 2023 60-63
7. Slingo and Slingo. Climate impacts of Anaesthesia. BJA vol 126 June 2021

LOOKING BACK ON A CAREER IN ANAESTHESIA

Dear fellows,

I have been retired for over 20 years.

I gained my FFARACS in 1967 – almost 60 years ago – at the age of 36 after several years as a GP and service in the RAF with the Middle East Air Force.

I was thrown into anaesthetics at the deep end as I arrived from Yorkshire into Queensland with a job at the Maryborough Base Hospital as Senior Medical Officer; only to find,on arrival, I was supposed to act as the hospital anaesthetist. I had never given an anaesthetic in my life!

Queensland Health realised this was not ideal and I was sent to the Brisbane General (became the Royal Brisbane later) for one month as an anaesthetic resident. I then returned to Maryborough and over 16 months administered GAs for over 600 operations without any real problems; covering everything from road trauma to caesars. including an elderly ENT doctor who insisted on ether administered through a home made machine of his. That was not all though, the Superintendent had an FRCS, but if he was away and an appendix, etc came in I had to deal with it. Anaesthetising the patient, leaving a nurse squeezing the bag (no ventilators) whilst I operated – with occasional remarks to the nurse like another ml of Flaxedil please, then at the end returning to the top end to wake the patient up.

Despite this hair raising introduction however I was hooked, I liked the challenge.

I applied for an anaesthetic registrar position at the South Brisbane Hospital (became the Princess Alexandra Hospital)

and after four very hard years was rewarded with my FFA, went into private practice and became a visiting anaesthetist at the PAH.

Apart from actual anaesthesia I was on the Queensland committee of the faculty at one stage and chair of the Queensland ASA. At various times on the boards of two private hospitals in Brisbane.

Since retiring to the Sunshine Coast I have remained busy with several different organisations, mainly non-medical but I attend meetings of the Sunshine Coast Local Medical Association just to keep my professional genes wagging!

I am now 95 but have no health problems and am very active.

My original reason for this dissertation was to say that I feel you should cease my *ANZCA Bulletin* which does not look a cheap publication and now even the obituary entries appear to be a generation behind me.

On gaining my FFA I understood I was the 19th FFA in Queensland – a couple more fellows now I think.

I have thoroughly enjoyed my career and really didn't want to retire at 73 but thought I had better.

When I came to Australia it's population was about 8 million, now 28 million. I feel I have done my bit with four children, four grandchildren and four great-grandsons (so far).

Thank you.

Best wishes,

Brian M. Smith, MB, BS, FFARACS, FANZCA

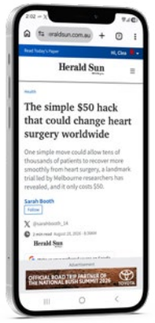
The views expressed by letter writers do not necessarily reflect those of ANZCA.

ANZCA
FPM

New Blue Book audio on GLP-1s, insulin, and fasting

New audio recordings from *Australasian Anaesthesia* (aka the Blue Book) are now available on SoundCloud. Listen to chapters on bronchoalveolar toileting, GLP-1 receptor antagonists, the history of insulin, and the "Sip Til Send" initiative. Head to https://soundcloud.com/ and search "ANZCA". You don't need an account and can download the recordings for easy offline listening.

Media coverage



IRON INFUSION BEFORE HEART SURGERY HELPS PATIENTS RECOVER FASTER

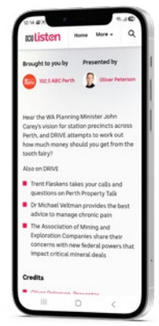
Professor Paul Myles was interviewed by media outlets about the *Intravenous iron to treat anaemia before cardiac surgery (ITACS): an international, double blind, placebo controlled randomised trial*, funded by the National Health and Medical Research.

The world-wide study published in the *British Medical Journal* involved 955 patients across 33 Australian hospitals and nine internationally and is the first large-scale trial to show that intravenous iron can improve outcomes for anaemic cardiac patients.

The landmark study found that a simple iron infusion administered in the weeks before heart surgery could soon become standard care as the infusion reduces blood transfusions and shortens recovery.

Professor Myles was interviewed for an article on 19 August in the *Herald Sun* and an article in the *Adelaide Advertiser* featured the following day. The *Herald Sun* article was syndicated online to the *Daily Telegraph*, the *Geelong Advertiser*, the *Cairns Post*, *The Mercury*, *Adelaide Now*, *The NT News*, *The Courier Mail*, *The Townsville Bulletin* and *The Toowoomba Chronicle*.

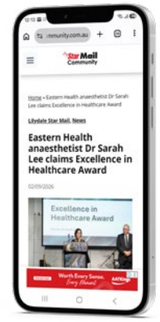
NATIONAL PAIN WEEK



FPM Dean Professor Michael Veltman was interviewed in a 15-minute segment on 27 July on the ABC Radio Perth Drive program.

Professor Veltman discussed National Pain Week, the incidence of chronic pain in the community and took calls from listeners. Professor Veltman highlighted the FPM-led first national standards to improve the quality and consistency of pain management education during the interview.

AMA AWARD FOR AUSTRALIAN ANAESTHETIST



Eastern Health anaesthetist Dr Sarah Lee was profiled in The *Star Mail* in Melbourne on 2 September after receiving the Excellence in Healthcare Award by the Australian Medical Association for her efforts to improve anaesthesia education.

Dr Lee said she felt incredibly humbled and honoured, particularly when she looked at the remarkable people who had received the award before her.

"Although there is one name on the award, there are many people behind it. I have been very fortunate to have the support of my directors at Eastern Health, my department, my mentors, colleagues and the wider ADVANCE team," she said.

Dr Lee was presented with the award at the AMA26 national conference in Melbourne.

PAIN DEVICES

Former FPM director of professional affairs, Associate Professor Mick Vagg was interviewed for an 18 July feature article in *The Age* and *Sydney Morning Herald* about pain device implants.

The article said A/Prof Vagg referred to "the faculty's 2023 guidelines advising members there was no reason to think the pain pumps were any better than oral painkillers."

What we're talking about online

On Facebook, one of our most popular posts was the Winter *ANZCA Bulletin* article on Timorese anaesthetist Dr Mario Soares. The post received 18,139 views and 129 interactions.

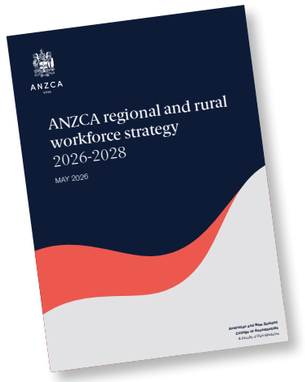
Across our social media platforms, some of our most-viewed posts included:

- Library and Information Week, including resource guides on artificial intelligence in healthcare.
- Dr David Bramley joining a panel discussion at the Geoffrey Kaye Museum of Anaesthetic History for Open House Melbourne.
- Dr Sarah Lee receiving the AMA Excellence in Healthcare Award for her contributions to anaesthesia education.

ANZCA and government



Advocacy in action: Shaping the workforce and health policy agenda



AUSTRALIA

Release of updated regional and rural workforce strategy

The new *ANZCA Regional and Rural Workforce Strategy 2026-2028* has been released, reaffirming the college's commitment to improving access to anaesthesia, pain medicine and perioperative medicine services for regional, rural and remote communities across Australia and New Zealand.

Building on ANZCA's inaugural 2021 strategy, the updated version outlines 20 priority areas focused on addressing workforce maldistribution and strengthening the specialist medical workforce outside metropolitan centres. The strategy is guided by four key pillars: Plan, Select, Train, and Support and Retain.

The strategy also highlights the college's significant achievements since 2021, including establishing the Rural Generalist Anaesthesia Training Program, continued growth of Specialist Training Program (STP) funded training places and support projects, implementing rurally based training pathways and rotations, expanded pain medicine training opportunities, and targeted advocacy and professional development resources to support regional and rural workforce growth.

This forward-looking strategy will support ongoing collaboration with governments, health services, medical colleges and communities to improve health equity and workforce sustainability.

Decommissioning N_2O pipelines

In June 2026 the college wrote to all Australian and New Zealand health departments communicating our commitment to minimising the health impact of climate change and promoting environmental sustainability.

The letter promoted our joint statement with the Australian Society of Anaesthetists and New Zealand Society of Anaesthetists on decommissioning nitrous oxide (N_2O) medical gas pipeline systems, requested jurisdictional commitment to reducing the associated environmental hazard, and offered to assist in moving to point-of-care N_2O cylinders.

The jurisdictional responses have been positive, with seven received so far. The collective responses indicate that there is now broad policy consensus across Australia and New Zealand that reticulated N_2O systems should be progressively decommissioned in favour of lower-emission alternatives.

Jurisdictions appear to be at different stages of implementation, but all support the direction and have expressed a willingness to work with ANZCA on guidance, clinical engagement and implementation activities. Some jurisdictions have invited meetings to discuss further.

As a result of this proactive advocacy, the college was invited to participate and present at the State and Territory Climate and Health Working Group meeting in September 2026. The presentation covered the commitment of ANZCA and its members to nitrous oxide manifold decommissioning, the experiences and challenges that ANZCA members have had when working on decommissioning, and how national coordination could help with decommissioning across the country.

This joint forum provides a valuable forum for knowledge sharing across jurisdictions, enabling discussion of implementation experiences, technical considerations and key lessons learned.

Queensland Health funding extended

In June the Queensland Anaesthetics Rotational Training Scheme (QARTS) was successful in receiving extended financial support from Queensland Health to June 2027. The funding, provided to respective Queensland hospital and health services, is for the part-salary of five senior medical officers to continue to coordinate the training and placement of over 300 anaesthesia registrars in Queensland.

QARTS is essential in enabling the sustainability of the anaesthesia workforce in Queensland. The growing numbers of trainees, the increasing complexity of trainee needs and how these interact with the demands of ANZCA training requirements as well as those of the employers (hospitals), a looming crisis in our regional anaesthetic workforce, and foreseeable training bottlenecks, are strategic issues which are best dealt with a collaborative like QARTS.

The college will work with QARTS to look at the long-term sustainability of this funding and other Queensland workforce needs.



CPMC meeting at ANZCA House

The CEOs and presidents of Australia's medical colleges met at ANZCA House on 2 and 3 September for a quarterly meeting of the Council of Presidents of Medical Colleges (CPMC).

The two-day meeting included a series of government/health sector stakeholder sessions providing relevant updates as well as discussion time.

Stakeholders included Mark Butler, the Minister for Health and Ageing, Dr Mike Freelander, Chair of the Standing Committee Health Disability and Ageing, the Australian Medical Council (AMC), the Medical Board of Australia (MBA), the Commonwealth Department of Health, Disability and Ageing, the Australian Medical Association (AMA), and the Australian Private Hospitals Association.

The meeting also covered sessions on a range of shared strategic and operational priorities across the colleges, covering cross-college collaboration, college governance and the future strategy and direction of CPMC. In relation to cross-college collaboration, ANZCA and the College of Intensive Care Medicine (CICM) provided a presentation on the recently launched Dual Training Recognition Process.

The process is a great example of college collaboration to enable an innovative mechanism for combining training towards FANZCA and FCICM in less time than it currently takes to complete both training programs.

NEW ZEALAND

Government

Proposed amendments to legislation governing the regulation of health practitioners in New Zealand were not introduced before Parliament rose ahead of the general election on 7 November.

Most of the amendments proposed in the bill are widely opposed by the medical councils and colleges, as they represent a substantial shift away from professional self-regulation.

Regulation is the focus of one of the questions ANZCA posed to the main political parties – Labour, National, NZ First, Greens, ACT, The Opportunities Party (TOP) and Te Pati Māori – based on ANZCA's 2026 Manifesto. Other questions focused on health policy and system design, a secure training pipeline, enhanced pain medicine services, a national perioperative medicine model, and improving equitable access to health services for rural communities, Māori and Pacific peoples.

Similar themes are found in the Council of Medical Colleges' Workforce Manifesto | Te Kaunihera o Ngā Kāreti Rata o Aotearoa, with the urgent need for action in the face of a particularly harsh influenza season exposing systemic workforce and infrastructure failures. Soaring hospitalisations of children prompted Pharmac | Te Pātaka Whaioranga to announce free annual influenza vaccinations for children under five from 2027.

The government acted quickly in response to its consultation on the medicines list for designated paramedic prescribers. ANZCA's submission argued that it was premature to move medicines currently managed under standing orders into a prescribing framework without equivalent oversight, audit processes, or clear treatment parameters.

Ministry of Health | Manatū Hauora acknowledged feedback suggesting that the prescribing framework should complement, rather than replace, standing orders, and accepted that standing orders will still need to be retained "at least in the short to medium term" and "are likely to remain central for emergency and immediate-use medicines, while prescribing authority is most relevant where ongoing treatment and continuity of care are required."

Nevertheless, the following table illustrates the outcome: only four prescription medicines and no controlled drugs from the proposed list of 120 were excluded, and 122 have been added to the list that was gazetted in early August.

ABOVE LEFT

Associate Professor Kerin Fielding, CPMC Chair visiting the museum at ANZCA House.

Summary of the number of medicines considered under this consultation

Medicine category	Prescription medicines			Controlled drugs		
	Initial number	Excluded	Final number	Initial number	Excluded	Final number
Consultation proposal	120	4	116	8	0	8
Suggested additions	133	17	116	8	2	6
Total	253	21	**232**	16	2	**14**

Changes to MCNZ

New Zealand's Minister of Health Simeon Brown recently declined to reappoint a number of board members to the Medical Council of New Zealand including Dr Rachelle Love, MCNZ's first wāhine Māori chair.

Two Free Speech Union members, Dr Roderick Mulgan and Dr Manoja Kalupahana, have been appointed to the board, now chaired by Dr Kenneth Clark.

MCNZ's 2026 Medical Workforce Survey Report shows the medical workforce continues to grow at a faster rate (2.3%) than the population (0.65%). Board Chair Dr Clark also noted "changes in the make-up of the profession, including a younger Māori and Pacific medical workforce, more women in medicine and growth across a number of vocational areas.

At the joint meeting held in Wellington, Australian and New Zealand regulators reaffirmed their commitment to cultural safety and equity as key principles, fundamental to their work in ensuring public safety.

HQSC releases new strategy

ANZCA has welcomed the release of the new Health and Disability Systems Safety Strategy 2026-2036 by the Health Quality and Safety Commission (HQSC) | Te Tāhū Hauora.

Dr Martin Thomas, who is an anaesthetist, led the work on the development of the strategy, which sets out a system-wide approach to strengthening quality and safety across New Zealand's health and disability sector. The college is encouraged by the strategy's recognition that achieving safe, high-quality, people-centred care depends on the expertise and commitment of the health workforce.

HQSC has released a new report on surgery and risk, confirming that rates of death within 30 days of surgery in New Zealand align with those reported in countries like Australia, the UK and US.

Planned surgery is more common and has lower rates of death within 30 days than emergency surgery; differences in outcomes between population groups are also reported. New data analysis techniques were used to build a national picture of disabled people's experiences of healthcare quality and safety, "A Window on Disability". Despite disability data gaps, a clear pattern of systemic barriers and poorer health outcomes across the lifetimes of disabled people is reported.

Smoking and vaping

Fears about the repercussions of the repeal of New Zealand's "Smokefree 2025" legislation, spearheaded by Minister Casey Costello, seem to have been well founded, with the decline in smoking stalling, as vaping escalates. Costello's advocacy for vaping as an alternative to smoking appears similarly misplaced, with maternal vaping identified as a risk factor for sudden unexpected death in infancy (SUDI).

The unexpected result of the New Zealand study reported in the *Journal of Paediatrics and Child Health*, suggests that nicotine, rather than smoking tobacco, may be the cause; increased vaping may also explain the ethnic disparities and persistently high mortality rates from SUDI in New Zealand. There is continuing concern with illicit vapes; last year a warning over pods laced with the anaesthetic drug etomidate was issued, and other drugs like ketamine, GBL and even methamphetamine have also been detected.

Figure available on the Ministry of Health website.

Naloxone and buprenorphine funding for chronic pain

FPM NZ National Committee chairs Dr Charlotte Hill and Dr Paul Vroegop have been invited to discuss their application to Pharmac to fund naloxone and buprenorphine for the treatment of long-term chronic pain. Another meeting is also planned between the Data Governance Group (Health NZ | Te Whatu Ora) and FPM to develop reference sets for chronic pain.

Employment opportunities for specialist pain medicine physicians (SPMPs) in New Zealand have taken a significant hit under Accident Compensation Corporation's (ACC)'s new contracting model for pain services management.

Despite several meetings and a proposed pilot for an SPMP-led pain service to test an alternative approach, ACC declined to change its model, which effectively excludes SPMPs from key roles.

Operationally, the model relies on non-SPMP triage in the first instance, with complex pain clients then moved into the pain management program. SPMP consults will only occur if patients are referred from the program.

The next phase of ACC's Turnaround Plan 2026/27 raises similar concerns: without early specialist input, people with complex regional pain syndrome (CRPS) are likely to be adversely affected.

FPM has written to ACC's chief executive outlining these concerns and requesting official information on the number of CRPS cases accepted and declined, how and by whom CRPS is assessed, and the time taken for referral to a specialist appointment and treatment.

Dr Hill is presenting "From Fragmented Care to National Consensus: Co-designing CRPS Guidelines for Aotearoa New Zealand" at the New Zealand Society for Surgery of the Hand Meeting in October 2026.

SUBMISSIONS AND CORRESPONDENCE

The college prepares submissions and makes representations to government and other stakeholders on a range of policy initiatives and inquiries. 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

- Streamlining selection into training/positions project - Health Workforce Taskforce.
- Anaesthesia demand and supply workforce modelling report - Department of Health, Disability and Ageing (DoHDA).
- Draft endorsement for scheduled medicines for pharmacists - Pharmacy Board of Australia.
- Draft guidance Intravenous fluid therapy: Principles for safe and appropriate use and safe administration of intravenous fluids: Avoiding venous air embolism - Australian Commission on Safety and Quality in Health Care (ACSQHC).
- Draft revised Registration standard: General registration for international medical graduates (IMGs) on the Standard pathway – Medical Board of Australia (MBA).
- Formalise the process for IMGs applying for general registration via the Competent Authority pathway – MBA.
- Draft National Scheme Common Professional Capabilities Framework and the draft pilot common professional capabilities for family, domestic and sexual violence and digital health - Australian Health Practitioner Regulation Agency (Ahpra).
- Streamlining the Specialist pathway – MBA.
- Clinical input on critical medical devices to support supply chain resilience – Therapeutic Goods Administration (TGA).
- Royal Australasian College of Surgeons (RACS) Model Resource Criteria for Trauma Centres – RACS.
- Health Insurance Amendment (Incentive Payments and Other Measures) Bill 2026 - Senate Community Affairs Legislation Committee.
- National Accreditation Portal for specialist medical college accreditation of training settings - CPMC / Miller Blue.
- Consultation Paper on Fee Transparency – DoHDA.
- Private Health Sector Reforms – DoHDA.
- Therapeutic Goods Amendment (Medicines Shortages and Other Measures) Bill 2026 and Therapeutic Goods (Charges) Amendment Bill 2026 - Senate Community Affairs Legislation Committee.
- Methodology presentation 3 July 2026 - Out-of-Pocket Costs 'Transparency by Default' Working Group.
- Stage 1 New Specialist Provider Assessment of the Australian and New Zealand College of Orthopaedic Surgeons (ANZCOS): Stakeholder Consultation – Australian Medical Council (AMC).
- Consultation on the Medical Research Future Fund (MRFF) Australian Medical Research and Innovation Strategy and Priorities - Australian Medical Research Advisory Board (AMRAB).

New Zealand

- Drug Overdose (Assistance Protection) Legislation Bill - New Zealand Parliament Health Committee.
- Proposed Specified Prescription Medicines list for Designated Paramedic Prescribers - Manutū Hauora | Ministry of Health.
- Dexmedetomidine Hydrochloride (confidential) - Pharmac | Te Pataka Whaioranga.
- Legislation (Definitions of Woman and Man) Amendment Bill - New Zealand Parliament: Social Services and Community Committee.
- Professional Standards Physician Associates – Medical Council of New Zealand (MCNZ) |Te kaunihera o Rata o Aotearoa.
- Draft 2026 New Zealand Core Data for Interoperability (NZCDI:2026) Standard - Health New Zealand | Te Whatu Ora.



“So just like that I was dying”

Dr Steven Hocken was getting ready to sit his final exam when a colonoscopy changed everything. He tells his remarkable story of diagnosis, treatment and recovery.

It was August 2023 and everything was going to plan. I had just landed my dream provisional fellowship job, the final exam was a month away and I was ready.

There was only one issue. The rectal bleeding I had noticed six months ago was getting worse. As a responsible doctor, I had seen a GP two weeks after symptoms had started, gone through the expected PR exam and been told that it was likely haemorrhoids.

As most can attest, life gets very busy in the lead up to exams so I ignored the worsening bleeding for six months. Then one Sunday in August I developed abdominal pain. By this stage my wife was worried sick, so I marched down to my local emergency department and had a CT abdo/pelvis. All it showed was mild proctitis.

I was seen by gastroenterologist Dr Adrian Swaine, who reassured me that my age and lack of medical history pointed to a diagnosis of ulcerative colitis. He booked me for a colonoscopy in three days and trepidation turned to curiosity. I was going to experience the patient-side of medical care.

When consenting patients for colonoscopy sedation, I would explain that it was an uncomfortable procedure but it could be done without any sedation if required. I decided that this may be the only opportunity to experience this for myself, so I convinced the anaesthetist to hold off on propofol unless I asked for it.

Everyone was entertained by the weird patient who insisted on having his scope awake and the mood was light. Then the camera went in, a very obvious cancer came into view and Adrian went from relaxed to all-business. He took a biopsy before proceeding with the rest of the colonoscopy, explaining to me the tests and appointments that would occupy my next two weeks as he went.

I was referred to colorectal surgeon Dr Andrew Riddell (Andy) who arranged a week filled with scans and blood tests, culminating in an MDT at the quaternary public hospital where I happened to work. Here a room of specialists would decide my stage and consequently my fate.

I took a break from the pain round to meet Andy for coffee so he could let me know the outcome. I had been Andy’s intern years before and we had a good relationship, so we felt a formal appointment was unnecessary.

After years of practice talking to cancer patients, Andy remained composed as he told me I was classified as stage 4 and was inoperable. Confused and horrified, I asked what that meant for my prognosis. He gently explained that I would now be cared for by oncology, but that if chemotherapy was effective I had two to three years to live.

I returned upstairs to let my APS consultant know that I had just been told I was going to die and that I would not be returning to work that week, if ever. Andy recognised that I was in no state to care for myself and drove me home. He then sat down with my wife and three daughters, telling them the news so that I didn’t have to. I will be forever grateful to Andy for this.

So just like that I was dying.

Processing this information came later because such a life event involved urgent paperwork. Life insurance and income protection were activated and I took emergency leave from work, not knowing whether I would return.

The college was honestly wonderful. I was sitting the exam in two weeks, but final exam chair Dr Anthony Coorey allowed me to withdraw without financial penalty.

I spent hours of precious pre-chemotherapy time recording videos for my children. I was going to miss out on countless life events, but I wanted them to know how proud I was of them. I even made a video for the unborn grandchild I would never meet, telling them how much I loved them.

LEFT

Dr Steven Hocken presented at this year’s ANZCA Annual Scientific Meeting in Auckland in front of his wife Melissa Hocken and daughters Summer (12), Auri (8) and Daphne (10).

“Andy remained composed as he told me I was classified as stage 4 and was inoperable. He gently explained that I would now be cared for by oncology, but that if chemotherapy was effective I had two to three years to live.”

"I spent hours of precious pre-chemotherapy time recording videos for my children."

I started chemotherapy the day of the written exam. It was highly emetogenic so I was given IV dexamethasone and I can tell you, the perineal itching is real if it gets pushed too quickly. Sophie, a junior registrar and colleague, kindly brought me and my wife coffee and board games to help pass the time.

Chemo was eight hours of boredom, leaving you feeling chilled to the bone and indescribably exhausted. Each drug in the regimen had its own set of side-effects. The oxaliplatin caused laryngospasm if you drank fluids that were colder than room temperature. My hair thinned significantly from the irinotecan. The flurouracil caused the skin to peel off my hands and feet. Painful and inconvenient, causing the fingerprint biometrics for my phone and drug cabinet at work to constantly fail. The bevacizumab interrupted angiogenesis, meaning I had epistaxis for a year.

