AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • **SEPTEMBER 2025**

WILL YOUR FUTURE ANAESTHETIC TECHNIQUE BE PRESCRIBED BY ARTIFICIAL INTELLIGENCE?

ARTIFICIAL INTELLIGENCE AND DIGITAL HEALTH IN ANAESTHETIC PRIVATE PRACTICE

AI IN PHOTOGRAPHY

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Please note that Dr Lan-Hoa Lê is a resident teacher at the Central Coast Meditation Centre. Dr Lê is also a qualified mindfulness and meditation practictioner as well as a specialist Anaesthetist and Wellbeing Advocate.

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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

The Australian Society of Anaesthetists (ASA) exists to support, represent, and educate Australian anaesthetists to protect the status, independence, and best interests of Australian anaesthetists and to ensure the safest possible anaesthesia for the community.

LETTERS TO AUSTRALIAN ANAESTHETIST:
Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval. Letters should be no more than 300 words and must contain your full name and address. Please email editor@asa.org.au to submit your letter or to contribute.

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Contents

Would you like to contribute to the next issue?

If you would like to contribute a feature or lifestyle piece for the December 2025 edition of Australian Anaesthetist, the following deadlines apply:

- Intention to contribute must be emailed by 17 October 2025
- Final article is due no later than 24 October 2025

Please email the editor at editor@asa.org.au. Image and manuscript specifications can be provided upon request.

Australian Society of Anaesthetists®

A MEMBER SOCIETY OF THE WFSA WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS

DR MARK SINCLAIR
PRESIDENT

FROM THE ASA PRESIDENT

DURING SEPTEMBER I, ALONG WITH ASA VICE PRESIDENT DR VIDA VILIUNAS, IMMEDIATE PAST PRESIDENT DR ANDREW MILLER, AND CEO DR MATTHEW FISHER, WILL HAVE THE OPPORTUNITY TO TRAVEL TO SOUTH AFRICA TO ATTEND THE SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS' NATIONAL CONGRESS IN CAPE TOWN. THE CONGRESS WILL BE FOLLOWED IMMEDIATELY BY THE MEETING OF THE COMMON ISSUES GROUP (CIG). THE CIG MAY ALREADY BE FAMILIAR TO OUR MEMBERS, AS IT GENERALLY MEETS ON AN ANNUAL BASIS, COINCIDING WITH EITHER THE ANNUAL CONFERENCE OF THE HOST SOCIETY, OR THE WORLD CONGRESS OF ANAESTHESIOLOGY (WCA) IN THE YEARS THIS IS HELD. THE HOST SOCIETY IS DECIDED ON A ROTATIONAL BASIS, WITH THE ASA HOSTING IN 2024, AT THE WCA IN SINGAPORE.

The other member nations of the CIG are New Zealand, Canada, the USA, and the UK. As the name of the group suggests, we spend a couple of days meeting to discuss the common issues each individual nation faces in terms of the delivery of anaesthesia services, and the day-to-day medico-political issues faced by our anaesthetist members. And of course, to compare and contrast the situations in each individual nation. Both the strengths of, and the challenges faced by, each individual nation's healthcare systems provide valuable lessons to us all.

No doubt members are aware, for example, that in the USA the private healthcare sector is much stronger than the publicly-funded sector. And at the same time, the for-profit health insurers have a great deal of power over the delivery of healthcare, via the so called 'managed care' situation. In Australia too, the private sector is very strong, and provides the majority of surgical procedures to Australian patients. Insurers operating in Australia do not have the same power over healthcare delivery and funding as in the USA, but there seems little doubt they would like more such power. Our for-profit insurers (which cover over 80 per cent of the insured Australian population) deny they aim for a USA-style managed care model. This may, strictly speaking, be true, as the legislative environment in Australia prevents this degree of insurer involvement. But there is no doubt the insurers would like more control over the system for their own financial benefit. This is not something that can happen overnight, but we must keep in mind that this probably does not overly bother the insurers. They are already very profitable, and their aims do not necessarily involve rapidly increasing profits over the next few years, but rather,

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gradual and sustained improvement in their profitability over decades. We must therefore keep watch on the initiatives that are already evolving in this sphere, being mindful that each small deliberate step the insurers take (such as purchasing significant ownership stakes in private hospitals, as we have already seen) will add up over time.

There is no doubt the private healthcare sector is facing challenges, as exemplified by the Healthscope group going into receivership, and the closure of a number of facilities, which in particular have adversely affected obstetric services. The private sector must continue to be strong, and be supported, in order that the public system does not become unduly burdened. But for-profit insurers must not be allowed to move in and take over, with their prime motive being financial profitability.

The ASA National Scientific Congress in Canberra will only be a few weeks away when members receive this edition of *Australian Anaesthetist*. Members attending the NSC are encouraged to take advantage of the opportunity to catch up with ASA office bearers for a chat about any issue you care to discuss. Office bearers will be available at the ASA booth in the Health Care Industry hall at various times, particularly during breaks, but of course the stand will be attended by ASA staff at all times. As mentioned in other releases, the ASA Annual General Meeting will be held during the NSC, on Saturday 4 October. I encourage all members to attend the AGM, not only so that we reach a quorum of 50 members and have a 'legal' AGM, but mainly to hear about important updates on the work of the ASA.

One specific issue to be raised at the AGM is a change to our Constitution, to allow members who attend online to be counted in the attendance figures, and of course count towards a quorum. Online attendance has been possible in the past, but these attendees have not counted towards a quorum, nor have they had voting rights. An appropriately worded motion for such a change to the ASA Constitution will be circulated at least 21 days prior to the AGM. Meanwhile, the ASA continues to take advice on re-jigging sections of the Constitution, in order to ensure compliance with the Australian Charities and Not-for-profits Commission (ACNC) requirements. Because of its listing as a charitable organisation, the ASA receives certain tax concessions on its income. Aspects of our work which are recognised in this way include our educational events, support of research and publication, and aid to overseas nations. Where there is doubt over specific ASA activities and ACNC compliance, changes to the Constitution may be needed. This will of course require discussion and voting at an AGM, and members will be informed of the details well in advance of this.

Dr Mark Sinclair
MB BS, GAICD, FANZCA

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

FROM THE CEO

ARTIFICIAL INTELLIGENCE - ARE WE BEING REPLACED OR ENHANCED?

UNDERSTANDING ARTIFICIAL INTELLIGENCE (AI) IS A COMPLEX BUSINESS AND MAYBE I SHOULD ASK ONE OF THE PLATFORMS TO TELL ME WITHOUT BIAS OR HALLUCINATION? I AIM TO UNDERSTAND AI ACROSS MANY DOMAINS – WHAT DOES IT MEAN FOR ME (PERSON, CEO, MEMBER OF PUBLIC) AND THE FUTURE (CLIMATE, DATA, PEOPLE ENGAGEMENT) AMONG MANY CONSIDERATIONS. WHAT IS THE 'STUFF' ONLY HUMANS CAN DO, WHAT IS THE 'STUFF' WE DO AS HUMANS THAT AI CAN DO, AND WHAT IS THE 'STUFF' HUMANS CAN ONLY DO WITH AI.

So when Alan Turing proposed a test to see if a machine could mimic human intelligence in 1949, progressing to ELIZA in 1966 being one of the first chatbots simulating conversation with humans, to Deep Blue in 1997 beating the chess champion Kasparov, and to generative AI today, what I do understand are my own limitations and to a degree, the limitations of AI (doesn't understand context like people, can confidently hallucinate and reflect biases based on what it is trained to do).

Reading that last sentence, I have had to critically re-appraise myself just so the kettle is not calling the pot black, however the risks of AI are real. Risks such as privacy and data security, hallucinations and misinformation, deepfakes and identity fraud, and bots pretending to be real users to manipulate online spaces.

In 2024, the CSIRO Australian e-Health Research Centre, aehrc.csiro.au, published a paper on AI trends for healthcare, titled *AI for healthcare is as easy as ABC - CSIRO*, csiro.au/en/news/All/Articles/2024/April/AI-healthcare-trends, which I can recommend if you are interested. In their introduction, David Hansen CEO and Research Director, CSIRO's Australian e-Health Research Centre, states "To fully harness AI and machine learning we need not to just let it happen but rather plan for its introduction into healthcare. This means we will be able to benefit properly from AI by ensuring the frameworks are firmly in place for ethical implementation and that the safety, quality, and monitoring guidelines are established as we strive to create newer and better AI based digital tools."

AI can impact where people source information. The ASA is a member of the Australian Ethical Health Alliance which was formed in 2019 to enhance healthcare in Australia by promoting principles that prioritise patient interests and ensure access to safe healthcare. Drs Peta Lorraway, Vida Viliunas and I attended a forum that focussed on 'Ethical healthcare in an era of disinformation and misinformation'.

This included 'What kind of knowledge matters?', how do we engage communities and build trust, building literacy capabilities of people, and ensuring inclusion and equity are central tenets to defend the integrity of health information, communication and evidence. The 2025 *Edelman Trust Barometer Special Report: Trust and Health* https://www.edelman.com/trust/2025/trust-barometer/special-report-health, was discussed, including the factors destabilising the influence of health experts, the diminishing trust in media reporting health information, how people engage with health information and the role of social media and AI. Interestingly, 45% of people aged 18 to 34 years, and 34% of people aged 35 to 54 years were most likely to make health decisions based on uncredentialed advice. Of these age cohorts, 58% and 44% respectively have regretted a health decision they made based on misinformation.

This report and forum also showed that there is opportunity for the ASA to lead in this space.

So, what are we doing at the ASA-level for the organisation and employees? Firstly, we are educating ourselves through a variety of avenues such as those I list below:

Voluntary AI Safety Standard | Department of Industry Science and Resources
https://www.industry.gov.au/publications/voluntary-ai-safety-standard

Engaging with artificial intelligence | Cyber.gov.au
https://www.cyber.gov.au/resources-business-and-government/governance-and-user-education/artificial-intelligence/engaging-with-artificial-intelligence

Artificial intelligence (AI) transparency statement | Australian Government Department of Health, Disability and Ageing
https://www.health.gov.au/about-us/corporate-reporting/our-commitments/ai-transparency-statement

Directors' Guide to AI Governance
https://www.aicd.com.au/innovative-technology/digital-business/artificial-intelligence/governance-of-ai.html

Our approach is about being informed and mindful about what we may input into AI tools, not sharing sensitive data, not assuming generated content is accurate, revising policy, using approved tools and locking down as required, and importantly being transparent yet cybersecure.

And to be fully transparent, I did write this but drew from many sources from people to the web.

Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

Please forward all enquiries or correspondence to Sue Donovan at: sdonovan@asa.org.au or call the ASA office on: 02 8556 9700

Get involved in your ASA ...

Find out more about the Society's various committees and groups that work alongside the ASA to help support, represent and educate anaesthetists.

To inquire about how you can contribute and express your interest in being involved, email the Operations Manager, Suzanne Bowyer at committees@asa.org.au

- **Economic Advisory Committee**
- **Professional Issues Advisory Committee**
- **Public Practice Advisory Committee**
- **Editorial Board of Anaesthesia & Intensive Care**
- **Overseas Development and Education Committee**
- **Trainee Members Group Committee**
- **General Practitioner Anaesthetists Group**
- **National Scientific Congress Committees**
- **Communications Committee**
- **Retired Anaesthetists Group**
- **The History of Anaesthesia Library, Museum and Archives Committee**
- **ASA State Committees of Management**
- **Wellbeing Advocates Committee**

ARTIFICIAL INTELLIGENCE AND DIGITAL HEALTH IN ANAESTHETIC PRIVATE PRACTICE:

supporting safe, compliant and patient-centred care

Balancing freedom with responsibility

Private anaesthetic practice offers clinicians flexibility, autonomy, and the ability to shape their careers around preferred case mixes. However, it also brings a host of non-clinical responsibilities: billing, informed financial consent (IFC), patient communication, compliance with AHPRA standards, and navigating complex private health insurance arrangements. These administrative demands can often feel like a second job, especially for those managing solo practices or working in small groups.

As patient expectations for transparency and digital engagement grow, so too does the need for systems that support clinicians to deliver care that is not only clinically excellent but also aligned with AHPRA guidelines and Australian Consumer Law (ACL) obligations. With patients becoming more informed about their rights and practitioners facing increasing scrutiny from regulators, the stakes for getting these processes right have never been higher.

At our practice, artificial intelligence (AI) has become an integral part of our daily workflow, helping us efficiently manage administrative tasks, improve accuracy, and ensure compliance with regulatory standards. Crucially, these digital health tools also enable us to enhance patient experiences, while consistently upholding privacy and patient safety. This article explores how AI is being seamlessly integrated into anaesthetic private practice to streamline workflows, strengthen regulatory compliance, and optimise patient care - always supporting, never replacing, clinician judgement.

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Clear communication as a cornerstone of care

"Informed financial consent is not simply about quoting a fee - it's about ensuring patients understand their financial obligations."

Clear and timely communication is essential to supporting patient autonomy and meeting AHPRA's Code of Conduct (Section 4.2), which requires clinicians to provide information in a way patients can understand and use to make informed decisions. Patients must be able to assess their choices, weigh risks, and anticipate costs without being surprised by unexpected gaps in their cover. Section 18 of the ACL also requires practitioners to avoid misleading or deceptive conduct, even inadvertently.

