AUSTRALIAN

Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • **DECEMBER 2025**

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AUSTRALIAN
Anaesthetist
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.

CONTACT US:

AUSTRALIAN SOCIETY OF ANAESTHETISTS,
PO Box 76 St Leonards NSW 1590, Australia
T: 02 8556 9700 E: asa@asa.org.au W: www.asa.org.au

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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 March 2026 edition of Australian Anaesthetist, the following deadlines apply:

- Intention to contribute must be emailed by 10 January 2026.
- Final article is due no later than 17 January 2026.

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

DR VIDA VILIUNAS OAM
PRESIDENT

FROM THE ASA PRESIDENT

IT IS AN HONOUR TO BE THE LATEST PRESIDENT OF THE ASA AND TO HAVE DR MARK SUSS AS VICE PRESIDENT. THESE ROLES ARE SUPPORTED BY THE ASA BOARD, COUNCIL, ITS COMMITTEES AS WELL AS A GREAT MANAGEMENT TEAM. FORTUNATELY, THE BOARD RETAINS THE EXPERIENCE AND STEADY HAND OF DR MARK SINCLAIR AS THE ASA'S IMMEDIATE PAST PRESIDENT.

That's a team that puts the ASA in a good position to respond to issues on the horizon for anaesthetists.

For the ASA, several areas of focus have emerged.

1. Continued engagement with government via our policy team, the Economics and Professional Issues Advisory committees over a range of issues. Effective communication of the ASA's message to get the best outcomes for all our patients and members.
2. The reform of the ASA's constitution. At the October AGM, members passed the proposals to
   - allow on-line attendance to meetings for members
   - ensure compliance with the Australian Charities and Not-for-profits Commission (ACNC) and to
   - simplify the requirements for State and Territory Committees of Management

   There is more work to be done to ensure that the constitution complies with all regulatory requirements and is relevant to contemporary needs.
3. Maintaining the importance of the ASA to all medical providers of anaesthesia to meet their educational and professional needs and provide support to them. Ensuring that anaesthetists turn to the ASA for effective support and representation is the basis of the mission of the ASA.

The ASA's workforce modelling survey showed a modest 4% shortfall between the forecast and required workforce by 2027. Ensuring that the professional and well-being needs of all anaesthetists are met will go a long way to ensuring our existing workforce is practising optimally.

This is a pivotal time for the ASA to shape the direction and future of anaesthesia. The ASA's vision is to advocate for the specialty, for the safety of our patients and an accessible and equitable health system.

If you have feedback, suggestions or concerns, please contact the ASA at asa@asa.org.au. Every idea, action, involvement and voice contributes to our strength and the breadth of our representation.

Let's do this together.

Dr Vida Viliunas

OAM

FROM THE CEO

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

THE DECEMBER EDITION OF THE AUSTRALIAN ANAESTHETIST PROVIDES A GOOD OPPORTUNITY TO REFLECT ON THE YEAR JUST GONE AND FOCUS ON PLANS FOR 2026 GIVEN THE ASA MEMBERSHIP YEAR IS A CALENDAR YEAR.

During 2025, we experienced growth in membership numbers and our footprint in the broader environment. The implementation of our new society management system has led to efficiencies and improved user experience whilst providing us with data to evolve further on your behalf. The member survey informed us of what keeps you up at night, what you value about the ASA, and how we may improve as a membership organisation representing specialist anaesthetists. The operations of the ASA, through its people and systems, continue to focus on professional excellence to add value and benefit to the ASA. This builds on the foundations of the ASA as it enters its 92nd year.

A focus for us into 2026 is our governance as a registered charity, given we qualify in the subtypes of advancing public debate, advancing health and another purpose beneficial to the community including education. This is recognised through our objectives and the activities we undertake and why we continue to focus on our Vision for the Specialty: "Anaesthetists practising optimally on behalf of patients, their safety and the health system" whilst we strive to be "An exemplary society of anaesthetists advocating for the specialty, patients, patient safety and an accessible, equitable health system" to ensure that we "support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public".

To achieve this, we have a Strategic Plan that states we will: Represent the anaesthesia specialty to stakeholders; Advocate for patient and community access, equity, and patient education; Engage with anaesthetists and provide member services; Provide professional development activities and resources; Support the welfare and wellbeing of members; and Ensure good governance and management.

The operations of the ASA, through its people and systems, continue to focus on professional excellence to add value and benefit to the ASA. This builds on the foundations of the ASA as it enters its 92nd year.

When I reflect on the calendar of appointments from the previous year, it reminds me of what we have done, what we are aiming to do and that sometimes there is a long lead phase to achieve. Some of the highlights in our 91st year were utilising the research in our Workforce Supply & Demand Modelling 2032 report, the parliamentary engagements, the relationship-building across sectors, our amazing NSC25 in Canberra, our domestic and international contributions and collegiality, the focus on our strategic directions, supporting the success of our investment in CPDHome to enable it to be offered free to all ASA members, celebrating successes and reflecting on where we need to rethink, evolving the ASA team, enjoying the vibe and success of ASURA in Hobart, more parliamentary and departmental engagements, and learning along the way.

What is quite evident, and humbling, is the commitment of our volunteers to progress the work of the ASA. Whether that be the work with government agencies, our work overseas in building capacity and capability, the care and support for people in the specialty, the education and networking events, or the not-so-apparent work being done to ensure the best for members, the broader specialty and the public.

Personally, I thank the Board, staff, committee Chairs, and business partners of the ASA who I engage with and support me in forwarding the interests of the ASA into its next 90 years.

Thank you for your support and I hope your engagement with, and experience of the ASA continues to be evolving to exemplary.