After a two-month break I got back to studying. I figured that if I passed the final exam I would be more employable for registrar locums because I didn't have time to finish training. Despite painful peeling fingertips, I passed the written and took an extra week off chemo so I could viva in Melbourne. I decided to live like a specialist for a day, arriving to the exam in a red Ferrari and horsepower-fuelled confidence. It must have helped because I passed.

I stayed on chemo for a year, but after the first three months I was able to work part time. This helped my mental health tremendously because at work I wasn't the sickly cancer patient, I was the capable post-final exam registrar.

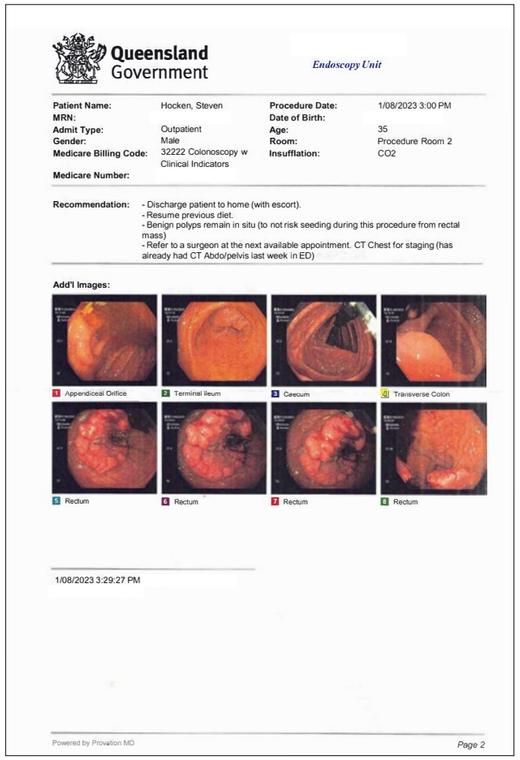
Every day I checked the list of patients for the next day's operations and hopelessly dreamed about my name being on that list.

Then at the year mark I had a repeat PET scan and the cancer was all but gone.

My oncologist Dr Melissa Eastgate had guided treatment since my diagnosis but was now uncertain because of how rare this outcome was. My MDT was repeated and the team agreed that I was now a candidate for an ultra-low anterior resection. My name was on the list.

I had my surgery at the hospital where I worked, the Royal Brisbane and Women's Hospital. The surgery was uneventful and I made it to the surgical ward with an oxycodone PCA and a mission to avoid complications. I was walking laps around the ward, sucking on an incentive spirometer every 30 minutes and sitting out of bed for hours.

One of the downsides to being healthy is that you hide critical illness and while I was walking laps I was becoming progressively more septic. On day four I woke at 0300 vomiting and febrile with a lactate of six. A CT showed an anastomotic leak and a pelvis full of pus so that night I was back in surgery having an ileostomy formed.



Queensland Government

Endoscopy Unit

Patient Name: Hocken, Steven
MRN:
Admit Type: Outpatient
Gender: Male
Medicare Billing Code: 32222 Colonoscopy w Clinical Indicators
Medicare Number:

Procedure Date: 1/08/2023 3:00 PM
Date of Birth:
Age: 35
Room: Procedure Room 2
Insufflation: CO2

Recommendation:
- Discharge patient to home (with escort).
- Resume previous diet.
- Benign polyps remain in situ (to not risk seeding during this procedure from rectal mass)
- Refer to a surgeon at the next available appointment. CT Chest for staging (has already had CT Abdo/pelvis last week in ED)

Add'l Images:

1 Appendiceal Orifice · 2 Terminal Ileum · 3 Caecum · 4 Transverse Colon
5 Rectum · 6 Rectum · 7 Rectum · 8 Rectum

1/08/2023 3:29:27 PM

Powered by Provation MD — Page 2

"I learned how terrifying it is being in agony and not knowing whether the doctors would believe you and give you analgesia."

I spent the next two weeks dealing with complications. The ileus failed to improve so I ended up on TPN, a strange experience feeling no hunger for weeks. Pain was an ongoing issue and I developed resistances to particular opioids within days but found that rotations caused a significant improvement.

I had a pain crisis when my stoma acutely obstructed and I called APS to be reviewed immediately, one of the perks of being a patient in the hospital where you work. Other than the blinding pain, I learned how terrifying it is being in agony and not knowing whether the doctors would believe you and give you analgesia. This changed my practice and I am now far more trusting of patients and generous with drugs during a pain crisis. After almost a month I was discharged home on tapentadol and clonidine.

The ileostomy and I didn't enjoy our time together over the next six months as we battled midnight leaks, bowel obstructions and prolapses. At one point my stoma prolapsed five times in a week, requiring propofol and fentanyl sedation to push it back in.

The final prolapse was irreducible and I needed a more formal attempt in theatre, so I asked for the opportunity to experience "the K-hole" with a ketamine-only sedation. I emerged loud and disinhibited in my own PACU, with my colleagues chuckling at my antics as they walked past the bedspace to see their next patients.

The stoma was reversed 18 months ago and life is significantly simpler. I remain on six-monthly PET scans but all scans, bloods and colonoscopies are cancer-free.

I finished my training a year behind schedule but became a FANZCA and crossed the stage at the ASM. My kids struggled tremendously while I was sick but are now back to kicking goals at school and living their best lives. My wife is more cautious, not wanting to feel hopeful yet as she doesn't want to relive the horrors of the last few years. She'll come around.

I have a new sense of enjoying each day as it comes. I'm working my dream job, my health is back and my family is amazing. I couldn't ask for more.

Dr Steven Hocken, FANZCA

OPPOSITE PAGE

Dr Steven Hocken's colonoscopy scans.

BELOW

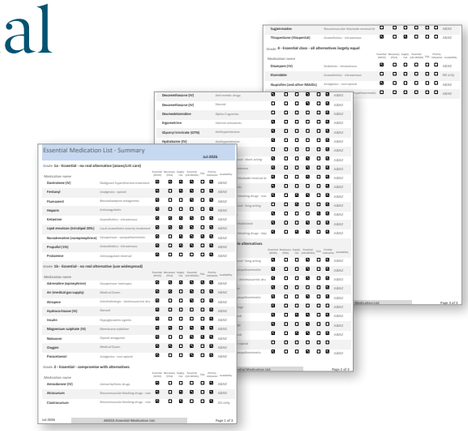
Dr Steven Hocken where he works at Caboolture Hospital.





Safety and quality

The ANZCA Essential Medications List



The effective and safe provision of anaesthesia and pain medicine requires the use of potent and distinctive medicines. Supply is not always reliable. Where supply is at risk or fails, consideration must be given to prioritisation of access to the most essential drugs, seeking acceptable alternatives, or modifying techniques where possible.

To support decision making across the supply chain and clinical management pathways ANZCA has developed the ANZCA Essential Medications List (ANZCA EML). It is based, with permission, on the National Essential Anaesthetic Drugs List (NEADL) produced by the Association of Anaesthetists in the UK. It has been updated and modified to include pain medicine and to reflect medications which are considered key to practice in Australia and New Zealand. Its development included advice from the Faculty of Pain Medicine, the Obstetric Anaesthesia Special Interest Group and the Society for Paediatric Anaesthesia in New Zealand and Australia.

Medicine supply is susceptible to disruption from a number of causes and impacts clinical care in several ways. Market forces may affect purchasing decisions or supplier availability. Supply chain vulnerabilities for a given drug may require an alternative presentation of that active drug from a different supplier, or if there is a shortage in an active ingredient an alternative medication may need to be considered if it has a similar effect.

Substitution can introduce safety risks particularly where medicines have unfamiliar appearance, concentrations, labelling or excipients. Use of similar-acting alternatives or even changes in clinical practice may be required to deliver necessary clinical care. The important issues of safety related to drug substitution (for example, look-alike ampoules) has been highlighted in ANZCA safety alerts and in *PG51 Medication safety*.

Essential medicines lists (EMLs) have been developed for a number of purposes by different jurisdictions and organisations, including the World Health Organization. Currently however, there exists no EML that is focussed on the needs of both anaesthesia and pain medicine in Australia and New Zealand. The closest resource, as noted above, is the National Essential Anaesthesia Drug List (NEADL) produced by the Association of Anaesthetists (Great Britain and Ireland) (AAGBI). ANZCA is grateful to the AAGBI for permission to draw heavily on the structure and relevant content in developing this resource.

The ANZCA EML is to assist decision makers at all levels in planning when shortages are imminent, or alternative supply sources are being considered. This includes practitioners, departments, hospital pharmacies, procurement, hospital groups or regional supply networks, and national levels, including Australia's Therapeutic Goods Administration (TGA) and Medsafe in New Zealand. It aims to provide a central resource that departments can use to plan drug supply and share with their pharmacies, especially in times of shortage. ANZCA has informed many regulators and relevant organisations of the presence of the list and how to access it, and has received positive responses, including an invitation to contribute to the Therapeutic Goods Administration Medicine Shortages Stakeholder Forum.

A classification has been applied to each medication to help describe whether the medication or its class (mode of action) is essential, and to provide some insight into alternatives (if any) and how suitable they may be.

It should be noted, that the ANZCA EML is intended to be advisory and not be prescriptive. It should be emphasised that individual clinical circumstances and clinician responsibility determine medication use on any given occasion.

Feedback is welcome on the list, and it will be updated when needed.

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

Dr Michelle Mulligan, FANZCA
ANZCA Director of Professional Affairs, Policy

Related resources

The TGA has a useful resource related to managing supply and alternative drug access on its website.

Essential Medicine Lists from a number of sources have been considered in the development of the ANZCA EML. These include:

- the World Health Organization (WHO Model List of Essential Medicines)
- the TGA (Therapeutic Goods (Reportable Medicines) Determination 2025)
- the Association of Anaesthetists GB and Ireland (National Essential Anaesthesia Drug List (NEADL) 2021)
- the US Food and Drug Administration List of Essential Medicines

In addition, ANZCA includes a list of Emergency Medications (PS55 Minimum safe facilities Appendix 1), however these are focussed on emergency situations, not routine care.

New resource aims to prevent operating room fires

Non-airway fires continue to occur in the operating room (OR) and can cause significant patient burns.

Events have been reported in multiple jurisdictions in recent years, including three cases in Victoria, which prompted an approach from the Victorian Perioperative Consultative Council (VPCC), part of Safer Care Victoria, asking ANZCA to develop a resource on minimising risk factors.

A review of incidents reported to webAIRS identified 23 relevant burn events. Electrocautery was the commonest ignition source, and reported fuels included tissue or hair, drapes, and chlorhexidine/alcohol skin preparations. Supplemental oxygen was noted in half of these cases.

The causes and contributing factors are well documented and detailed in appendix 3, Non-airway burns/fires in the operating room, of the ANZCA professional document *PS55 Minimum facilities*. The appendix was revised in 2024 and includes a fire risk evaluation algorithm reproduced with permission from the Anesthesia Patient Safety Foundation.

The persistence of these events despite a well-established understanding of the fire triad, supported the need for a point-of-care resource reflecting the need for all members of the theatre team to evaluate and consider risk.

ANZCA has therefore developed the poster *Operating room fire safety – precautions for non-airway surgery*, in collaboration with, and endorsed by, Australian College of Perioperative Nurses (ACORN), Australasian College of Perianaesthesia Nurses (ACPAN), and the Royal Australasian College of Surgeons (RACS), for placement in theatres and relevant procedural areas. Its structure is deliberately multidisciplinary as no single discipline controls all three components of the triad. Use of the poster should be accompanied by the education and training of relevant staff on the prevention and what to do if an operating room fire occurs.

The underlying factors which create increased risk when in proximity to each other in the OR are:

- An oxidising agent – typically an oxygen-rich environment, although nitrous oxide is also an oxidiser.
- An ignition or heat source – most commonly monopolar diathermy, although lasers and light sources may also be responsible.
- A fuel or substrate – commonly the patient's own tissue or hair, surgical drapes and residual alcohol-based skin preparation, with clothing and gauze also reported.

Elevated local oxygen concentrations significantly increase the likelihood of a fire. A concentration above 30 per cent is a practical risk threshold, although what matters is avoiding an oxygen-enriched environment in addition to the other factors. Supplemental oxygen with an open airway during head and neck procedures can also lead to ignition of plastic of masks or nasal prongs.



The poster can be downloaded via our website.

A burns case for removal of a scalp lesion occurred where the (plastic) drapes were sealed off around the surgical site, which created a 'tent' of oxygen around the patient's face. A spark from diathermy pierced the plastic drapes and initiated a fire in the patient's hair, which possibly had residual wetness from the alcoholic skin prep.

Recommendations include using the minimum necessary oxygen concentration, with particular caution with high-flow devices near an ignition source. Where a general anaesthetic is acceptable, a cuffed tracheal tube provides a closed system, or a well-seated supraglottic airway can substantially reduce oxygen leakage into the surgical field. Turning down supplemental oxygen delivery before diathermy may not help without sufficient time and airflow to wash out the excess.

For body surface asepsis, alcoholic chlorhexidine is recommended in infection prevention standards, except for on or near mucous membranes and eyes. To be safe and effective the alcohol prep must have dried and not be pooled or wicked into skin, drapes, sheets or hair. Aqueous preparations are often used as an alternative skin prep for superficial head and neck procedures, and near mucous membranes and eyes.

A patient having a procedure on the skin near the perineum suffered significant burns when pooled alcohol prep was ignited by monopolar diathermy and set the drapes on fire. This occurred with ambient oxygen levels.

Monopolar diathermy carries a particular fire risk because sparks and heat may occur away from the point of direct tissue contact. Where clinically feasible, bipolar is preferable, though it does not eliminate the risk entirely.

Together, these cases illustrate that there is no single cause of operating room fire: different combinations of familiar hazards can produce the same preventable event.

The poster aims to promote shared communication of potential risk factors and sit alongside a standardised institutional fire response, with the team alert to smoke or acute patient agitation and with saline and a wet pack immediately available.

Operating room fires remain uncommon, but preventable events continue to occur, which shows that awareness alone is insufficient. The purpose of the poster is not to introduce a new concept but to translate established knowledge into shared, reliable practice.

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

Associate Professor Pierre Bradley, FANZCA
Member VPCC Anaesthesia Sub-committee

Please note: Generative AI tools were used during manuscript preparation to assist with editorial review by one of the authors. All content was reviewed and verified by the authors, who take responsibility for the final manuscript.

References

1. Australian and New Zealand College of Anaesthetists. PS55 Position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations – Appendix 3: Non-airway burns/fires in the operating room. Melbourne: ANZCA, 2024.
2. Australian and New Zealand College of Anaesthetists. Operating room fire safety – precautions for non-airway surgery. Poster, co-endorsed with the Royal Australasian College of Surgeons, the Australasian College of Peri-Anaesthesia Nurses and the Australian College of Perioperative Nurses. Available at: anzca.edu.au/safety-and-advocacy/safety-alerts-and-resources/fires-in-the-operating-room-poster
3. Steer A, ANZTADC Case Report Writing Group. Burns in the Operating Theatre! A webAIRS review. Australian Anaesthetist 2023; December: 44–46.

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 infusion leakages (31 Jul 2026)
- Care with interstitial (percutaneous) continuous glucose monitoring (CGM) devices (13 Aug 2026)
- Reports of susceptibility to GA in certain patients of Venezuelan origin (Updated 17 September 2026 – originally published 4 June 2026)
- Residual anaesthetic drugs in the dead space volume of IV lines (Updated 17 Sep 2026 – originally published 21 October 2025)

WebAIRS

Complications of ophthalmological blocks

Ophthalmological procedures are commonly performed using local anaesthetic (LA) techniques, with a predominance of peribulbar and sub-Tenon's blocks rather than retrobulbar blocks.[1]

Sharp needle techniques (such as retrobulbar and peribulbar blocks) provide good akinesia but are associated with uncommon but serious sight- or life-threatening complications such as globe perforation, haemorrhage, retinal artery occlusion, optic nerve injury and brainstem anaesthesia.

Although sub-Tenon's blocks carry a lower risk of complications compared to sharp needle blocks[2] there have been reports of cardiac and respiratory arrest,[3] local anaesthetic systemic toxicity (LAST),[4] brainstem anaesthesia with contralateral amaurosis,[5] central retinal artery occlusion,[6] and orbital cellulitis[7] following sub-Tenon's blocks.

Two incidents reported to webAIRS illustrate both the potentially serious complications of ophthalmic regional anaesthesia and the importance of considering alternative causes when deterioration occurs following a block.

CASES

A man in his 70s presented for ophthalmic surgery. Apart from well-controlled hypertension and depression, he had no other known medical co-morbidities.

He had a sub-Tenon's block performed under light sedation without issue. Shortly after commencement of surgery, he became distressed and dyspnoeic, with SaO2 of 85% despite supplemental oxygen, which resulted in surgery being abandoned. His oxygen requirement continued to escalate in the post-procedure period, and he was admitted to the ward for further investigations. A chest X-ray revealed fluid overload, and a subsequent transthoracic echocardiogram demonstrated severe left ventricular failure. He was treated for pulmonary oedema, and a cardiology consult was sought for the management of his newly diagnosed cardiomyopathy.

In another case, a woman in her 80s underwent elective ophthalmic surgery. A peribulbar block was performed with light sedation, and the surgery was completed uneventfully. On the ward round the following day, the patient reported worsening vision in the operative eye. Upon further investigation, a globe perforation was diagnosed. Despite corrective surgery, she had significant loss of vision in the operative eye as a consequence of the complication of the peribulbar block.

DISCUSSION

Local anaesthetic techniques for ophthalmic procedures range from topical drops through to regional anaesthesia techniques. Analysis of large datasets of patients undergoing ophthalmic procedures have demonstrated a very low risk of serious complications with regional anaesthesia techniques.[1,2] Nonetheless, life-threatening complications such as cardiorespiratory instability, seizures, and death have been reported due to ophthalmic blocks.[3,4,8,9]

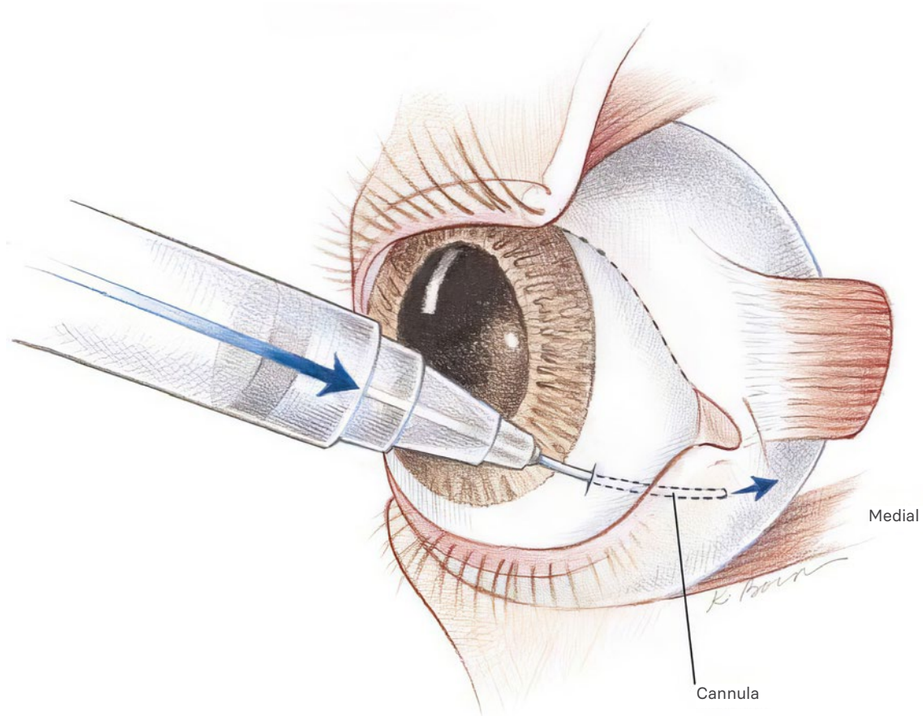
Trigeminal nerve stimulation can induce the vagally-mediated oculocardiac reflex leading to bradyarrhythmias and cardiac standstill, which is a well-recognised complication of ophthalmic procedures (particularly strabismus surgery),[10,11] but can also occur with injection during the performance of an ophthalmic block.[3] Cardiac arrest due to brainstem anaesthesia has also been reported.[3,8,12]

A number of mechanisms for the development of brainstem anaesthesia and central nervous system toxicity have been proposed, including direct intra-vascular injection of LA and retrograde flow to the cerebral circulation or puncturing the dural sheath of the optic nerve during injection leading to subarachnoid spread of LA.[3,5,8,12-14]

Development of respiratory distress due to pulmonary oedema is a rare but recognised complication of ophthalmic blocks, and has been attributed to neurogenic pulmonary oedema after retrobulbar[15] and peribulbar blocks[16,17] that occurred between five and 30 minutes after the block was performed in the absence of a primary cardiac event.

The mechanism of neurogenic pulmonary oedema in the context of ophthalmic blocks is poorly understood,[15,16] with widely held hypotheses such as neuroendocrine changes to the pulmonary microcirculation, sympathetic discharge leading to a hyperdynamic circulation and tachycardia, and direct injection of the LA into the subarachnoid space leading to brainstem involvement[16] providing inadequate explanations for the precise mechanism underlying these events.

Contribution of underlying cardiac disease to the development of pulmonary oedema is possible in some cases, although it is notable that in some reports the patients had no underlying cardiac disease or trigger for this complication. It remains unclear whether the pulmonary oedema that occurred in the first case mentioned earlier was a periprocedural manifestation of underlying (and undiagnosed) cardiac disease, or alternatively whether it was a rare complication of the ophthalmic block performed. Given that there are no cases of isolated neurogenic pulmonary oedema specifically with sub-tenon blocks and the rarity of this complication, it is more likely to be due to underlying cardiac disease.



Sight-threatening complications such as globe perforation,[2,15,18,19] retrobulbar or peribulbar haemorrhage or retinal artery occlusion[6] have been reported with all ophthalmic blocks, but have a higher incidence with the performance of sharp needle blocks compared with sub-Tenon's blocks. Orbital swelling[20] and cellulitis[7,21] have also been reported following ophthalmic blocks, with some cases of orbital swelling potentially attributed to a hyaluronidase-induced orbital inflammation[20,21] and others clearly owing to infections from seeding of pathogens via the breach of the conjunctiva into the sub-Tenon's space.[21]

Additionally, post-operative visual loss has been reported due to orbital apex syndrome resulting from temporary blockade of the optic nerve and cranial nerves III, IV and VI following sub-Tenon's block, and is postulated to occur due the proximity to orbital apex structures and the potential for deep orbital spread of LA.[22]

Unlike other sight-threatening complications such as central retinal artery occlusion, the visual loss associated with orbital apex syndrome is transient due to the temporary blockade of the optic and cranial nerves. Diplopia and inferior rectus fibrosis have also been reported following a sub-Tenon's block,[23,24] likely due to rectus muscle trauma sustained during the performance of the block, or alternatively due to myotoxicity of local anaesthetic agents. Other complications, such as chemosis and subconjunctival haemorrhage are relatively common and generally not associated with visual loss.[19,25]

Given the rarity of serious life- or sight-threatening complications associated with ophthalmic blocks, large datasets are required to identify these complications. The webAIRS dataset contains more than 13,700 anaesthesia-related incidents across Australia and New Zealand, thus providing the ANZTADC group with the opportunity to identify uncommon complications and their potential contributory factors, thus supporting the safety of LA techniques for ophthalmic surgery.

ABOVE

Reprinted from Techniques in Regional Anesthesia and Pain Management Eye Blocks, Vol 4, No 1 (January), Rubin A, Eye Blocks, p.49, Copyright (2000), with permission from Elsevier.

There are currently 87 incidents reported to webAIRS since its inception 17 years ago involving ophthalmic procedures. ANZTADC is planning to review these incidents and is seeking co-analysers with an interest in this area to contribute to the analysis, with a view to publication in a professional journal. Please contact ANZTADC@anzca.edu.au if you are interested.