For example, a patient undergoing elective surgery may assume their private health fund will cover all costs. Without clear, proactive communication, this can lead to complaints and significant stress if they later receive an out-of-pocket bill. AHPRA has highlighted such cases as examples of avoidable patient dissatisfaction and potential breaches of professional standards.

Artificial intelligence-assisted systems can help by generating tailored consent documents and preoperative instructions. These adapt to procedure type, insurance classification, and patient demographics. This ensures patient communications are:

- Compliant with AHPRA and ACL requirements, providing the clarity and transparency expected of modern healthcare.
- Accessible, with language and format tailored to individual needs, including those with low health literacy or non-English speaking backgrounds.
- Consistently documented, supporting practitioners in case of future disputes, Medicare audits, or legal challenges.

Privacy is paramount - all content generation occurs using procedural metadata and preconfigured templates, not identifiable patient records. Patient information remains encrypted and securely stored in compliance with Australian Privacy Principles (APPs) and national privacy legislation.

Compliance as a patient safety issue

"Administrative errors can undermine patient trust and trigger investigations."

Errors related to billing and informed consent are not merely minor inconveniences, they can result in patient dissatisfaction, formal complaints, and even regulatory actions. The 2023 AHPRA report highlighted a significant rise in notifications, with concerns about transparency in fee disclosure and consent processes reaching 11,200 - a 15.4 per cent increase from the previous year.

Digital health tools that embed compliance into everyday workflows provide proactive safeguards for clinicians and patients alike. These technologies help practitioners avoid critical issues such as:

- Insufficient disclosure of potential out-of-pocket costs to patients.
- Incorrect use or combinations of MBS codes leading to claim rejections.
- Unintentional breaches of privacy obligations during data storage or transmission.

Key features of these compliance-focused systems include:

- Automatic validation of MBS codes, identifying conflicts or omissions that could lead to denied claims or underbilling.
- Cross-checking fee estimates against health fund participation rules to avoid unexpected patient expenses.
- Automated reconciliation processes to ensure submitted claims match payments received.
- Secure storage and easy retrieval of informed financial consent (IFC) records to demonstrate compliance during audits.

By reducing cognitive workload and standardising documentation practices, these tools help anaesthetists align seamlessly with AHPRA's clinical governance standards and consumer protection requirements outlined in the ACL.

Where we've applied AI: understanding theatre lists

Our practice's most immediate and beneficial use of AI has been in processing theatre lists, which frequently arrive via email, fax, or uploaded documents in semi-structured formats. These lists often vary widely in layout, terminology, and completeness.

Our digital infrastructure employs advanced natural language processing algorithms to rapidly scan theatre lists, automatically extracting critical details such as:

- Patient demographics
- Surgeon details
- Type of operation
- Scheduled start time
- Hospital location

This automation enables the pre-population of mandatory database fields, suggested MBS coding, and initiation of consent workflows. Tasks traditionally taking between five to 1ten minutes per patient now require less than one minute, providing significant time savings.

Automating these administrative processes allows anaesthetists to redirect their focus towards core clinical responsibilities, reducing stress and maintaining consistent adherence to pre-operative preparations, informed financial consent, and billing protocols. By handling these routine tasks within our AI ecosystem, we reduce overhead costs, enhance accuracy, and foster clearer, more consistent patient communication.

Critically, our AI systems prioritise data minimisation and security. Only essential data is encrypted and processed, with all identifiable patient information securely stored on Australian-based servers, fully compliant with national privacy regulations. Additionally, AI-

Anaesthetists are professionals who function at a high level, and it is a common experience that work performance can continue even if the person is quite unwell. It is often stated that for high functioning individuals work performance is the 'last thing to go.'

generated outcomes are always subject to clinician review, ensuring practitioner judgement remains central to every decision-making process.

Future directions: responsible AI that supports, not replaces

The next generation of AI tools promises to further enhance patient-centred care in private practice. Several areas under active development include:

- Predictive Billing: Real-time suggestions for MBS codes tailored to specific procedures, surgeons, and hospitals. These systems would factor in complexity modifiers and health fund rules, reducing the risk of underbilling or coding errors. Importantly, clinicians remain in control of final decisions, ensuring alignment with professional judgement.
- Insurance Risk Stratification: early identification of potential coverage issues allows anaesthetists to provide patients with realistic expectations around costs. For example, if a patient's fund tier or waiting periods pose a likely barrier to claiming, clinicians can address this proactively. This supports AHPRA's focus on informed consent and helps practitioners avoid potential disputes or complaints.
- Multilingual consent tools: supporting clear, culturally appropriate communication with patients from diverse backgrounds. This is consistent with Section 4.3 of AHPRA's Code of Conduct on culturally safe and responsive care. Future tools may include auto-translation or culturally adapted templates for pre-operative instructions.

All of these innovations are being designed with strong privacy protections and clinician oversight to ensure AI serves as a decision-support tool rather than an automated decision-maker.

Empowering clinicians and patients

An unexpected benefit of integrating these systems has been their role in education. Rather than relying on lectures or guidelines alone, clinicians are presented with contextual guidance as they work - such as displaying relevant health fund rules alongside item numbers.

This embedded learning approach is valuable for:

- New fellows and international medical graduates navigating private billing for the first time.
- Experienced anaesthetists seeking confidence that their practices remain current and compliant.
- Practice managers and billing staff who require accurate, up-to-date information without extensive training.

By aligning workflows with AHPRA's expectations for professional development, these systems encourage continuous improvement without additional administrative burden.

Designing for privacy and trust

"AI in healthcare must prioritise patient privacy, clinician control, and compliance with Australian law."

Concerns about privacy and data security are valid and must be addressed head-on. Ethical implementation of AI requires:

- Data minimisation, ensuring only essential information is processed.
- Encryption and secure storage, with data hosted on Australian servers in compliance with privacy legislation.
- Clinician oversight, ensuring AI outputs require anaesthetist approval before action is taken.

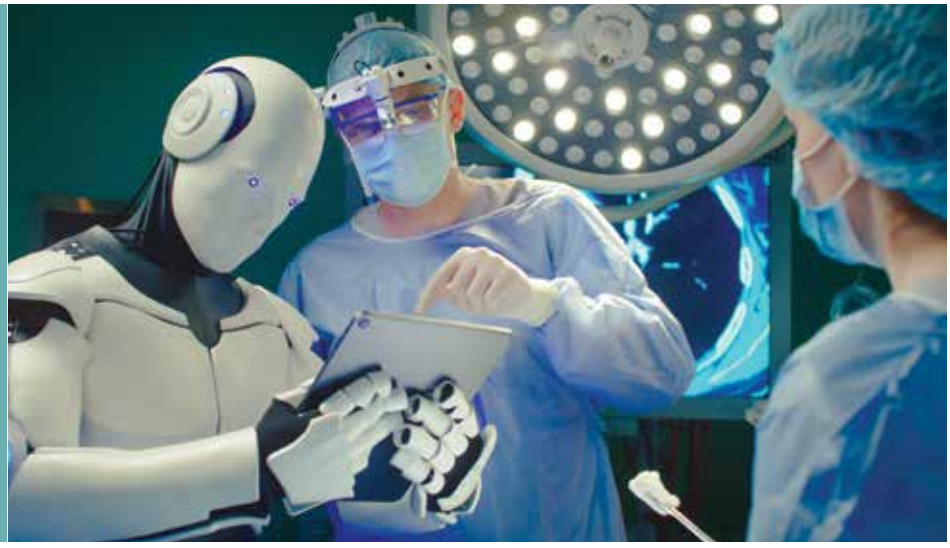
This approach aligns with AHPRA's standards on confidentiality and broader obligations under the Privacy Act 1988 and APPs.

Dr Stanley Tay
Dr Joshua Szental

Dr Stanley Tay and Dr Joshua Szental are anaesthetists with an interest in digital health innovation, compliance, and improving workflows for private practitioners.

WILL YOUR FUTURE ANAESTHETIC TECHNIQUE BE PRESCRIBED BY ARTIFICIAL INTELLIGENCE?

ARE FEARS OF JOB DISPLACEMENT, SKILL EROSION AND THE LOSS OF PROFESSIONAL AUTONOMY JUSTIFIED WHEN IT COMES TO THE RISE OF ARTIFICIAL INTELLIGENCE (AI) IN ANAESTHETIC MEDICINE? WILL THE 'ART OF ANAESTHESIA' PREVAIL?



Many anaesthetists worry that the integration of AI into their field could ultimately lead to job displacement and a decline in clinical skill. But are these fears grounded in reality, or are they an overreaction to the transformative potential of AI's integration into this clinical space? To assess whether there is a genuine risk of skill degradation and job loss - both now and in the future - it's worth reflecting on how we arrived at this point.

Anaesthetists practising today may recall that not long ago, it was standard practice for some anaesthetists to bring their own anaesthetic agent into the operating theatre. This highlights just how far the field has come in a relatively short time.

The technological developments which have transformed anaesthetic practices to date have been overwhelmingly beneficial. The introduction of AI is just the latest in a long line of innovations. Drug infusion systems and patient monitoring technologies, for instance, have been integral to anaesthesia since the 1990s.

So what kind of change is AI likely to bring? The literature suggests that "predicting and preventing unfavourable outcomes is an important use of AI in anaesthesia"[i]. There are benefits to be gained through the use of AI algorithms to identify patterns, particularly given that "humans have a limited ability to accurately and continuously analyse large amounts of data"[ii].

Studies[iii] have been undertaken in relation to:

- depth of anaesthesia monitoring,
- control of anaesthesia,
- event and risk prediction,
- ultrasound guidance,
- pain management, and
- operating room logistics[iv].

Artificial intelligence-powered applications for patient monitoring – tracking vital signs such as heart rate, blood pressure and oxygen saturation – are transforming anaesthetic practice. These systems can alert the anaesthetist to any significant changes in real time during surgery, enabling faster and more informed clinical responses. Automatic recording of patient data via AI applications can reduce administrative error and enable the anaesthetist to review and interpret data and make decisions accordingly, rather than be consumed with administrative processes. AI recording of data observations also provides scope for future analysis. In addition, AI applications can be used to calculate and assist with drug delivery, increase accuracy and reduce anaesthetist time commitments. Studies have shown that using AI for image-guided techniques has benefits related to prediction of events and risk reduction

in anaesthesia[v]. Some examples of AI used for the prediction of events involve the prediction of hypertension and hypoxaemia[vi] following surgery.

So how do we safeguard the practical skills of anaesthesia – skills that are developed through hands-on experience? It is essential that clinicians have the requisite levels of skill, particularly given that the integration of AI into anaesthetics is by no means uniform across healthcare settings. The availability of AI tools varies depending on the facility's resources and its level of technological innovation. Therefore, it is important that anaesthetists maintain their skills in order to deliver safe and effective care across a wide range of environments, including those without access to AI support.

Maintaining core clinical skills ensures that anaesthetists can adapt to any setting and respond confidently, regardless of the tools at hand. Where AI is available, it should be viewed as an optional aid - used at the anaesthetist's discretion, provided they are comfortable with the technology and understand how to operate it effectively. This approach preserves clinical autonomy while embracing innovation.

Indeed, AI tools should not be relied upon without careful review of their output due to the errors which can result from its use. For instance, our experience at Avant is that AI applications may generate information that was never provided by the patient or the practitioner. Artificial intelligence output must be carefully reviewed at the time of the event, to ensure that extraneous information has not been incorporated as this may create an incorrect clinical record and ultimately impact patient care.

For these reasons, it will always be necessary for the anaesthetist to undertake their preoperative assessment of the patient and their clinical situation and discuss any aspects of concern with the appropriate clinician. Artificial intelligence may assist with this process administratively, in particular, by using prompts to remind the anaesthetist to ask about GLP-1 agonists, other diabetes and blood thinning medications. While AI can play a part in this process – by providing ready access to data for the anaesthetist to consider and analyse – it should not be relied upon to make the decisions which flow from the integration of all of these factors.

The literature suggests that another advantage AI might offer in the future may be related to provision of training systems to assist early career doctors particularly on how to respond to complications and critical events – without compromising patient safety.

Conclusion: AI should assist not replace

It's difficult to imagine that an algorithm-driven robot could successfully intubate a patient in an emergency situation. This is only one of the more extreme reasons why AI is a welcome support for, but not replacement of, the human clinician.

Artificial intelligence has the potential to significantly improve clinical decision-making and therapeutic responses in anaesthesia through its ability to analyse and integrate large volumes of data from a variety of sources and identify significant issues. In fact, AI analysis of data may lead to developments in patient care that would have taken human researchers many years to identify. Further, robotic applications of AI for 'conscious sedation using closed loop systems'[vii] and for the maintenance of anaesthesia and haemodynamic management[viii] is advantageous to the clinician and the patient.

For all its technical sophistication, AI is not a substitute for the nuanced capabilities of the human clinician. It does not have eyes or ears which can interpret subtle changes in the operating theatre, and it cannot triage or interpret information in relation to those changes in real time with the same depth of understanding or adaptability as a trained anaesthetist.

The anaesthetist, who has spoken to the patient and their surgeon, is the pivot point for decisions to be made which have the capacity to significantly impact the patient's health and safety. Anaesthetic medicine is dynamic. Anaesthetists are skilled professionals who are required to synthesise information from a range of sources to decisively respond to situations as they occur. When a complication arises, the response must be immediate – any delay can lead to rapidly worsening outcomes, potentially catastrophic.