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**

ASANSC2025 | CANBERRA

COME TOGETHER | 2-5 OCTOBER 2025

DR GIRISH PALNITKAR
NSC2025 CONVENOR

DR ADAM ESLICK
NSC2025 SCIENTIFIC CONVENOR

NSC2025 CONVENOR'S WRAP

CANBERRA NATIONAL SCIENTIFIC CONGRESS

THE 2025 AUSTRALIAN SOCIETY OF ANAESTHETISTS' NATIONAL SCIENTIFIC CONGRESS (NSC2025) WHICH WAS HELD IN SUNNY CANBERRA, HAS BEEN WIDELY HAILED AS A RESOUNDING SUCCESS UNDER THE THEME "COME TOGETHER." THE CONGRESS BROUGHT CLINICIANS, RESEARCHERS, EDUCATORS, AND LEADERS FROM ACROSS AUSTRALIA AND BEYOND INTO ONE DYNAMIC FORUM. OVER FOUR DAYS, THE NATIONAL CONVENTION CENTRE CANBERRA HOSTED ANAESTHETISTS FROM AUSTRALIA, NEW ZEALAND, AND FURTHER AFIELD, FOSTERING AN ATMOSPHERE OF COLLABORATION, CURIOSITY, AND PROFESSIONAL RENEWAL THAT TRULY EMBODIED THE SPIRIT OF THE THEME AND HIGHLIGHTED THE STRENGTH OF THE ANAESTHETIC COMMUNITY.

The NSC began on the evening of 1st October with the President's Welcome Reception which was held at the relaxed Verity Lane. In the presence of the ACT Health Minister, Ms Rachel Stephen-Smith and several Past Presidents of the ASA, Dr Mark Sinclair warmly welcomed delegates, setting the tone for an engaging and collegial Congress ahead.

The following day was dedicated to workshops, masterclasses and small group discussions. Delegates engaged in a diverse range of thought-provoking workshops – from the classic CPD activities such as ALS, CICO and anaphylaxis to the trending topics of gastric ultrasound, limb blocks and cultural safety. Adding a creative twist to the program, more unconventional sessions such as "*Persuasion and Influence*", "*Hypnosis*" and even Wine Tasting were also on offer, each proving to be highly popular and well received.

After a beautiful and respectful Welcome to Country by Ngunnawal elder, Auntie Serena Williams, the main lecture series commenced on Friday 3rd October. Professor Russell Gruen delivered an insightful Kester Brown Oration, exploring the meaning of wisdom in healthcare with the new backdrop of artificial intelligence.

The subsequent plenaries and concurrent sessions were headlined by our internationally recognised keynote speakers, including Professors Tim Cook (UK), Cynthia Wong (USA) and Edward Mariano (USA), and Australia's own Dr Alicia Dennis. These keynotes were also complemented with four other outstanding overseas speakers in Drs Guillermo Martinez, Gordan Mijovski, Ben Antonio and Andy Klein. In particular, we wish to thank Fisher & Paykel as the industry sponsor for Dr Klein. A strong Australian contingent rounded out what was an outstanding array of speakers, the quality of which could be compared with

any international meeting. Special thanks must go to Drs Lachlan Miles, Louise Ellard, Natalie Smith and Indy Lin for their contribution in several areas.

Curating such an expert group of speakers generated a modern, relevant and insightful scientific lecture series that explored various facets of anaesthesia including, but not limited to: the future of patient safety, perioperative innovation, and the evolving role of anaesthetists in an increasingly complex healthcare landscape. Delegates praised the programs balance between clinical depth and broader themes including workforce sustainability, technology and leadership. The scientific program concluded on the final day in a humorous yet thought-provoking debate on the vexed question: Are all anaesthetists also perioperative physicians?

The Congress theme, "Come Together," resonated on multiple levels. It reflected not only the physical gathering in Canberra—a city whose name derives from the Ngunnawal word for "meeting place"—but also the deeper aim of uniting different facets of the specialty. Sessions fostered the bridging of research and clinical practice, strengthened connections between metropolitan and regional practitioners, and highlighted the value of tackling shared challenges collectively. Open discussion on workforce pressures, safety culture, and training pathways were constructive, and forward-looking, laying a strong foundation for collaborative solutions in the years ahead.

Beyond the lecture series, NSC2025 succeeded in building a sense of community and collegiality. Alongside the President's Welcome Reception, the social program included a family night of 'bouldering and burgers' at BlocHaus & Capital Brewery and paddleboarding on Lake Burley Griffin. Undoubtedly, the highlight of the social program was the Gala Dinner held in the Great Hall of New Parliament House. The timing of the Congress alongside Canberra's Floriade festival added a touch of vibrancy, offering delegates a chance to enjoy the famous flower show between sessions.

As with previous NSCs there was a strong research focus. Congratulations must go to the SPARC award winners, A/Prof Jonathon Fanning (Gilbert Troup and runner up Best Poster), Prof Victoria Eley (Runner up Gilbert Troup), Dr Madeline Collings (Best Poster), Dr James Molloy (Rupert Hornabrook winner and TMG Best Poster) and Dr Kyle Williams (Best TMG Audit). The quality of the research presented at this year's congress was of a very high calibre and made judging very difficult. All participants need to be commended for their hard work. The "rapid fire" SPARC session was also a great success with a "soundless" theatre environment created using headphones. It allowed the session to be run within the bustling health care industry exhibition area. As always, the exhibitors (HCI) area, was generously supported by industry, and we thank them for their continued support; without which it would be impossible to hold a Congress of this size.

Within the HCI area, a part was dedicated to local artisans with a connection to anaesthesia. This was the "Artwalk". Several outstanding paintings, photographs and ceramic pottery pieces were on display, showcasing the creativity of the local community. In addition, local bicycle manufacturer and Commonwealth Games medallist, Chloe Hosking displayed her custom-made cycles which was well received by the cycle centric delegates.

The NSC in Canberra was a resounding success, a testament to the countless hours of planning, dedication and preparation by the organising committee - without whom this congress would not have been possible. Hopefully this NSC helped dispel some of the "anti-Canberra" myths amongst the out-of-town delegates! The weather was perfect; Floriade was in full bloom and there was a buzz to the city. Canberra is an amazing city that hosted an equally amazing Congress! Thank you to everyone involved. Now the baton has been handed over to the Hunter Valley team for the 2026 Combined Scientific Congress and we look forward to seeing you there!!

Signing out!