Dr Jina Hanna, Dr Yasmin Endlich
and the ANZTADC Case Report Writing Group

References

1. El-Hindy N, Johnston R, Jaycock P, Eke T, Braga A, Tole D, et al. The Cataract National Dataset Electronic Multi-centre Audit of 55 567 operations: anaesthetic techniques and complications. 50–5.
2. Eke T, Thompson JR. Serious complications of local anaesthesia for cataract surgery: a 1 year national survey in the United Kingdom. Br J Ophthalmol. 2007 Apr 1;91(4):470–5. doi:10.1136/bjo.2006.106005
3. Cai SC, Dempster AM (Amie) W, Chua AW. A case of cardiorespiratory collapse following bilateral sub-Tenon's blocks from brainstem anaesthesia. Anaesth Intensive Care. 2024 Nov;52(6):415–9. doi:10.1177/0310057X241265729
4. Masha L, Awtry E. Cardiac arrest during a sub-tenon block: a sign of acute lidocaine and bupivacaine toxicity. Clin Case Rep Rev. 2015;1(3). doi:10.15761/CCRR.1000117
5. Lu M, Kaabi MA, Qian CXY. Case Report: A Unique Case of Brainstem Anesthesia and Contralateral Amaurosis After a Subtenon B. Retin Cases Brief Rep. 2026;20(1):129–31.
6. Chua AW, Chua MJ, Harrisberg BP, Kumar CM. Retinal artery occlusion after ophthalmic surgery under regional anaesthesia: A narrative review. Anaesth Intensive Care. 2024 Mar;52(2):82–90. doi:10.1177/0310057X231215826
7. K. Muqit MM, Saidkasimova S, Gavin M. Acute orbital cellulitis after sub-Tenon's eye block. Anaesthesia. 2004 Apr;59(4):411–3. doi:10.1111/j.1365-2044.2004.03728.x
8. Kostadinov I, Hostnik A, Cvenkel B, Potočnik I. Brainstem anaesthesia after retrobulbar block. Open Med. 2019 Mar 2;14(1):287–91. doi:10.1515/med-2019-0025
9. Quantock CL, Goswami T. Death potentially secondary to sub-Tenon's block. Anaesthesia. 2007 Feb;62(2):175–7. doi:10.1111/j.1365-2044.2006.04894.x
10. Juan I, Lin M, Greenberg M, Robbins SL. Surgical and anesthetic influences of the oculocardiac reflex in adults and children during strabismus surgery. Surv Ophthalmol. 2023 Sep;68(5):977–84. doi:10.1016/j.survophthal.2023.04.004
11. Arnold RW. The Oculocardiac Reflex: A Review. Clin Ophthalmol. 2021 Jun;Volume 15:2693–725. doi:10.2147/OPTH.S317447
12. Chin YC, Kumar CM. Brainstem anaesthesia revisited: Mechanism, presentation and management. Trends Anaesth Crit Care. 2013 Oct;3(5):252–6. doi:10.1016/j.tacc.2013.06.001
13. Ruschen H, Bremmer FD, Bremner FD, Carr C. Complications after Sub-Tenon's Eye Block. Anesth Analg. 2003;96(1):273–7. doi:10.1097/00000539-200301000-00054.%20PMID:%2012505965
14. Multiple Cranial Nerve Palsies Complicating Retrobulbar Eye Block. Anaesth Intensive Care. 1998;26(6):662–4. doi:https://doi.org/10.1177/0310057X9802600609
15. Kwinten FA, De Moor GP, Lamers RJ. Acute Pulmonary Edema and Trigeminal Nerve Blockade After Retrobulbar Block. Anesth Analg. 1996;83:1322–4. doi:https://doi.org/10.1097/00000539-199612000-00032
16. Kumar CM, Lawler PG. Pulmonary oedema after peribulbar block. Br J Anaesth. 1999 May;82(5):777–9. doi:10.1093/bja/82.5.777
17. Chhabra A, Singh P, Kumar M. Pulmonary oedema in a patient undergoing vitreo-retinal surgery under peribulbar block. Indian J Anaesth. 2012;56(4):387. doi:10.4103/0019-5049.100828
18. Schrader WF, Schargus M, Schneider E, Josifova T. Risks and sequelae of scleral perforation during peribulbar or retrobulbar anesthesia. J Cataract Refract Surg. 2010 Jun;36(6):885–9. doi:10.1016/j.jcrs.2009.12.029
19. Kumar CM, Eid H, Dodds C. Sub-Tenon's anaesthesia: complications and their prevention. Eye. 2011 Jun;25(6):694–703. doi:10.1038/eye.2011.69
20. Kumar CM, Dowd TC, Dodds C, Boyce R. Orbital swelling following peribulbar and sub-Tenon's anaesthesia. Eye. 2004 Apr;18(4):418–20. doi:10.1038/sj.eye.6700673
21. Liang SY, Moloney G, O'Donnell BA, Fernando G. Orbital cellulitis as a postoperative complication of sub-Tenon anaesthesia in cataract surgery. Clin Experiment Ophthalmol. 2006 Dec;34(9):897–9. doi:10.1111/j.1442-9071.2006.01361.x
22. Cao X, Ge Z, Gong Y. Transient orbital apex syndrome with magnetic resonance imaging evidence following sub-Tenon's ropivacaine anesthesia during combined cataract and macular surgery: a case report. BMC Ophthalmol. 2025 Nov 29;26(1):3. doi:10.1186/s12886-025-04544-4
23. Blum RA, Lim LT, Weir CR. Diplopia following sub-tenon's anaesthesia: an unusual complication. Int Ophthalmol. 2012 Apr;32(2):191–3. doi:10.1007/s10792-012-9535-3
24. Jaycock PD, Mather CM, Ferris JD, Kirkpatrick JNP. Rectus muscle trauma complicating sub-Tenon's local anaesthesia. Eye. 2001 Sep;15(5):583–6. doi:10.1038/eye.2001.189
25. Fulton R, Urquhart C. Regional anaesthesia for eye surgery. Anaesth Intensive Care Med. 2019 Dec;20(12):725–7. doi:10.1016/j.mpaic.2019.10.003

Tip of the spear – leading sustainable change from a regional department

A regional theatre list doesn't wait for a business case. In Wonthaggi, 132 kilometres southeast of Melbourne on the Bass Coast,two sustainability projects at the local hospital show what's possible when a small department decides to just start.



We all know low, fresh gas flows are better for the patient, the budget, and the planet. What we did not know was what our department actually did in practice. Knowing the evidence and living it on every list are two different things, and the gap between them is where most of the opportunity sits. That uncertainty was the trigger for everything that followed.

STARTING WITH WHAT WE DIDN'T KNOW

We began with an audit of fresh gas utilisation across the department. The hunch was that there was room to improve, and the audit confirmed it. Quantifying it precisely was another matter. We run a paper-based anaesthetic record, which makes direct data analysis near impossible; our anaesthesia platforms have no end-tidal agent control or target features to lean on; and an unknown but probably significant proportion of our caseload is total intravenous anaesthesia (TIVA), muddying any agent-consumption denominator.

None of those limitations are unusual in a regional service, and any one of them could have been a reason to wait for better infrastructure. We went ahead regardless, because the intervention we had in mind was safe, cheap, and easy to implement. The audit had told us enough to act.

A SIMPLE LOW-FLOW INTERVENTION

We ran a single education session on low-flow inhalational anaesthesia and paired it with a one-page infographic mounted on every anaesthetic machine, so the prompts sat where the decisions are made. The infographic covered the practical points across induction, maintenance, and emergence: fresh gas flow at or below minute ventilation at induction, an overpressure approach once on a closed circuit, a target total flow below one litre per minute where appropriate, and turning the vaporiser off early rather than washing out at high flow. Safety and oxygenation came first throughout, with the approach individualised for unstable or high-demand patients.

The effect was immediate. Volatile use fell by approximately 43 per cent, saving about $A3500 over an eight-week period. The emissions avoided over that window were equivalent to driving an average car about 1200 kilometres. No new equipment, no new agents – just more deliberate use of what we already had. Our hunch had been right, and the cheapest possible intervention had paid for itself many times over.

ABOVE

Dr Benn Lancman and Dr Saurabh Kumar helped drive Wonthaggi Hospital's sustainability efforts.

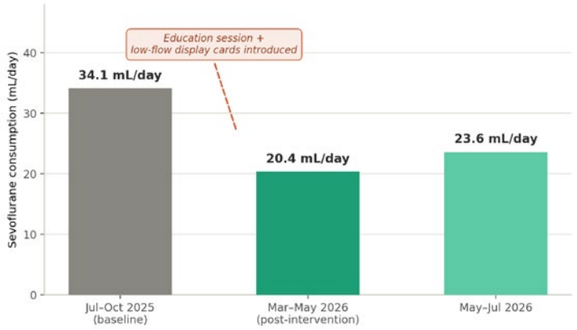
Low-Flow Anaesthesia Education Cuts Sevoflurane Use by 40%

A department-wide sustainability initiative, tracked across three theatre anaesthetic workstations

Between the Jul–Oct 2025 baseline period and the Mar–May 2026 follow-up, sevoflurane consumption across the department's three anaesthetic machines fell from 34.1 mL/day to 20.4 mL/day — a 40.3% reduction.

The change followed a targeted intervention: an educational session on low-flow anaesthesia technique for anaesthetic staff, paired with the placement of low-flow reference cards directly on each machine as a point-of-care prompt.

Oxygen and air consumption remained broadly stable across the same window, indicating the reduction reflects a genuine shift in fresh-gas-flow practice rather than a fall in caseload.



-40.3%	13.7 mL	3
Drop in sevoflurane use following intervention	Less sevoflurane consumed per day, department-wide	Anaesthetic machines covered by the initiative

A modest rebound to 23.6 mL/day in the following period (May–Jul 2026) suggests the effect of a single educational push may partially fade over time without reinforcement — consumption remains 30.8% below baseline, but has not held at its lowest point.

This points toward periodic refresher sessions or a permanent visual nudge (rather than a one-off intervention) as the more durable strategy for sustaining low-flow practice.

REMOVING STERILE GOWNS FOR SINGLE-SHOT SPINALS

The same logic carried into our second initiative. As a primarily consultant-run service caring for a low-risk patient population, we were ideal candidates for stopping the use of sterile surgical gowns for single-shot spinals. The ANZCA position statement was essential here – it gave us the evidence base and the institutional weight to bring our local infection prevention team on board, which turned a potentially contentious change into a straightforward one.

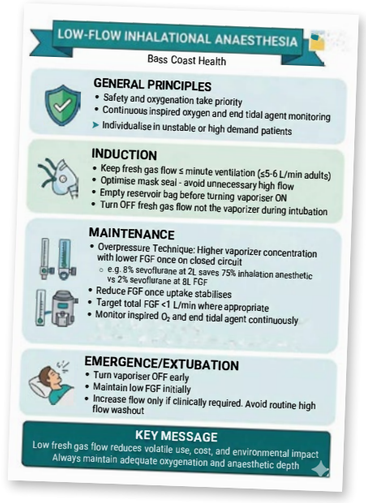
The numbers support the decision: for every 1000 disposable gowns avoided we estimate a saving of around 1636 kilograms of carbon dioxide, 268 kilograms of solid waste, and up to $4000. A local audit of our own case volumes is under way to confirm the impact at Wonthaggi. What struck us most was the pace – from updated guidance to changed routine practice in weeks, not months.

RECYCLING WHAT WE CAN'T AVOID

Not every reduction is about using less in the first place. Alongside the flow and gown changes, we've kept a line open on the waste we can't eliminate. We recycle single-use surgical instruments through the Medsalv program, recovering 359 kilograms for reprocessing between September 2025 and May 2026, and we collect plastic caps from medication containers for recycling rather than landfill. Like the gowns change, neither required capital investment or a business case – just a labelled bin and a decision to start.

SMALL, NIMBLE, AND AT THE TIP OF THE SPEAR

The thread running through both projects is that a small department changed quickly. We are a group of people who know one another, share the same machines, and can agree on a new approach over a single meeting. There is no large committee to convince and no critical mass of entrenched habits to overcome. The compactness that is sometimes cast as a limitation is, for change management, a genuine advantage.



The gowns change is the clearest example of that speed. ANZCA published its position statement, and within days one of our group had shared it in our department's WhatsApp group. When the published consensus guideline followed, we talked it through with our infection prevention lead – an email with the evidence and an updated draft of the policy – and we were live with the new practice two weeks later. There was no waiting list for a committee slot, just a guideline, a conversation, and a decision.

Regional services are not destined to lag behind their metropolitan counterparts. On both of these initiatives we were ahead, and we suspect we are not alone. This is an argument for engaging with and contributing to anaesthesia in the regions rather than viewing it as the place change arrives last.

With the right mindset, a small department can be the tip of the spear.

We're not stopping there. A recent *ANZCA Bulletin* article on the transition to NRFit connectors prompted us to look at our own – we're now scoping the conversion at Wonthaggi. It's the same pattern again: watch for the right moment, and move quickly once it arrives, rather than waiting to be told to.

None of this is technically sophisticated, and that is the point: the barrier is rarely capability, and far more often the decision to start.

We are happy to share our infographic and education materials with any department interested in adapting them locally.

Dr Benn Lancman, FANZCA
Director of Anaesthetics and Perioperative Medicine
Bayside Health – Wonthaggi Hospital

Dr Saurabh Kumar, ACRRM/RGA candidate
Bayside Health – Wonthaggi Hospital

Decommissioning piped nitrous oxide systems



ABOVE

From left: Anaesthetist Dr Peter Elepfandt and Robin Antony, Manager Anaesthetic Support, examine the new yoke and nitrous cylinder on an anaesthetic machine at Cairns Hospital.

BACKGROUND

Increasingly the feasibility and importance of decommissioning N_2O medical gas pipeline systems (MGPS) is recognised by governments as well as hospitals and healthcare services across Australia and New Zealand. In-depth considerations on how to transition to point of care (POC) cylinders and decommission the N_2O MGPS have been published[1-4].

In most hospitals the leak from the N_2O MGPS is equivalent to several hundreds of tonnes of CO_2 released annually. N_2O, on average, represents 20 per cent of a hospital's scope 1 (direct) emissions[3,5] and the leak from the MGPS is the single biggest contributor to this. Since eliminating the leak does not require any change in clinical practice, decommissioning the N_2O MGPS presents the opportunity to reduce a hospital's scope 1 emissions, often by 10% or more within a timeframe of 12-18 months.

In contrast to the National Health Service in the UK, in Australia and New Zealand the aspiration to reach net zero is usually not accompanied by a budget, and the capital cost for decommissioning is a significant barrier in chronically underfunded health services. Even if a timeline for the decommissioning exists, such as in NSW Health EOFY 26/27,[6] budgetary constraints often have to be overcome.

A return on investment (ROI) of only two years has been reported[5,7]. This article highlights the significant cost of compliant maintenance and meaningful monitoring for leakage and contrasts this to the cost of transitioning to POC N_2O cylinders. Demonstrating the financial benefit by calculating the return on investment can help to overcome budgetary barriers.

Depending on the setting and needs of the hospital, the components of the business case will vary widely, and the examples provided in Table 1 are not exhaustive.

As is the case for many other environmental sustainability improvements,[8,9] for N_2O MGPS the medium to long-term cost for business as usual is higher.

RETURN ON INVESTMENT CALCULATION

The return on investment[#] can be calculated as capital investment divided by yearly savings.

$$\frac{\text{Capital cost for transition – capital cost for appropriate continuation}}{\text{Cost of nitrous MGPS including maintenance (pre–transition) - Cost of POC nitrous including maintenance (post-transition)}}$$

In preparation for the business case, quotes for the relevant components for transitioning as well as for continuing with the current system should be obtained demonstrate the financial effect. This can be done for the whole system, as well as for individual components. For example, the cost for decommissioning a single N_2O wall outlet is $A50 with a yearly service cost of $A13.36 resulting in a ROI of 3.7 years. This means maintaining an unused outlet for more than 3.7 years is more expensive than decommissioning it.

The capital cost and ongoing cost tables are displayed at the end of this article. They are sourced from various hospitals and mostly from personal communication. They are provided as ballpark figures to avoid potential business confidentiality issues.

COST OF LEAK DETECTION AND RECTIFICATION

As the cost for finding and rectifying leaks is highly variable it is not feasible to include this in the ROI calculation. As MGPS are complex, the leak finding process can be costly. In one hospital this exceeded $A30,000, which in itself is more than the usual cost for decommissioning.

LEAK MONITORING

If the N_2O MGPS must be maintained, ongoing leak monitoring is crucial as significant leaks can develop at any given time.

The discrepancy methods and pressure test only provide a snapshot in time. The weighing method has a significant lag in detection and only shows a large leak. The most sensitive and accurate method is to install a flow meter at the manifold.[3,10]

NON-FINANCIAL ITEMS FOR BUSINESS CASE

Environmental impact

Once the volume of the leak has been estimated[5] and compared to the health service's total scope 1 emissions, the significance of the initiative becomes clear. Currently there is no dollar value attached to carbon emissions, however the opportunity for positive PR and improving compliance with KPIs exists.

Occupational exposure risks

Concerns over occupational exposure to N_2O have been raised by occupational health and safety bodies the world over[11,12] and when measured, many high use areas like maternity exceed allowed levels several fold. Contributing factors are unknown site of leaks and older mechanical mixers. The transition process provides the opportunity to address this issue as additional benefit and to reduce potential risk of litigation.

Maternity

Maternity wards that have transitioned report an improvement in workflow and maternal satisfaction as labouring women can move around the room more easily with a mobile unit. In addition, fewer mobile units are required than fixed units as they can be shared between several suites. Some units have moved to using entonox (see also "other users").

One rural hospital that is recurrently cut off during wet season reported a reduction in downtime due to their new mixers not needing to be sent for repairs and maintenance.

Other users

Other users such as dentistry, gastroenterology, emergency, medical imaging, oncology or paediatrics will have similar cost considerations to maternity. In many cases the use of entonox may be appropriate and reduce the need for monitoring which saves additional cost. The entonox regulator and demand valve are cheaper, simpler and less prone to faults than N_2O / O_2 mixers.

In some settings the use of methoxyflurane represents an alternative and more environmentally sustainable method for analgesia.[13]





ABOVE FROM LEFT

Decommissioned N_2O wall outlet.

Portable nitrous trolley system for PRN connection.

SUMMARY

Despite the aspiration to reach net zero, sustainability improvements are still commonly contingent on demonstrating cost savings.

Transitioning to POC N_2O cylinders and decommissioning of the N_2O MGPS can reduce a hospital's scope 1 emissions by an amount that is difficult to achieve with other initiatives in a comparably short timeframe.

Once testing and maintenance costs are considered it is possible to build a business case for transitioning to POC N_2O cylinders and demonstrate a short ROI.

Dr Peter Elepfandt, FANZCA
Senior Staff Specialist Anaesthetist, Cairns Hospital.

References

1. C. Woinarski, J. Anderson, R. McIntyre and M. Taylor, "Back to the future: A return to point-of-care nitrous oxide cylinders," *Australian Anaesthesia,* pp. 298-307, 2025.
2. E. Balmaks, "Tackling leaks from nitrous oxide infrastructure," *ANZCA Bulletin,* pp. 24-25, July 2025.
3. E. Kayak, F. McGain, H. Burch, B. Dunne, Y. Gu, J. Davies, R. McIntyre, D. Story, C. Mitchell, S. Gaff, E. Balmaks, J. Skowno, C. Woinarski, J. Correy, S. Chanchlani, G. Cooper, A. Wyns and M. Skellern, *Detecting and reducing nitrous oxide leaks in healthcare facilities: a practical guide,* Interim Australian Centre for Disease Control, Department of Health and Aged Care, 2024.
4. E. Kayak, R. McIntyre, F. McGain, J. Skowno, S. Gaff, G. Cooper, M. Skellern, A. Wyns, "A summary guide for detecting and reducing nitrous oxide infrastructure leaks in healthcare facilities", Anaesthesia and Intensive Care 2026
5. ANZCA, ASA, NZSA, *Statement on decommissioning nitrous oxide medical gas pipeline systems,* 2025.
6. NSW Ministry of Health, *NSW Health Position Statement on the Decommissioning of Reticulated Nitrous Oxide in NSW Health Facilities,* NSW, 2025.
7. Doctors for the Environment Australia, *Healthcare facility nitrous oxide infrastructure, Position Statement,* 2024.
8. G. Gasciauskaite, J. Lunkiewics, M. Tucci, C. von Deschwanden, C. B. Nöthiger, D. R. Spahn and D. W. Tscholl, "Environmental and economic impact of sustainable anaesthesia interventions: a single-centre retrospective observational study," *British Journal of Anaesthesia,* vol. 133, no. 6, pp. 1449-1458, 2024.
9. E. A. Parkinson, E. Plews, C. Hewavitharane, G. Catchpole, R.-A. Nunoo, H. Arora and C. Chapman, "The Financial and Environmental Cost of Anaesthetic Emergency Drugs: Comparing Ampoules With Prefilled Syringes," *Cureus,* vol. 18, no. 3, 2026.
10. J. J. Skowno, H. R. Kahlaee, A. J. Inglis and D. McKinnon, "Hospital-level flow measurement to detect nitrous oxide leakage," *Anaesthesia,* 2024.
11. (NIOSH), National Institute for Occupational Safety and Health, "About Anesthetic Gases and Reproductive Health," 27 March 2024. [Online]. Available: https://www.cdc.gov/niosh/reproductive-health/prevention/anesthetic-gases.html. [Accessed 14 May 2026].
12. England NHS, "Guidance on minimising time weighted exposure to nitrous oxide in healthcare settings in England," 02 February 2023. [Online]. Available: https://www.england.nhs.uk/long-read/guidance-on-minimising-time-weighted-exposure-to-nitrous-oxide-in-healthcare-settings-in-england/. [Accessed 14 May 2026].
13. A. L. Gaskell, C. G. Jephcott, J. R. Smithells and J. W. Sleigh, "Self-administered methoxyflurane for procedural analgesia: experienc in a tertiary Australasian centre," *Anaesthesia,* no. 71, pp. 417-423, 2016.

Footnote

In financial terms this technically calculates the payback period.

For those interested there is an informal ANZ nitrous oxide decommissioning WhatsApp group which you can join via the QR code.

CAPITAL COST

Item	Cost (AUD)		Considerations
Manifold			
Decommissioning of MGPS	$8500 - 25,000		Including decommissioning of all outlets, biggest cost commonly is disabling all alarms.
Flow monitoring	$13,000 - 30,000		The most appropriate method for ongoing monitoring to detect new leaks.
Anaesthetic			
Retrofitting yoke on anaesthetic machine	$3300 - 5500	Per machine	Most useful for theatres with acute need for nitrous (e.g. Cat1 LSCS) but also saves space and is convenient.
Yoke on newly ordered anaesthetic machines	<$500	Per machine	Most useful for theatres with acute need for nitrous (e.g. Cat1 LSCS) but also saves space and is convenient.
Portable nitrous trolley system connected PRN	<$1000	Per trolley	Good option if nitrous usage can be predicted, significantly cheaper, cost for trolley, pressure reduction valve and hose, only few trolleys needed for theatre complex.
Machine specific cylinder cradle	<$1000	Per machine	Cradle plus pressure reduction valve to connect cylinder to existing nitrous inlet.
Mini manifold	$13,000		E.g. for MRI.
Abolishing nitrous use	ZERO!		Several Australian anaesthesia departments (incl. tertiary hospital) have abolished nitrous use completely.
Maternity / other areas			
Electronic mixer with stand	$13,500		Usually one mobile unit can be shared across several labour suites.

ONGOING COST

Item	Required as per AS 2896:2021	Frequency	Cost (AUD)	Comment
Manifold / wall outlets				
Pressure testing			$3500	Only can be undertaken during time of no/low clinical use, additional cost for POC cylinders/pressure reduction valves/ trolleys etc. to be supplied to areas where needed during 4-6h testing, only gives a snapshot, would need to be repeated yearly to be meaningful.
Manifold inspection	Yes	Yearly		
Manifold rebuild	Yes	3 yearly	$1000-2000	
Wall outlet inspection	Yes	Yearly	$13-15 per outlet	To be considered if decommissioning unused wall outlets whilst maintaining manifold - e.g. yearly inspection $13.36, decommissioning $50 - ROI of 3.6 years.
Wall outlet gasket replacement	Yes	4 yearly or as needed		
Nitrous cost				Cylinder rental + refills, several centres have estimated the cost for leaked nitrous to be >$10,000 per yea.
Anaesthetic				
Theatre pendant service	Yes	Yearly		Difference between service with and without nitrous outlet on pendant presents a saving.
Theatre pendant rebuild	Yes	As per manufacturer (e.g. 10 yearly)		Difference between rebuild with and without nitrous outlet on pendant presents a saving.
Nitrous cost				Cylinder rentals + refills.
Maternity				
Service cost for nitrous mixers				One large unit changed from 21 fixed units to 8 mobile units, the older units were difficult to maintain, savings in yearly service cost >$13,000.
Nitrous cost				Cylinder rentals + refills.