That said, there may be benefits through prompts provided by AI tools which might assist the clinician to consider alternative diagnoses and avoid fixation error. For instance, an AI tool may suggest a less likely diagnosis for consideration which might not have occurred to the clinician.

While a human presence must always remain central to the delivery of anaesthetic medicine, AI can play a valuable role in refining and enhancing patient care. Whatever the upgrades, AI should never replace the human component because clinical judgement, empathy, and real-time responsiveness are irreplaceable qualities that AI cannot replicate.

Tracy Pickett

BA, LLB, Legal and Policy Adviser, Avant

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AI IN PHOTOGRAPHY

THIS ARTICLE DISCUSSES THE ADVENT OF ARTIFICIAL INTELLIGENCE (AI) IN PHOTOGRAPHY, WHICH HAS REVOLUTIONISED THE MEDIUM, BUT ALSO RAISES SIGNIFICANT ETHICAL, MORAL, AND LEGAL CONCERNS. IT BRIEFLY EXPLORES THE HISTORY OF PHOTO EDITING, HOW IT IS DONE AND WHY.

Historical context: the evolution of photo editing

The saying "The camera never lies." emerged around 1859 when photography became public. Ironically, the first human photograph (Figure 1, Daguerre, 1838) shows a seemingly empty Paris street with just one man getting a shoeshine – anything moving vanished due to the long exposure time.[i]

This phrase was repeated through the years, even mentioned by Robert Louis Stevenson in *In the South Seas* published in 1896.[ii] Photographers do lie, but for many different reasons.

On 2nd October 1917, Captain Frank Hurley resigned his commission as official war photographer for the Australian Imperial Force after clashing with his superior, Chief Historian Captain Charles Bean, over the use of composite images of the Third Battle of Ypres (Passchendaele). Bean felt that Hurley's methods were "little short of fake" and not to be used under any circumstances. Hurley later wrote:

"None but those who have endeavoured can realise the insurmountable difficulties of portraying a modern battle by the camera. To include the event on a single negative, I have tried and tried, but the results are hopeless. […] Now, if negatives are taken of all the separate incidents in the action and combined, some idea may then be gained of what a modern battle looks like."[iii]

Figure 1: Boulevard du Temple, Paris, 3rd arrondissement-Louis Daguerre Daguerreotype. Made in 1838.

After General Birdwood's intervention, Hurley was permitted to display six clearly-labeled composite images at a London exhibition, withdrawing his resignation.[iv]

Hurley was rescued from Shackleton's Endurance expedition, and was later criticised for composite photographs because they were non-scientific.[v]

Reasons for photographic editing: the human eye vs. digital cameras

Human eyes excel with:

- 20-stop dynamic range
- 180 to 200 degree field of view
- Adaptive colour perception and focus
- Real-time adjustment to light changes
- Sharp central vision (fovea) with motion-sensitive periphery
- Brain compensation for visual gaps

Digital cameras have

- Limited dynamic range (10-14 stops)
- Narrower field of view with non-distorting lenses
- Static resolution across frame
- Manual/software adjustments needed
- Struggle in low light (noise at high ISO)
- Superior in freezing moments with consistent quality

These differences explain why photo processing is often necessary to match human visual experience.

Figure 2: Battle of Zonnebeke , France/Belgium, 1917, by Frank Hurley, gelatin silver print, State Library of New South Wales (now in the public domain because its term of copyright has expired)

Figure 3: Pseudomnesia: The Electrician - Boris Eldagsen reproduced with kind permission of artist

Other reasons for photographic editing

- Photographers may edit images to enhance their aesthetic appeal
- AI can be used to manipulate images, creating false or misleading content
- Creation of unique and innovative artistic effects, pushing the boundaries of traditional photography
- Enhancement of food, clothing, real estate, or holiday travel images for commercial/ advertising
- Enhancement to increase appeal for social media – cropping, recolouring, adding text etc
- Restoration and preservation of historical images, as an example the National Film and Sound Archive of Australia
- Analysis and enhancement of images for scientific research purposes, such as astronomy, infrared, or night vision images
- Screening for radiology diagnosis as reviewed by Reabal Najjar[vi]. (Caution is required in training large language models as mentioned by Narla, Akhila et al.[vii] where the model learned that pictures of skin lesions including rulers were more likely to be malignant, rather than focussing on the lesion!)

Methods of photographic editing

Traditional photo enhancement required skilled techniques like dodging, burning, filters, retouching, and montage - all time-consuming processes.

Digital photography emerged in the late 1990s. Software like Photoshop, Lightroom, and GIMP revolutionised photo editing, enabling quick, non-destructive manipulation through sophisticated tools.

Smarter Editing and Enhancements

AI is making it easier than ever to perfect photos. Some of the most impressive developments include:

- Content-Aware Fill: Intelligently removal of objects and fill in gaps seamlessly
- Image Upscaling: Enhancement of resolution without losing detail
- Bokeh Effects: Once achievable only with expensive lenses, creation of beautiful background blur even on smartphones
- Real-Time Image Processing: Adjustment of lighting, color, and clarity instantly, giving you a polished look before you even press "save."

AI-Powered Organization and Recognition

- Auto-tags faces, scenes, locations
- Groups images by content type
- Adds searchable keywords automatically

Ethical, Moral, and Legal Concerns

The great success of AI editing can potentially lead to copyright infringement, fraud, and misrepresentation.

German artist Boris Eldagsen won the Creative Open Category at the 2023 Sony World Photography Awards with his entry titled 'Pseudomnesia: The Electrician'(Figure 3). Sony described Eldagsen's image as a haunting black and white portrait of two women from different generations. However, Eldagsen later revealed that the image was not taken with a camera, but generated with OpenAI's DALL-E 2, created with prompts. Refusing the award, Eldagsen said he submitted the AI-generated image to spark a discussion about the future of photography and the role of AI in the art form. He acknowledged that he had misled the competition organisers about the extent of AI involvement. Of legal interest is that OpenAI claims copyright over all images produced by DALL-E 2

Figure 4: Chess player in Hyde Park (photo by author)

Figure 5: Same Image edited by generative AI in Photoshop using Firefly

Figure 6: AI Generated Grateful Orthopedic Surgeon (Adobe Firefly)

With Adobe Firefly within Photoshop, the author removed the bystander, inserted a bicycle rider, pigeons, and an interested bystander. The player's hat was also altered. All was done within ten minutes.

where Adobe cedes copyright to images produced by Firefly to the user.

The comedian and performing artist Tim Minchin gave an amusing acceptance speech at the G'DAY USA for his Excellence in the Arts Award in February 2025. Minchin discussed people's response to art based on its creation method. He used an example of two identical-looking portraits, one a photograph and one a painting.

Key points:

1. When viewers learn a human hand-painted the realistic portrait, they're amazed by the skill and effort involved.
2. If told the artist used a projection to paint it, they're less impressed.
3. If revealed that AI created the painting, people lose interest completely.

His main argument was that humans value art not just for its technical perfection, but for the human intent, struggle, and imperfections behind it. We connect with the human element (including flaws) in ways we don't with AI-generated work, regardless of its technical quality. However, he did say he was still optimistic about AI-assistance in the Arts.

Many studies have been performed exploring preferences for AI versus human-generated photographs.

Most show bias against AI-produced material, but very little difference when the origin is not known.[viii,ix]

Professional photographers have two main AI concerns: their work being used without permission, and the violation of client confidentiality and non-disclosure agreements when images are shared with AI companies.

Photographers are protesting by switching software providers, avoiding having their work training AI systems that could replace them.[x]

Adobe has made clarifying position statements.[xi]

Deepfake AI can create videos from a single photo, making people appear to speak or act falsely. This technology poses serious risks for misinformation and fraud. Fearing child exploitation, many parents now refuse to upload or store their children's images anywhere online.

Figure 4 is the original photograph of a chess player and disinterested bystander in Hyde Park Sydney. Figure 5 shows the edited version. With Adobe Firefly within Photoshop, the author removed the bystander, inserted a bicycle rider, pigeons, and an interested bystander. The player's hat was also altered. All was done within ten minutes.

Figure 6 is an example of a fully generated photo in Adobe Firefly using the prompt 'an older and stout orthopedic surgeon still in gown, mask, and gloves with blood on them thanking his masked anesthesiologist effusively for successfully getting an unwell patient through a difficult procedure'.

The photo was one of several generated, but in the image chosen the surgeon wore no theatre cap, so using the AI eraser, Firefly placed the cap onto his head. The blood on gloves request wasn't generated, likely due to built-in safety limits in commercial AI models.

In the public domain are a number of communities supported by AI-powered image generation large language models (LLMs) with the ability to create high quality images and videos from text prompts plus or minus input images. An example is 'stable diffusion'. Using elegant user interfaces and pre-trained 'tensors' or containers of data, it can

Any photograph can be edited to depict not only what was actually there, but also what someone wished or pretended was there, or what a human observer might have perceived if they had been there, or even what would have been aesthetically pleasing, blurring the lines between fact, fantasy, and art.

generate images on computers with lower computational resources. Tensors can be further trained for specific purposes.

In conclusion, it has been usual practice historically to edit photographs to convey the scene and story because the human eye sees much more of a scene than the camera does. The advent of digital photography first made this easier. Subsequently AI alteration and generation of photos has made editing easy, fast, and almost undetectable. This ability, along with the issues concerning training LLMs with many available images has led to many moral, ethical and legal issues.

Any photograph can be edited to depict not only what was actually there, but also what someone wished or pretended was there, or what a human observer might have perceived if they had been there, or even what would have been aesthetically pleasing, blurring the lines between fact, fantasy, and art. Ethically it is reasonable to edit photographs to more closely represent what the photographer saw because of the differences between the camera and human perception, but any departure from this intent raises concerns about authenticity, manipulation, and artistic integrity unless there is disclosure.

Most proposed remedies require voluntary disclosure by the photograph's owner.

An early reviewer of the article informed the author that the AI had given the surgeon six fingers. The author had not noticed until informed, raising the question "Did the reader notice?" It is a reminder that AI technology is not perfect and can make errors, so human oversight is still essential.

Disclosures

1. The author holds shares in AI companies.
2. In the spirit of disclosure as expressed, various AIs were used to edit images as indicated, but also used in research, fact checking, and analysis of punctuation and grammar.

Dr Philip Dey

FANZCA, MBBS UNSW

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PUBLIC PRACTICE ADVISORY COMMITTEE

THE PUBLIC PRACTICE ADVISORY COMMITTEE AIMS TO UNDERSTAND AND RESPOND TO THE NEEDS OF THOSE ANAESTHETISTS WHO WORK IN PUBLIC PRACTICE IN ALL STATES AND TERRITORIES OF AUSTRALIA. THE COMMITTEE IS MADE UP OF A CHAIR AND A REPRESENTATIVE FROM EVERY STATE AND TERRITORY ASA COMMITTEE. WE MEET TWO TO THREE TIMES PER YEAR TO DISCUSS ISSUES RELEVANT TO PUBLIC PRACTICE ANAESTHETISTS AND THE CHAIR ATTENDS ASA COUNCIL MEETINGS FOUR TIMES PER YEAR.

Current issues of relevance to public anaesthetists include:

1. State and Territory awards and enterprise bargaining agreement

Background

There is an award or EBA specific for every state and territory that will apply to either specialists or doctors-in-training who work in public hospitals. Within the specialist agreements there is often a differentiation between a Staff Specialist and a Visiting Medical Officer (VMO) in terms of rates of pay and conditions. The definitions of these subgroups differ between states. Hospitals within a state or territory can choose to go above and beyond (or below, for example with Clinical Support Time) the award/ EBA. The negotiating body for public hospital awards/ EBAs varies between states but is usually the Australian Medical Association or Australian Salaried Medical Officers Federation, and in most jurisdictions there is a negotiation approximately every three to four years to review and improve the current award/EBA.

NSW

The current award has been in place for NSW since 1989 and has not kept pace with the changing medical environment in terms of either pay or conditions for doctors-in-training and specialists. This has led to an attrition of doctors out of the NSW public medical system over a period of years by those who seek better pay and conditions in other states, which has ultimately led to a crisis and workforce shortage in NSW. The ASA has supported anaesthetists, such as Dr Andrew Weatherall from Westmead Children's Hospital, who have joined other specialists in attempting to renegotiate the NSW Award over approximately the last two years. The failure of this process led to the two-day strike by Staff Specialists and doctors-in-training that occurred in NSW in April 2025.

2. Ahpra process for specialist registration of UK and Irish anaesthetists

The ASA is fully supportive of the longstanding ANZCA process for assessing and accrediting Specialist International Medical Graduates (SIMG). We know that SIMGs make up nearly 20 per cent of our current workforce and therefore are crucial to the delivery of safe anaesthetic care in both metropolitan and regional areas of Australia. It is crucial for patient safety and quality assurance that the medical colleges remain part of the assessment of overseas specialists within Australia.

3. Task substitution in anaesthesia

Background

The ASA is committed to supporting a medical model for the administration of anaesthesia in Australia. This includes those with a FANZCA, SIMGs, GP anaesthetists and rural generalists. We have been working with ANZCA and at state and government levels to ensure we come up with solutions that ensure equity of access to anaesthetic care wherever you require it in Australia. Our Workforce Survey Report released in 2024 predicted a shortage of anaesthetists in the period up to 2032 relating to retirement and the changing nature of workforce (eg anaesthetists predicting they would work less than full time in the future). The ASA advocates for local solutions to this problem which include more anaesthetic training positions and an increase in GP anaesthetists/ rural generalists.