Dr Girish Palnitkar
NSC2025 Convenor

Dr Adam Eslick
NSC2025 Scientific Convenor

Our Committee

Dr Girish Palnitkar
Convenor

Dr Adam Eslick
Scientific Convenor

Dr Freya Aaskov
Workshop Convenor

Dr Shruti Krishnan
Workshop Co-Ordinator

Dr Elizabeth Merenda
Workshop Co-Ordinator

Dr Jennifer Herrick,
Workshop Co-Ordinator

Dr Julia Hoy
Social Co-Ordinator

Dr Mark Skacel
Committee Member

Dr Vida Viliunas OAM
ASA President

Dr David Elliott
NSC Federal/Sci Program Officer

Ms Rhian Foster
ASA Education and Events Manager

HEALTHCARE RECEPTION

Australian Society of Anaesthetists Booth

Professor Edward Mariano & Dr Ken Sleeman

Professor Edward Mariano, Dr Tom Neal-Williams & Associate Professor Suzi Nou

Healthcare Industry Reception

Healthcare Industry Reception

Delegates networking and connecting at the Healthcare Industry Reception

NSC2025 SESSIONS & WORKSHOPS

Professor Allan Cyna, Professor Tim Cook, Professor Cynthia Wong & Dr Adam Eslick

Dr Girish Palnitkar and ASA Education & Events Manager, Rhian Foster

Dr Vida Viliunas OAM

Dr Vida Viliunas OAM, Dr Liz Crowe & Dr Mark Sinclair

Professor Allan Cyna

Associate Professor Suzi Nou

NSC2025 SESSIONS & WORKSHOPS

Professor Edward Mariano

Professor Tim Cook

The Great Debate

Welcome to Country by Aunty Serena Williams

NSC2025 sessions & workshops

NSC2025 sessions & workshops

WELCOME RECEPTION

Dr Girish Palnitkar, Dr Michelle Horne, Dr Archana Shrivathsa & Dr Grace Gunasegaram

Dr Ken Sleeman & Dr Peta Lorraway

Dr Mark Sinclair & Dr Michelle Horne

Dr Simon Martel, Dr Lan-Hoa Le, Dr Janette Wright & Dr Bernard Kelly

Welcome reception

Welcome reception

GALA DINNER

Drs Adam Eslick, David Elliot and Girish Palnitkar

Dr Allan Tyson, Dr Phillip Mayne, Dr Vida Viliunas OAM, Dr David M Scott OAM & Dr Richard Connolly

Dr Girish & Pranjali Palnitkar

Dr Merredith Cully, Dr Gordan Mijovski, Dr Michelle Horne & Dr Archana Shrivathsa

A/Prof Suzi Nou & Professor Russell Gruen

Drs Renee & Adam Eslick and Dr Mark Sinclair

AGM 2025

Associate Professor Indy Lin

Dr Andrew Miller, Dr Mark Suss, Dr Mark Sinclair, Dr Matthew Fisher & Dr Vida Viliunas OAM

Dr Mark Sinclair & Ms Bel Simmons

Dr Mark Sinclair

Dr Rachel Hocking

AGM 2025

UP CLOSE WITH NSC2025 KEYNOTE SPEAKERS

At the NSC2025, Australian Anaesthesia podcast host A/Prof Suzi Nou sat down to record podcasts with our keynote speakers. Please enjoy reading the highlights of her discussions here.

Listen to the full interviews via the links provided.

Professor Tim Cook

Royal United Hospitals Bath NHS Trust

Biography

Consultant in Anaesthesia and Intensive Care Medicine,
Royal United Hospitals, Bath
Honorary Professor of Anaesthesia
University of Bristol
Honorary Professor of Anaesthesia
University College London
Director of National Audit Projects
College Advisor on Airway.

Prof Cook works in Bath and as a full time District General Hospital consultant in Anaesthesia and Intensive Care Medicine.

Prof Cook has been fortunate to have been centrally involved in five Royal College of Anaesthetists (RCoA) National Audit Projects learning from major complications of anaesthesia: as clinical lead for NAP3 and 4 (NAP3 - epidurals/spinal anaesthesia, NAP4 - airway management) and as co-lead and director of the program for NAP5-7 (NAP5 - accidental awareness during general anaesthesia – undoubtedly the most 'patient facing' of all NAPs to date - NAP6 - perioperative anaphylaxis and NAP7- perioperative cardiac arrest (published in November 2023). These big projects involve the nation's anaesthetists and intensivists collaborating to shine a light on patient-centred aspects of anaesthetic practice and safety. They are a form of professional-citizen science and are recognised to have changed the landscape of anaesthesia clinical practice and anaesthesia research engagement, both in the UK and beyond. The projects have all had important lessons for clinical care beyond anaesthesia including in critical care and emergency medicine.

I know you for all the amazing work you've done with the National Audit Projects (NAPs), but to you, what has been the biggest success in your career?

I've always been a full-time consultant. I've never been an academic. I have been doing this for 37 years and I'm quite proud of that. I'm proud of the trainees that have come through my trust, some of whom I hope to have been inspired to go on to have good clinical careers. But also, some have engaged in research while I've been in Bath and not necessarily under me.

The NAPs have been a central part of my career for more than 20 years. I'm very lucky because they are genuinely a national collaborative project and I'm the person that gets put up as sort of a figurehead for them because I am involved with quite a few of them. I'm proud of what we, as an anaesthetic community, have achieved and I'm proud to have been able to lead those or direct those to what we have produced.

That's a fantastic undertaking. And as you said, it's a national project. Did leading a project on such a big scale come with some challenges?

Yeah, they're bizarrely called 'national audits', but they're not audits. They're what we call service evaluations. So bizarrely, not research, but they are research. They're some of the most successful research papers that have been produced in anaesthesia in the last two decades.

I've been in a fortunate position that they're largely organised by the College and therefore there's an infrastructure behind the projects, which has enabled

me to do those. But balancing a full-time clinical job with leading and directing those projects has been a challenge.

I think anybody who takes on additional roles accepts there is some sacrifice. By themselves and by the people at home who support them - their families. The biggest challenge with the first NAP was getting national engagement.

Effectively, it was a new endeavour, so for NAP 3, which studied central neuraxial blockade, I had to get all hospitals to engage with us as much as we could. The first 70 per cent was easy, you just send out an email, they came back and said "Yes, we'll do it." And the next 30 per cent was increasingly difficult and essentially, I ended up ringing switchboards to get to the right person, etc, to get them engaged.