Capital and ongoing cost related to N_2O MGPS and transition to POC cylinders. Where possible values from multiple sources are presented as ballpark figure to maintain business confidentiality. Prices in NZ are commensurate. The list is not exhaustive and will vary depending on the setting and needs of the healthcare service.

Faculty of Pain Medicine



The future of pain medicine – why sustainability matters



Over recent months, the FPM Board has endorsed a five-year sustainability plan for pain medicine that outlines how we navigate the challenges and opportunities facing our specialty. The aim is to focus on the areas where we can have the greatest impact, and why this matters to every fellow, trainee and member of our broader pain medicine community.

Pain medicine is operating in a rapidly changing environment. Demand for our services continues to grow as populations age, multimorbidity increases and more people live longer with complex health conditions. At the same time, we face workforce pressures, funding challenges, increasing expectations of specialist leadership and significant gaps in the data needed to demonstrate the value of our work.

We cannot prevent change, but we can help shape it. Together, I believe we can position the faculty well for the future.

Pain medicine sits at the intersection of chronic disease, disability, mental health and complex multidisciplinary care. Every day, specialist pain medicine physicians help reduce opioid-related harm, improve function, support workforce participation and coordinate care for some of the most complex patients in the healthcare system. Often these contributions remain invisible within policy, funding and health system decision-making.

The sustainability plan isn't primarily about preserving the status quo. Every area of medicine is different now from what it was a decade ago, and every area will be different again ten years from now. Some things are predictable: the population will continue to age, there will be more cancer survivors, and there will be more pressure to justify the costs of the increasing health care burden. The need for pain management will only increase. My aim is to have pain medicine remain influential and be recognised for the value it brings.

The plan is built around four pillars: system and funding reform, workforce and training sustainability, credibility and system trust, and organisational sustainability and influence.

To start with, I would like to focus on one issue that has become increasingly important in recent months: data.

Data collection is becoming fundamental to demonstrating both the benefits of specialist pain medicine and the challenges our patients and services face. Without robust outcomes data, it becomes more difficult to advocate for policy reform, influence funding decisions, plan workforce growth or demonstrate the value of multidisciplinary pain management.

Many fellows will be aware that we were informed earlier this year that the electronic Persistent Pain Outcomes Collaboration (ePPOC) would cease operations following the University of Wollongong's decision to close the program. This represents a significant challenge for the sector. FPM is actively exploring future options and working with partners across the pain community to consider what a post-ePPOC environment might look like. Whatever form a replacement takes, maintaining the ability to collect meaningful outcomes data will remain critical for both patient care and advocacy.

A dedicated session at the Spring Meeting explored these issues and strategies for maintaining outcomes measurement into the future.

At the same time, there are reasons for optimism.

Building on the vision and work of previous faculty leadership, including past deans Dr Kieran Davis and Dr Dilip Kapur, the pain device implant registry has now entered its pilot phase. This represents an important step in strengthening our evidence base and demonstrating the safety, quality and outcomes of implantable pain therapies. As the pilot progresses, we anticipate opportunities for broader participation across the specialty.

The reality is that the future influence of pain medicine will depend not only on the quality of the care we provide, but also on our ability to demonstrate its value.

In future editions of the *Bulletin*, I will outline other aspects of the sustainability plan and the role they play in securing the future for our specialty.

Professor Michael Veltman
Dean, Faculty of Pain Medicine

Reflections on the first FPM Foundations MCQ examination

Congratulations to my fellow candidates who passed the inaugural FPM Foundations MCQ examination. I would like to acknowledge the FPM team involved in designing and implementing the new examination format, which was delivered seamlessly.

Preparing for the examination was rewarding. I was fortunate to have the support of an excellent study group. Together, we established a study timeline, identified key resources and met weekly over six months.

Careful selection of resources was important. *Essentials of Pain Medicine* (Celador, Rudiger and Tameem) provided a valuable overview, particularly of less familiar topics, while *Questions and Answers in Pain Medicine* (Suer and Sehgal) supported active recall. Some answers in the latter required verification and consideration within the Australian and New Zealand clinical context. Our study group was valuable in identifying errors and debating alternative answers. Other useful resources included *Bonica's Management of Pain* (Ballantyne, Fishman and Rathmell), *Acute Pain Management* (Macintyre and Schug), the recommended scientific literature and FPM position statements.

Timed MCQ practice was particularly beneficial. Artificial intelligence tools provided a useful means of generating additional questions from study notes and relevant scientific papers, facilitating learning through repetition. As with any secondary resource, the resulting questions and answers required careful verification.

Some candidates found it helpful to summarise each essential topic area, with separate notebooks for subjects such as statistics.

My principal reflection is that preparation should begin early and be planned realistically. Clinical work, family responsibilities, health and unexpected interruptions inevitably compete with study. A sustainable approach is likely to lead to success.

I wish all future candidates the very best with their preparation and training.

Dr Jolene Ralph
Trainee representative
Training and Assessment Executive Committee (TAEC)

FPM WEBINAR SERIES:
BEYOND THE CLINIC
Empowering specialist pain medicine physicians to build confidence, expand expertise, and strengthen capabilities in areas that matter most beyond the clinic.
FPM
Faculty of Pain Medicine
ANZCA



UNDERSTANDING AND SURVIVING THE COMPLAINTS PROCESS WITH DR LIZ CROWE
What happens when a complaint is made about you – and how can you navigate the process while protecting your wellbeing? This webinar is designed for pain specialists and anaesthetists who may be navigating a complaint, supporting a colleague or seeking to be better prepared.
Tuesday 20 October 2026
6.30-8pm AEDT
Zoom webinar
CPD: Category 2: Knowledge and skills – learning sessions
SCAN HERE TO REGISTER

Farewell Susie Lord – a lasting contribution





Many fellows know Associate Professor Susie Lord as a familiar figure at faculty meetings and events, as much for her thoughtful contributions and leadership as for the colourful jewellery collection that has brightened countless board meetings over the years. Her departure from the FPM Board provides an opportunity to reflect on the depth and breadth of her contribution to the faculty over almost nine years of board service.

Susie joined the FPM Board following her election in 2018 and quickly became known for her thoughtful strategic insight, meticulous attention to detail and unwavering commitment to advancing the specialty of pain medicine. She served on the FPM Executive Committee from 2020 to 2024 and chaired the FPM Professional Affairs Executive Committee (PAEC) during that period. Under her leadership, PAEC strengthened its reporting and governance processes and improved transparency and communication between the committee, board and fellowship.

Susie has made significant contributions across many areas of faculty work. She played an important role in major governance initiatives, including the board restructuring project, and was instrumental in developing the Clinical Care Standard for Procedures. As chair of the FPM Procedures Clinical Care Standard Working Group, she brought together diverse perspectives and guided the work with characteristic rigour, helping deliver an important resource that will support safe, evidence-based and patient-centred care across the specialty for years to come. She has also passionately advocated for paediatric pain medicine, ensuring the needs of children and young people remained visible in faculty priorities and board discussions.

One of Susie's most significant contributions, however, has occurred largely out of sight of the fellowship. Through her leadership of the ANZCA and FPM Reconciliation Action Plan Working Group and her longstanding commitment to Indigenous health, she has worked tirelessly to strengthen relationships between the Faculty and Aboriginal, Torres Strait Islander and Māori communities. She helped forge closer connections with organisations such as the Australian Indigenous Doctors' Association (AIDA) and championed opportunities for Indigenous medical students to engage with pain medicine, including promoting the college's scholarship program supporting attendance at the ANZCA Annual Scientific Meeting. Through these efforts, she has helped create pathways for future generations of doctors while ensuring reconciliation remains an active and meaningful priority for the college.

Those fortunate enough to have served alongside Susie on committees, working groups or the board know that her contribution extends far beyond her expertise and leadership. Alongside her intellectual rigour and commitment to excellence sits a deep sense of empathy and compassion. She has a remarkable ability to bring people together, navigate complex issues thoughtfully and ensure that the team not only completes the work to a high standard, but that everyone involved feels respected, valued and enriched by the experience. Many colleagues have left meetings not only better informed, but better for having worked with her.

On behalf of the fellowship and the board, we thank Associate Professor Susie Lord for her outstanding service, leadership and dedication to the FPM Board. Her contribution over the past nine years has been substantial and far-reaching. Through her governance, advocacy, mentorship and commitment to reconciliation, she has helped shape the faculty for the better and leaves a legacy that will continue to benefit fellows, trainees, patients and communities for many years to come.

While the FPM Board may miss the distinctive splash of colour that often accompanied her arrival in the boardroom, Susie's wisdom, generosity, leadership and unwavering commitment to the specialty will leave the greatest and most enduring mark. We thank her sincerely for her service and look forward to her ongoing contributions to the college and the broader pain medicine community.



Associate Professor Michael Vagg
Former Director of Professional Affairs, FPM

ABOVE

A/Prof Susie Lord (left) and as a member of the FPM Board (right).

Entrustable professional activities: The next phase for FPM training

FPM is preparing to introduce entrustable professional activities (EPAs) as an important part of its evolving approach to workplace-based assessment.

EPAs describe the core professional activities pain medicine trainees need to perform safely and increasingly independently. Rather than relying on a single assessment event, they bring together evidence from everyday clinical work, supervisor observation and feedback to support judgements about capability, supervision and progression.

This phased approach will allow trainees and supervisors to become familiar with the framework while ensuring the transition is supported, practical and informed by real-world experience.

The introduction of EPAs is expected to provide clearer expectations for trainees, more structured feedback and stronger evidence of progression towards independent specialist practice, while ensuring that assessment reflects the activities that matter most in contemporary pain medicine. For supervisors of training, EPAs make explicit a judgement that already occurs routinely in clinical practice. For example: *Can you trust the trainee to assess this patient independently and provide the information needed to make safe clinical decisions, or do you need to see the patient yourself or clarify aspects of the assessment first?*

A 10-week trial commenced in August at four sites: Townsville Hospital, Joondalup Health Campus in WA, The Queen Elizabeth Hospital in Adelaide, and Auckland City Hospital. The initial trial is testing whether two draft EPAs are clear, feasible and useful in real training settings before broader implementation. It will help us evaluate assessment processes, gather feedback, identify practical considerations and refine the resources needed to support implementation.

The faculty is offering a practical EPA workshop series for supervisors of training and PDS supervisors during the remainder of 2026. Two core 90-minute workshops will cover EPA foundations and the supervisor's role, and how workplace-based feedback can provide meaningful evidence for EPA decisions. Each workshop is offered on three different dates and times to maximise access, with further sessions planned in early 2027 on difficult decisions, local implementation and calibration. Supervisors are strongly encouraged to register online for one session from each of the two 2026 workshops, with at least one SOT from every training unit participating wherever possible.

The seven EPAs will be introduced progressively from 2027, with their current titles and proposed implementation timeframes set out on the next page:

EPA number	Title	Short title	Implementation timeframe
EPA 1	Using a sociopsychobiomedical framework, perform a comprehensive assessment of the patient with pain	'Assessment'	2027
EPA 2	Undertake safe pharmacological management of pain	'Pharmacology'	2027
EPA 3	Using the patient assessment synthesise a multidimensional formulation	'Formulation'	2027
EPA 4	Constructing, negotiating and communicating interdisciplinary pain management plans	'Management plans'	2027
EPA 5	Leading multidisciplinary teams (title TBC)	'Lead MDT'	2027
EPA 6	Educating patients (title TBC)	'Education'	2028
EPA 7	Managing clinical workflow (title TBC)	'Patient flow'	2028

For more information about EPAs at the FPM and to register for upcoming workshops, please visit https://www.anzca.edu.au/entrustable-professional-activities-epas-at-fpm

Future Bulletin *articles will explore the EPA trial in more detail and highlight what trainees and supervisors can expect as the transition progresses.*



Dr Tipu Aamir
Chair, FPM Learning and Development Committee

New fellows

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

Dr Lam Chi Cheung, FHKCA (Anaesthesiology), FFPMANZCA (HK)

Dr Jayanti Dutta, FRACP, FFPMANZCA, (ACT)

Dr Craig Kennedy, FRACGP, FFPMANZCA (Qld)

Dr Harrison Mihailidis, FAFRM (RACP), FFPMANZCA (Vic)

Dr Shun Yu Alex Wong, FHKCA (Anaesthesiology), FFPMANZCA (HK)





Reflections on private practice pain medicine

In his first year as ANZCA CEO, Dr Lance Emerson visited a private pain medicine clinic in Geelong. These are his reflections.



I recently had the opportunity to visit a private pain medicine service at Epworth Geelong with Martina Otten, Executive Director of the Faculty of Pain Medicine.

The visit coincided with the 10-year anniversary of Epworth Geelong, and it was fitting to see firsthand a pain medicine service that has been part of the hospital since its inception.

The service is an accredited practice development stage training site and plays an important role in supporting pain medicine training in a private practice setting. We were warmly welcomed by Associate Professor Michael Vagg, former FPM dean and director of professional affairs, and pain specialists, new fellows, trainees and the broader clinical and administrative team.

The visit included a tour of the consulting rooms and ward, discussions about procedural practice, billing, hospital liaison, nursing support, multidisciplinary care, training models and the business realities of delivering specialist pain medicine services in private practice.

The visit also provided an opportunity to hear patient stories. Like the experiences shared by many people living with chronic pain, these stories reflected the long and often difficult journey people take before they receive the right help for complex chronic pain. They were a strong reminder of why timely access to appropriately trained specialists and multidisciplinary care matters.

We also heard directly from those working at the coalface of pain medicine. The discussions highlighted the complexity of caring for people living with chronic pain, particularly where clinical, psychological, social, compensable and funding factors intersect. This work is demanding, highly specialised and often difficult to capture through simple activity or outcome measures.

We discussed the importance of multidisciplinary care and the role of structured pain management programs. The discussion about group programs, patient selection and outcomes reinforced the value of team-based models of care and the need to better describe, support and evaluate these models across different settings. It was clear that effective pain care relies not only on specialist medical expertise, but also on strong nursing, allied health, administrative and hospital support.

ABOVE

From left: FPM DPA Education Dr Melissa Viney, FPM trainee Dr Balram Dhillon, ANZCA CEO Dr Lance Emerson, FPM Executive Director Martina Otten, Director of Pain Matrix Associate Professor Michael Vagg.

From a training perspective, the visit provided a strong example of the important role private practice can play in developing the next generation of pain medicine specialists. We met current trainees and recent fellows from diverse professional backgrounds, including anaesthesia, psychiatry and general practice.

Each had come to pain medicine through a recognition of the complexity of the patients they were caring for, an interest in chronic pain and a desire to develop deeper capability in this field. Their enthusiasm for pain medicine was striking and spoke strongly to the value of the specialty and the breadth of expertise it brings together.

The service also supports fellows and trainees undertaking the supervised clinical experience pathway of the Procedures Endorsement Program. This is an important contribution to procedural training and to ensuring that clinicians have access to high quality, supervised practice in an appropriate clinical environment.

The visit raised important strategic questions for ANZCA and FPM: How do we best support fellows working in private practice? How do we strengthen training pathways, procedural capability and mentoring? How do we advocate for funding and service models that reflect the complexity of chronic pain care? And how do we support better data collection and outcomes measurement, while recognising the many variables that influence a person's pain journey and response to care?

Pain medicine sits at the intersection of clinical excellence, multidisciplinary collaboration, health system design and patient-centred care. Visits such as this are invaluable because they help ensure our strategic priorities remain grounded in the experience of clinicians, trainees, patients and services.

I am grateful to Associate Professor Michael Vagg and the team for their generosity, openness and thoughtful engagement. The visit provided important insights that will inform ongoing discussions about how ANZCA and FPM can continue to support sustainable, high-quality pain medicine training and practice into the future.

Dr Lance Emerson
CEO, ANZCA

FPM
Faculty of Pain Medicine
ANZCA

Opioid calculator
Celebrating 10+ years

- Educating prescribers and patients about safe opioid dosing.
- Adapted from the FPM Opioid Dose Equivalence Table.
- Essential tool for clinicians, medical students and researchers.
- Simplifies the Daily Morphine Equivalence Dose calculation.
- Traffic light dose warning.

APPLE STORE
ANDROID STORE



Perioperative medicine



POM momentum continues to grow

The Chapter of Perioperative Medicine (ChPOM) continues to build momentum across education, advocacy and service development, with strong growth in course participation, expansion of clinical immersion sites, and important work under way to define the future direction of perioperative medicine in Australia and New Zealand.

COURSE EXPANDING

A key highlight for 2026 has been the continued success of the ANZCA Course in Perioperative Medicine.

Since launching in 2024, demand has consistently exceeded expectations, reflecting growing recognition of the value of multidisciplinary perioperative care. In 2026, every unit of study recorded its highest enrolment to date, with 269 unit enrolments across the year, up 71 per cent on 2025 and more than double the 2024 total.

In trimester 1, combined enrolments in units 1 (preoperative assessment) and 2 (preoperative planning) more than doubled on 2025. Trimester 2 recorded 87 enrolments across units 3 (optimisation) and 4 (intraoperative impacts on patient outcomes, and trimester 3 began on 21 September with 43 enrolments in unit 5 (Postoperative assessment and management and 36 in unit 6 (Discharge planning and rehabilitation), up 54 and 24 per cent respectively on last year.

More than half the participants were FANZCAs, highlighting the strong engagement of anaesthetists in advancing perioperative medicine education. To meet demand, the participant workshop will run twice a year from 2027, doubling capacity from 40 to 80 places, with dates for both options available on the participant toolkit page.

The growing community of graduates is another milestone worth celebrating. To date, 34 clinicians have become graduates of the chapter (GChPOM) through the course pathway, including 25 FANZCAs, seven physicians, one general practitioner and one international fellow. A further seven will be conferred in October, bringing the total to 41.

Equally significant has been the continued growth in the number of clinical immersion sites to 40 across Australia and New Zealand, creating more opportunities for participants to complete the course. Sir Charles Gairdner Hospital in Western Australia is the most recent clinical immersion site. The chapter is also in the process of onboarding sites including, Eastern Health in Victoria and Taranaki Base Hospital in New Zealand and is continually looking to partner with jurisdictions to identify and expand new clinical immersion sites based on demand and gaps in the workforce.

A particular focus is on strengthening rural and regional participation to ensure patients and clinicians outside metropolitan centres can benefit from perioperative medicine initiatives.

In September, the chapter joined the ANZCA team at the 18th National Rural Health Conference in Adelaide. The question clinicians asked most often was how to establish a perioperative service when resources are already stretched, which sits at the heart of the chapter's work to extend perioperative medicine beyond tertiary centres.

The quality of the educational experience continues to be a priority. In July, the chapter delivered a redesigned online participant workshop that received positive feedback. All 27 respondents rated the workshop as useful, while self-reported confidence across the five-unit 3 and 4 learning outcomes increased from 3.6 to 4.2 on a five-point scale.

Nearly two-thirds of participants rated the day as extremely useful, 96 per cent reported that the balance of presentations, case discussions and activities was good or excellent, and 89 per cent agreed that the program strengthened their confidence in optimisation, prehabilitation and critical care protocols.

An expanded face-to-face workshop incorporating communication skills training aligned with the ANZCA Perioperative Patient Pathway is planned for 24-25 November in Hobart.

From December 2026, the course will move to MyPortfolio, which will become the primary platform for progress monitoring and assessments. The change will give participants, supervisors, units of study leads and the chapter team clearer visibility of progress and course requirements, and reduce reliance on manual processes. Learn@ANZCA will continue to support some learning activities, and the curriculum, assessment standards and course requirements remain unchanged.

JOINT COMMITTEE MEETING

In July, members of the Advocacy and Policy Committee and the Education and Assessment Committee came together for a joint strategic workshop to explore the future state of perioperative medicine and ANZCA's role within it.

Facilitated discussions focused on workforce challenges, multidisciplinary models of care, funding sustainability, health system reform and the development of a compelling value proposition for decisionmakers.

Participants also began defining measurable indicators of high-quality perioperative medicine services, including risk assessment, shared decision-making, multidisciplinary clinic access and postoperative outcomes. The outcomes of these discussions will inform the chapter's future strategy, workplan and business case development.

Innovation remains another area of active exploration. At the joint committee meeting, members considered the opportunities and risks associated with artificial intelligence in clinical practice and education.

Discussions covered AI governance, documentation tools, patient resources, privacy considerations and future applications that could improve clinician efficiency and patient care while maintaining appropriate safeguards.

The Education and Assessment Committee is also exploring AI-supported tools to enhance telehealth assessments, improve feedback quality and reduce assessor workload.

POLICY AND ADVOCACY

The chapter has also progressed important policy and advocacy initiatives.

Work has commenced on a professional document relating to multidisciplinary perioperative clinics, while engagement has continued with hospitals and specialty stakeholders interested in strengthening perioperative models of care.

Discussions have also occurred regarding alignment between perioperative medicine and trauma care, creating opportunities for broader collaboration across specialties.

LOOKING AHEAD

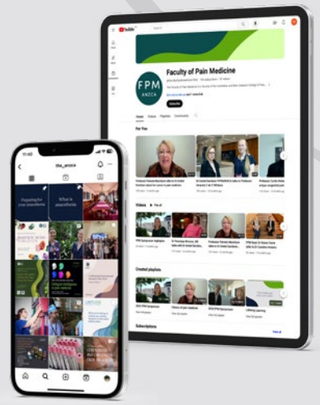
Priorities include expanding rural and regional engagement, delivering additional webinars and workshops, progressing professional document development, enhancing participant resources and continuing work on defining what excellence in perioperative medicine looks like across the patient journey.

Together, these achievements reflect a chapter that is growing in influence, strengthening its educational offering and helping position perioperative medicine as an increasingly important contributor to better patient outcomes and more sustainable healthcare systems.

Dr Chris Cokis
Chair, Chapter of Perioperative Medicine Board

ANZCA
FPM

Follow us on social media



Wherever you go to for information, events, news, and networking, we've got you covered! Follow us...

@anzca.bsky.social | @anzca-fpm.bsky.social

@the_anzca | @gkmuseum

@ANZCA1992

Australian and New Zealand College of Anaesthetists

Faculty of Pain Medicine (ANZCA)

Australian and New Zealand College of Anaesthetists

Faculty of Pain Medicine



Before the curtain rises: Making pre-admission visible

NSW practitioners Belinda Edinborough, a clinical nurse consultant, and Dr Rajni Lal, geriatrician and perioperative physician, explain the importance of pre-admission screening.

"When I worked in theatre, everyone knew me. When I moved into pre-admission screening, I became invisible."

Belinda described pre-admission screening and the pre-admission clinic (PAC) as the work that happens behind the scenes – essential preparation for each operation, yet largely unseen and often unrecognised. She was influencing the surgical journey earlier, while there was still time to identify risk, gather missing information and change the plan. Yet because it happened away from theatre, few people saw its complexity or impact.

Many clinicians and nurses will recognise this feeling. Much of the work happens quietly – reviewing records, chasing results, calling patients and noticing the detail that changes everything.

As we talked, we realised that the perioperative journey has much in common with a theatre production.

CENTRE STAGE

Surgery is centre stage. The patient on the operating table, with the surgeon, anaesthetist, nurses and theatre team under the lights.

Within the ANZCA perioperative medicine community, the perioperative physician is often described as the conductor of the orchestra. We suggest the role is broader still, resembling a production manager who helps coordinate what is required before, during and after each surgical performance.

But no successful performance begins when the curtain rises. What looks routine on a theatre list may represent weeks of preparation behind the scenes.

THE FIRST DRAFT OF THE SCRIPT

The request for admission (RFA) and patient health questionnaire (PHQ) provide the first draft of the script. They describe the procedure and begin to tell us who the patient is, but important details about medications, frailty, function, cognition, language and support at home may be missing.