Non-medical administration of anaesthesia

A shortage of anaesthetists in some jurisdictions has led to local solutions to the problem which includes nurse-led sedation. One example of this is called EDNAPS – Endoscopist Directed Nurse Administered Propofol Sedation - which is already occurring in health services in parts of Australia. In the United Kingdom, this has included the creation of Anaesthesia Associates who undergo a two- year training program (often with no health care background) and then enter the workforce. Unfortunately, this has been introduced without proper governance and has prompted a UK Government review and recent World Medicine Association report , https://www.wma.net/policies-post/council-resolution-on-the-role-of-physician-associates-and-other-non-physician-providers-in-the-united-kingdom-and-other-countries/. The ASA has written a statement about the efficacy of Anaesthetic Associates as part of an anaesthetic team, https://asa.org.au/news-and-media/physician-associates-and-anaesthetic-associatesuk-systematic-review#:~:text=There%20is%20no%20evidence%20that,not%20dismissed%20as%20"negativity".

4. What is the value of ASA membership for those in public practice?

The mission of the ASA is to support all anaesthetists in Australia to advance their skills whilst advocating for the specialty to continue to provide safe and high-quality patient care.

We support those in public practice through:

1. **Education**
    a. For residents and registrars
        i. Online primary and final exam practice
        ii. Part 0 and Part 3 courses.

    b. For consultants
        i. Evening Communication and Leadership webinars - four times per year

    c. For all
        i. The Australian Anaesthesia Podcast with Suzi Nou
        ii. Australian Anaesthetist - quarterly magazine
        iii. Anaesthesia and Intensive Care – bi-monthly journal
        iv. ACE education events – Tripartite anaesthesia events governed by ANZCA/ ASA/ NZSA

2. **Advocacy**
    a. For ongoing improvement in EBA/ awards for public hospital doctors-in-training and specialists.

3. **Support**
    a. Peer Support – network of members who have been trained to provide peer support for other members in times of need.

    b. CRASH Return to Work scholarships – 50 per cent discount for ASA members to attend online or in-person CRASH Course.

In addition, many public hospital anaesthetists benefit from the continued improvement and updating of the RVG by the ASA Economics Advisory Committee which may be used to claim for after-hours work in their hospital.

If you have any issues arising in your practice in a public hospital please reach out to your state or territory ASA Committee Chair for support and advice.

PROFESSOR ALWIN CHUAN
CHAIR, SCIENCE PRIZES AND
RESEARCH COMMITTEE

FROM THE SPARC CHAIR

This marks my final contribution as Chair of the Science, Prizes, Awards and Research Committee, as I conclude my term after five rewarding years. During this period, SPARC has overseen the awarding of ASA research grants and National Scientific Congress prizes to a distinguished cohort of emerging and established researchers across Australia.

As both an academic and a past recipient of ASA research funding, I can personally attest to the significance of these grants. They provide not only essential financial support for early- and mid-career researchers but also a critical platform for building track records that strengthen future competitive grant applications. It is the ongoing vision of the ASA that SPARC's monetary and non-monetary awards that continue to drive innovation and promote excellence in anaesthesia, pain medicine, and intensive care.

I am pleased to announce that Dr Indy Lin, from Adelaide, will succeed me as Chair. Dr Lin is a highly accomplished academic with a PhD in regional anaesthesia, with particular expertise in improving outcomes in orthopaedic surgery. Her leadership, clinical insight, and research acumen will be of great value to SPARC and the ASA. I look forward to supporting her in the transition as I continue on the committee in the role of Immediate Past Chair.

Finally, I would like to extend my sincere gratitude to our 2024 – 2025 SPARC grant reviewers and NSC prize adjudicators, whose names are listed in Box 1. Their time, diligence, and commitment to ensuring a rigorous and impartial academic platform is deeply appreciated. In particular I thank them for offering constructive and thoughtful feedback to applicants, which is helpful for their growth as researchers.

Grant Reviewers and Prize Adjudicators 2024-2025

Dr Brigid Brown
Professor Shalini Dhir
Dr Yasmin Endlich
Dr Michelle Gerstmann
Dr Elmar Helmich
Professor Ken Hillman
Dr Mark Koning
Dr Indy Lin
Dr Paul Maclure
Professor Stuart Marshall
A/Professor Lachlan Miles
Dr Craig Morrison
Dr Ben Olesnicky
A/Professor Bisola Onajin-Obembe
Dr Jennifer Reilly
Dr Behnam Sadeghirad
Dr Su-Jen Yap

Box 1

Applications are open for the September round of the ASA's Small Grants. This grant emphasises quick turnaround for funding of $3000 for original research in anaesthesia, pain medicine, and intensive care. Further information, and application criteria is available on the ASA website:

https://asa.org.au/asa-awards-prizes-and-research-grants/ or contact sdonovan@asa.org.au

webAIRS

webAIRS

Dr Ross Scott-Weekly
and the ANZTADC Case Report
Writing Group

A REVIEW OF PAEDIATRIC MEDICATION RELATED INCIDENTS REPORTED TO WEBAIRS

Medication-related incidents are common in anaesthesia.[1,2,4] Paediatric patients may pose special complexities due to weight-based dosing and the requirement for dilution prior to administration. It is likely that the true rate of medication incidents is underreported.[4] We reviewed the webAIRS database for medication-related incident reports in patients 0-16 years of age to describe common themes that emerge in children.

The webAIRS database is an Australasian database of anaesthetic incidents. It has collected anonymous reports since 2009 under qualified privilege. At the time of data analysis there were 13,411 events reported and 1,459 paediatric reports. Of those 1,459 reports, 153 incidents involved medication related events. These reports were reviewed and analysed for both for descriptive statistics but also to assess the major themes that arose.

In keeping with the main population of children having anaesthesia, the majority (82%) of patients were ASA1 and 2, having elective surgery in-hours. Approximately two thirds were elective and one third were acute cases. Eighty percent of reported cases were attended to by a specialist anaesthetist. Two thirds of reports were judged to be preventable by the reporting anaesthetist.

Medication overdose was the most common cause of reports. This was the underlying issue in 64 of 153 (42%). Eighteen cases involved opioids, including four cases where opioids were used to flush IV lines rather than saline.

Nineteen cases involved the inadvertent double dosing of paracetamol between theatre and out-of-theatre areas. The clinical scenario is usually an oral dose given pre or postoperatively and intravenous paracetamol given intraoperatively. A single inadvertent additional dose of paracetamol is very unlikely to be clinically significant,[5] however it does represent poor clinical practice and there are specific populations where it may be more significant. Intravenous paracetamol is significantly more expensive that oral paracetamol.[3] A simple way to minimise paracetamol double dosing, is minimise its use intraoperatively and only give it in select patients where the enteral route is not feasible.

There were five reports of patient exposure to previously used syringes. These incidents can have significant ramifications for patients. Blood and Body Fluid Exposure testing involves blood sampling of both recipient and donor, which in the paediatric population can be traumatic. These incidents occurred due to non-disposal of previously used drug trays, failure to remove TIVA syringes from infusion pumps or rechanging of previously used IV fluid bags and giving sets.

Thirty-six (24%) of the reports were related to allergy or anaphylaxis. Fourteen of these required admission to high dependency or intensive care units. Two of the 36 cases resulted in severe harm to the patient. The risk of anaphylaxis in children is variably reported, but likely to be less than that seen in adults.[6]

Of interest, there were only three reported cases of malignant hyperthermia, three cases of local anaesthetic systemic toxicity and two cases of suxamethonium apnoea. There were two cases of residual muscle relaxant in IV lines being flushed into the patient outside of the operating theatre.

Communication issues, especially between trainees and consultants, was commonplace throughout all the reports. Depending on the anaesthetic training scheme structure, subspecialty paediatric anaesthesia training is often undertaken as a relatively brief block. This results in high turnover of trainees through subspecialty units with entrenched norms and small cohesive teams of specialists. Assuming knowledge between the specialist and trainee in this case has led to errors in dosing, drug dilution and choice of medication for patients.

In 50% of patients, the events had no effects on the patient. A further 24% had minor effects. There were 23 cases which required an unplanned intensive care or high dependency unit admission, primarily due to allergy. There were no reported deaths due to medication incidents.

Medication related adverse events are a common cause of webAIRS reports in paediatric patients and it is almost certain that the true rate of events is underestimated here. The most common

issues were overdose, allergy and the use of a drug which was not planned to be used. The morbidity from these events appears to be relatively low. There are a few slips such as paracetamol double dosing, opioid syringe swaps, residual muscle relaxant in IV lines and reusing syringes for subsequent patients that are easy to inadvertently do. Being aware of these pitfalls may prevent some of these errors from occurring.

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ANZCA
Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine

MS SUZANNE BOWYER,
ASA OPERATIONS MANAGER

ASA 2025 MEMBERSHIP SURVEY

The 2025 ASA Member Survey provides a comprehensive assessment of the value members derive from their association with ASA, how this value varies across different member segments, and where the organisation can focus its efforts to enhance member engagement and satisfaction. Thank you to those members who participated.

THE ASA 2025 MEMBER SURVEY WAS DISTRIBUTED TO THE FULL CENSUS OF MEMBERS IN JUNE 2025. WITH RESPONSES FROM NEARLY 600 MEMBERS ACROSS ALL CAREER STAGES, WORK SETTINGS, AND REGIONS, THE SURVEY OFFERS RICH INSIGHT INTO THE CURRENT STATE OF ASA'S MEMBERSHIP EXPERIENCE.

PREPARED BY

survey matters.

Overall, the survey findings confirm that ASA continues to be highly valued by its members.

Four out of five respondents reported being satisfied with their membership and said they would recommend ASA to a colleague. These strong satisfaction and loyalty indicators reflect the association's success in delivering on its core mission—particularly its representative and advocacy functions.

Despite the high scores overall, satisfaction and engagement are not evenly distributed across the membership. Notably, members in the early stages of their careers, those with fewer years of membership, and those working in public hospitals report consistently lower satisfaction, engagement, and perceived value for money than their more experienced or private sector counterparts.

Specifically, only 75% of public hospital members reported being satisfied with their membership, compared to 84% in the private sector. Value for money perceptions were also lower in this group, with just over half (52%) of public hospital members agreeing membership is good value—15 points lower than private sector members.

Career stage and membership tenure also influence how members perceive value. Newer members—those with fewer than five years of membership—reported the lowest levels of satisfaction (72%) and were least likely to recommend ASA (69%). In contrast, satisfaction and advocacy levels increase steadily with time: among members with over 20 years of membership, satisfaction reaches 84%, and 85% would recommend ASA to others.

This suggests that while ASA's value becomes more evident over time, earlier and more intentional engagement may be necessary to retain and engage new members.

The core value proposition of ASA membership remains advocacy—both in terms of representing the role of the specialty and in influencing the broader healthcare landscape.

Advocacy was the most widely recognised benefit, rated as important by 89% of members and frequently mentioned in open-ended feedback. Members see ASA's policy work, representation in national healthcare discussions, and leadership in protecting professional autonomy as central to the value of membership. This aligns with members' strategic priorities, where representation was ranked well above other areas such as professional development, advocacy to the public, engagement, and member welfare.

The Relative Value Guide (RVG) remains a cornerstone of ASA's practical value to members. It was used by more than two-thirds of respondents, rated important by 81%, and received the highest satisfaction score of all services (87%). Its utility is especially high among private practitioners and more experienced members, and it plays a key role in helping ASA differentiate itself from other professional bodies.

Education and professional development are also important to members, particularly those earlier in their careers. Usage data show that younger members engage more with trainee exam resources, and the ASA Learning Resource Library, while more experienced members favour the ACE meetings and National Scientific Congress. Overall satisfaction with ASA's CPD offerings is strong—82% for the NSC, 75% for trainee exam support, 78% for virtual education, and 72% for ACE event.

Despite this high satisfaction, the association's competitive position in this space is less clear. Over four in five members have undertaken CPD with another provider over the last 12 months, with ANZCA the most commonly mentioned alternative provider. Only 18% of members rated ASA's CPD as "better than others," with nearly 70% stating it was about the same. This indicates that while education is a strength, it is not yet a clear differentiator and more could be done to enhance ASA's visibility and leadership in this area.

Communication also remains a critical function for ASA, and most members regularly engage with its core channels. The Presidents' newsletter and Anaesthesia & Intensive Care Journal are each accessed by 73% of members, yet only 43% and 39% respectively rated them as important. Satisfaction scores for both were also moderate, and members—particularly early-career professionals—expressed preferences for shorter, more frequent, and digitally accessible content.

Beyond these core offerings, the survey reveals that value for money, a sense of professional belonging, and perceptions of member consultation are the strongest drivers of overall satisfaction.

Encouragingly, most members feel the association provides avenues for engagement, with 72% indicating they are able to participate in ASA activities such as committees or events, and 66% agreeing that ASA seeks their opinions on professional issues.

A moderate sense of belonging is also evident—62% of members say they feel part of a respected professional community. This connection is stronger among long-standing members, with 70% of those with over 20 years of membership reporting a strong sense of professional community.

The survey also explored the challenges facing members and the wider profession.

Lack of rebate indexation was the top concern across the membership, ranked among the top three challenges by more than half of respondents. Other key challenges included practitioner wellbeing (48%), maintaining clinical knowledge (41%), and navigating complex relationships with health insurers (34%).