Subsequently, people not just fell into line, but people engaged. They understood the projects had merit; they got something back from them. And since then, there's kind of been a miraculous occurrence in that you have this faith people put into you. Because all the work for the NAPs is done on the front line by the clinicians.

Did you start by taking small steps? Or did you just go right, I'm just going to go straight into a national audit?

Originally around 2005, the College had 50,000 pounds sitting around. They didn't really know what to do with it. They said, "We need to do a project." And at that time, there was a guideline, which was not very evidence-based. A guideline, which had something like 123 recommendations for how to run epidurals on the ward when we were doing a lot more perioperative epidurals. And the original plan was that we were going to audit that.

We were just going to do an audit of compliance with 123 recommendations, and we convened a group of all the stakeholders who were going to come in and do it. The process has evolved since then, but we did go from zero to national full steam ahead, pretty much straight away. So no, we didn't start small.

Wow. That is a huge undertaking. So well done getting that off the ground. Were there quite a few relationships to build and people to get on board?

When you're trying to find a career, you try and find a crowd that suits you, you try and find your tribe. Our tribe is passionate about what we do. We don't cause many complications, but we care about the complications because we clear up other people's complications.

I think we do have a very patient-centred approach. We're also often a bit geeky, and so is the NAPs kind of work. Anaesthetists want to know about rare events and we're invested in it. And the topics are chosen specifically to be important to patients, important to anaesthetists, not easily studied by other mechanisms and not previously studied in full.

And it is worth saying that 20 years ago when we started, there wasn't a lot of the 'citizen science' particularly in anaesthesia. There's a bit of a wilderness in terms of anaesthesia research, but now we have the NAPs every month, we have these service evaluations and there is probably a big increase in the overall research that we do. I think the NAPs have partly been about making and understanding that we, as anaesthetists, can do simple research on a small level, but when you put it together in big piles, it creates something of value.

Thinking about the approach that anaesthetists have towards safety, I'd like to know whether you think it differs from other medical professionals?

Well, classically there's a dichotomy. There's the kind of cowboy anaesthetist who doesn't see risk and gets on with everything, and then there's the more meticulous, perhaps slightly more cautious anaesthetists. But as a specialty, I think we've moved away from the cowboys and perhaps too much towards the more cautious approach. I think in my view, anaesthetists, remain the type of specialists to get up and do things. I guess the big change is that we've always understood risk. We've always accepted there is some risk, certainly in the UK.

The big transformation has been that we must communicate that risk to patients because, as patient representatives have said to me on projects, you always need to remember, in these projects, it's the patient that takes the risk, not the anaesthetists, so we are proxies for our patients.

I think you run more preoperative clinics and patients are seen well before the day of surgery to a greater extent than ever before. I think you've been even better at that for many years. We often see patients only on the day, and the challenge of getting information, risk information to the patient so that you can make a balanced decision - we call those 'BRAN' discussions: Benefits, Risks, Alternatives, and the act of doing Nothing to the patient.

I think ultimately, we're there to facilitate surgery or in the case of intensive care, facilitate management of a critically ill patient, so I think we always will take on risk, but I think we judge, balance, mitigate risk and communicate it to patients.

Have you been doing follow-up work in terms of the implementation of the NAP audits?

Yeah, it's the worst bit of what we've done. Partly because in the planning of the NAPs, they're big projects. They take originally three, now four and a half-year to five years. It's a lot of effort to determine what the changes are. We make recommendations. In NAP 3 we had learning points, and then the patient representative in NAP 4 said "We want to get rid of learning points and make recommendations because learning points are for people to read and ignore and recommendations are for organisations to implement."

There is quite good soft evidence of change. There is a lot of things where we can track changes in practice. So, we've brought in various Standard Operating Procedures on the back of what we found in the NAPs, for example airway checklists, pathways for anaesthesia awareness. Also, now every hospital in the UK has an airway lead. They should have an anaphylaxis lead, etc as well.

Then we track changes as we go. Because we're doing activity surveys, we can see how practices change, e.g. the fall off in use of thiopentone in obstetrics, the increase in use of TIVA and processed EEG monitoring.

So, we can track changes which reflect our recommendations. For NAP 4 and NAP 6 we have two specific projects looking at changes in practice. Both have shown quite significant what we call closure of the safety gap.

If you consider that a recommendation from one of the NAPs is addressing an unmet need, if we can measure how much compliance there was with that need before implementation and afterwards, we can see how the gap has closed. And in anaesthesia, after NAP 4, for two years on, we had around a 50 per cent closure of the safety gap.

In ICU, we had a 60 per cent closure, and we tracked about 80 per cent of ICUs and of the 60 per cent of anaesthetic departments making changes. The big question of course, is whether the changes make patient outcomes better. So, the first goal of the NAPS was to provide patient information, and that's what they do. They provide data for patients; they provide data for anaesthetists. And getting back to that risk mitigation, you can only act on data.

The NAPs have made a fantastic contribution to our knowledge. It is wonderful to have you here in Canberra. I hope you enjoy some of Canberra as well - and thank you very much for joining me in brief today.

Suzi. Thanks very much. It's my pleasure.

Listen to the full interview on the Australian Anaesthesia podcast available on our website: https://asa.org.au/asa-public-podcasts/australian-anaesthesia

Or please scan the QR code.

Professor Edward Mariano

Biography

Prof Mariano is the Professor and Vice Chair in the Department of Anaesthesiology, Perioperative and Pain Medicine at Stanford University School of Medicine and is Chief of the Anaesthesiology and Perioperative Care Service at the Veterans Affairs Palo Alto Health Care System.

He has developed techniques and patient care pathways to improve postoperative pain control, patient safety, and other outcomes and has published over 300 articles and book chapters. He has held leadership positions in the California Society of Anaesthesiologists, American Society of Anaesthesiologists, American Society of Regional Anaesthesia and Pain Medicine, and multiple journal editorial boards including being an Editor of Anaesthesia.