The screeners are the script editors and production planners. They bring the information together, identify what is missing and determine what preparation each patient requires. They decide the type and timing of assessment and whether review by an anaesthetist, perioperative physician or another specialty is needed.

This requires more than following criteria. Experienced screeners notice inconsistencies and warning signs. They know when an answer needs another question or when a patient who appears straightforward on paper may need more support.

Good screening means the right patient sees the right clinician, in the right clinic, at the right time. Poor screening can mean unnecessary appointments, delayed optimisation or problems discovered only on the day of surgery.

BACKSTAGE

PAC is backstage. Nurses, anaesthetists, perioperative physicians, pharmacists, allied health clinicians, interpreters, administrators, booking and scheduling teams, surgical teams and other specialties prepare the elements needed for anaesthesia, surgery and recovery.

PAC is sometimes viewed as a place where forms are completed and patients are "cleared" for surgery. Anyone who has worked there knows this understates its role. It is the nurse who notices that a patient does not understand which medications to stop. The pharmacist who untangles a medication list. The interpreter who allows the patient to explain what concerns them. The administrator who finds an appointment before surgery. The clinician who looks beyond the procedure and sees the whole person.

Blood tests, ECGs, imaging and other investigations are not simply boxes to tick. They may uncover anaemia, renal impairment, poorly controlled diabetes, previously unrecognised cognitive impairment, frailty, cardiac symptoms or significant functional decline, findings that may change the anaesthetic approach, the proposed procedure, the timing of surgery or the support required immediately after surgery, and beyond discharge.

Sometimes PAC confirms the existing plan is appropriate. Sometimes it makes the perioperative journey safer. Sometimes it reveals the patient is not yet ready for that journey. Occasionally, it prompts the team to reconsider whether the proposed operation remains the right option. The value of PAC is therefore not measured simply by the



number of patients seen, but by what changes because the patient was assessed: a diagnosis identified, an unnecessary appointment avoided, a medication plan clarified, surgery appropriately deferred. Many of these interventions are difficult to count, because their success is reflected in the complication, cancellation or misunderstanding that did not occur.

CHOOSING THE SCRIPT TOGETHER

A referral may propose surgery, but it does not determine whether surgery is right for that person. Shared decision-making is where the patient and team choose the script together. Using ALL-BRAN, we first ask, listen and learn what matters to the patient. We then consider the benefits, risks, alternatives and natural course of each option.

The patient is not simply the audience. They become a co-author, helping decide which script reflects their priorities, or whether this production should proceed at all.

REHEARSAL

Once the script is chosen, prehabilitation is the rehearsal. Exercise, breathing techniques, nutrition, smoking or alcohol reduction, sleep, psychological wellbeing and planning for support at home prepare the patient for surgery and recovery.

It relies on patients and carers working with nurses, physiotherapists, dietitians, pharmacists, medical and surgical teams, and community services.

WHAT WE COUNT

Our health system is good at counting and funding activity: appointments, procedures, theatre lists and completed operations. It is less good at recognising the time and judgement involved when careful assessment changes the plan.

If surgery does not proceed because it is unlikely to benefit the patient, or does not align with what matters to them, it can appear as though nothing happened. In reality, considerable work may have gone into reaching that decision through screening, investigations, referrals, clinical assessment, coordination and conversations with the patient and family.

The operation that happens is visible. The operation thoughtfully avoided is not. Yet both can represent good perioperative care.

FRONT OF HOUSE

After surgery, the ward and Enhanced Recovery After Surgery pathway become front of house.

The patient's experience is shaped by communication, comfort, hydration, nutrition, pain relief, toileting, mobilisation, delirium prevention and preparation for home. Even excellent surgery can be undermined if the patient is left thirsty, in pain, confused, immobile or uncertain about what happens next.

A successful operation must become a successful recovery, and this again depends on the whole team.

SEEING THE WHOLE PRODUCTION

The operating theatre will always be centre stage, but outcomes are created across the entire production.

They depend on the quality of referral, expert screening, thoughtful booking, timely assessment, appropriate investigations and coordinated optimisation. They are strengthened by shared decision-making, prehabilitation and clear communication, and continue through surgery, recovery and the transition home.

If we want safer surgery and better recovery, we cannot invest only in what happens under the theatre lights.

We must also recognise those working backstage and front of house. Much of their best work will never be seen on stage. But without them, the performance could not go on.

Ms Belinda Edinborough, clinical nurse consultant

Dr Rajni Lal, geriatrician and perioperative physician Blacktown and Mount Druitt Hospitals, Western Sydney Local Health District



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

THEN APPLY NOW FOR THE 2027 CONFERENCE!

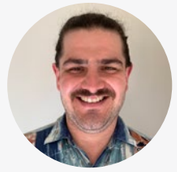
Complete the online application form available on the meeting webpage (available via the QR code) and email a copy of your CV to the meeting organiser (events@anzca.edu.au) by **Friday 23 October 2026**. Successful applicants will be notified in mid-December.

HERE'S WHAT A FEW OF THIS YEAR'S DELEGATES HAD TO SAY ABOUT THEIR EXPERIENCES.



It was an inspiring and professionally rewarding experience. The program brought together emerging leaders from Australia, New Zealand and beyond, providing an invaluable opportunity to learn from outstanding speakers, connect with peers and mentors and reflect on the future of leadership in anaesthesia.
Sessions explored contemporary leadership, cultural safety, effective communication, clinician wellbeing, resilience and leading change within complex healthcare systems.
A recurring message was that leadership extends beyond formal positions. It is grounded in clinical excellence, self-awareness, collaboration and the courage to make a positive difference.
The conference challenged me to think differently about my own leadership journey and provided practical skills that I will apply in my clinical practice, department and college roles.
I highly encourage colleagues to apply for this exceptional and rewarding opportunity.

Dr Jane Leadbeater, FANZCA



It was an invaluable opportunity to develop my leadership skills and reflect on what it means to be a leader.
The whakataukī He waka eke noa — we are all in this canoe together — captured the spirit of the conference, highlighting the importance of shared purpose, collaboration and supporting one another.
The conference reinforced that leadership is not defined by title, but by a can-do attitude, a willingness to give things a go, supporting others, communicating with purpose, and creating an environment where people can contribute and succeed. Engaging with new fellows and experienced leaders from diverse backgrounds challenged my thinking, broadened my perspective, and highlighted the importance of humility, active followership and inclusive leadership.
As an Indigenous Health Committee delegate, I also reflected on the importance of culturally aware leadership and its role in improving outcomes for Māori and other Indigenous communities.
I left feeling inspired, more confident to pursue leadership opportunities, and equipped with practical lessons I can use throughout my career. I highly recommend the conference to any new fellow.

Dr Jayden Ball, FANZCA



The conference provides a unique opportunity to network with peers and leaders across Australia and New Zealand as well as globally. The theme for the 2026 conference was "The pursuit of consciousness".
The sessions encouraged us to not only think outside the box as a leader but to also remember the importance of balancing professional growth with personal wellbeing.
I found the ELC to be an insightful and enriching experience. It provided me with an opportunity to reflect on my own leadership journey, gain new perspectives and connect with peers and mentors. I left the conference with a greater appreciation of the complexities of leadership in anaesthesia and pain medicine, as well as practical insights that I can apply to my own journey as I develop further in my practice.

Dr Supriya Chowdhury, FANZCA FFPMANZCA

SCAN TO APPLY AND VIEW THE PROGRAM

ANZCA
FPM

Call for abstracts now open

Thinking of submitting an abstract for the 2027 ASM? You may be eligible for one or more prizes! Check out the ASM prizes below and visit the ASM website – asm.anzca.edu.au – for more information and eligibility requirements. Be sure to check out the resources to help you with your abstract writing and submission.

Gilbert Brown Prize
ANZCA and FPM fellows within eight years* of fellowship

ANZCA Trainee Research Prize
ANZCA trainees or fellows within one year* of fellowship

ANZCA Trainee Quality Improvement Prize
ANZCA trainees or fellows within one year* of fellowship

Open Science Prize
All ASM registrants

Open Quality Improvement (QI)/Quality Assurance (QA) Prize
All ASM registrants

FPM Dean's Prize
FPM fellows within 10 years* of fellowship or FPM trainees

FPM Best Free Paper Award
All ASM registrants

**Taking into account career disruption*

SCAN HERE
FOR MORE
INFORMATION

Key dates

Program available
Late November 2026

ASM and FPM Symposium registration opens
12pm AEDT, 1 December 2026

Abstract submissions close
11.59pm AEDT, 17 January 2027

Notification to abstract authors
Early March 2027

FPM Symposium
30 April 2027

ANZCA ASM
30 April – 4 May 2027

Together for Tomorrow

2027 ANZCA ASM
30 April-4 May | Adelaide
#ASM27ADL

Gold sponsors

BD CSL Medtronic

This event is supported by

Business Events Adelaide · South Australia · Government of South Australia · Adelaide Convention Centre



Continuing professional development

CAPE Fear – don't be part of the show!

In June I had the privilege of taking over the role of chair of the ANZCA Continuing Professional Development Committee from Dr Debra Devonshire.

On behalf of all of us at ANZCA, and especially the committee and CPD team, I would like to thank Deb for the incredible work she has put into the role and congratulate her on a very successful tenure. She has navigated our CPD program through a time of immense change over the past eight years on the committee and seven years as chair.

Thanks to her, along with the dedicated committee and CPD team, we have a CPD program that reflects the high standards of clinical practice that we are rightly proud of at ANZCA, while simultaneously meeting the increasingly demanding requirements of the regulatory authorities in both Australia and New Zealand.

While Deb moves on to other important roles at ANZCA, it is more critical than ever to be revising and updating our CPD program to meet the changing needs of our fellows and the ever-changing regulatory requirements.

It is extremely important to me, and to the CPD team, that we do this with minimal disruption to the working lives of busy clinicians who already conduct their work with a strong focus on enhancing and retaining the best available knowledge and skills relevant to their practice.

To that end, my colleagues on the committee, the hard-working CPD team and I are here to help, by answering your questions and by directing you to our enormous range of CPD resources, particularly in the ANZCA Library (https://libguides.anzca.edu.au/cpd). Please contact us if you need us (cpd@anzca.edu.au).

THE CPD SPRING CHALLENGE

It's Spring and this is the Spring edition of the *ANZCA Bulletin*, so I invite you to join me in completing the "Spring CPD Challenge".

Every December, when summer is just starting and thoughts turn towards warmer weather and a holiday, a special horror film plays across Australia and New Zealand: anaesthetists and pain medicine physicians everywhere start to panic as they scramble to complete their mandatory CPD requirements. Some clinicians even contemplate what CPD activities they can do on New Year's Eve – aargh!

This year a special version of this film will appear which I'm going to call "CAPE Fear". There's no Javier Bardem or Robert De Niro but it's still potentially pretty scary. The "CAPE" framework will be new to many of you (although the familiar culturally safe practice hasn't changed).

"Some clinicians even contemplate what CPD activities they can do on New Year's Eve – aargh!"

It was developed as a mandatory requirement by the Australian Health Practitioner Regulation Agency (Ahpra) for all doctors registered in Australia in 2022 (with closely overlapping requirements by the Medical Council of New Zealand).

Completion of each requirement is mandatory, but not particularly onerous, since each of the A, P and E components can be incorporated, where appropriate, into other CPD activities that you're already completing. For example, if in a morbidity meeting there is a discussion around the impact of professional behaviour on the management or outcome of a particular case, the "P" in the CAPE framework can be included, as well as the time and practice evaluation points logged for the meeting as usual.

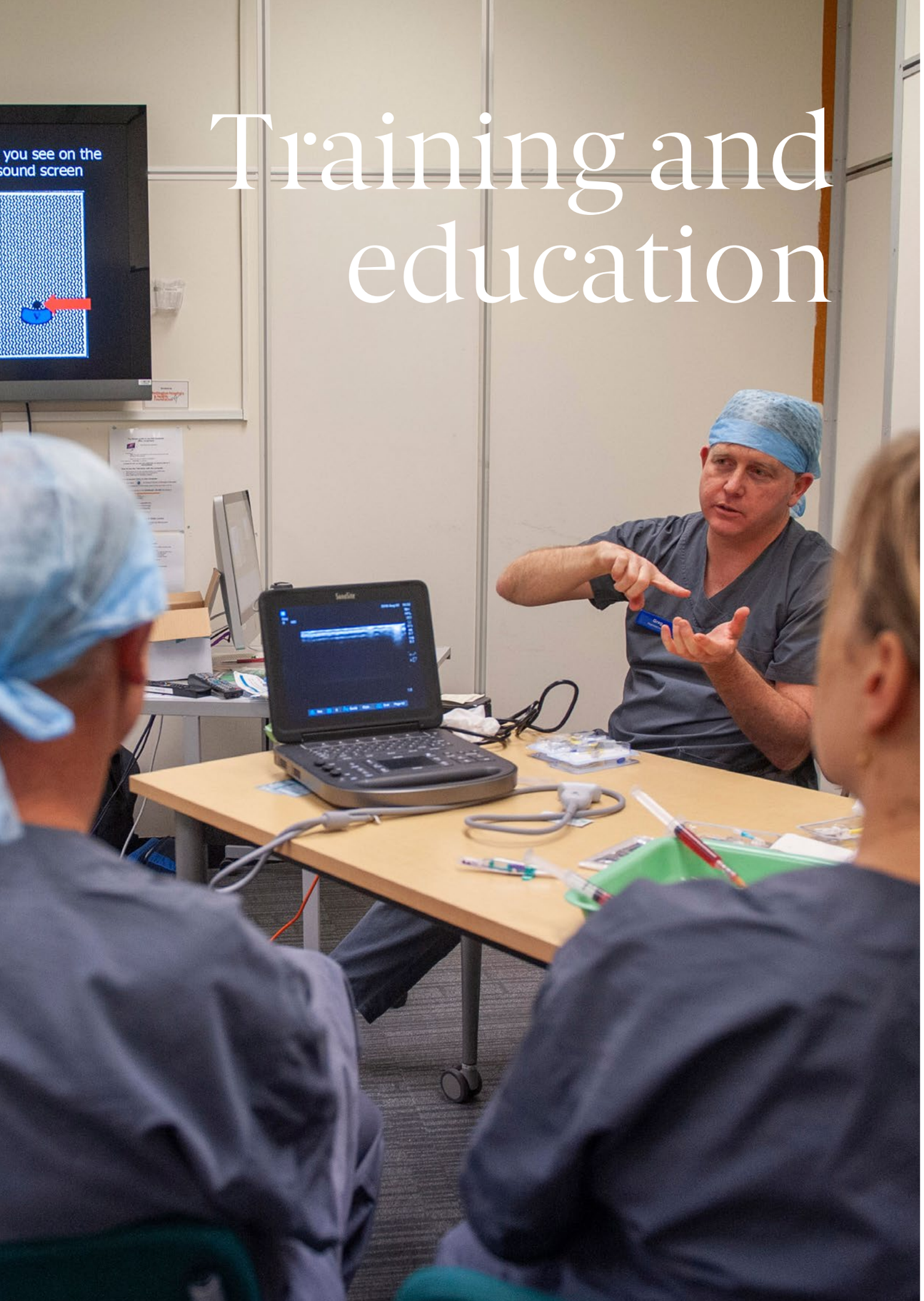
The same is true for any content relating to health inequity, professionalism or ethical practice in a lecture at a conference, for example. The trick here is to anticipate your CAPE needs in advance as much as possible. Trying to capture all of this in December will be highly problematic, so this Spring I challenge you to join me (yes, I struggle with this myself) and complete the CAPE components of your CPD portfolio (and all the other components, if you're up for it) *before the end of November.*

If you struggled to complete your CPD last December, only to say to yourself in January "what a nightmare, I swear I'm not doing that again!" then you navigated what I call the "January CAPE of Good Hope".

This year why don't you break the cycle? Plan ahead, take the Spring Challenge, and don't let last January's CAPE of Good Hope turn into your December CAPE Fear!



Dr Mark Priestley, FANZCA
Chair, ANZCA and FPM CPD Committee



Training and education

Trainee working to inspire African Australian doctors

When Dr Anei Ochan-Thou began his medical degree in Sydney, he quickly realised something was missing.

"I didn't see people who looked like me or came from a similar background to me," he recalls.

"I felt invisible, but at the same time very visible because of where I came from and my identity as an African Australian."

The first-year anaesthesia registrar at Austin Health is now helping change that reality for the next generation of African Australian doctors, while embarking on his own specialist training journey.

Born in Sudan, Dr Ochan-Thou arrived in Melbourne with his family when he was four years old. He is the first doctor among his six siblings and both his parents trained as nurses in Sudan.

His pathway into anaesthesia developed gradually during his internship at Western Health in Melbourne, as he rotated through specialties including infectious diseases, general surgery, orthopaedics, emergency medicine and psychiatry.

"I enjoyed all my rotations," he says. "What drew me to anaesthesia was that it combines a strong clinical knowledge base with procedural skills, while allowing you to work alongside almost every specialty."

A six-week anaesthesia rotation at Western Health cemented his decision.

"The department was magnificent. Having consultants who believed in me and gave me a clear picture of what the career looked like was incredibly inspiring."

After a critical care hospital medical officer year at Austin Health, he successfully gained a place on the ANZCA training program and will sit the primary examination next year.

Alongside his clinical study and placements Dr Ochan-Thou founded SUDO-AUSTRALIAN, MD, a not-for-profit organisation dedicated to supporting aspiring African Australian medical students and doctors.

What began as a personal blog documenting his experiences at medical school has evolved into a national mentoring initiative featuring podcasts, community events and financial support for future students.

"I think telling stories is incredibly important," he says. "If we don't tell our own stories, someone else will tell them for us – and often not accurately."

The organisation's podcast, *Medicine Through Our Eyes*, features African Australian doctors from a range of specialties sharing their personal journeys into medicine, providing visible role models for students who may otherwise struggle to imagine themselves in the profession.

Earlier this year, SUDO-AUSTRALIAN, MD hosted its inaugural "UNSCRUBBED" event in Melbourne. Expecting about 40 people to attend, Dr Ochan-Thou welcomed more than 120 people, including high school students, medical students, trainees, consultants and more than 25 African Australian doctors.



"Having consultants who believed in me and gave me a clear picture of what the career looked like was incredibly inspiring"

Named after the freedom of stepping out of theatre scrubs, UNSCRUBBED encouraged honest conversations about identity, belonging, racism, allyship and representation within medicine.

The event also raised more than $A2000 to establish the organisation's first bursary program which will help aspiring medical students meet the costs of the Graduate Medical School Admissions Test preparation and exam fees.

"Financial barriers can stop people pursuing medicine," Dr Ochan-Thou says. "We wanted to help remove some of those barriers because I know what it's like not having that support."

His work has already attracted wider recognition. Earlier this year he received the Spotlight Award at the Amari Gala, recognising his contribution to the African Australian community through SUDO-AUSTRALIAN, MD.

Despite balancing registrar training, study for the primary examination and growing the organisation with his wife Prisca who is completing a law degree, Dr Ochan-Thou remains optimistic about the future.

He believes increasing diversity within medicine benefits not only the profession, but also the patients it serves.

"Representation matters," he says. "When people can see someone with a similar background succeeding in medicine, they begin to believe that pathway is possible for them too."

Carolyn Jones
Media Manager, ANZCA

NZ fellow recognised with Dr Ray Hader Award for Pastoral Care

The Dr Ray Hader Award for Pastoral Care promotes compassion and a focus on the welfare of anaesthetists, other colleagues, patients and the community.



DR JOHN CURRIE

For more than three decades, Waikato anaesthetist Dr John Currie has quietly shaped the careers and wellbeing of generations of colleagues and trainees, earning him the 2025 Dr Ray Hader Award for Pastoral Care.

The award recognises ANZCA fellows who demonstrate exceptional commitment to the welfare, mentoring and pastoral support of others – qualities that colleagues say Dr Currie has embodied throughout his career.

Known for his compassion, generosity and calm leadership, Dr Currie founded and continues to lead the Waikato Hospital's Department of Anaesthesia and Pain Medicine's Addiction Prevention and Intervention Service, creating a culture where difficult conversations about addiction and wellbeing can take place openly and without judgement.

Each year he welcomes trainees into his home for an informal discussion about addiction in anaesthesia, often over homemade pizzas. He also oversees the department's controlled drug monitoring program and coordinates confidential interventions when concerns arise, helping ensure both staff wellbeing and patient safety.

His influence extends well beyond formal programs.

As the department's former welfare representative, Dr Currie established a framework for trainee support that continues to guide welfare initiatives today. Colleagues describe him as someone whose response to requests for help is invariably, "Great, let's do it."

Whether acting as a formal supervisor of training or an informal mentor, he is known for his kindness, encouragement and unwavering support.

His approach to teaching has left a lasting impression on trainees.

No matter how challenging the operating list, Dr Currie's reassuring words – "We'll have a great day, and coffee's on me" – set the tone for a learning environment where education, teamwork and collegiality flourish.

His calm demeanour and generosity with his knowledge have helped countless trainees develop confidence both inside and outside the operating theatre.

Dr Currie's commitment to pastoral care has also extended to patients.

He established and led the department's obstetric pain service, supporting women, midwives and obstetricians through complex pregnancies and often emotionally challenging circumstances. Even today, colleagues continue to seek his advice on difficult obstetric cases, valuing both his clinical expertise and compassionate perspective.

Away from clinical practice, Dr Currie is an accomplished craftsman who has designed and built practical equipment for the department. Each year he hand-turns fountain pens as farewell gifts for departing trainees – a thoughtful tradition that has become a lasting symbol of his appreciation for those he has mentored.

Dr Currie has been much more than an anaesthetist. He has been a mentor, advocate, teacher and trusted friend whose quiet acts of generosity have enriched his department and the wider profession.

**This article was prepared with information supplied by Dr Currie's award nominators.*



Dr Currie's hand-turned fountain pens.

ANZCA
FPM

Applications for the Dr Ray Hader Award for Pastoral Care are now open

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

Dr Ray Hader was a Victorian ANZCA trainee who died of an accidental drug overdose in 1998 after a long struggle with addiction. This award was established in his memory by his friend Dr Brandon Carp.

The award is open to all ANZCA trainees and fellows residing in an ANZCA training region and takes the form of a certificate and grant of $A2000 for training or educational purposes.

Nominations for the award must be received by Friday 6 November 2026. For the nomination process as well as more information, visit the college website.

ANZCA
FPM

College bursaries

Did you know each year ANZCA offers a number of bursaries to trainees who are experiencing financial hardship?

Eligible trainees can receive up to a 50 per cent reduction in their annual training fees. All applicants will also receive an extension to the annual training fee due date.

In November, trainees will receive an email about the 2027 training fees, which will include further information on bursary applications, such as opening and closing dates.

Applicants must be registered as a trainee with ANZCA or FPM.

For further information, please contact the ANZCA Training team via email at training@anzca.edu.au or call +61 3 9510 6299.

Queensland fellow clocks up 14 years as a SOT



Dr Simone Malan-Johnson is a supervisor of training (SOT) at Caboolture Hospital in Queensland.

SUPPORTING TRAINEES

The hospital's anaesthesia department has seven ANZCA trainees, one rural generalist anaesthesia trainee and one emergency department trainee.

Dr Malan-Johnson is deeply committed to supporting trainees, both in their professional development and through personal challenges. In addition to her clinical and educational responsibilities, she is ANZCA's Queensland Trainee Committee's Deputy Education Officer, reflecting her strong leadership and dedication to medical education.

A passionate educator, she has also contributed as a primary examiner and has invested significant time and effort in mentoring trainees through the ANZCA Primary Examination.

HOW IS YOUR SOT ROLE UNIQUE?

Each department and everyone's personality bring uniqueness to the role. I was unwittingly "dobbed "into the role before the advent of the training portfolio system (TPS) in 2013. I always enjoyed teaching and mentoring junior colleagues through the exam and have a particular interest in how the brain learns, effective study and exam techniques. I got my head around the administrative and other requirements through asking other SOTs.

WHAT DO YOU LIKE ABOUT YOUR ROLE?

Working in a small department I have been able to really get to know my trainees. Each one has a background and a story that have led them to this point. I love getting to know what motivates (and what challenges them) and my reward is when they are successful and move ahead with their career.

WHAT ARE SOME OF THE CHALLENGES?

The truly difficult conversations I've experienced have been with the rare person who needs to consider an alternative career pathway, either because they or their lifestyle are just not suited to anaesthesia, or due to a significant challenge with the exam hurdle. Probably the biggest challenges have been adopting the new TPS system 13 years ago, and now MyPortfolio!