These concerns vary by segment: early-career and trainee members were more likely to prioritise training pathways and mental health, while experienced members were more focused on remuneration and sector advocacy. Understanding these nuanced needs will be important as ASA continues to shape its advocacy agenda.

Finally, the strategic pillar of member welfare presents both a challenge and an opportunity.

While this signifies that ASA is directing its focus to the areas of most value to members, with rising concerns around burnout, workplace culture, and work-life balance—particularly among early-career members—strengthening ASA's role in member welfare could be a valuable step in deepening member engagement and support amongst this cohort.

Positively, two thirds of members believe ASA understands the issues they face, and 72% say the association represents the profession effectively. Of note, again members in public hospitals are less likely to say ASA understands the challenges they face (51%) or that it represents their interests effectively (77%), compared to much higher agreement among private hospital members (72% and 88%, respectively).

In summary, ASA remains a highly valued organisation with strong loyalty among its membership.

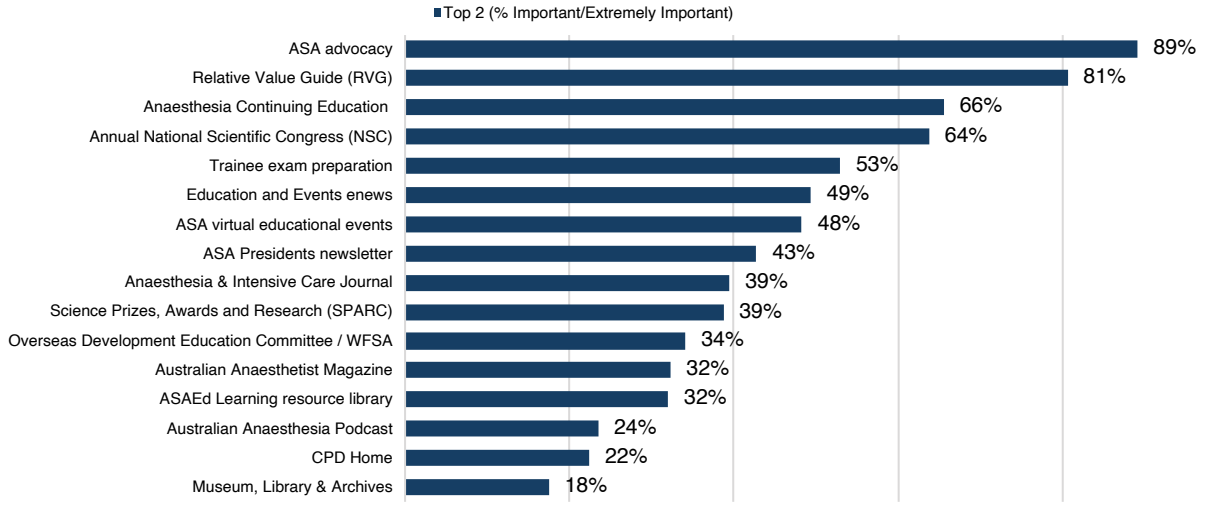
Its advocacy and representation work are central to its identity and clearly appreciated and there is strong engagement with core professional development and training resources. However, there is an opportunity to improve the membership experience for early-career professionals, public hospital members, and those newer to the association.

By focusing on its CPD offering, evolving its communications, listening more actively to members, and investing in member wellbeing, ASA can strengthen its value proposition and ensure relevance to the full spectrum of its professional community.

Thank you once again to all members who took the time to participate in the survey. Your feedback is incredibly valuable and will play a key role in shaping our strategic direction and priorities moving forward. We're committed to listening and learning from your insights, and as part of this commitment, we'll be conducting this survey every two years to ensure we stay aligned with your needs and expectations.

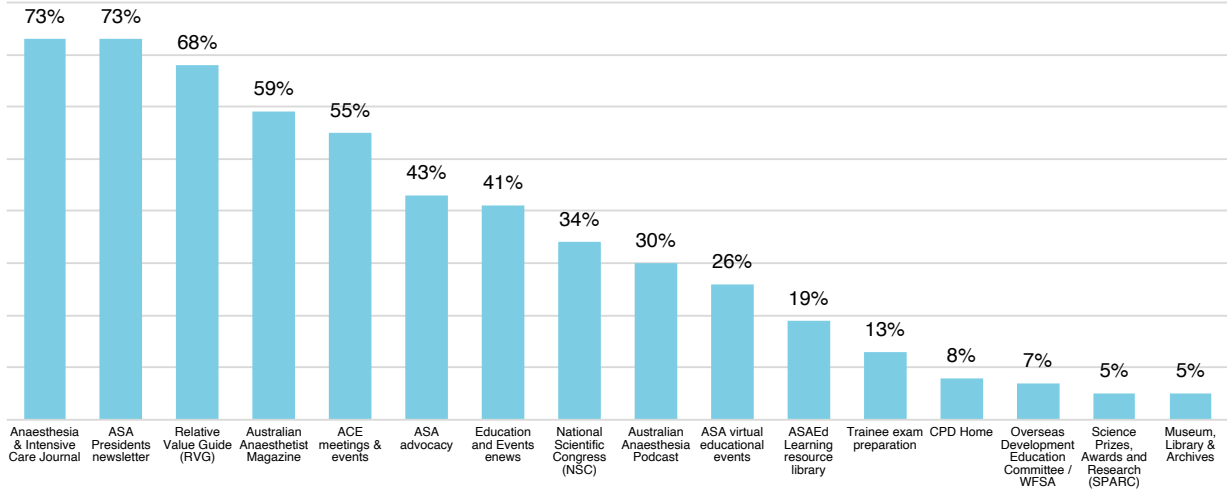
MEMBERSHIP BENEFITS

Core advocacy, clinical resources and education are most valued by ASA members

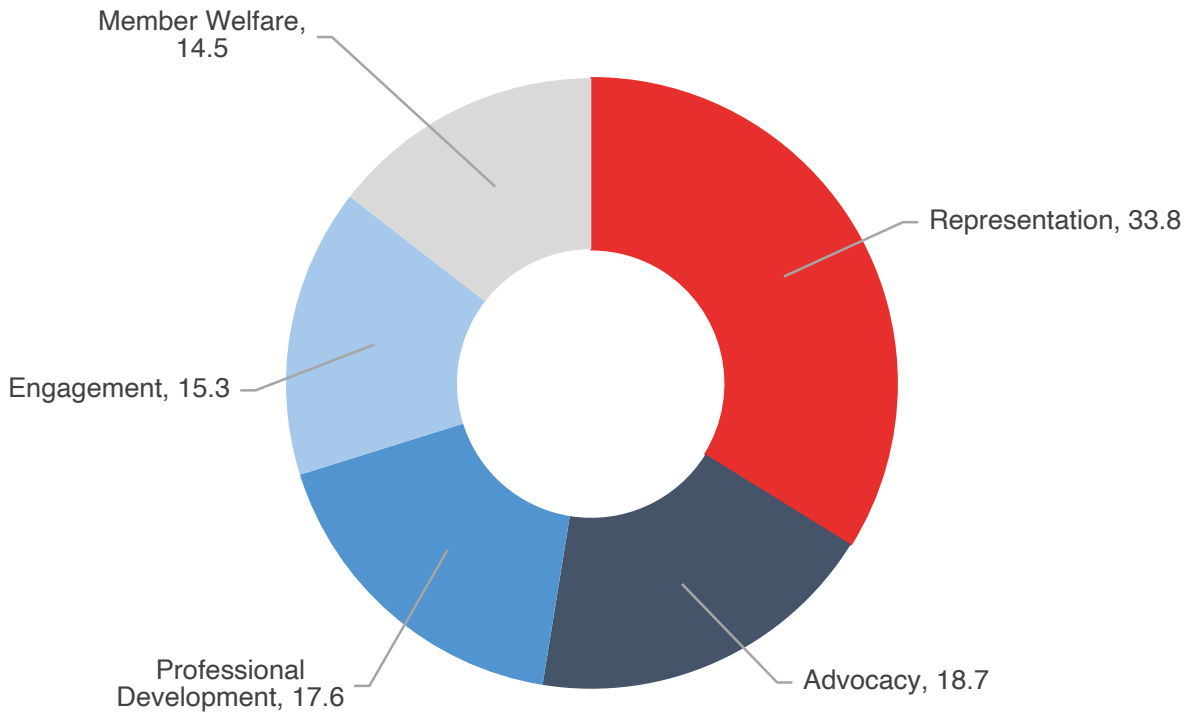


SERVICE USAGE

Traditional publications and professional tools are the most widely accessed



Strategic Priorities



Representation: Advocating for the anaesthesia specialty to stakeholders, ensuring that the interests and expertise of anaesthetists are effectively communicated and considered in healthcare discussions and policies.

Advocacy: Promoting patient and community access to anaesthesia services, ensuring equity in care, and enhancing patient education to improve understanding of anaesthesia and related procedures.

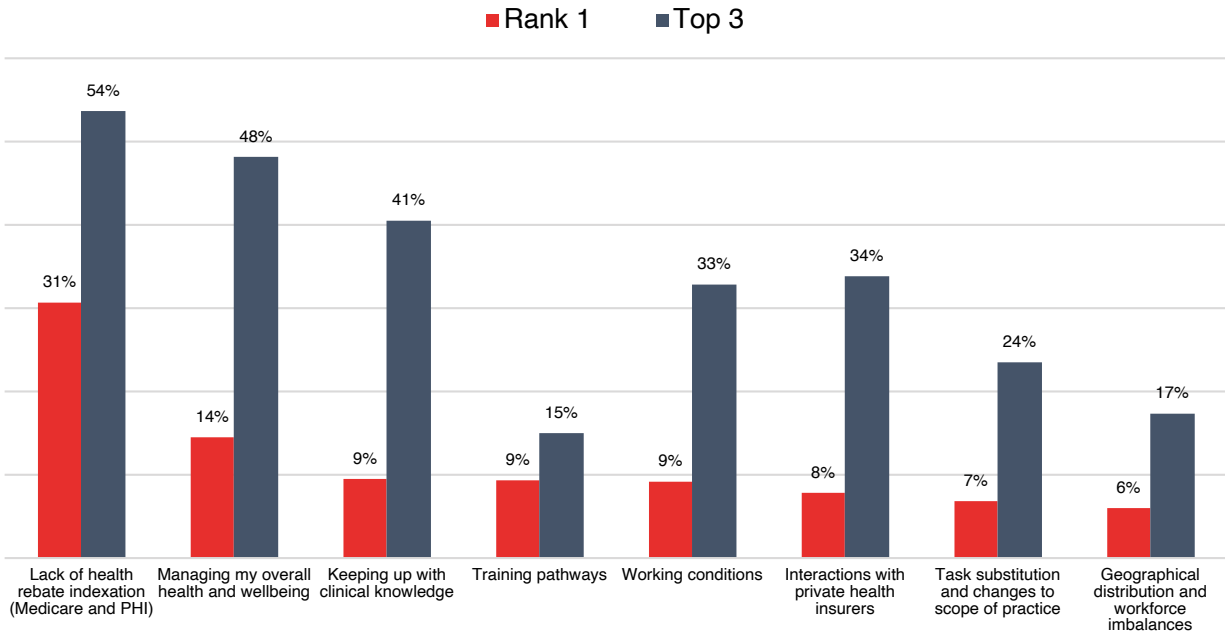
Professional Development: Offering continuous professional development activities and resources to improve the skills and knowledge of anaesthetists

Engagement: Fostering active involvement with anaesthetists, providing valuable member services, facilitating communication among practitioners, and building a supportive professional community.

Member Welfare: Supporting the welfare and wellbeing of members by prescribing high standards of practice and professional conduct and maintaining a healthy and effective workforce.

WHAT YOU TOLD US: ANAESTHESIA CHALLENGES

Rebate indexation and wellbeing are the most pressing career challenges



Two-thirds of ASA members (67%) believe the leadership understands the challenges they face, with strong agreement among long-term members (71%) and those in private hospitals (72%). These results reflect broad confidence in ASA's leadership and suggest that its efforts to engage with member concerns are being recognised

DR MICHAEL LUMSDEN-STEEL
EAC CHAIR

ECONOMICS ADVISORY COMMITTEE

Out of Hospital Anaesthesia

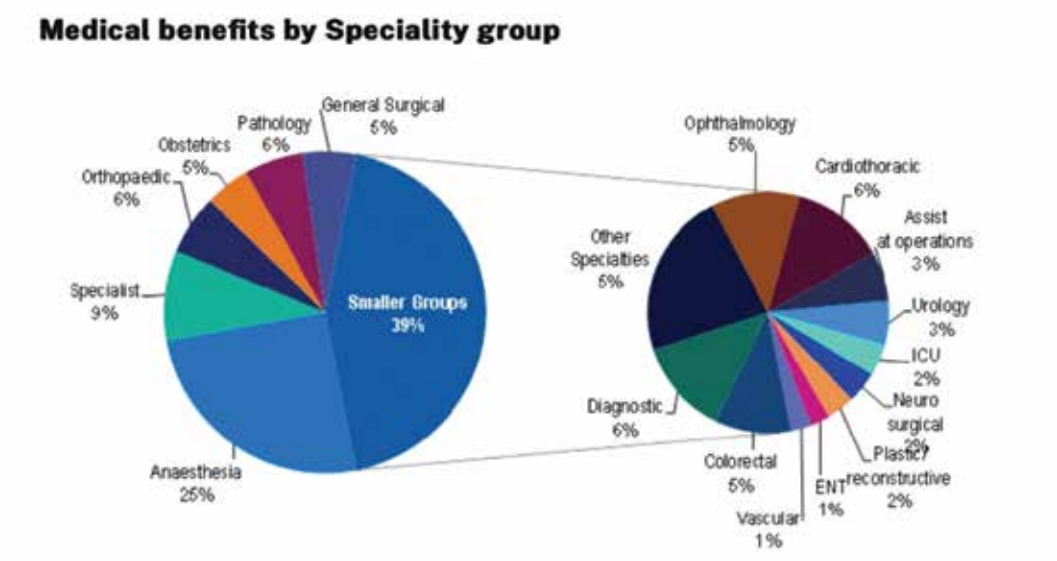
The Department of Health and Aged Care 75-85% project team continues to review MBS items and align the assigned MBS benefit to the clinically appropriate location for services – which the MBS defines as being In Hospital, or Out of Hospital. A 75% MBS rebate applies when the eligible service is provided in-hospital (at a designated Hospital), whereas the 85% rebate applies when the service is provided out-of-hospital (e.g., in a separate clinic or private rooms).