He is a recipient of the Veterans Health Administration's John D. Chase Award for Physician Executives Excellence and Distinguished Service Awards from ASRA Pain Medicine and ESRA Spain. Within the U.S., Prof Mariano has worked on key national healthcare initiatives including the accreditation of regional anaesthesiology and acute pain medicine fellowships, pain management guidelines, development of quality and cost measures in perioperative care, and the National Academy of Medicine Action Collaborative Countering the U.S. Opioid Epidemic.

What would you say have been some of your crowning achievements?

If I go back 20 or more years, I will say that my aspirations as a physician were initially never really tied into doing much more than patient care, and I think that's important. I think I started getting interested in medicine for all the good reasons that most students get interested in medicine. It's so unique to be a physician and have the kind of impact that we have on humanity and our community. I think because of that, the various paths that I've taken in my career in the last couple of decades have all been somewhat related to that.

What are you most proud of in your career?

Patient care, when I am in theatre, I have zero degrees of separation between me and affecting patient outcomes. I think that everything should somehow be one degree of separation or less - directly related to patient care.

Also, when I've become involved in education, I also consider that one degree of separation. When I teach someone, whether that be a trainee or if I'm at a congress and I'm teaching an audience, I feel proud when they take something away from that. If they can use what I teach in their day-to-day practice to help their patients, then, that's one degree.

How do you impart the goal of patient care on trainees? Is there help to drive trainees into research? How do you address the topic of patient care?

You know, I think that the most important thing you can learn, especially as an anaesthetic trainee, is how valuable you are. What we offer in terms of patient care is an understanding of your impact on the patient's life in that moment while they're undergoing invasive procedures or surgery. It is so meaningful because you really are, in those minutes to hours, the ultimate patient advocate.

It's certainly a privileged position transitioning to research quite late in your clinical life from leadership positions. I'm sure that would've come with many challenges. What would you say would've been some of your most significant leadership positions?

One of the most difficult things that I've realised as a research consultant going back to university to do a graduate education program is that your clinical work doesn't stop. And so, you still must put in the clinical hours. I still had to take my calls as assigned. I had classes that were in the late afternoon or evening or on weekends, and I still had to take exams.

So yes, I think one of the most logistically difficult things that I had to face was transitioning between all in-person classes to online exams. This was back in 2005, a long time ago, so definitely more common place now than it used to be. I remember being told by one of my class instructors that I hadn't turned in any of my homework assignments, when I had

One of the most difficult things that I've realised as a research consultant going back to university to do a graduate education program is that your clinical work doesn't stop. And so, you still must put in the clinical hours.

done all my homework assignments, and of course, I asked, well, what do you mean? Well, you didn't go to the online classroom and turn them in. Luckily, I was forgiven - sometimes that student life never escapes us.

Do you have any mentors that standout and have inspired you?

There are just too many. I mean this is going to be a very abbreviated list. One is Professor Ron Pearl at Stanford. He was Chair at Stanford for 22 years. He started as Chair right before I started residency. He was the Chair and the individual who convinced me to be Chief Resident of my class. When I had to find my first consultant job in San Diego, he's the one who called the Chair at the University of California, San Diego to find out if they were interested in hiring me. I had no idea how to find a job, so Prof Ron Pearl helped me to find my first job.

Is there anything that you would like to say to our listeners, our Australian audience or anaesthetists in general?

Congratulations to you and good luck in your training as an anaesthetist. It is the best job in the world! I love it! I have to say, it has brought me a lot of success - especially in a career we've worked at for so long. If you can go years or decades and still get excited about what you're doing, then you're doing it right!

Listen to the full interview on the Australian Anaesthesia podcast available on our website: https://asa.org.au/asa-public-podcasts/australian-anaesthesia

Or please scan the QR code.

SEREIMA BALE PACIFIC FELLOWSHIP REPORT

BEYOND THE GLITZY FIVE-STAR RESORTS, FIJI IS A COUNTRY OF RICH CULTURE AND GREAT DIVERSITY. THE CAPITAL SUVA IS IN THE STEAMY EAST OF THE MAIN ISLAND VITI LEVU. HERE STANDS THE COLONIAL WAR MEMORIAL HOSPITAL (CWMH), THE MAJOR TERTIARY REFERRAL CENTRE FOR FIJI AND SOME NEIGHBOURING PACIFIC NATIONS

Across the road is the Fiji National University (FNU) which delivers the Anaesthesia program, as well as a new Intensive Care training program. The anaesthesia training program is comprised of a Diploma, then Masters course. FNU programs are a popular choice for many Pacific Nation trainees making student groups multinational and multicultural. This mix of Pacific cultures lends itself to friendly banter. The debate focusing on which Pacific nation has the sweetest and cheapest lobster was one I took keen interest in.

The current anaesthetic cohort include local Fijian students, as well as those from Timor Leste, Solomon Islands, Kiribati, Tonga, Tuvalu and Vanuatu.

The students and their teachers are a committed group of hard working doctors with impressive skills. They work in environments where patients present late and resources are limited. They rely on their clinical acumen to guide assessment and treatment. They lived and worked through the COVID pandemic in this environment and it would seem that nothing phases them. Some of the anaesthetic trainees have worked as generalist doctors in remote islands providing emergency, anaesthetic and surgical services. Some have delivered anaesthetic care for 5 years in their own countries, and come with extensive experience when they start their formal anaesthetic training.

The valuing of relationships and recognising the most important resource- human resources, is something I've taken with me from Pacific Island culture.

My role along with Dr Wayne Shipton and Dr Pedro Godinho was to aid the FNU staff in preparing these students for their up-coming exams and provide supervision within theatre. So, how to best achieve this goal? And in this unfamiliar environment who is teaching who? Guided by those who came before me, I took the first two weeks to observe practice. This was invaluable, as the reasons for differences in practice soon became apparent. I was also introduced to the simple recipes taught to and used by junior trainees to keep patients safe in the CWMH environment- teachings I was careful not to contradict.