WHAT WOULD YOU SAY TO COLLEAGUES CONSIDERING BECOMING A SOT?

Be prepared to volunteer some of your own time. Get to know your trainees. It is a rewarding role and helps shape our profession for the future.

WHAT IS A RESOURCE THAT HAS HELPED YOU IN YOUR ROLE AS A SOT?

The SOT network. I found asking an experienced colleague as good as, or better than searching online resources. Although ANZCA offers some excellent resources too.

WHAT'S YOUR BEST TIP TO TRAINEES PREPARING FOR AN EXAM?

There are no shortcuts for this exam. Put your head down, work hard, make the sacrifices and get it right first time so you can move on with your life!

ANZCA and FPM's transition to new accreditation standards

From 2027, anaesthesia and pain medicine training settings will be accredited against the Australian Medical Council's (AMC) accreditation standards for specialist medical college accreditation of training settings. Here's what the change means for training settings and how ANZCA and FPM are preparing for it.

Accreditation is an important part of maintaining high-quality specialist medical education and training, as well as ensuring high-quality patient care. It helps ensure trainees have access to the supervision, clinical experience, resources and learning environments they need to develop into safe and capable specialists. While the new accreditation standards will introduce some changes, they also provide an opportunity to build on the strengths of our current approach, further enhancing training quality, supporting patient safety, and contributing to the delivery of high-quality patient care into the future.

WHY IS ACCREDITATION CHANGING?

The move to the new accreditation standards is part of a broader reform to strengthen specialist medical training accreditation and ensure it is fit for the future.

The change follows the National Health Practitioner Ombudsman (NHPO) Processes for Progress report, which identified opportunities to make accreditation more transparent, consistent, fair, responsive and accountable across specialist medical colleges. The review highlighted the importance of clearer standards, greater transparency in accreditation decisions, stronger monitoring of training settings, and more consistent approaches to managing concerns and non-compliance.

In response, the AMC worked collaboratively with specialist medical colleges and health jurisdictions to develop a common set of Model Standards and Procedures for the accreditation of specialist medical training settings. The Medical Council of New Zealand (MCNZ) also participated in the consultation process and endorsed the AMC Model Standards and Procedures in March 2026, supporting a more consistent approach to specialist medical training accreditation across Australia and New Zealand.

For ANZCA and FPM, adopting the new standards provides an opportunity to further strengthen and modernise our accreditation approach, while retaining the flexibility to reflect the specific requirements of anaesthesia and pain medicine training.

WHAT DOES THIS CHANGE MEAN FOR ANZCA AND FPM TRAINING SETTINGS?

Training settings are at the heart of training programs, and we recognise that accreditation requires a significant commitment of time, people and resources. As we prepare for this new approach, our focus has been on making the transition as clear and practical as possible, while retaining the things that matter most to trainees, fellows, supervisors and training settings.

There will be some changes, particularly in the evidence gathered through the accreditation process and how it is assessed. However, the purpose of accreditation remains the same: to support high-quality training environments for trainees and supervisors, promote patient safety, and contribute to the delivery of high-quality patient care. We have worked carefully to ensure the strengths of our current approach are retained as we transition to the new standards.

The new standards are grouped into four domains, outlined on the next page. We have undertaken detailed mapping of our existing requirements against the new standards, with a high level of alignment identified. This means that much of what training settings already do to support trainees, supervisors and high-quality education and training will continue to be recognised.

A small number of specialty-specific requirements, considered essential to the delivery of anaesthesia and pain medicine training, were identified as not being adequately covered. Following a five-month consultation process with Australian jurisdictions, Health New Zealand and the AMC, in September 2026, the AMC Specialist Education Accreditation Committee (SEAC) formally approved that the college-specific requirements and addition to intent statement be incorporated as part of the standards for ANZCA and FPM.

This outcome reflects ANZCA and FPM's strong advocacy for accreditation standards which recognise the distinctive features of anaesthesia and pain medicine training, supporting patient safety, and contributing to the delivery of high-quality patient care

AMC-approved college-specific requirements	
Anaesthesia	**Pain medicine**
Trainees are supported to successfully complete all the assessment requirements of Introductory Training before they work beyond level one supervision.	The training occurs within a sociopsychobiomedical framework in which medical, allied health and nursing teams assess and treat patients cohesively to support patient outcomes.
AMC-approved addition to intent statement for criterion 2.1.3	
Trainee selection and appointment occur in accordance with ANZCA guidelines.	

The new standards introduce some areas that have not previously been explicitly covered by our accreditation frameworks. We see these as an opportunity to further strengthen training environments and ensure they continue to meet the needs of trainees, supervisors and the profession into the future.

Over time, the use of common standards across specialist medical colleges should also support greater consistency and reduce duplication for training settings that support trainees across multiple specialties.

Trainee health and welfare

- Training takes place in a learning environment that supports trainee health and welfare.

Supervision, management and support structures

- Clear governance structures support the delivery of effective education and training.
- Trainees receive appropriate and effective supervision.
- Trainees are supported in delivering quality patient care, including culturally safe care.

Educational and clinical training opportunities

- Trainees are provided with the appropriate depth, volume and variety of clinical and other learning experiences.
- Learning opportunities are transparent, equitable and appropriate for the level of training.

Educational resources, facilities and equipment

- Trainees have access to appropriate educational resources and facilities.
- Trainees have access to appropriate clinical equipment.

WHAT ARE ANZCA AND FPM DOING TO PREPARE FOR THIS CHANGE?

As we prepare for the 2027 transition to the new accreditation standards, we're putting training settings at the centre of our approach – listening to your needs, preparing carefully and working to make the transition as clear and practical as possible.

The Accreditation Renewal Steering Group, with representation from all training programs and most jurisdictions, is leading this significant change. There is still work to do before the new approach goes live in 2027, but we're already putting the foundations in place. This includes developing evidence guidance, reviewing accreditation processes, and preparing resources and support for training settings and accreditation teams.

For ANZCA and FPM, this is about more than implementing a new set of standards. It is an opportunity to make accreditation clearer, more consistent and more useful for the training environments we accredit.

We'll continue to keep you informed as the work progresses and provide further information, guidance and resources ahead of implementation. While the standards may be changing, our focus remains the same: supporting high-quality training, promoting patient safety, enabling the delivery of high-quality patient care, and the people who make it possible.

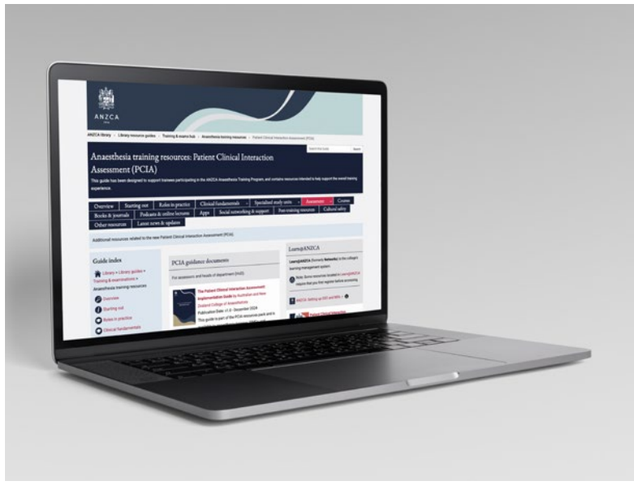
For more information, visit the ANZCA webpage on changes to training setting accreditation standards and procedures.

Dr Mark Young, FANZCA
Chair, ANZCA Training Accreditation Committee

Dr Tania Morris, FANZCA, FFMPANZCA
Chair, FPM Training Accreditation Committee

Patient clinical interaction assessment now required

ANZCA is reminding trainees and specialist international medical graduates (SIMGs) that successful completion of the patient clinical interaction assessment (PCIA) is now a prerequisite for progression to provisional fellowship and fellowship.



Only advanced trainees (ATs) and SIMGs on the examination pathway who commenced from 2025 are required to complete the PCIA.

The PCIA is a workplace-based assessment introduced in early 2025. It assesses whether an anaesthesia trainee or SIMG can independently provide preoperative care for patients with significant comorbidities, without supervisory input.

There is no limit on the number of attempts on the assessment which considers whether the trainees or SIMGs can:

- Independently assess complex patients.
- Obtain a comprehensive clinical history.
- Perform a focused physical examination.
- Identify perioperative risks.
- Develop appropriate optimisation strategies.
- Communicate effectively and professionally with patients.
- Demonstrate consultant-level clinical judgement and decision-making.

Following the patient consultation, the PCIA assessor will discuss the patient's comorbidities, perioperative risks, optimisation and surgical planning with the trainee or SIMG. The assessment concludes with a structured feedback discussion focused on learning and professional development.

The PCIA was introduced to restore the direct observation component previously included in the final examination medical viva. This direct observation component involved observing trainees' interactions with complex patients with comorbidities to elicit a clinical history and examination. It was removed from the final examination in 2020 due to restrictions imposed by the COVID-19 pandemic.

For advanced trainees, the PCIA can be undertaken at any time within advanced training before progressing to the provisional fellowship year (PFY) at the core unit review.

SIMGs who are required to complete the examination can undertake the PCIA after a satisfactory CPA report covering at least three months prior to applying for fellowship.

Completion of the PCIA is not a prerequisite for eligibility to enrol in the ANZCA final examination.

It does not replace the final examination medical viva. The key difference between the PCIA and the new format final examination medical viva, introduced in 2020, is that the PCIA involves real time observation of the trainee interacting with a real patient in the clinical environment.

The PCIA only needs to be completed by SIMGs who are undertaking the exam route (as well as advanced trainees).

All departments accredited within the ANZCA Anaesthesia Training Program that employ advanced trainees or SIMGs are expected to support PCIA.

To ensure this assessment can be delivered effectively, the head of department (HOD) should appoint one or more PCIA assessors. The number of assessors should reflect the number of advanced trainees and SIMGs within the department. If your department has multiple assessors, the HOD needs to nominate a lead assessor.

Successful completion needs to be recorded in MyPortfolio or the SIMG e-portfolio.

More information about the PCIA is available on the ANZCA website.

If you need support with the PCIA, or do not have access to a PCIA assessor, please contact the Training team at training@anzca.edu.au

Scholarship support for trainees and fellows

The ANZCA Global Development Committee Scholarship supports a final year ANZCA trainee or a first- or second-year fellow to accompany a visiting team on an overseas clinical or educational/teaching visit.

Here, four recent scholarship recipients reflect on their experiences.



LEFT

Dr Johnpillai (front row, far right) visiting faculty with their local hosts at Guido Valadares National Hospital.

DR DOMINIC JOHNPILLAI, WELLINGTON

Timor-Leste

From 23-27 February 2026, I was among a group of anaesthetists who travelled to Dili, Timor-Leste to deliver a short education program at the request of the host country.

Dr Chris Bowden led a World Federation of Societies of Anaesthesiologists leadership workshop for senior clinicians and managers, followed by three days of trauma education for registrars and junior doctors, coordinated by Dr Meg Walmsley with Dr Phil Blum and Dr Justy O'Shea.

This was my first visit to Timor-Leste, and travelling alongside colleagues with decades of experience in the country – some dating back to its UN-administered transition – gave me an important context to the health system's development.

As a junior consultant with a developing interest in global anaesthesia, it was a privilege to be a part of such an experienced team, and brought home the importance of long-term relationships and mutual respect.

The trauma education program was organised in the months before the trip, with topics divided between tutors. My responsibilities included delivering a lecture on shock and major haemorrhage, and a workshop on ultrasound covering regional anaesthesia (popliteal and supraclavicular blocks) and resuscitative echocardiography.

Adapting to a multilingual audience with varied experience levels was difficult, and I found myself constantly revising my slides to make them more visual. Thankfully, I was supported by a local senior registrar I'd previously worked with during the Sereima Bale Australian Society of Anaesthetists Pacific fellowship in Suva, who led the ultrasound teaching.

While I provided the popliteal fossa, he used a laser pointer to map out my anatomy projected live on the big screen, educating much more effectively in Tetum.

Not knowing any local language was challenging, but I was grateful that participants were patient and helpful with translating on the fly. Despite my best attempts at redundancy, I struggled to get my tech working, and was supported with laptops and patience by other faculty.

Balancing this trip with my individual capacity during a period of significant professional and personal change was a genuine challenge, and I am grateful to the ANZCA Global Development Committee and also to my family for making my involvement possible.

I have learnt so much as a recipient of the 2026 scholarship and strongly encourage potential future scholars to jump at this chance.

Thank you so much to the ANZCA Global Development Committee and to the teaching faculty, and to our Timor-Leste colleagues for having me along.

DR VISHNU BHARDWA, SOUTH AUSTRALIA

Papua New Guinea

In September 2025, a delegation of ANZCA fellows attended the annual Medical Symposium of the Medical Society of Papua New Guinea and PNG Society of Anaesthetists & Intensivists, representing a population who share the planet's most megadiverse country, known to be made up of some 600 islands, 800 languages, and thousands of distinct ethnic groups.

Delivering safe and equitable anaesthesia services over such a demanding geographical area is clearly developing positively despite numerous challenges, including betel nut-induced oral cancers, violent crime and gender inequality. Often, the greatest burden falls to anaesthetic scientific officers (ASOs) in largely unsupported remote locations.

Within 16 of the 22 provincial health authorities, more than 80 per cent of all anaesthetic treatments were delivered by some 94 ASOs, who are often from a nursing background and do not hold a medical degree. This totalled over 25,000 cases in 2024. In contrast, the number of specialist anaesthetists is just 37 for a population over 10 million, most of whom work in Port Moresby General Hospital. It is here that the ANZCA Global Development Committee (GDC) has been able to provide advanced life support and basic life support (BLS) training to more than 50 per cent of all staff, with recent course workshops now being delivered by local trainers.

Our contribution during the week was delivering a skills workshop designed for doctors and ASOs with a range of experience, to introduce and develop foundational procedural competence. With generous donations from multiple sites across Australia and Karl Storz, we were able to train and teach our PNG colleagues how to safely and appropriately use advanced airway equipment for videolaryngoscopy, bronchoscopic intubation, regional anaesthesia and supraglottic airway placement. This was alongside the well-established BLS protocols for paediatric, neonatal and adult resuscitation – helped by our mannequin friends Annie and Laerdal.

The opportunity to work with ANZCA's GDC and colleagues from all over the Pacific was a landmark privilege for me. I learnt several principles of international development and how to contribute effectively.

While a visiting medical team arriving to provide clinical services remains a vital part of global outreach, surely the greatest impact we can have is to share our knowledge and skills. This would aid the development of self-sustaining training pathways to disseminate vital key competencies throughout the local fraternities.

Give a friend a fish, and they'll eat for the day. Teach a friend how to bronchoscopically intubate safely, and we all grow stronger as an anaesthetic family.





ABOVE

From top: ASO national research project prize winner John Palua with a Lifebox capnograph for use in a local health care setting.

Anaesthesia trainees practicing neonatal airway management and resuscitation drills.





LEFT FROM TOP

From left: Local anaesthetists Dr Bata Anigafutu, Dr Jack Put, Dr Delwyn Pitakoe with Australian anaesthetists Dr Meg Walmsley, Dr Phil Blum and Dr Ari Isman in Honiara, Solomon Islands.

Dr Ari Isman teaching local anaesthetic registrars as part of the paediatric education week.

DR ARI ISMAN, QLD

Solomon Islands

I was fortunate to travel across the Pacific to Honiara, Solomon Islands, where I helped to facilitate an intensive week of paediatric teaching for local anaesthetists and anaesthesia registrars. Together with my colleagues, we delivered a mixture of didactic lectures and immersive simulation scenarios with the ultimate aim to support the local team's learning goals and help them build further confidence in caring for the critically ill children of the region.

The teaching schedule covered a broad range of practical topics, including caudal anaesthesia and regional analgesia, burns management and fluid resuscitation, perioperative planning for neonatal surgery, and management of patients with congenital heart disease undergoing non-cardiac surgery.

I was incredibly inspired by the eagerness and appreciation that the team demonstrated in having us, with some registrars travelling by boat and plane from nearby islands to attend their only formal teaching block of the year. It was also encouraging to see some registrars return from previous years for further teaching, highlighting the value of these opportunities in reinforcing their previous learning and extending their knowledge.

I was struck by the local team's ability and willingness to manage complex, high-risk cases despite significant resource limitations. They had no invasive blood pressure monitoring or critical care facility for postoperative patients; occasionally, even appropriately sized endotracheal tubes or blood gas cartridges were unavailable. Yet these limitations did not deter them from providing the best care for their community. In fact, during our visit, one of the consultants anaesthetised a critically ill neonate with gastroschisis without any invasive monitoring or postoperative intensive care unit support; there was simply no alternative.

Visiting the Solomon Islands with two highly respected colleagues was incredibly valuable. Their longstanding relationships with the local staff made me feel immediately welcomed and allowed me to gain insight into the living and working conditions on the island, as well as the geographical and geopolitical challenges affecting healthcare across the region.

I felt honoured to be part of this trip and grateful for the insight it provided into anaesthesia in a resource-limited setting. I look forward to sharing the experiences with my department and, hopefully, return again for further teaching.

A special thanks to ANZCA and the Global Development Committee for helping to bring this experience to life.

DR ALEXANDER GOSWELL, NSW

Philippines

I was incredibly lucky to join the Smile For Me crew on their most recent outreach mission to the Philippines in May. My anaesthesia colleagues were Dr Stephen Klugman, Dr Gretel Davidson, Dr Siv-Eing Lim, and Dr Deahnne Levas. Over the course of one week with two operating theatres running four operations simultaneously, we anaesthetised 48 children for cleft palate or cleft lip repairs and dental extractions.

This year's surgical outreach was conducted at ACE Medical Hospital in Cebu in May. Everything kicked off for us on a humid Sunday morning with the screening clinic – a controlled chaos of a day where nearly 60 children were screened by nurses, surgeons, and us. After clinic we reviewed the medications and triple checked the old Aisys Carestation machines.

Monday through to Thursday were our operating days. We had two operating rooms in the hospital, with two operating tables in each. Each list had an assigned anaesthetist. I was lucky enough to run my own list – with Gretel floating around to help with inductions, extubation, and any issues in recovery. I thoroughly enjoyed being part of an operating theatre with two operations happening simultaneously. I watched my far more experienced colleague Siv-Eing run her list and she gave me real-time feedback and advice. We supported each other during induction/extubation, and during the stable maintenance phase we could 'shoot the breeze'.

Repairing the cleft lip or palate of a child makes a significant difference to the life of that child. It means not being bullied at school, it means not being embarrassed when eating food with their friends and family, it means a better shot at normal language development, and it means more self-confidence. If this was all that the mission achieved, this would be justification enough, but Smile for Me are also doing important work advocating for change in the healthcare provision in Cebu and fostering relationships with government bodies in the Philippines.

I'm remarkably lucky and very proud to have been part of this 2026 mission. I'm floored by the generosity of the anaesthetists, surgeons, nurses, and volunteers who make this happen every year. I would go again in a heartbeat.

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





ABOVE

From top: All smiles during surgery outreach for Dr Alex Goswell and his young patient.

(from left) Local practitioner Theresa with Dr Stephen Klugman and Dr Deahnne Levas.

Self matters

What helps doctors recover while they keep working?

Sarah McGuinness, a specialist in leadership, burnout prevention and sustainable performance through her company Revolutionaries of Wellbeing, discusses burnout, the largely invisible side of medicine.

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

Over my lifetime, I've had 10 surgeries under general anaesthesia – thanks largely to the spectacularly dodgy knee genes. Each time, I've been acutely aware that my life is in the very capable hands of the anaesthetist, and I'm enormously grateful for the care and patience in managing the added excitement that apparently comes with anaesthetising a redhead.

Of course, as patients, we see only one side. You reassure us, explain what will happen, keep us safe while we are at our most vulnerable, and are often there when we wake in a groggy haze wondering if the operation has, in fact, happened yet.

What we don't see is everything on your side: the unrelenting responsibility and pressure, long and unpredictable hours, mixed cultures across work groups, accumulated fatigue, high emotional load – and the expectation that, regardless of how you feel, you will remain focused and function at your best.

It was this largely invisible side of medicine that I explored in my Master's research into senior doctors recovering from burnout while continuing to work. The study involved 43 senior doctors with leadership responsibilities across New Zealand and used a dual-lens approach, examining system factors alongside a two-week diary of work conditions, non-work activities and recovery.

Burnout has three core components: emotional exhaustion, cynicism and reduced professional efficacy. It is an occupational phenomenon resulting from chronic workplace stress that has not been successfully managed (World Health Organization, 2019). Having experienced burnout and worked with organisations nationally and internationally, I prefer to see it as the canary in the coal mine – a marker of a system that is not working. Burnout is rife across healthcare, including anaesthesia (Paterson et al., 2026).

Within medicine, its contributors span individual, social and organisational domains, including perfectionism, overcommitment, workplace relationships, workload, staffing, leadership, control and the professional norms of medicine (Moura et al., 2020; Patel et al., 2018; Seidler et al., 2014).

And while we have considerable literature on these factors, we know far less about burnout recovery. I found virtually no research examining how doctors in New Zealand recover while continuing to work.

So, the more sunlight we bring to these issues, the better. With that in mind, I recently shared my findings in a webinar with Professor Sir Ashley Bloomfield and Dr Joanna Sinclair, consultant anaesthetist and Health New Zealand's Chief Wellbeing Officer. Together, we explored what they mean for doctors, leaders and healthcare organisations.

SO, WHAT CAN WE LEARN FROM THE STUDY AND DISCUSSION?

Perhaps the most important finding was what I've called the functional recovery paradox. Participants were doing enough day-to-day recovery to continue functioning at work and home, but their burnout scores did not appear to change over time.

They were exercising, connecting with others, walking the dog, cooking, reading and watching television. These activities helped them switch off and restore enough capacity to meet the next day but did not seem enough to shift the deeper burnout. Functioning, therefore, can be a poor proxy for how someone is really doing.

Work also followed people home. Longer hours were associated with poorer same-day psychological detachment, the ability to mentally switch off (Sonnentag & Fritz, 2015), while better work conditions supported recovery that day and the next. Control over work time was the only variable directly associated with burnout.

Social and professional support were not associated with lower burnout scores, although a more nuanced picture appeared in the daily diaries. Social activities supported day-to-day recovery, and participants frequently described family, friends, colleagues, mentors and supervisors as valuable sources of connection, perspective and practical help. It is possible this support was helping people recover and continue functioning, without being enough to buffer the effects of ongoing work conditions.

Participants' recovery activities themselves were what we generally recommend people do: exercising, socialising and taking time to rest. A colleague once told me surfing was the only activity that allowed him to detach completely, largely because he couldn't take his phone into the water.

BRINGING THE PICTURE TOGETHER: THE 5P MODEL

So, what can we do? To bring these findings together, I use a 5P model: Person, People, Place, Pressures and Promoters.

It provides a practical way to look at the factors drawing on or supporting our capacity, and where there may be room for change.



Here's how you can bring the model to life: You might like to take five minutes to work through these questions on your own, with a supervisor or even as a team. Then choose one realistic thing within your sphere of influence that you could shift, strengthen or raise with someone else.

- **Person:** Our health, circumstances, patterns and the capacity we have available.
  Ask: How am I arriving at work right now, and what capacity do I realistically have?
- **People:** The relationships, support and team dynamics surrounding us at work and at home.
  Ask: Who am I looking out for – and who is looking out for me?
- **Place:** The culture, systems and conditions in which the work happens.
  Ask: What within my workplace is making recovery easier or harder?
- **Pressures:** The immediate and ongoing demands adding to the load, including those beyond our control.
  Ask: Which pressures can I influence, and which need to be shared or escalated?
- **Promoters:** The resources, activities and conditions that protect or replenish capacity.
  Ask: What activities and conditions replenish me, and how can I make more room for them?

"The energy and the support from colleagues was fundamental. It was the thing that kept me going – getting in, actually getting into work and interacting with my colleagues."

– Professor Sir Ashley Bloomfield, former Director-General of Health NZ and now a professor at the University of Auckland, reflecting on how the social dimension of recovery was critical during the Covid-19 response.