The ASA is keen to hear from any member performing out of hospital anaesthesia (excluding anaesthesia for dental procedures 20900 and 20905), by contacting the ASA policy team and advising the procedures being done, and the anaesthesia RVG items being claimed.

At the time of writing, the Department has not been able to confirm when MBS items 23010, 25000, 25014 will have their 85% rebate reinstated.

Insurance Summit

In late June I attended the Private Health Insurance Summit (PHI Summit) in Melbourne with ASA Policy and Public Affairs Manager, Bernard Rupasinghe. Despite there being no actual presentations by anaesthetists, anaesthesia was the most mentioned specialty over the two days. The Australian Prudential Regulation Authority (APRA) reports that anaesthetists receive 25% of all PHI payments made



to specialists, followed by Specialist (unspecified) at 9%, and orthopaedic, cardiothoracic, pathology and diagnostic at 6%.[1]

The big themes relevant to anaesthetists discussed at the meeting were Out of Pocket Costs, Ambulatory Surgical Centers, Sustainability of Private Hospitals, Bundled Fees, No Gapping Short Stay Procedures, Public in Private, and the Medical Cost Finder.

Out of Pocket Costs

Anaesthetists were mentioned in relation to "out of pocket" (OOP) costs (the ASA prefers the term ***insurance shortfall***). The points of contention raised in discussions around OOP was the "drip feeding of OOP" costs, i.e. the patient receives the surgeons fee, followed by the surgical assistants fee and finally, the anesthetists fee (including on the day of surgery). Anaesthetists in particular were singled out for on the day of surgery "fee pressure", with anecdotal examples of pre-anaesthesia IFC (including an OOP greater than $500.00) and of the anaesthetists advising the patient that if they didn't pay the fee, the procedure wouldn't go ahead. This dripping feeding of OOP costs is one of the reasons insurers are arguing for fees to be bundled – to avoid what the PHI's repeatedly refer to as "*bill shock*". In the room there was little support for Informed Financial Consent (IFC) being provided on the day by a specialist where there is an insurance shortfall.

The gold standard for IFC[2] is a written estimate of the fee (a range is acceptable), together with a reasonable indication of the likely out-of-pocket expenses, provided to the patient prior to the day of the procedure, along with written acceptance by the patient. The ASA acknowledges that this standard will not always be achievable, but it invites anaesthetists to arrange their practices to attain this objective wherever possible. Obtaining IFC from patients is sound, ethical, professional practice. Ultimately, IFC is also good business practice and will result in fewer disputes over accounts, lower debt recovery costs, fewer bad debts, and increased patient satisfaction.

Communicating with patients is critical, including when introducing yourself to the patient, as part of the pre-anaesthesia consultation and, ideally, obtaining written IFC. Ideally, establishing clinical rapport with a patient, and any pre-anaesthesia consultations would be kept separate from fee discussions, although this is not always practical or possible.

The Department of Health Medical Costs Finder Team have commented that patients are not necessarily expecting a no-gap experience, but a critical component of this is appropriate IFC, timeliness of IFC, and communication with the patient that is clear, transparent, respectful, and avoids pressure or coercion by the anaesthetists on the day of the procedure. Patients have the right to cancel a procedure on the day of surgery if they are, for whatever reason, not willing to proceed. Clearly, cancellations have flow on effects for the patient, the list, hospital activity and funding, and potentially your relationship with proceduralists.

Medical Costs Finder website

Earlier this year the Government announced additional funding for the Medical Costs Finder website[3] to deliver the technical capability to analyse annual Medicare, hospital and insurer data for every common medical service and display the average fee that each doctor charged, alongside the national average for that service. It remains to be seen whether the Department will report individuals fees, and how the range of fees will be presented.

Requesting prepayment of fees

Where prepayment is requested for those patients who are self-funding, or where anaesthetists are not participating in PHI No Gap or Known Gap schemes, an itemised account for the services should be sent to the patient **within 10 days** of the service being provided to enable them to recover the Medicare and PHI rebates for the anaesthesia services provided. The ASA has received correspondence from patients who are frustrated that they have were asked to prepay for their anaesthesia service but have then been unable to obtain an invoice for the service to facilitate their refunds, which is necessary for the patient to be able to claim and receive the patient Medicare rebate.

Communicating with patients is critical, including when introducing yourself to the patient, as part of the pre-anaesthesia consultation and, ideally, obtaining written IFC. Ideally, establishing clinical rapport with a patient, and any pre-anaesthesia consultations would be kept separate from fee discussions, although this is not always practical or possible.

Ambulatory Surgical Centres and short stay joint replacements

The cost benefits of Ambulatory Surgical Centres (ASCs) and short stay joint replacements were also promoted at the PHI Summit. The benefits of specialised centres, with teams working together regularly, combined with online support for home rehabilitation programs, were presented. A high volume orthopaedic surgeon (around 800 joint replacements per year) presented the pathway for same day discharge, overnight stay / discharge next day and rehabilitation at home, the systems required and patient satisfaction for these pathways. Arguments were strongly made by some PHIs this is a good way, and that high volume centres are providing high patient satisfaction scores. PHIs have been working with hospitals to establish joint replacements programs, which has usually involved some form of uplift payment to the doctors, and/or allowing a maximum known gap fee, to provide fee certainty for patients, and reduce the patients out of pocket expenses.

A counter argument was put forward by a major hospital group during one of the panel discussions. The "cherry picking" of the fit, healthy low complexity patients undergoing major elective surgery

at ASC's leaves the more complex cases (patient ASA, comorbidities, surgical complexity and rehabilitation requirements) to be undertaken in the private hospitals that are resourced to support complex care. These hospitals raised concerns that they are financially penalised when surgeons choose to undertake high volume surgery at ASCs, where those ASC's are paid the same facility fee as a hospital that maintains ICU and other services to support complex surgery being undertaken. Large private hospitals may also have emergency departments, support after hours emergency surgery, which requires specialists also participating in an on call roster and accepting patients referred from Emergency Departments for admission under their care.

Bundled fees were raised by PHI's, particularly with respect to obstetric care, as a strategy to avoid "bill shock" with the fee being paid to the Obstetrician and all subsequent fees being paid to specialists from the primary specialist. The scope to explore private midwife led care in private was again mentioned.

NO Gapping short stay procedures was mentioned as a high priority by the PHI's, but little further information was provided was to what this means.

Public in Private was also raised as an option to help public hospitals meet clinically recommended timeframes.

Grattan Institute Report on Specialist Care

Most anaesthetists would be aware of the recently published report by the Grattan Institute: **Special treatment: Improving Australians' access to specialist care.**[4] The report makes many recommendations, including withdrawing all Medicare funding from specialists who charge extreme fees (defined by Grattan as fees that are, on average, more than three times the schedule fee).

The Grattan Report fails to make any mention of Government indexation Medicare Items below CPI, let alone health CPI for Medical, Dental and Hospital Services (approximately 1.5 times CPI)[5]. The Anaesthesia RVG, implemented in 2001, has never been indexed at CPI, and between 2012 and 2019 Medicare rebates were frozen. Quoting the Grattan report:

There is no good reason for these extreme fees. They aren't needed for specialists to be fairly compensated for their skills, or to provide quality care. They don't cross-subsidise care for poorer patients. But they do stop people from getting care they need. And most patients lack the information or ability to shop around to avoid them.

The federal government should remove public funding from specialists who charge extreme fees, and name them publicly.

By this definition, any anaesthetist charging the AMA Fee, or setting their RVG higher than $69.30 is an extreme biller. This is just nonsense. It is unclear how the Grattan Institute determined an extreme fee as being anything greater than MBS fee x 3, or what the Grattan Institute defines as "fairly compensated".

This sentiment is alarming and punishes patients, not doctors, by denying Medicare rebates to patients who have received a Medicare eligible service.

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1. APRA (2025). Quarterly private health insurance membership and benefits summary - March 2025 | APRA. [online] Available at: https://www.apra.gov.au/quarterly-private-health-insurance-membership-and-benefits-summary-march-2025.
2. The ASA Position Statement on Informed Financial Consent. Available at https://asa.org.au/wp-content/uploads/2024/05/ASA_PS04_Informed-Financial-Consent.pdf.
3. https://medicalcostsfinder.health.gov.au.
4. Grattan Institute. (2025, June 16). Special treatment: Improving Australians' access to specialist care - Grattan Institute. https://grattan.edu.au/report/special-treatment-improving-australians-access-to-specialist-care/
5. Medical, Dental and Hospital Services increased 4.6% in the 12 months to March 2025. See https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/latest-release.

MBS Item	MBS Fee	MBS Fee x 3	AMA equivalent	AMA Fee	% of MBS fee
Pre-anaesthesia Consultation					
17610	$50.95	$152.85	CA002	$212.00	416%
17615	$101.30	$303.90	CA004	$424.00	419%
17620	$140.30	$420.90	CA006	$636.00	453%
17625	$178.70	$536.10	CA008	$848.00	475%
Pain Medicine Consultation – Pain Medicine Specialist					
2801	$178.70	$536.10	AF010	$415.00	232%
2806	$89.40	$268.20	AF020	$190.00	213%
2814	$50.95	$152.85			
2824	$216.75	$650.25	AF040	$490.00	226%
Anaesthesia RVG					
1 RVG Unit	$23.10	$69.30	1 RVG Unit	$106.00	459%

DR JAMES HOSKING
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

THIS IS MY FIRST CONTRIBUTION TO AUSTRALIAN ANAESTHETIST HAVING TAKEN OVER THE CHAIR ROLE FROM DR PETER WATERHOUSE AT THE COUNCIL MEETING IN MAY. CONGRATULATIONS AND THANKS TO PETER FOR ALL HIS HARD WORK SINCE 2020 AS THE CHAIR OF PIAC.

I asked Google Gemini "How has anaesthesia practice in Australia changed since 2020?"

It's response included the following:

Changes in Training and Exams

- **Exam Modifications:** The Australian and New Zealand College of Anaesthetists (ANZCA) adapted exam formats, including exploring hybrid or online options and removing some components (e.g. the patient clinical interaction from the medical viva).

Technological Advancements

- **Artificial Intelligence (AI):** AI is increasingly being explored and integrated into anaesthesia:
  - Predictive analytics: AI systems analyse patient data to predict complications like hypotension or postoperative nausea and vomiting, aiding in proactive management.
  - Automated workflows: Machine learning models aim to streamline anaesthesia administration, reduce human error, and optimise perioperative operations.
  - AI-driven pain management: Algorithms are being used to guide personalised pain management techniques.
  - Image optimisation in ultrasonography: AI assists in optimising images, identifying anomalies, and performing automated measurements in point-of-care ultrasonography, which has rapidly expanded in the perioperative setting.
- **Advanced Monitoring Technologies:**
  - Non-invasive haemodynamic monitoring: Devices offering real-time cardiac output and fluid status monitoring without invasive catheters are becoming more prevalent.
  - Depth of anaesthesia monitoring: Technologies like bispectral index continue to play a role in minimising intraoperative awareness.
- **Digital Health and Telemedicine:**
  - Tele-anaesthesia: Remote monitoring and consultation are being used to provide care in rural or resource-constrained environments.
  - Electronic Health Records (EHR): Enhanced EHR systems facilitate communication and decision-making across perioperative teams.
- **Robotics:** While still emerging, robotic technologies are being explored for:
  - Robotic-assisted regional anaesthesia: To improve needle insertion and nerve localisation accuracy.
  - Automated intubation devices: To ensure precise airway control.

Evolution of Guidelines and Evidence-Based Practice

- **Rapid development of guidelines:** The rapid influx of new medical information, particularly during the pandemic, accelerated the development of clinical practice guidelines.
- **Living and focused guidelines:** There's a move towards "living" guidelines that are continuously updated and "focused" guidelines that address specific topics more rapidly.
- **MBS Changes:** The Medicare Benefits Schedule for anaesthesia services has been updated (e.g. in March 2022) to align with contemporary clinical practice and support high-value care, following recommendations from review taskforces.