I was privileged to deliver pain tutorials to the Diploma and Masters students. The curriculum is taught using a case based format which lends itself to open discussions and sharing of knowledge. In Pacific nations such discussions commonly take place around a communal bowl of kava. This practice is used to break down social hierarchies and fosters unity and equality. It is used to enhance the exchange of ideas from parties who may not always agree. While I'm sure some of the students would have relished combining a kava session with a pain tutorial, it was only in spirit that I tried to emulate the effects of this custom during teaching sessions. The valuing of relationships and recognising the most important resource- human resources, is something I've taken with me from Pacific Island culture. Other non-theatre roles included marking of practice SAQs, providing practice via exams, marking written assignments and presenting at department meetings. Most importantly I hope that I gave the trainees confidence to value their own existing knowledge and skills, which are not to be underestimated. We are all products of our environment, and theirs seems to foster early independence and calm in the face of crisis. When it comes to sweet lobsters, it appears that Niue Island provides the perfect conditions, but the debate continues.

Dr Nina Loughman

CONJOINT PROFESSOR
ALWIN CHUAN
CHAIR, SCIENCE PRIZES,
AWARDS AND RESEARCH
COMMITTEE

SCIENCE, PRIZES, AWARDS AND RESEARCH COMMITTEE

I invite members to apply for the multiple ASA research grants and prizes that are available in 2026.

The ASA will consider all applications, with emphasis on three priority themes:

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

Eligibility:

Trainee members, and members within five years of full membership who have been financial members of the ASA for over 12 months. Applicants are welcome from research teams, but at least one member needs to meet the eligibility requirements.

Requirement to present work in a public forum e.g. a future NSC, publish in a peer review journal, Australian Anaesthetist or ASA podcast.

The research grant may be used to purchase or lease equipment, facilities or material or to fund administrative or scientific support.

FOR FURTHER INFORMATION and APPLICATION FORMS LOG IN TO

asa.org.au/asa-awards-prizes-and-research-grants/

or contact the Executive Assistant to CEO & Board Sue Donovan sdonovan@asa.org.au.

This is my last article as Chair of SPARC, and as such I wish to express my gratitude to the ASA for the privilege of holding this role. I assumed the chair position during the Covid-19 pandemic, which disrupted our personal, clinical, and academic/research lives. This was very evident in the running of the scientific and research content of the National and Combined Scientific Congresses, and for clinician-researchers who had to pivot their projects. But I also saw firsthand the creativity, adaptability, collaborative spirit, and commitment of anaesthetists to meet challenges.

In the years since, I am very pleased to have overseen strengthening of the ASA's vision to support safe and evidence-based care for our patients. Some notable highlights for me were: updating the transparency and rigour of the review process for research grants and prizes to standards similar to the NHMRC; increasing the attractiveness of the ASA grants with a proportional increase in the number of applicants year-on-year; revising the process of abstract

In the years since, I am very pleased to have overseen strengthening of the ASA's vision to support safe and evidence-based care for our patients.

submission for the National Scientific Congress; securing funding for ASA scholarships for emerging anaesthetic leaders and educators from low- and middle-income countries. These remain active areas for the SPARC committee, and this is a suitable segue to introduce the incoming chair, Dr Indy Lin. Indy hails from Adelaide and recently completed her PhD in patient outcomes after regional anaesthesia in orthopaedic surgery. She is an incredibly capable clinician, researcher, colleague, and mother and will bring fresh perspectives to the role. Indy has already initiated multiple innovations and she will hit the tarmac running. See her article in this edition of Australian Anaesthetist.

As for me, I will assume the Immediate Past-chair position and remain on the SPARC committee to help Indy. This will free up some time for me to pursue some long-term research ideas in artificial intelligence, collaborative trials in the Asia-Oceania region, and computerised metrics in medical education. I take this opportunity to thank many people who have made my tenure as SPARC chair an immensely satisfying and enriching time: Rhian Foster, our indomitable Education and Events Manager; Sue Donovan, Rachel Cannon and many others in the ASA secretariat who hold so much corporate knowledge and mete out efficiency and good humour in equal measure, usually in a perfectly timed manner; David Elliott our Federal NSC officer for keeping the show running through the good and tough times; the many scientific convenors and the scientific committees for your patience and willingness to go the extra mile to make each and every National Scientific Congress the best ever; and to the ASA Council and Board for your unwavering support in growing our specialty.

Per Ardua Ad Astra,

Conjoint Professor Alwin Chuan

PRE-NATIONAL SCIENTIFIC CONGRESS (NSC) ADJUDICATED GRANTS

Annual Research Grant Award Winner

Dr Matthew Bright

WAVELET-II: Individualised haemodynamic optimisation informed by the lower limit of cerebral autoregulation in a cardiac population

Dr Bright is a consultant cardiac anaesthetist at The Prince Charles Hospital, Brisbane, and commenced his PhD at the University of Queensland. His higher research degree program will use wavelet semblance analysis as a novel method for determining lower limits of cerebrovascular autoregulation thresholds during Personalised External Aortic Root Support surgery. Important outcomes include assessing autoregulation metrics, identifying predictors of impaired reserve, acute kidney injury, myocardial injury, stroke, and delirium due to hypoperfusion injury.

The ASA Annual Research Grant will be pivotal in enabling this translational research by providing essential equipment and protected PhD research time for Dr Bright to lead study initiation, patient recruitment, intraoperative monitoring, and signal analysis.

Kevin McCaul Prize Winner

Dr Jonathan Chen

Shoulder tip pain during and after caesarean section: a narrative review

Dr Chen is an anaesthetic registrar at The Royal Women's Hospital, Melbourne. His winning application was on shoulder tip pain as a complication after caesarean section surgery. This review summarises the available evidence on mechanisms, incidence, and management strategies of shoulder tip pain, and highlights simple, low-risk interventions that may enhance maternal comfort and postoperative recovery.

The ASA Kevin McCaul Obstetrics Anaesthesia Prize recognises the contribution of Dr Chen's study to drive a prospective study at the author's institution to understand and manage this common postoperative complication.

ASSOCIATE PROFESSOR
DR INDY LIN
INCOMING CHAIR,
SCIENCE PRIZES, AWARDS
AND RESEARCH COMMITTEE

CELEBRATING RESEARCH AND COLLABORATION

It is a privilege to step into the role of Chair for the Science Prizes, Awards and Research Committee (SPARC) within the Australian Society of Anaesthetists. I follow in the footsteps of Conjoint Professor Alwin Chuan, whose exceptional leadership over the past five years has elevated SPARC to a thriving community of clinician-researchers united by a shared purpose: advancing perioperative patient care through collaboration and innovation. I thank Alwin for this, and for continuing to contribute in an advisory capacity as Immediate Past Chair.