TURNING THE SHIP THAT IS HEALTHCARE

As Dr Sinclair said during the webinar, shifting the healthcare system is a little like turning the massive tanker that became stuck in the Suez Canal: it will take time and intergenerational coordinated effort to improve the overall working conditions. In the meantime those little diggers we saw working the problem on the side of the canal can make a difference, no matter how small it seems.

Each step may seem small, but as I say to my kids: small steps conquer mountains. Which brings me to one of my favourite quotes, widely attributed to Margaret Mead: "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

For more information about Sarah McGuinness visit https://rowwellbeing.com/sarah-mcguinness/



Sarah McGuinness

References and suggested reading

Doolittle, B. R. (2021). Association of burnout with emotional coping strategies, friendship, and institutional support among internal medicine physicians. *Journal of Clinical Psychology in Medical Settings, 28*(2), 361–367. *https://doi.org/10.1007/s10880-020-09724-6*

McGuinness, S. (2026). *"Looked at the stars with my daughter": A dual-lens study of daily recovery and burnout in senior doctors with leadership responsibilities in New Zealand* [Master's thesis, Massey University]. *https://mro.massey.ac.nz/items/641e2d50-67bf-431a-b59e-f3f42792a332/full*

Moura, E. C. de, Furtado, L., & Sobral, F. (2020). The burnout epidemic during the COVID-19 pandemic: The role of LMX in alleviating physicians' burnout. *Revista de Administração de Empresas, 60*(6), 426–436. *https://doi.org/10.1590/S0034-759020200606*

Patel, R. S., Bachu, R., Adikey, A., Malik, M., & Shah, M. (2018). Factors related to physician burnout and its consequences: A review. *Behavioral Sciences, 8*(11), Article 98. *https://doi.org/10.3390/bs8110098*

Paterson, E., Paterson, N. A. B., & Ferris, L. J. (2023). Mental health and well-being of anaesthetists during the COVID-19 pandemic: a scoping review. *Anaesthesia, 78*(2), 197-206. *https://doi.org/10.1111/anae.15879*

Paterson, E., Way, K. A., Paterson, N. A. B., & Ferris, L. J. (2026). Occupational stress in anaesthetists: A narrative review of psychosocial risk management using a human factors systems approach. *British Journal of Anaesthesia, 137*(2), 579–590. *https://doi.org/10.1016/j.bja.2026.04.037*

Rogers, E., Polonijo, A. N., & Carpiano, R. M. (2016). Getting by with a little help from friends and colleagues: Testing how residents' social support networks affect loneliness and burnout. *Canadian Family Physician, 62*(11), e677–e683. *https://www.cfp.ca/content/62/11/e677*

Seidler, A., Thinschmidt, M., Deckert, S., Then, F., Hegewald, J., Nieuwenhuijsen, K., & Riedel-Heller, S. G. (2014). The role of psychosocial working conditions on burnout and its core component emotional exhaustion: A systematic review. *Journal of Occupational Medicine and Toxicology, 9*, Article 10. *https://doi.org/10.1186/1745-6673-9-10*

Sonnentag, S., & Fritz, C. (2015). Recovery from job stress: The stressor-detachment model as an integrative framework. *Journal of Organizational Behavior, 36*(S1), S72–S103. *https://doi.org/10.1002/job.1924*

World Health Organization. (2019, May 28). *Burn-out an "occupational phenomenon": International Classification of Diseases. https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases*

Free ANZCA Doctors' Support Program

Converge international

How to make an appointment:

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

- Telephone 1300 995 262 in Australia or 0800 459 020 in New Zealand.
- Email eap@convergeintl.com.au
- Identify yourself as an ANZCA/FPM fellow, trainee or SIMG (or a family member).
- Appointments are available from 8am to 6pm Monday-Friday (excluding public holidays).
- 24/7 emergency telephone counselling is available.
- Go to your app store to download the Converge International app or visit our website.

HELP IS ALSO AVAILABLE VIA THE

Doctors' Health Advisory Services:

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

WELLBEING HUBS

For Aboriginal and/or Torres Strait Islander Peoples

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

For Māori

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

Advances in continuous positive airway pressure



Anaesthetist Dr Duncan Campbell invented the Campbell ventilator. In the 1960s in the UK he worked with Dr Patrick Steptoe, the pioneer of IVF, to make safe laparoscopic surgery possible. Here, now in his 90s and writing for the *ANZCA Bulletin*, he explains advances in continuous positive airway pressure (CPAP).

Before 1974 the value of continuous positive airway pressure (CPAP) for babies with respiratory distress was recognised but there were problems, the main one being that the gas delivery pressure was difficult to control. Over-pressure was often the cause of pneumothorax and hypotension. Temperature and humidity control were also of concern.

CPAP was rarely used for adults as there were even greater problems in providing the much higher gas flows while maintaining constant low inspiratory and expiratory pressures.

In 1974 an improvement resulted with the introduction of the Campbell ventilator[1] which changed neonatal management and was able to provide satisfactory CPAP for adults.

The improvement was in the precise setting and stability of the airway pressure throughout the breathing cycle without any appreciable change in the low expiratory resistance. This was due to the unique property of the integral Venturi system whereby the entrained flow automatically adjusted with respiration to keep the circuit pressure constant. No mechanical valves existed and a safety feature was that dangerous high pressures could not occur as the Venturi was always open to atmosphere. Also, there was the facility to alter the settings from CPAP to controlled ventilation and to reverse this at the flick of a switch.

Ventilator features with diagrams, traces and functional analyses were published in *Anaesthesia and Intensive Care* in 1976. Full patent cover[2] was granted without argument and has never been contested.

ADOPTION IN PAEDIATRIC AND NEONATAL CARE

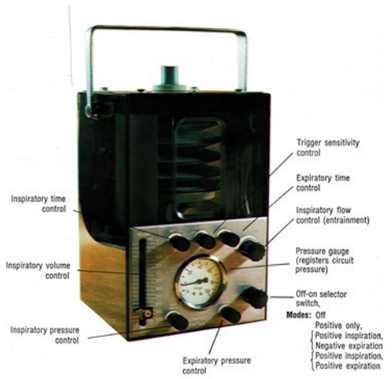
The ventilator was first presented and described at the Australian Society of Anaesthetists Hobart Meeting in 1974. Dr John Keneally was at that meeting. He and his anaesthesia colleague Dr John Overton were seeking suitable ventilators for theatre use at the Royal Alexandra Hospital for Children (RAHC) in Sydney. The adjustable CPAP effective for both neonates and adult size children was a particularly attractive feature for them and the ventilator performed ideally during trials. As a result, numerous ventilators were purchased and used for many years. RAHC was the first to purchase these ventilators and subsequently became a centre for neonatal



A NEW COMPACT, VERSATILE, FLUIDIC CONTROLLED VENTILATOR

D. I. CAMPBELL*

Royal Prince Alfred Hospital, Sydney



ABOVE

From top: Dr Campbell collecting the first ventilator made for him by Ulco in 1974.

Dr Campbell's article about the ventilator was published in Anaesthesia and Intensive Care in 1976.

An image highlighting key features of one of the early Campbell ventilators.

and paediatric cardiac surgery, where these ventilators were of special value both in the theatres and in the intensive care unit.

Dr Peter A Barr was a neonatologist at the newborn intensive care unit, Royal North Shore Hospital, Sydney. This centre received severely ill babies from six other maternity hospitals in Sydney's northern region. Dr Barr was associated with RAHC and realised that these ventilators would be ideal for the treatment of neonatal distress, and a great improvement on anything else on the market. He equipped his unit with many of them. Severely distressed babies were intubated on admission and managed with controlled ventilation until sufficiently recovered to be managed with CPAP. In 1979 Dr Barr submitted a paper on a study of 35 consecutive babies requiring controlled ventilation and subsequent CPAP using these ventilators[3]. This was published in 1980, and he comments on the improved survival of these babies compared with previous years.

Dr David Henderson-Smart, neonatologist and later director of the neonatal intensive care unit at King George V Hospital, Sydney, also had a close relationship with RAHC and like Dr Barr, realised that these ventilators would be ideal for the treatment of neonatal respiratory distress in his unit. Within a short time after the children's hospital had made their purchase, Dr Henderson-Smart bought several.

Following this, there were usually one or two neonates being ventilated or on CPAP in his unit. Dr Henderson-Smart's expertise and success became widely recognised as so many neonates who would previously have died now survived, and he had referrals from much of NSW.

EXPANSION AND ONGOING USE

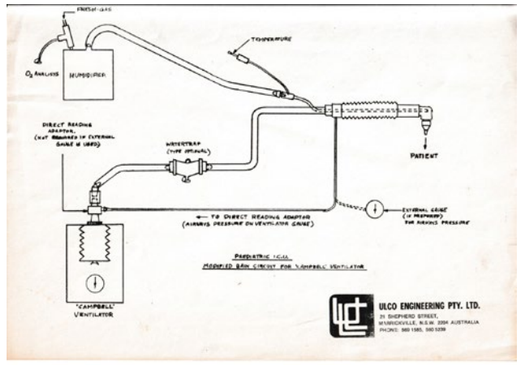
Many Australian hospitals acquired these ventilators. More than 3500 were eventually sold. Anaesthetists frequently used the CPAP function for adults and children at the end of major surgery on high-risk patients when changing from controlled to spontaneous respiration.

TRANSITION TO ADULT RESPIRATORY CARE (EARLY 1980S)

In the early 1980s, at Royal Prince Alfred Hospital, Sydney, chest physicians became aware of the work of Dr Henderson-Smart and realised that as the ventilator was also an adult ventilator, it could be used for patients with Chronic Obstructive Pulmonary Disease (COPD). A trial on a borrowed ventilator confirmed this view. It was also realised that a complete ventilator was unnecessary as only the CPAP portion was required for COPD patients.

DEVELOPMENT AND COMMERCIALISATION OF STANDALONE CPAP UNITS

Ulco, the ventilator's manufacturer was approached as Ulco held the patent which was assigned to them after ventilator production began[4]. The request was that Ulco make only the CPAP portion of the ventilator, as this was the only part required for COPD patients. Ulco at that time had full orders for ventilators and was unwilling to make partial ventilators but permission from Ulco would be required to avoid infringement of the patent by any company wishing to make this CPAP portion.



Lengthy discussions were held and it was eventually agreed that that there would be no conflict of interest as Ulco did not plan to make 'CPAP-only' units, and as the markets were distinct, 'CPAP-only' units would not affect ventilator sales. Ulco also thought that agreements with another company could be costly to set up with possibly no financial advantage as at that time the belief was that demand for 'CPAP-only' units would be small – a view that turned out to be incorrect mainly because of the underappreciation of the prevalence of sleep apnoea.

Agreements were achieved and 'CPAP-only' units began to appear on the market, but none were made by Ulco. As their value to the community became apparent, production gradually increased and then snowballed to achieve the massive volume of CPAP equipment on the market now. This is now accepted as important respiratory equipment used by physicians globally as well as by many individuals who manage conditions such as sleep apnoea in their own homes.

This article documents previously unpublished work on this unexpected advance in CPAP. This was made available to anaesthetists, paediatricians and respiratory physicians by an 'add-on' to a ventilator which was initially thought to be of interest only in the operating theatre, and even then, only for poor risk patients.

Dr Duncan Campbell, FANZCA
Sydney, NSW

References

1. Campbell DI. A new compact versatile fluidic controlled ventilator. *Anaes Intens Care* 1976; 4:7-15.
2. Campbell DI. Fluidic pneumatic ventilator. Australian patent 75,078. Lodged 6/11/73. Published 6/5/76. Accepted 1/7/77.
3. Barr PA. Milliken ST. Mechanical ventilation of infants with severe hyaline membrane disease in a regional newborn intensive care unit. *Aust Paediatr. J.* 1980; 16:83-89.
4. Ulco Engineering Pty. Ltd. 21 Shepherd St. Marrickville NSW Australia. (Historical)

ABOVE

ULCO Engineering's paediatric circuit diagram for the Campbell ventilator.

Breaking records for Open House Melbourne





For several years, the museum and college have participated in the annual event, Open House Melbourne (OHM), however it is not always a given that we will be accepted.

The festival has been held on the last weekend of July since 2008, and it gives the community rare access to off-limits and historical or contemporary buildings and spaces.

This year, the museum's expression of interest was accepted, and we were once again featured as part of Open House Melbourne.

Each year the theme for Open House Melbourne changes so that buildings and spaces can offer additional experiences and explore a variety of facets of architecture and urban design. It is an opportunity for visitors to hear the stories associated with the buildings and learn about how they are used.

This year's theme was Generous City, exploring how architecture, design, and creativity can foster a culture of openness, equity, and connection. In response to this theme, we hosted a panel discussion with ANZCA fellow Dr David Bramley and Professor Julie Willis, past dean of architecture of the University of Melbourne to discuss how hospital design and architecture contribute to an integrated multidisciplinary approach to patient and medical staff care.

The discussion was held in the ANZCA House auditorium on 24 July with 39 attendees. The interview was recorded and is available on ANZCA's YouTube channel and the On Demand Open House Melbourne website.

Ulimaroa, ANZCA's heritage-listed building, opened its doors to the public on the weekend of 25 and 26 July and visitors were in awe of the Italianate style heritage listed building. We had a record-breaking 418 visitors over the two days, and it was a resounding success with tours running every 30 minutes.

This year was unique with visitors able to see ANZCA House in action as it was host to the Faculty of Pain Medicine Advanced Clinical Skills Course. Trainees developed communication and interview skills with trained actors, learnt how to facilitate positive behaviour change and honed their oral exam skills in a viva bootcamp.

It was another first this year with ANZCA and the museum selected as in-kind venue partners with OHM, by hosting the official thank you event for OHM's collaborators and volunteers. ANZCA's chief executive officer Lance Emerson, and museum curator, Veronica Dominiak, both presented to more than 130 attendees about the history of the college, the specialty and the buildings.

The museum would not have been able to run this event without the huge support and help of the college staff members and the ANZCA history and heritage advisory panel members who volunteered their time by welcoming people, co-ordinating crowds and organising tours. We were able to learn and listen to the stories behind why people picked our venue out of the 180 programs, tours, talks and building openings across OHM.

Open House Melbourne is a powerful festival which brings people together. Not only does it enable the community to get a sneak peek into the college, marvel the architectural sights and learn about medical history, it allows us to raise awareness of the vital role anaesthetists and pain medicine specialists play in improving health outcomes and quality of life for patients and communities.

Veronica Dominiak
Curator, Geoffrey Kaye Museum of Anaesthetic History

ABOVE FROM LEFT

Some of the ANZCA staff who helped during Open House Melbourne, from left, Laura Foley, Nonie Chan, Veronica Dominiak, Umberto Lallo, and Jinty Wilson, with History and Heritage Advisory panel member Dr Jun Parker.

Open House Melbourne Collaborator & Volunteer Thank You event hosted on 6 August 2026.

Research



Foundation update

A YEAR OF RESEARCH OUTCOMES REPORTED

This issue of the *ANZCA Bulletin* marks the first full year of our series of articles reporting on the outcomes and impacts of selected research studies led by college fellows and funded through the ANZCA Foundation.

Since the series started in September 2025, four articles have reported the results of 17 foundation-funded research projects. They have highlighted new scientific discoveries, world-firsts, potential improvements for clinical practice, examples of translation and implementation, demonstrations that large clinical trials needed to answer key questions are feasible, and insights for improving professional practice among perioperative teams in clinical settings.

With between 25 and 30 research projects and teams funded every year, these reports represent just a sample of research study final outcomes reports received annually by the foundation and the ANZCA Research Committee.

This research, funded by ANZCA and ANZCA Foundation donors and led by ANZCA and FPM fellows and trainees, is regularly published and cited in the world's leading peer reviewed medical journals, positioning anaesthetists and pain medicine physicians at the forefront of innovation in medical science and clinical practice.

MOST EVER PROJECTS TO BE FUNDED

The ANZCA Research Committee meeting on 14 September resulted in a new record of 28 new research studies to be funded through the foundation in 2027, reflecting a large number of high-quality grant applications received.

NEW ASSESSMENT RUBRIC

A new rubric, designed by assessment experts, was used for the first time by the Research Committee to guide reviewers in scoring applications. Revised reviewer criteria were developed, including one specifically focussed on the potential impact proposed studies are likely to have on scientific knowledge and clinical practice in the specialties.

A range of positive comments was received by grant reviewers, which included:

"The ANZCA review framework is clear and useful. The four-domain structure provides an appropriate balance between scientific merit, impact, personnel and feasibility."

"The four criteria are clearly defined and map well to the kind of strengths and risks that matter in a research proposal."

"The revised rubric with explicit descriptors was clear and helpful, and made the scoring more objective."

In addition, several constructive suggestions were also received and noted for future consideration, in areas such as the value of applicant rebuttals, consideration of emergent more complex clinical trial designs, and appropriateness of outcome measures. It is expected that the revised criteria and new rubric will deliver an improved balance between ensuring a high level of research quality and potential to deliver positive impact on healthcare outcomes.

More detail on the revisions will be articulated before the next grant round in relevant communications, including the research guidelines on the ANZCA website, grant round announcements, and foundation updates.

DONORS PLAY A MAJOR ROLE

Several funding grants committed by the Research Committee for 2027 have again been made possible by the generosity of major foundation donors and patrons. Each year these dedicated awards are allocated to funded research grants in areas of research in anaesthesia, pain medicine and perioperative medicine specified by each benefactor in agreement with the foundation and the Research Committee.

Full details of all the ANZCA Foundation Named Research Awards and the recipient studies and investigators will be included in the summer edition of the *ANZCA Bulletin*. The foundation thanks all generous donors and patrons for supporting this important research.

ITACS TRIAL REVEALS BENEFITS

The foundation is pleased to note that a major study, an important sub-study of which was funded by a foundation grant, has shown that preoperative intravenous iron for anaemic cardiac surgery patients reduces blood transfusions and reduces recovery time.

The Intravenous iron to Treat Anaemia before Cardiac Surgery (ITACS) international multicentre randomised clinical trial study, with funding from the National Health and Medical Research Council, involved 955 patients in 42 hospitals. It found patients receiving intravenous iron were one-third less likely to require a transfusion and spent more time at home in the first three months postoperatively.

The landmark trial, led by Professor Paul Myles, has been published in the *British Medical Journal*.

Up to 40 per cent of cardiac surgery patients currently require blood transfusions during or after their procedures, which is associated with greater risks of complications and longer hospital stays. For every 100 patients receiving intravenous iron, 44 less units of blood products were needed while patient outcomes were significantly improved, providing an opportunity to improve standard practice and related outcomes more widely in this important area.

CONTACT AND SUPPORT

For queries, contact:

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

Trena Ronnfeldt, Fundraising Administration Officer, tronnfeldt@anzca.edu.au

Research grants program:

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

ANZCA Clinical Trials Network:

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

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

Curiosity key to launching anaesthesia research role



ABOVE

From left: Dr Jimin Kang, Dr Fangce (Jack) Xu, Dr Cyril Tang (back), Dr Emily Squires and Dr Kanika Chaudhri

Consultant anaesthetist Dr Jimin Kang has some simple advice for trainees or junior doctors interested in pursuing clinical research.

"You don't need experience, just curiosity."

The outgoing chair of the Queensland Anaesthetic Registrars' Research Collaborative (QARRC) started her consultant career earlier this year at Logan Hospital and is keen to spread the word about the benefits of combining the specialty with research.

"Our message is that you don't need prior research experience to get involved in our group. There are many different roles ranging from a general member to site collaborator and trainee hospital lead. Or you can join the executive committee and provide support as a consultant mentor," she explains.

"Every level of involvement is welcome, you don't need prior research experience to get started."

Dr Kang is one of a group of anaesthesia registrars, advanced trainees and junior doctors who are taking their first steps into clinical research with the support of more established and experienced FANZCAs and FFPMANZCAS and the ANZCA Clinical Trials Network (CTN).

At CTN's recent 2026 strategic research workshop held on the Gold Coast, Dr Kang and several of her peers gathered at the Gold Coast University Hospital for a satellite meeting aimed at nurturing the next generation of anaesthesia researchers. The session explored how research could remain a defining feature of anaesthesia training despite clinical workload and an intensive curriculum.

Younger anaesthetists are increasingly looking beyond the operating theatre to ask the questions that could change clinical practice. And according to Professor Philip Peyton, a leader in Australian and global anaesthesia clinical trials, that curiosity is vital to the future of anaesthesia research.

Trainees and early-career researchers are becoming an increasingly important part of the broader research community in Australia and New Zealand.

CTN now supports clinical trials across more than 120 hospitals and has recruited more than 69,000 participants since the first CTN trial began in 1996, creating an unusually strong platform for the next generation of investigators.

For Professor Peyton, who reflected on his own pathway to anaesthesia research after initially having his heart set on being a scientist, says encouraging young researchers is essential to ensuring that this legacy continues.

"It's important that we encourage the next generation," he says. "We need people coming through who are interested in research, who understand how clinical trials work and who can take the network forward."

The message from established researchers is increasingly being matched by opportunities for trainees to become involved, often through mentoring and collaboration by colleagues in hospital anaesthesia departments.

Queensland is one example of the growing interest in building research capacity among trainees.

The state's anaesthesia community already has a strong collaborative training structure through the Queensland Anaesthetics Rotational Training Scheme (QARTS), which oversees ANZCA-accredited rotations across the state. Since 2019, the QARCC has connected anaesthesia trainees across the state's hospitals to produce high-quality multicentre, anaesthesia-focused research, audit and quality improvement work. The projects are all led by the trainees.

Professor Peyton believes that participation in trials is valuable even for clinicians who never become principal investigators as research is a team activity. Large trials depend not only on chief investigators but on site investigators, trainees, research co-ordinators, statisticians, patients and many others.

"Don't lose that passion for research if you have it when you start out. Life does catch up with you but stick with it if you can. I completed my PhD when I was on the wrong side of my 50s so there's no right or wrong way. What is important is that we continue to improve the quality of evidence for clinical practice in our specialty."



The challenge is ensuring that enthusiasm can be translated into sustained involvement.

Meeting Dr Kanika Chaudhri, a trainee anaesthetist from Sydney's Prince of Wales Hospital knows that clinical workloads, exam preparation and health service pressures can make it difficult for trainees to find time for research. She completed her PhD at the George Institute for Global Health where she embraced medical research projects. As an anaesthetic senior resident medical officer at Royal North Shore Hospital she secured research funding and the Chief Executive Award for her work in perioperative care within the district.

"I learnt that no grant is too small," she says. "You get to meet and collaborate with so many people and having mentors really helps."

Dr Chaudhri says time management is a big consideration when embarking on research. She will sit her primary exam next year and is balancing her studies with perioperative medicine research.

"Research doesn't feel like work to me. Some people go fishing or run marathons to relax. My passion is research so I work on that."

CTN's emerging-investigator initiatives are designed to address some of the barriers that can deter trainees and consultants moving into anaesthesia research through focused mentoring, education, collaboration and funding. CTN's 2026-2029 strategic plan explicitly identifies strengthening engagement with fellows, trainees and emerging research leaders as a priority.

ABOVE

Dr Emily Squires (Qld)



Professor Peyton says tomorrow's investigators should be encouraged to "scratch the surface" by challenging established thinking and to consider new approaches.

"it's important to have a genuine curiosity about research with key drivers being motivation, mentorship, management, money (grant applications) and exploring opportunities to get involved in multi-centre trials."

As Queensland FANZCA, cardiac anaesthetist Dr Matthew Bright explains, "the hardest project will be your first."

Dr Bright, the inaugural recipient of the 2025 ANZCA CTN Emerging Investigator Prize says: "Research is a bit like a game of snakes and ladders. Everything takes far longer than you might think.

"There is no good or bad time to start research – doing it during your anaesthesia training can be tricky but it depends on the individual."

Dr Kang explained to the meeting how a 2019 survey of Queensland anaesthesia trainees found they wanted to do research but time pressure, hospital rotations and limited training meant they had no clear path to pursue research.

"QARRC was established to remove those barriers. If you're interested, get proactive and find the right people to guide you along. As an intern at Princess Alexandra Hospital I had already had some experience in research and it was there that I was introduced to Associate Professor David Highton (ANZCA CTN Executive's deputy chair) who gave me some project ideas."

One of the studies QARCC delivered has been the iHype: Hypotension in elderly patients study, a retrospective cohort study of hypotension treatment thresholds, run across 10 Queensland hospitals with 1700 patients older than 65 undergoing non cardiac surgery.