Workforce and scope of practice

- **GP Anaesthesia:** The Joint Consultative Committee on Anaesthesia continues to oversee and examine general practitioner registrars undertaking advanced rural skills training in anaesthesia, acknowledging the ongoing need for GP anaesthetists in rural and remote areas. The curriculum for GP anaesthesia was updated in 2020.
- **Perioperative nursing roles:** Amendments have been made to perioperative nursing standards, including the inclusion of enrolled nurses in the anaesthesia nurse role (with appropriate supervision and competence).
- **Expanding roles of other professionals:** Discussions and initiatives are emerging around expanding the scope of practice for other healthcare professionals, such as registered nurses and physician assistants, into perioperative care, including 'sedationist' roles. This is a point of ongoing discussion and professional advocacy to ensure patient safety and quality of care.
- **International Medical Graduates (IMGs):** There is an ongoing focus on efficient recruitment and employment of IMGs to address workforce shortages, with ANZCA playing a key role in assessing their skills and qualifications.

While I am yet to see many of the AI improvements as mentioned in my own practice, there is clearly movement in many of the other areas of practice. The MBS continues to be a target both for Government and the media with many 'experts' receiving large amounts of column space in national broadsheets. Expanded scope of practice in Australia already includes pharmacy prescribing models and nurse sedation models.

Looking back to Peter's first PIAC report in Australian Anaesthetist in 2020, there are several aspects that are still pertinent in 2025:

- Bundled care: 'No gap' models and 'fixed fee' models continue to be instituted around the country. The ASA continues to be concerned with models where the insurers place themselves between the patient and the doctor, with our belief in patient choice, clinical autonomy and the Anaesthesia RVG.
- Real-time prescription monitoring: This has been rolled out in many jurisdictions now, with the ACT being next on the list. Most states have exemptions for all in-hospital prescriptions, while Queensland originally had no exemptions but now has exemptions for all in-hospital activities, but notably not discharge prescriptions.
- Public-in-private surgery: Most jurisdictions are now of the belief that this is the panacea to all long waiting lists. Many funding models exist around the country from fixed hourly rates, to various levels of the RVG for remuneration. The ASA is still concerned about appropriate preoperative workup of these patients and access to pre-existing medical records.

In my time as Chair PIAC the ASA will continue to advocate for the profession as a whole while also providing advice and support for individual members. In the words of Jean-Baptise Alphonse Karr "the more things change, the more they stay the same".

ASA ARCHIVES AUDIO-VISUAL RECORDS

THE ASA HOLDS MANY HISTORICAL ITEMS AND BOOKS IN THE HARRY DALY MUSEUM AND THE RICHARD BAILEY LIBRARY. A LESS OBVIOUS PART OF THE ASA'S RECORDS IS THE LARGE NUMBER OF AUDIO-VISUAL RECORDS HELD IN THE ARCHIVES.

During a visit to the American Society of Anesthesiologists, Dr. Richard Bailey was impressed by the very large collection of taped interviews with senior members of the speciality. On return to Australia, he sought to set up a similar collection here. From the early 1980s, with the assistance of the Royal Prince Alfred Hospital Anaesthetic Department (especially Professor Doug Joseph and Dr. John Loadsman), interviews were carried out with many senior anaesthetists. Initially these were recorded using two cameras and recorded to U-Matic tape. This format was limited to one hour so often more than one tape was needed.

Over the years many recording formats were used for interviews including U-Matic, audio cassettes, VHS, CDs, and DVDs. In recent years it has become obvious that these formats have a limited life, especially the magnetic tapes, and the HALMA Committee has been gradually converting them to computer readable MP3 or MP4 files. Some of the U-Matic tapes had already been converted to DVDs by the foresight of Richard Bailey and previous curator Peter Stanbury.

The Anaesthetist Interviews converted to date are:

- Dr Ben Barry interviewed by Dr Brian Horan 29/07/1986
- Dr Brian Dwyer interviewed by Prof Doug Joseph 16/10/1988
- Dr Brian Pollard interviewed by Dr John OLeary 18/09/1986
- Dr Charles Sara interviewed by Dr John Overton Part 1 16/10/2001
- Dr Charles Sara interviewed by Dr John Overton Part 2 16/10/2001
- Dr Charles Sara interviewed by Prof Doug Joseph 20/05/2005
- Dr Geoffrey Kaye "The Way it Was" 1983 Part 1
- Dr Geoffrey Kaye" The Way it Was" 1983 Part 2
- Dr George Davidson interviewed by Dr Richard Bailey 25/05/2005
- Dr Gwen Wilson interviewed by Dr Richard Bailey June 1995
- Dr Ivan Shalit interviewed by Dr Owen James
- Dr Kevin Byers interviewed by Prof Ross Holland 18/12/2001 (MP3)
- Dr Len Shea interviewed by Dr Brian Dwyer 23/05/2005
- Dr Maude interviewed by Dr Richard Bailey 19/01/1974
- Dr Patricia Coyle interviewed by Prof Ross Holland 17/03/2000 (MP3)
- Dr Peter Heery, & Dr Harry Windsor, interviewed by Dr Richard Bailey 1986 (MP3) - on early cardiac surgery
- Dr Phil Jobson interviewed by Dr Richard Bailey 25/05/2005
- Dr Judy Nicholas interviewed by Dr Richard Bailey
- Prof Doug Joseph interview by Dr Brian Dwyer 1988

Also in the Archives are many recordings of documentaries and of papers presented at Annual General Meetings of the Society.

Documentaries include:

- A Very Great Matter - A history of anaesthesia1988
- Augustine Guide for orotracheal intubation 1992
- Documentary on Anaesthesia 1974
- Interplast Australia "A second chance"
- Movie by Dr Gordon Troup 1932 re ether and blind tracheal intubation
- "Open Drop Ether" 1944 Westminster Hosp.
- Eclampsia pre 1941

A notable record of the papers presented at AGMs is Dr. Gertie Marx's paper: "Evolution of Obstetric Anaesthesia"

The HALMA Committee hopes that in the future access to these files should be available to members on a devoted computer in the Harry Daly Museum at the ASA headquarters and/or on the ASA website.

Dr William Herlihy

HALMA

References

https://www.woodlibrarymuseum.org/library/living-history/

AROUND AUSTRALIA

Australian Capital Territory

Dr Valerie Quah

Chair of the ACT Committee of Management

Canberra anesthetists are busy preparing for the ASA National Scientific Congress in October, led ably by conveners Dr Girish Palnitkar and Dr Adam Eslick.

It is shaping up to be an excellent meeting with robust academic content and great networking opportunities. We look forward to welcoming our interstate and international delegates.

A new Staff Specialist contract for Canberra Health Services has been finalised. Dr. Lance Lasersohn has driven the negotiations which sees a significant uplift in remuneration for high-fraction staff specialist anaesthetists.

And finally, we recognise the efforts of Dr Vida Viliunas whose indefatigable contributions as Vice President of the ASA and ASA Education Officer continue unabated!

Queensland

Dr Brett Segal

Chair of the Queensland Committee of Management

The last few months have been busy for representation of our specialty at state level. A delegation from Federal ASA and State Committee met with Queensland's Minister of Health, The Hon Timothy Nicholls. This productive meeting was geared towards workforce issues, with ASA CEO Dr Matthew Fisher presenting the ASA's Anaesthetist Workforce Modelling Report to the Ministry which showed an increasing workforce crisis not only in Queensland but nationally. We pushed the fact that to have more specialist anaesthetists, of which there are in excess of 80 FTE funded positions vacant in Queensland alone. The Government needs to train more anaesthetic registrars. This requires additional funding for these positions in the public hospital system, especially in regional Queensland where shortages are 'hardest hit'. There is also an option of looking at increasing training capacity in our ANZCA-accredited private hospitals. We reminded Government that ANZCA do not control training numbers, more so the government through their funded posts. Anaesthesia continues to increase in popularity amongst new graduate doctors with plenty of good quality candidates waiting to be allocated a spot on our State's training scheme, QARTS. It was good to see in the recent state budget there was increased funding for more clinical positions, although it will have to be seen how this funding is allocated. We also discussed Public-in-Private and the Surgery Connect Program and the ongoing struggles with adequate and consistent remuneration around the State.

The same delegation also met with Senior Directors at the Department of Health's Surgery Connect Program. We were delighted to hear that a central on-line repository of clinical documentation will be accessible to clinicians taking care of Surgery Connect patients. This unfortunately does not extend to local hospital and health service outsourced patients. The issues with negotiating with local private hospitals for terms, conditions and remuneration will continue as centrally based negotiations ended a long time ago and there are no plans to restore this as the program has grown significantly. They did suggest that those patients allocated to Surgery Connect may offer a better bundled value (compared to the local HHS outsourced patient) should the private facility wish to pursue that in their negotiations with Surgery Connect. At the time of the meeting the funding for the Surgery Connect program was being reviewed and it appears from the recent Budget there has been a substantial injection of funds into the program that

will be recurrent over the next 4 years, meaning we are likely to see even more of these cases appearing in private facilities.

Ongoing negotiations by the ASA continue with private hospitals including Uniting Healthcare and Mater Misericordiae with some progress being made with an uplift in the unit rates offered for some procedures. We continue to negotiate on behalf of our members but would encourage our membership to get your non-member colleagues to join the ASA as they will get the benefits of this ongoing process.

I, along with ASA Executive Councillor, Dr Peta Fairweather, attended Queensland Health's Statewide Anaesthesia and Perioperative Clinical Care Network (SWAPNet) Forum. There was significant discussion concerning workforce issues and it was encouraging to see that SWAPNet, which is the body that reports directly to government, are saying the same thing as the ASA told government representatives previously.

At the time of writing we are planning the Part 3 Course which will be held on the last Saturday of August to be followed by a social networking event in the evening.

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

It's been a busy few months in WA with **ACE events** taking centre stage.

The **Major Haemorrhage Workshop**, held on 28 April, marked the third event in the 2025 ACE WA Lecture Series. This popular session featured a station-based format that maintained participant engagement throughout the evening and offered a balance of case-based discussions and practical, hands-on learning.

Special thanks are extended to workshop lead facilitator Dr Rebecca Monaghan, and to the session facilitators: Dr James Anderson (RFDS), Dr Roger Browning (KEMH), Dr Andrew Challen (FSFHG), Dr Clinton Ellis (SCGH), and Dr Jamie Salter (KEMH), for their valuable contributions to the program's success.

The **Human Factors workshop**, led by our local multi-talented human factors expert (and anaesthetist!) Dr Andrew Challen (FSFHG) was held on May 21. Dr Challen discussed his experience with prehospital and emergency teams across the globe where optimisation of human factors has been critical to successful management of critically injured and ill patients.

This interactive small-group discussion explored key facets of human behaviour associated with crisis management and team training with a case-based focus and drawing on participants' own experiences.

June saw the team in Broome for the WA ACE Country Conference, themed 'Kimberley Dreams and Trauma Teams' and convened by Dr Pallavi Kumar (FSFHG) and Dr Kiara van Mourik (RPH). The conference featured diverse and incredibly knowledgeable multidisciplinary speakers from around Australia, and explored the unique challenges of delivering an effective trauma and medical retrieval service in the vast landscape of Western Australia and other limited-resource settings.

Dr Jennifer Stedmon, a stalwart of WA anaesthesia and humanitarian work, was our esteemed keynote speaker and presented her lifetime's worth of work around the world.






Malignant Hyperthermia and Acute Severe Behavioural Disturbance workshops provided Emergency Response CPD for attendees, while a field workshop to the Broome RFDS base provided attendees with hands-on experience of prehospital trauma care in regional WA.

We would like to thank all of our amazing speakers and workshop convenors for their time and effort in contributing to the conference, and Melanie Roberts and Ineke Krom from the ANZCA WA office for their commitment and hard work in delivering an excellent event.

Advocacy and representation by the ASA (WA) Committee has also continued in areas of private maternity services, public in private patients and billing, and various safety issues. We thank ASA Federal and the AMA WA for their ongoing support, and welcome feedback from members.

South Australia / Northern Territory

Dr Nicole Diakomichalis

Chair of the South Australia / Northern Territory Committee of Management

The SA/NT Committee met in person this May to discuss various issues affecting the anaesthesia workforce. One of the main issues is the closure of the private maternity unit in the Northern Territory. It is expected that the public hospital will take on approximately 300 births per year as a result. We await further news as how this is managed over the coming months and will continue to provide advice and support going forwards.

Some great news from South Australia is that the protracted negotiations with Return to Work SA (RTWSA) has resulted in a significant improvement to remuneration for our services. As mentioned previously, anaesthetic services have had a fixed rebate for the last 14 years in SA. We can now expect an 85% increase to all Anaesthetic item numbers for services provided for RTWSA work.

These negotiations commenced two years ago and the SA/NT ASA would like to acknowledge the efforts of the Australian Medical Association SA Vice President and ASA committee member Dr Louis Papilion for his role in securing this deal. We would also like to acknowledge RTWSA who negotiated in good faith throughout this process, which was at times a complicated issue.

We will continue to push for parity with our interstate colleagues who are awarded AMA rates for their work. We need to simplify this process so we don't have to enter these lengthy negotiations again. We will argue for legislative changes to link remuneration to the AMA fees list published annually.

We are continuing to organise the Part 3 course for this year as well as other networking events such as Bright Young Things, an event open to new consultants, which we plan to hold in the new year.