SPARC represents the ASA's commitment to supporting and recognising anaesthesia research at all levels - from early trainees presenting their first projects to established investigators spearheading larger integrative collaborations.

This year's ASA National Scientific Congress showcased that spirit at its best. The breadth and quality of research presented were outstanding. It was exceedingly challenging to choose a few winners from amongst this excellent field of contenders, and everyone who presented at the ASA NSC should be congratulated.

The Trainee Member Group Best Poster Prize was awarded to Dr James Molloy. Dr Molloy also received the Rupert Hornabrook Prize (Day Care Prize), named in honour of Dr Rupert Hornabrook who was the first Australian doctor to dedicate his entire career to anaesthesia, and whose pioneering contributions helped establish our specialty.

The Trainee Audit or Survey Prize was awarded to Dr Kyle Williams.

In the ASA Best Poster Prize category, Associate Professor Jonathon Fanning was runner-up, and the winner was Dr Madeline Collings.

Finally, in recognition of outstanding original research, the Gilbert Troup Prize runner up was Professor Victoria Eley. The Prize was awarded to Associate Professor Jonathon Fanning for "Evaluation of Wavelet Semblance Analysis for Determining the Lower Limit of Cerebral Autoregulation in a Non-Cardiac Surgery Population." This prestigious award includes a $10,000 cash prize, the Gilbert Troup medal, and an invitation to submit the winning paper to Anaesthesia and Intensive Care for consideration for publication.

Congratulations to all our prize recipients!

On behalf of the ASA and the SPARC committee, I also extend sincere thanks to all who contributed to the shortlisting, reviewing, chairing, and adjudication processes. The whole conference team should also be commended for making the ASA NSC a wonderful event.

SPARC represents the ASA's commitment to supporting and recognising anaesthesia research at all levels - from early trainees presenting their first projects to established investigators spearheading larger integrative collaborations.

NSC2025 WINNERS

Gilbert Troup Prize Winner
ASA Best Poster Prize Runner-up

Associate Professor Jonathon Fanning

BSc, MBSS, PhD, MSc(Oxon), GChPoM, FRACP, FANZCA, FCICM

Associate Professor Jonathon P. Fanning is a clinician-researcher with specialist qualifications in Anaesthesia (FANZCA), Intensive Care (FCICM), and Internal Medicine (FRACP). He completed his PhD at the University of Queensland focusing on perioperative cardiovascular complications and subsequently undertook an MSc in Clinical Trials at Oxford University. In 2021, he was honoured to receive a visiting Fulbright Scholarship to Johns Hopkins Medicine.

With over 15 years in clinical medicine, Jon maintains an active practice as an anaesthetist at The Prince Charles Hospital and an intensivist at St Andrew's War Memorial Hospital in Brisbane, Queensland. His leadership roles include Executive Board Member of the Australian Fulbright Alumni Association and Chair of the Queensland Cardiovascular Research Network.

Jon is fortunate to collaborate with colleagues across multiple disciplines and institutions, both nationally and internationally. He values the mentorship he has received throughout his career and endeavours to support the next generation of clinician-researchers in developing their skills and pursuing meaningful clinical research.

He is deeply grateful to receive this award on behalf of a team of researchers and clinicians who have all contributed across The Prince Charles Hospital and the Princess Alexandra Hospital in Brisbane. In particular, Jon acknowledges his close collaborator Associate Professor David Highton (Director of the Princess Alexandra Hospital Department of Anaesthesia), and two of his PhD students, Dr Matthew Bright (Cardiac Anaesthetist, The Prince Charles Hospital) and Ms Allison Kearney (Clinical Trials Coordinator, The Princess Alexandra Hospital) whom have contributed substantially to this research.

Gilbert Troup Prize Runner-up

Professor Victoria Eley

Professor Victoria Eley has worked as a specialist anaesthetist at the Royal Brisbane and Women's Hospital since 2007. Deeply involved with the Australian and New Zealand College of Anaesthetists (ANZCA), she is a member of ANZCA's Research Committee and Safety and Quality Committee. Victoria completed her PhD in the field of obstetric anaesthesia which remains her key area of interest. She has over 70 peer-reviewed papers, with her research reflecting the needs of patients, clinicians and institutions. Victoria is the Professor and Head of the University of Queensland Mayne Academy of Critical Care and supervises medical students, junior doctors, anaesthesia trainees and specialists in clinical research and research higher degrees.

ASA Best Poster Prize Winner

Dr Madeline Collings

Dr Madeline Collings is a PGY4 anaesthetic critical care resident at Eastern Health currently working as an intensive care registrar. Previously, she undertook her formative years in medicine at St Vincent's Hospital in Melbourne, gaining experience in anaesthesia and intensive care. She has strong interests in peri-operative pain management, health biostatistics and equitable healthcare, as a regular international medical volunteer - most recently with Cambodia Vision. Maddy is eager (but nervous) to commence anaesthetic training at Eastern Health in 2026.

Trainee Members Group Audit/Survey Prize Winner

Dr Kyle Williams

Dr Kyle Williams is a PGY2 doctor at Austin Health with an interest in Anaesthesia. He enjoys teaching medical students from Monash University and University of Melbourne and finds it rewarding to mentor and learn alongside them. Outside of clinical work, he is grateful for the opportunity to be involved in healthcare sustainability initiatives through his work with Medical Pantry, helping divert unused hospital equipment and supplies from landfill into medical and nursing education for clinical skills teaching, and now also into secondary schools. He looks forward to gaining further experience in critical care and research in anaesthetics next year.