The study found that most patients over 65 were exposed to intraoperative hypotension (IOH) during surgery. (IOH is linked to organ injury and mortality in older patients but treatment thresholds used in Australian clinical practice have never been defined.)

Future trials will examine if treating IOH affects patient outcomes.

Dr Cyril Tang, an advanced trainee at GCUH, is keen on pursuing a research role having already been working on AI models through his involvement with a radiology start-up.

"My ultimate goal would be to have a 50 per cent clinical practice and 50 per cent research. I'm working together with Dr Rachel Bourke and Dr Halia O'Shea, consultant anaesthetists in my department, on an ANZCA Foundation funded research project. We are using machine learning to try and predict post operative hypotension.

"This is an exciting project to be involved in as it also involves multidisciplinary collaboration with local data scientists and AI engineers from CSIRO."

At the Princess Alexandra Hospital in Brisbane, principal house officer Dr Fangce (Jack) Xu and resident medical officer Dr Emily Squires are also keen to pursue research opportunities through the department of anaesthesia with Associate Professor Highton.

Both presented trial proposals at the satellite meeting and were encouraged by the feedback from the floor.

Dr Squires says she is encouraged by the QARRC and its work pursuing research projects in Queensland.

"While I had already worked in clinical trials after completing my undergraduate degree in health and medical science I became interested in AI projects during my medical degree.

"One of the projects was an AI model for magnetic resonance fingerprinting and I have continued my interest since then through the department at Princess Alexandra Hospital.

"A lot of clinical research focuses on positive results but there's a lot more to consider even if you can't find something definitive. It opens up other possibilities and gives you more opportunities to examine the results to see if there are new findings that can be explored further."

**Held on Friday 21 August, the satellite meeting attracted around 70 attendees, including hospital executives, medical students, trainees, research co-ordinators, clinicians and senior CTN researchers. The meeting supports the CTN's commitment to extending engagement beyond the main workshop by providing an accessible introduction to research, networking, collaboration and proposal development, particularly for those unable to attend the full workshop due to travel, registration costs or time commitments.*

ANZCA CTN gratefully acknowledges co-convenors Dr Rachel Bourke, Associate Professor David Highton, Dr Matthew Bright and Dr Kanika Chaudhri, and thanks Gold Coast University Hospital for hosting the meeting.

Carolyn Jones
Media Manager, ANZCA

ABOVE

Dr Benjamin Moran (NSW) and Professor Victoria Eley (Qld) CTN Executive members.

CTN workshop makes a splash on the Gold Coast



A future-focused program of new research, implementation and collaboration brought the CTN community together on the Gold Coast.

Warm weather, ocean breezes and a vibrant venue set the scene for the 2026 ANZCA Clinical Trials Network Strategic Research Workshop.

Nearly 190 delegates, speakers and sponsors gathered at QT Gold Coast from 21-23 August, bringing together investigators, research co-ordinators, trainees, consumers and research partners from Australia, New Zealand and Hong Kong, and welcoming TopMedTalk for the first time.

This year's program focused on designing trials for impact and preparing research for implementation. Masterclasses explored estimand frameworks and implementation of hybrid trial designs, while dedicated streams for research teams and emerging investigators covered recruitment and consent, trial budgets, consumer engagement, grant development, Māori partnership and equity, and funding readiness.

Emerging investigators presented new research proposals in the Emerging Investigator Prize Session, spanning perioperative analgesia, paediatric pain, obstetric haemorrhage, cardiac surgery and myocardial injury, with feedback from experienced researchers across the network.

Saturday showcased the breadth of the CTN pipeline, opening with keynote presentations from Associate Professor Ingrid Hickman on embedding implementation outcomes into trial design and Dr Kristy Robledo on moving from primary analyses to evidence synthesis. Delegates also heard from investigators developing studies for network-wide delivery, alongside updates from established trials. The day concluded with the PUMA trial start-up meeting.

On Sunday, implementation moved centre stage, with Professor Philip Peyton taking delegates through a deeper dive into the ROCKet results, followed by a panel discussion on the implications for clinical practice with keynote speakers and pain medicine specialists. A light-hearted fast-takes session challenged some fundamentals of clinical trial design, before Associate Professor Lachlan Miles and Professor Paul Myles closed the scientific program with the lively "Great Debate": "De-implementation is the only implementation that matters."

The underwater-themed conference dinner gave delegates a chance to reconnect, with costumes, door prizes and treasure-map trivia. ANZCA President Dr Tanya Selak addressed delegates and congratulated Dr Sarah Lee, winner of the CTN Emerging Investigator Prize, supported by the ANZCA Foundation, for "Comparative effectiveness of intrathecal morphine versus intravenous methadone in major abdominal surgery: a single-centre, randomised, open-label, parallel-group, feasibility trial".

The workshop came at an important transition point for the network, with CLIP-II, SNaPP and ITACS recently published, and ROCKet, TRIGS and T-REX results forthcoming. The next wave of research is now taking shape through platform-ready, adaptive, observational and implementation-focused studies.

With the 2026-2029 CTN Strategic Plan well under way, the meeting provided a timely opportunity to reflect on progress and look ahead to the network's next phase.

Thank you to our convenors, speakers, chairs, delegates, major sponsor Research Path, exhibitors Avant and Spiral Software, ANZCA staff, Wallfly, the ANZCA Foundation and Gold Coast University Hospital for helping deliver another highly collaborative and successful CTN workshop and satellite meeting.

Karen Goulding
CTN manager

ABOVE

From left: Dr Matthew Moore (NZ), Ms Kathryn Rough (Vic), Peter Button (Qld, consumer advisor), Dr Kristy Robledo (NSW), Ms Paige Druce (Vic) and Dr Luke Perry (Vic).

ANZCA research – the outcomes

This is the fifth report in our series highlighting selected results from research projects funded by the ANZCA Foundation and led by ANZCA fellows, and their implications for best clinical practice



The foundation allocates more than $A1.6 million annually for grants for research in anaesthesia, pain medicine, and perioperative medicine. Continuing these grants is only possible thanks to regular contributions from foundation donors, investment earnings, and college support. They are allocated by the ANZCA Research Committee each year through the foundation.

This new selection of reports on studies completed in 2025 and 2026 again demonstrates new contributions to the science and practice of anaesthesia, pain medicine and perioperative medicine. Often including 'world-firsts', foundation-funded studies continually increase the knowledge, science and evidence that supports our fellows and other healthcare professionals to optimise patient outcomes across the huge diversity of medical scenarios and patient profiles in clinical practice.

In this edition we feature two initial studies to test the feasibility and guide the design of larger, definitive clinical trials, and another that developed the first ever simulation assessment tool specifically for facilitators in low-income contexts.

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

CARDIAC SURGERY PULMONARY ARTERY CATHETERISATION RCT FEASIBILITY STUDY LEADS TO $A3.7 MILLION GRANT

Project grant: Pulmonary artery catheterisation in cardiac surgery (PUMA Pilot): a multicentre, randomised, pilot and feasibility clinical trial

Dr Luke Perry, from The Royal Melbourne Hospital and The University of Melbourne, received an ANZCA Foundation project grant in 2023 and provided a final report for this study in 2026. His team included Professor Rinaldo Bellomo, Professor Julian Smith, Professor Alistair Royse, and Professor Reny Segal, Mr Marco Larobina, and Dr Luke O'Halloran and Dr Alistair McLean.

$A70,000

The ANZCA Research Committee and Foundation fund feasibility and acceptance studies because they are essential prerequisites for demonstrating that large multi-centre randomised controlled trials (RCTs) can be successfully conducted, and for securing the large peer-reviewed funding grants they require.

As RCTs are needed to determine whether there is definitive evidence of whether interventions explored in small-scale studies are associated with expected treatment effects when implemented at scale, feasibility studies are a critical part of the pathway to improved evidence-based practice and outcomes.

The PUMA pilot study is an outstanding example of the successful negotiation of this pathway, and of the role of Foundation grants in facilitating transitions to large RCTs, often then supported by the ANZCA Clinical Trials Network.

Prior to this study, the investigators observed that while cardiac surgery patients have been routinely managed with invasive pulmonary artery catheters for decades, their use has never been rigorously tested for safety and effectiveness. Observational studies had even suggested they may be associated with worse outcomes, while high-quality clinical trials in other populations such as sepsis patients showed worse or no difference in outcomes for patients, resulted in their de-adoption.

A large-scale RCT was needed to determine the safety and effectiveness of pulmonary artery catheters compared with central venous catheters in low-risk cardiac surgery.

The PUMA pilot study explored a range of feasibility outcomes including a primary outcome of protocol compliance, complemented by secondary outcomes of eligibility rate, recruitment proportion and rate, data completeness, and clinician refusal. A range of clinical outcomes were also explored. The recruited participants were adults of 18 years or over undergoing coronary artery bypass grafting, aortic valve replacement, or surgery on the aortic root or ascending aorta with or without aortic valve replacement, with a predicted operative mortality of less than two percent.

Preliminary results of the pilot study were presented at the 2026 ANZCA Annual Scientific Meeting's late breaking trials session in Auckland and the full results are currently under review for publication by JAMA Surgery.

The feasibility and acceptability of a large-scale RCT was convincingly established by the team's research. The PUMA Pilot was instrumental in obtaining a Medical Research Future Fund Category 1 funding grant of $A3.7 million for the PUMA trial, after achieving the highest grant ranking in its category. PUMA, a world-first and definitive multi-centre trial, was launched in June 2026.

LIGHT VERSUS DEEPER ANAESTHESIA FOR REDUCING DELIRIUM AND DEMENTIA

Project grant: Preserving brain health in older adults: does light general anaesthesia reduce postoperative delirium and cognitive decline? The Balanced-2 randomised controlled trial

Dr Carolyn Deng, Auckland City Hospital and University of Auckland, received an ANZCA Project Grant in 2023 for this study, and submitted her final report in 2026. Her team included Dr Doug Campbell and Professor Timothy Short, Auckland City Hospital and University of Auckland, and Professor Kate Leslie AO, Royal Melbourne Hospital and The University of Melbourne.

$A70,000

Postoperative delirium (POD), the commonest serious and preventable postoperative complication in older adults, is associated with increased length of hospital stay, discharge to long-term care facilities, memory loss, physical decline, and mortality. The risk of dementia in patients who experience this delirium is increased 12-fold. Previous studies and evidence suggest that titrating to a lighter plane of general anaesthesia using processed electroencephalography can reduce the incidence of POD.

The team intends to conduct a large randomised clinical trial to determine whether lighter general anaesthetic for older, high-risk adults, undergoing major non-cardiac, non-intracranial surgery, could reduce the proportion of patients who develop POD compared to those who receive deeper general anaesthetic.

The primary outcome of the clinical trial will be the difference in the number of patients experiencing POD in the light versus deep general anaesthesia groups, with secondary outcomes related to postoperative complications including episode severity, cognitive function, physical decline, and mortality.

The ANZCA Foundation grant has supported completion of the initial 'vanguard' phase of the study, required to answer questions that are important for the design of the larger study. The specific aims were to: test the trial protocol and feasibility; assess adherence to the randomised group and the separation of pEEG indices between the control and intervention groups; determine the duration of delirium screening; and determine the best cognitive screening tool in terms of ease of use, international applicability, and ability to administer remotely.

The feasibility study recruited 76 patients across three international hospitals in Hong Kong, Christchurch, and Auckland. Based on the results, the research team were able to significantly improve their main study protocol, including rationalising the intervention to simplify clinician participation, changing the assessment process to expedite each assessment, and ensuring that the intervention was internationally applicable suitable for remote administration.

The team is now continuing to recruit to the large clinical trial in Hong Kong and New Zealand with two further sites ready to be initiated in the second quarter of this year.

FIRST EVER EVIDENCE-BASED SIMULATION ASSESSMENT FRAMEWORK FOR LOW-RESOURCE SETTINGS

Project grant with scholarship: Developing a competency-based facilitation evaluation tool supporting healthcare simulation in resource-limited settings

Dr Adam Mossenson from Curtin University and St John of God Midland Public and Private Hospital, Western Australia, was awarded this ANZCA Foundation project grant with a PhD scholarship component in 2023 and submitted his final report in 2025. His team included Dr Patricia Livingstone, Dalhousie University, Canada, and Dr Janie Brown, Curtin University and St John of God Midland Public and Private Hospital.

$133,007

Healthcare simulation can be used to replicate or amplify clinical experiences without patient harm, to cost-effectively address barriers to providing high-quality medical care, especially in low-resource settings. However, its effective use in these settings is restricted by the limited availability of facilitators with the required knowledge, skills, and capabilities, including activity design, delivery, and debriefing.

The aim of this project was therefore to create a framework for the assessment of healthcare simulation facilitators specifically informed by practice in low-resource settings, to support further development of simulation capabilities in these contexts.

The team first conducted a literature review, and a systematic scoping review (published *Simulation in Healthcare*; 2023), which confirmed that there was no existing simulation assessment framework with the contextual suitability or evidence required to support usage in low-resource settings.

The existing Vital Anaesthesia Simulation Training (VAST) Community of Practice was used as an organisation through which developing simulation facilitation skills could be explored. Processes and structures required for facilitator skill development were mapped, and existing approaches reviewed. The researchers then developed and tested a new approach for the assessment of simulation educators, designed in collaboration with - and drawing on the knowledge of - healthcare providers deeply engaged in simulation education in low resource settings.

This approach, called the VAST Facilitation Observation and Rating Method (VAST FORM), is now supported by sufficient evidence to recommend its use in supporting simulation facilitator training in low-resource settings.

The direct and scalable benefit of this research is enhanced capacity for more appropriate assessment, education and skills training of healthcare providers delivering simulation activities in low-resource settings, to support the development of contextually appropriate individual and team competencies across a range of perioperative and country settings. Broadened and effective use of simulation is expected to promote the development of learners' knowledge, skills, and behaviours, and ultimately lead to enhanced patient care and outcomes.

For information on key publications, presentations, and implementation of ANZCA Foundation-funded study outcomes, please refer to 'Awarded grants and outcomes' on the 'Research grants' page of the ANZCA website.

CONTACT AND SUPPORT

For queries, contact:

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

Trena Ronnfeldt, Fundraising Administration Officer, tronnfeldt@anzca.edu.au

Research grants program:

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

ANZCA Clinical Trials Network:

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

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

Nominations for ANZCA Council Awards are now open



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

It's time to recognise the members of our college who make a difference to anaesthesia and pain medicine, with nominations for the 2026 ANZCA Council Awards now open.

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

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

The award recipients will be announced at the 2027 College Ceremony in Adelaide as part of the ANZCA ASM on Saturday 1 May. If you require assistance, please contact membership@anzca.edu.au.

Submissions are now open and close at 5pm Friday 30 October 2026.

ANZCA Research Consultation Service

High-quality research relies on more than clinical expertise. Behind every literature search, systematic review and evidence-informed professional document is a rigorous process of identifying, evaluating and synthesising the published literature. Working alongside ANZCA members through this process is the Research Consultation Service (RCS), which collaborates with researchers, clinicians and stakeholders to ensure robust research informs professional documents, policy and ultimately clinical practice.

Led by research librarian Kathryn Rough, the service facilitates the translation of research evidence into policy and practice through expert literature searching, systematic review support and collaboration on evidence-based initiatives across the college. Increasingly, the service is not simply supporting projects but contributing as part of multidisciplinary teams, helping to shape projects from their earliest stages through to publication and implementation.

RESEARCH PARTNERSHIP IN ACTION

One example is the work of FANZCAs Dr Phuong Markman and Dr Ruth Blank, who are undertaking a systematic review titled "Pulmonary aspiration in adults and children undergoing anaesthesia with liberal versus restrictive fluid fasting". Faced with thousands of search results requiring review, the team worked with RCS to develop their search strategy and manage the screening process. Both researchers highlighted the value of RCS throughout the review process.

Dr Blank noted, "Kathryn was an incredible help to us" and Dr Markman agreed:

"From the outset we received generous assistance. After helping us to finesse the search strategy, Kathryn set us up with the systematic review software Covidence, which saved us hundreds of hours of work. I cannot imagine conducting a systematic review of this scale without the expert and enthusiastic support from RCS."

The service's contribution extends beyond literature searching and systematic review assistance. Kathryn has co-authored a number of publications with ANZCA and FPM fellows, contributing specialist expertise in evidence searching and review methodology. Recently, FFPMANZCA Dr Meredith Daff worked with the service on the paper "A scoping review for published guidelines for use of ketamine in chronic non-cancer pain".

Dr Daff reflected on the experience:

"As a novice researcher, I found Kathryn's support and guidance throughout the scoping review process invaluable. In addition to conducting the required literature searches, she willingly shared her expertise in relevant aspects of manuscript development, navigating publication requirements, and troubleshooting challenges as they arose. Her assistance was instrumental in facilitating the review's completion and eventual publication."

FANZCA Dr Zhengjie Lim has also published a paper with Kathryn as a co-author this year – "Intravenous methadone versus regional and neuraxial analgesic techniques in the peri-operative period: a scoping review" – and credits her expertise with strengthening the project:

"The editors were impressed by the search strategy quality, and our ability to produce search terms that were both transparent and replicable. As authors, having Kathryn's support gives us the confidence that we have a quality manuscript in hand."

The collaboration has continued beyond that publication. Dr Lim is currently working with the service, and two librarians from Eastern Health, on an investigation into the methodological robustness of review articles published in anaesthesia journals. The project team hopes to raise awareness of the importance of reproducible search strategies and how early collaboration with medical librarians contributes to high-calibre research output. For Dr Lim, access to the RCS is one of the most valuable benefits of ANZCA membership: "At research meetings, overseas anaesthetists are frequently impressed by (and envious of!) the availability of highly qualified medical librarians as part of our college membership. Research is a core component of anaesthetic training and an essential aspect of our scholarly role as medical specialists; the ability to collaborate with in-house librarians within ANZCA goes a very long way toward supporting our ideas and endeavours."

These collaborations highlight the increasingly important role information specialists play in modern research teams. By contributing expertise in evidence retrieval, review methodology and knowledge synthesis, RCS helps researchers produce high-quality, reproducible research while navigating an increasingly complex evidence landscape.









ABOVE

Clockwise from top left: Dr Phuong Markman, Dr Ruth Blank, Dr Zhengjie Lim, Dr Dilip Kapur and Dr Meredith Daff



SUPPORTING EVIDENCE-INFORMED PROFESSIONAL DOCUMENTS

The impact of RCS extends well beyond research publications; it also contributes significantly to ensuring that ANZCA and FPM professional documents and associated background papers remain informed by the latest evidence. Working closely with the Safety and Advocacy unit and document development groups (DDGs), the service undertakes literature searches and evidence updates that inform document development and review.

Recent work has included contributions to the review and revision of *PS53 Handover responsibilities of anaesthetists* and a position statement on spinal cord stimulators. This work helps document authors identify emerging evidence, assess changes in the literature and ensure recommendations continue to reflect contemporary practice. While much of this work occurs behind the scenes, it helps ensure that ANZCA and FPM guidance, policy and advocacy activities remain current and are informed by the best available evidence.

FFPMANZCA Dr Dilip Kapur, the faculty's immediate past dean, has seen this value firsthand:

"The multidisciplinary nature of pain medicine, often spread across multiple clinical areas, can make productive searches a daunting exercise. Kathryn's expertise in strategic searches and her skills in handling platforms such as Covidence have not only saved us many hours of work, they have also helped us avoid some potentially serious errors."

LOOKING AHEAD

Whether assisting with a systematic review, collaborating on a publication or contributing to professional document development, RCS helps bridge the gap between evidence generation and evidence application. Through these partnerships, the service supports ANZCA's commitment to advancing knowledge and promoting evidence-informed practice across anaesthesia, pain medicine and perioperative medicine.

Contact the library: | +61 3 9093 4967 | library@anzca.edu.au | anzca.edu.au/library

Les Mendel

1943 – 2026



Les was born in Albury, NSW, and grew up in Melbourne with his younger brother, Harry. He attended Melbourne High School and graduated with a Bachelor of Medicine and Surgery from the University of Melbourne in December 1967. Following graduation, he spent two years working in various Melbourne hospitals as a junior and senior resident medical officer, before undertaking a further two years as an anaesthetic registrar until February 1972.

Later that year, Les travelled to London where Harry was already working as a motor mechanic on the Formula One Grand Prix circuit. After two years travelling around Europe and a brief return to Melbourne in 1974, he returned to London and took a locum position as a junior anaesthetist at Central Middlesex Hospital.

Les met Susie in London in 1976. In 1978 he asked her if she would return to Australia with him and she agreed. Because Susie disliked flying, Les sold his beloved Lotus Elan Sprint to pay for their voyage by sea, a sacrifice that anyone who knew his love of cars would appreciate. A year later they married in Melbourne and began a partnership that would last almost 50 years. They remained in Australia for five years while Les worked at several hospitals, spending his final year at the Royal Melbourne Hospital, and Susie completed a history degree at Monash University.

Les continued to build an impressive professional career. He had already obtained a Diploma in Anaesthesia from the Faculty of Anaesthetists in June 1977. He went on to achieve his Australian fellowship in anaesthesia from the Royal Australian College of Surgeons in November 1980 and later became an honorary fellow of the Royal College of Anaesthetists in June 1994.

Returning to the UK in February 1984, Les accepted a locum senior registrar post at Addenbrooke's Hospital, Cambridge. He also worked at Papworth Hospital with heart and lung transplant patients and was subsequently offered a twelve-month research position investigating drugs used in liver transplantation.

In early 1988, Les obtained his first consultant post at Louth County Hospital. He was the first consultant anaesthetist appointed there and six months later was joined by Robert Scott and Andrew Garnett. Louth Hospital was then developing as a pioneering small district general hospital, and Les helped lead that development as lead anaesthetist and intensivist. With his colleagues he planned and established a consultant-led intensive care service, helping to create a model of care that was innovative for its time.

Dr Robert Scott later recalled first speaking to Les while searching for a consultant post. Unlike many conversations he had had with other departments, Les stood out as warm, welcoming and genuinely interested in people. Rather than focusing solely on qualifications and competition, Les spoke enthusiastically about Louth and took the time to show him around. That meeting marked the beginning of a 20-year professional partnership and a valued friendship.

Les loved working at Louth Hospital and was deeply committed to the service he helped build. Although he was disappointed when changing national health service priorities led to the downgrading of the hospital in 1995, he accepted a transfer to Lincoln Hospital alongside Robert Scott and continued working there until his retirement in 2007. Throughout his career he maintained exceptionally high standards and was respected for his calm professionalism, sound judgement and dedication to patient care.

Among his special interests were paediatric anaesthesia and pain relief before, during and after surgery. Understanding how frightening a hospital visit could be for a child, he would return from trips to Australia with brightly coloured ties decorated with koalas, wombats and parrots. During pre-operative visits, these cheerful ties often became a welcome distraction for nervous young patients.

Les also devoted time to teaching and mentoring others. He worked closely with ambulance paramedics, helping them learn techniques such as intravenous cannulation and tracheal intubation. Many years later, some of those same paramedics still remembered his patient instruction and calm manner. It was particularly touching for his family to learn that when Les himself required transport to hospital during his final illness, he was cared for by paramedics he had trained decades earlier.

Those who knew Les will remember him as a quiet, gentle and unassuming man. He was polite, thoughtful and dependable, with a curious and rather wacky sense of humour that was never far from the surface, particularly after a few cans of Foster's Lager. He loved fast cars and the skill involved in driving them, yet he never took shortcuts when it came to patient care. One of the qualities his colleagues admired most was his belief in taking the proper time to complete a task safely and thoroughly. He would never rush simply for convenience, believing that patients deserved his absolute care and attention.

The many tributes received following his death reflected the esteem in which he was held. Former colleagues described him as "a lovely man", "such a gentle person" and someone with whom it was always a pleasure to work. These comments captured the essence of Les: a talented doctor, a trusted colleague, a loyal friend and a true gentleman.

For Susie, however, Les was something even more important. He was not only her husband but her best friend, always there for her and never letting her down. She feels blessed to have shared the past 50 years with him.

Les Mendel leaves behind a legacy of kindness, professionalism, integrity and friendship. He will be remembered with great affection by family, friends, colleagues and the many patients whose lives he touched. He will always hold a special place in their hearts.

**This obituary was compiled using information provided by Les Mendel's wife, Susie Mendel and Dr Robert Scott, consultant anaesthetist (retired), Lincoln and Louth, UK.*