DR JEANETTE RAE THIRLWELL

28/10/1938 — 30/05/2025

DR JEANETTE THIRLWELL WAS WIDELY KNOWN TO THE ANAESTHESIA COMMUNITIES OF AUSTRALIA AND NEW ZEALAND, AND INDEED GLOBALLY, DUE TO HER SKILLS IN MEDICAL PUBLISHING AND EDITING. SHE WILL ALSO BE REMEMBERED AS AN OUTSTANDING PAEDIATRIC ANAESTHETIST IN SYDNEY.

Jeanette grew up in Sydney and attended North Sydney Girls High where she was Vice-Captain and excelled at languages and hockey. She graduated in medicine from the University of Sydney in 1962 and represented the University in A-grade hockey. She also maintained her interests and lifelong love of music, playing both cello and piano, and was an avid concert goer.

As a junior resident at Royal North Shore hospital, she cared for a patient with a crushed chest injury, placed "on a new-fangled thing, a Bird ventilator". This made her more determined to learn about respiratory support and anaesthesia. She spent her second year in 1963 at the Royal Alexandra Hospital for Children (RAHC) (the Children's Hospital at Camperdown) where she was later to devote most of her clinical career.

Over the next eight years, Jeanette undertook her anaesthesia training and extensive higher level paediatric anaesthesia in Nottingham in England, Rotterdam in Holland, Hobart, Melbourne, Sydney, and two years as Assistant Professor at Stanford University in California. She returned to the Children's Hospital at Camperdown in 1971 where she was to spend the next 35 years of her professional career, finishing at the Children's Hospital at Westmead in 2005 (where RAHC had been moved to in 1995). A major component of her clinical work was for challenging paediatric cardiac surgery, and she was described by one of her senior cardiac surgical friends as "a good person and a rock-solid colleague".

Jeanette's other forte was in medical editing and publishing. She started in 1976 as an assistant to Dr Ben Barry, the founding editor of Anaesthesia and Intensive Care, and this was the start of over forty years of major involvement with the journal and the Australian Society of Anaesthetists (ASA) until the last few years of her life. She became Assistant Editor in 1979, was awarded a Diploma of Publishing and Editing in 1989, and held various positions, being the Executive Editor from 1993 until 2014. Nothing happened within the journal without Jeanette knowing about it and being sure it was correct and appropriate!

In 2005 with her friend and colleague Dr Richard Bailey, she initiated the Journal's annual History Supplement which continues to publish scholarly historical works related to anaesthesia and related fields. Jeanette and Richard edited this for nine years and it remains the single global publication still devoted to the history of our specialty for independently submitted manuscripts. It is a fitting tribute that the annual Best Paper Award in Anaesthesia and Intensive Care was renamed the Jeanette Thirlwell Best Paper Award in 2014 by the Chief Editor at the time, Dr Neville Gibbs.

Jeanette was also editor of the ASA Newsletters from 1994 until 2012 – the precursor to today's Australian Anaesthetist. These newsletters ensured the anaesthetists of Australia were kept well informed on all national developments – and it was this cohesive, collegial and all-inclusive approach that marked her style.

Jeanette loved history and was a stalwart in all areas of anaesthetic and medical history, including the corporate history of the ASA. Jeanette was a close friend and supporter of Dr Gwen Wilson, a world-class anaesthetic historian who recorded the history of the ASA and the development of anaesthesia in Australia from 1846. Jeanette edited the two volumes of Gwen's *One Grand Chain, the History of Anaesthesia in Australia*, and she engineered and coordinated the Gwen Wilson Archives Project cataloguing all of Dr Wilson's historical records that are archived within the ASA. Jeanette was a passionate supporter of our history in all its forms.

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Jeanette organised and chaired many conference sessions for the ASA and the Australian and New Zealand College of Anaesthetists (ANZCA). She was an inaugural member of History of Anaesthesia Library, Museum and Archives (HALMA) committee within the ASA, honorary curator of the Harry Daly Museum 2001—2017, chaired the History of Anaesthesia Special Interest Group, and was Co-Chair of the very successful 8th International Symposium for the History of Anaesthesia held in Sydney in 2013.

Some of the major publications that Jeanette edited and was involved with include:

- 1992 Kerr D, Thirlwell J. Australasian Anaesthesia (The Blue Book), ANZCA
- 1995 Wilson G. One Grand Chain. Volume 1. The History of Anaesthesia in Australia 1846¬—1934. ANZCA
- 2004 Wilson G, Kaye G, Phillips G, Baker B. One Grand Chain. Volume 2. The History of Anaesthesia in Australia 1934—1962. ANZCA
- 2004 Wilson G. One Grand Chain Vol 1. Book of References. ANZCA
- 2014 Phillips GD. Intensive care medicine in Australia. Its origins and development. ANZCA
- 2016 Cooper MG, Ball CM, Thirlwell JR. History of Anaesthesia VIII. Proceedings of the 8th Symposium on the History of Anaesthesia. ASA.

Many did not realise that Jeanette also served on the Publications Committee of the World Federation of Societies of Anaesthesiologists and edited the major paediatric anaesthesia textbook *Understanding Paediatric Anaesthesia* (two editions) with Charles Cote and Rebecca Jacobs. This became a very important text in low-resource settings, being used around the world.

Jeanette's commitments and many contributions over many years have been acknowledged by her peers with the following awards

- 1994 President's Award ASA
- 1997 Robert Orton Medal ANZCA
- 2000 Ben Barry Medal ASA
- 2005 Life Membership of the ASA

Jeanette Thirlwell to all her professional colleagues was quiet, unassuming, focused and very determined to contribute and achieve – and always at the highest level. She had a quick and dry sense of humour, her office and desk in the ASA were like her – meticulously organised! She sat on an early Faculty of Anaesthetists Committee for the training of women in anaesthesia, wrote an editorial and was an underappreciated role model for women in anaesthesia and medicine. Her editing work was extremely time consuming, but this was achieved efficiently along with her clinical work, a busy family life, and time for classical music, sailing and cross-country skiing.

In an email to me in 2007, she stated:

"I've loved my involvement in all aspects of my appointments … One of the most stimulating jobs recently is reviewing and editing and assessing the value of new and standard texts for developing countries. It gives one a sense of being able to contribute to others' progress and ultimate welfare…

Medicine is such a wonderful field to work in! What a privilege!"

In 1971, Jeanette married Dr Bob Jones, a paediatric neurosurgeon, who supported her fully in all her endeavours. With Bob, Jeanette had an instant family of five teenage stepchildren, and they then went on to have Caroline and Paul. She is survived by her children, stepchildren and their families.

Dr Michael Cooper
AM

DR JOHN DAVID PAULL OAM

1937 – 2025

ON 18 MAY THIS YEAR DR JOHN PAULL CELEBRATED HIS 88TH BIRTHDAY AT HOME IN TASMANIA IN THE COMPANY OF FAMILY AND FRIENDS. TEN DAYS LATER JOHN PASSED AWAY PEACEFULLY AT HOME.

John David Paull was born in pre-World War II London where his father was gaining medical experience. The family returned to Melbourne where John completed schooling and a medical degree at the University of Melbourne. Four years of his early career were spent as senior medical officer on the island of Nauru where he delivered valuable service to the community.

He returned to Melbourne to commence anaesthesia training at The Alfred Hospital under the mentorship of then Director, Max Griffith, gaining fellowship of the Faculty of Anaesthetists of The Royal Australasian College of Surgeons in 1971. John spent the rest of his career, 'retirement', and life contributing to anaesthesia and medicine.

In his clinical career he was Director of Anaesthesia at the Royal Women's Hospital in Melbourne and later, Box Hill Hospital. He was a progressive anaesthetist and leader; his wisdom and wit were much sought after and highly respected.

He had a special interest in teaching trainees, obtaining a diploma in education and serving as the Faculty of Anaesthetists' Education Officer. A whole generation of Victorian anaesthesia trainees passing through the Royal Women's Hospital benefited from his insights. At Box Hill he helped convene the groundbreaking return-to-work program for anaesthetists with substance use disorder. This work highlighted John's compassion and patience but also required him to be pragmatic about the realities of this difficult area.

John was highly intelligent and had an early start to his research career winning the Australian Society of Anaesthetists Gilbert Troup Prize as a registrar and went on to publish more than 70 peer-reviewed papers. He was on the editorial committees of both *Anaesthesia and Intensive Care* and the *International Journal of Obstetric Anaesthesia*. He chaired inaugural Victorian and National Health and Medical Research Council committees on anaesthetic mortality, aiming to compile objective information on which to act.

He served on the Victorian Regional Committee of the Faculty of Anaesthetists, holding many positions including that of Chair. He had one term on the board of the Faculty of Anaesthetists and was a Final Fellowship examiner for 12 years, the last two of these as Chair of the Final Examination Sub-committee. As part of this he acted as an External Examiner and undertook many lecture tours of Singapore and Malaysia. His name still generates fond memories and gratitude from the anaesthesia communities in those countries.

John moved to Tasmania in 1999 with his second wife Denise. He worked as a visiting medical officer anaesthetist in Launceston, convening the morbidity and mortality reviews and continuing to provide training and mentoring to young anaesthetists, particularly those from overseas who had extra need for guidance.

On retirement from clinical work in 2007 John threw his efforts into various history-related activities. He served as a senior deck hand on the tall ship Lady Nelson and in executive roles for the Royal Society of Tasmania. He vigorously researched and lectured about the history of anaesthesia, particularly in Tasmania.

This culminated in the 2013 publication of *Not Just an Anaesthetist*, the definitive biography of William Russ Pugh, the Launceston doctor who administered the first anaesthetic in the southern hemisphere. He followed this up with *Persistence Pays* in 2016 about the discovery of Pugh's journal of his voyage from England to New Holland in 1835.

In 2021 John was awarded the Medal of the Order of Australia for 'service to medicine, and to history'.

Altruistic to the end, his last act was to donate his body to the Tasmanian School of Medicine.

Dr Colin Chilvers
AM FANZCA (retired) Tasmania

Dr Ian Rechtman
FANZCA (retired) Victoria

Dr Amalie Wilke
FRACP Cabrini Health, Victoria

DR ANTHONY ALDER KELLY

MBBS FFARACS

05/06/1929 – 01/01/2025

IT IS A PARTICULAR PLEASURE TO HONOUR THE MEMORY OF MY COLLEAGUE AND FRIEND, DR ANTHONY KELLY. TONY WAS A MUCH ADMIRED MEMBER OF THE ANAESTHETIC COMMUNITY OF BRISBANE AND QUEENSLAND.

He was born in Brisbane on 5th June 1929 and attended Brisbane State High School for his initial education. He graduated MBBS from the University of Queensland on 12th December 1954. His first medical posting was as RMO at Maryborough Base Hospital where he remained until 1958. The hospital superintendents of his time were Ron Aitken and John Graff, both excellent surgeons, who stimulated his interest in both surgery and anaesthesia. Tony's experience was gained in surgery for hysterectomies, gall bladders and hernias, many of which he personally performed. Many visiting experts helped him maintain an interest in anaesthesia as well.

In 1958 he left the base hospital and entered general practice in Maryborough with a strong bias towards anaesthesia. The visitation of Dr Gavan Carroll, Consultant Anaesthetist at the Mater Hospital, Brisbane, further stimulated his anaesthetic interests to such an extent that he applied and was appointed Anaesthetic Registrar at the Mater in 1966. He had devoted himself to the care of his patients and built a great reputation in Maryborough. His patients were saddened by his departure.

To start a new life as a registrar is not easy, as well as studying for the FFA Primary and Second Part. He attacked and overcame the difficulties this entailed. He obtained his FFA in May 1970 and joined our Anaesthetic Group, now known as Wickham Terrace Anaesthesia, in 1971.

Tony distinguished himself while still a registrar at the ASA. AGM at The Park Royal Hotel in Brisbane. A visiting general practitioner collapsed near one of the trade exhibits. Tony led the successful resuscitation using all the local equipment available. The whole performance did his reputation no harm.

Almost immediately upon entering private practice he joined the anaesthetic staff at the recently constructed Prince Charles Hospital, the cardiothoracic centre for Brisbane. A major part of his anaesthetic load was babies with congenital heart defects and he developed a hypothermic technique for their anaesthetic. The work was demanding and often late into the night. He taught rotating anaesthetic registrars the basics of cardiothoracic anaesthesia. He had a particular talent for helping them overcome the apprehension of working at Prince Charles, for which they were grateful. He became the first anaesthetist in Queensland to use external jugular vein cannulation in babies, internal jugular vein cannulation in adults and radial artery cannulation for blood pressure measurement. He was the first Chairman of the Visiting Staff at the hospital, a position he held for eight years. He was also a valuable member of the Queensland Perimortality Committee. As well, he was Chairman of our anaesthetic group for two years. He retired as Visiting Medical Officer Prince Charles Hospital in 1989 and continued private practice with many of the senior surgeons of the town. He retired from practice in the early 2000s.

In January 1957 Tony married Elaine and they forged a wonderful relationship, extending especially to their two children, Malcolm and Amanda, who have provided them with much loved grandchildren. They relaxed often at the North Coast and made many visits to Fraser Island (K'gari) which he came to know intimately. Our families often travelled together to overseas locations for anaesthetic meetings.

Tony always conducted anaesthetics to the highest standard and developed a reputation for the highest care of his patients.

In the latter part of his life he battled diabetes. His care and attention to detail was admirable.

Over these many years we forged a memorable friendship. Tony may be gone, but his memory will live on.

Dr Phelim Reilly

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