Trainee Members Group Best Poster Winner

Dr James Molloy

Dr James Molloy is an advanced trainee at Royal North Shore Hospital. He was awarded the Trainee Members Group Best Poster Prize for his presentation *Anaesthesia Selection in Endovascular Treatment of Acute Ischaemic Stroke: A Retrospective Single-Centre Analysis*. He also received the Robert Hornbook Prize for *Anaesthetic Optimisation for Same-Day Discharge Total Knee Arthroplasty*, awarded for the best original research on a day-of-surgery theme. In addition, he presented *Strategic Sleep Episodes are Correlated with Reduced Fatigue-Induced Impairment in Anaesthetic Registrars during Night Shifts* in the Gilbert Troup session. James's research focuses on improving patient outcomes through optimisation of anaesthetic techniques and perioperative pathways, as well as enhancing trainee wellbeing and fatigue management in anaesthesia practice. He gratefully acknowledges the support of his supervisors, Associate Professor Matt Doane, Dr Ben Olesnicky, and Dr Oliver Hambidge, along with Dr Andrew Read and the department for their help in undertaking this research.

Join now and connect with your community

Australian Society of Anaesthetists®

ASA Registered Practice Managers Network

The ASA has long recognised the value, contribution and support that practice managers give to our ASA members, this has led to our ASA Registered Practice Managers Network.

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webAIRS

webAIRS

Dr Pieter Peach and the
ANZTADC Case Report Writing Group

FROM DATA TO DISCOVERY: what 12,656 WebAIRS reports can teach us!

Insights from recent analyses of the web-based Anaesthetic Incident Reporting System

The anaesthetist thought the rapid sequence induction had gone to plan. After an initial oesophageal intubation was immediately recognised, the patient was successfully intubated, breath sounds were equal, and the patient was stable throughout the procedure. Four days later, however, the patient developed subcutaneous emphysema and a mediastinal collection. A barium swallow revealed an oesophageal leak, likely from the bougie used during the initial oesophageal intubation. What followed was surgical repair, PEG insertion, ICU admission, and a two-month hospital stay with ongoing dysphagia.

This case, drawn from Dr Yasmin Endlich's analysis of 109 oesophageal intubations reported to webAIRS, presented at the 2025 ASM in Cairns and published in *Anaesthesia and Intensive Care*, illustrates that even immediately recognised complications can have significant clinical consequences. Among the 109 reports, six cases did not employ end-tidal CO2 monitoring, including two neonatal resuscitation cases, highlighting that this valuable tool for detecting esophageal intubation remains underutilised in clinical practice.[1]

It is just one of many stories emerging from over 12,656 incident reports that have been submitted to Australia and New Zealand's Web-Based Anaesthetic Incident Reporting System (webAIRS) since it was established in 2009.

Perioperative cardiac arrest

Dr Matthew Bright's analysis of 684 adult perioperative cardiac arrests, presented at the 2024 Brisbane ASM, paints a picture of who arrests and why. The typical patient is over 60 years old with significant comorbidities, with 62% of arrests occurring in patients aged 60 or older, and over 60% having an ASA status of 3 or more. The timing is predictable yet challenging: 30% during induction when we're most vulnerable, 50% during maintenance when vigilance may wane.[2]

Nearly 30% of patients who arrested perioperatively died, with rates climbing steeply with age and ASA status. For ASA 5 patients, mortality approached 80%. These aren't just numbers, they represent the real considerations in anaesthetic practice where decisions about proceeding with surgery in high-risk patients are frequently made under conditions of uncertainty.[2]

Drug errors

Picture this scenario: you're managing emergence after a routine procedure when you reach for what you think is glycopyrrolate. Instead, you've grabbed clonidine. The patient becomes profoundly hypotensive, and what should have been a smooth emergence becomes avoidably complicated.

Dr Shawn Lee's analysis of look-alike drug errors identified 28 such incidents involving clonidine and glycopyrrolate. While the physical similarity of the ampoules was the primary culprit, human factors played crucial roles: time pressure during emergence, fatigue, and the simple proximity of the drugs in storage. The solutions are simple yet require systems thinking: separate storage, original packaging retention, and standardised trolley layouts.

What happens in paediatric radiology

Associate Professor Suzi Nou's examination of paediatric anaesthesia incidents in radiology departments revealed the hidden dangers of remote practice. Eighty-nine incidents with 14 unplanned ICU admissions tell the story of anaesthetists working in challenging environments away from familiar equipment, without immediate assistance, managing difficult vascular access in children who can't remain still for crucial imaging.

Eighty-nine incidents with 14 unplanned ICU admissions tell the story of anaesthetists working in challenging environments away from familiar equipment, without immediate assistance, managing difficult vascular access in children who can't remain still for crucial imaging.

Half of these incidents occurred in MRI suites, where the magnetic field creates unique hazards and standard monitoring may be unreliable. These aren't just technical problems, they're system failures where the pressure to complete imaging conflicts with fundamental safety principles.

Preventable arterial line complications

Dr Victoria Tsang's analysis of 56 arterial line complications presented at the 2024 NSC in Darwin includes a case that demonstrates a devastating complication in what we would usually consider a low-risk intervention. An elderly patient sat in a chair in the intensive care unit while staff troubleshot arterial line problems. The pressure bag had run dry, creating air in the tubing. Suddenly, the patient developed dysarthria, hemiparesis, and facial droop resulting from a massive stroke from retrograde arterial air embolism. Despite multiple surgeries and inotropic support, the patient died two weeks later.

Most of the common equipment issues reported were related to transducer height with one case resulting in organ underperfusion and harm, and problems with the guidewire being lost inside the patient or unravelling. Of the clinical issues reported, 30% related to compromised flow, 10% to nerve injury, and 3.5% to intra-arterial injection medication errors.

Preventable central line complications

Of 163 central line incidents analysed by Dr Fergus Davidson and presented at the 2025 ASM in Cairns, nearly 70% were deemed preventable. The data reveals a pattern: arterial injury related to dilatation occurred in 29 cases, yet only two had used pressure checking before dilatation. Meanwhile, 17 arterial injuries occurred despite ultrasound guidance, suggesting that the use of ultrasound alone isn't the answer and more frequent use of transduction prior to dilatation may have a place in preventing arterial injury.

Eighteen incidents were reported where patients had a reaction to chlorhexidine-coated central venous catheters, two of these where there was a previously documented sensitivity to chlorhexidine.

Importantly, vigilance is required beyond the time of insertion. This is illustrated by three reports where patients with PICC lines undergoing ECT had residual suxamethonium present in the dead space of the line flushed whilst in theatre recovery.

Wrong-side blocks

Despite the 'Stop Before You Block' campaign introduced in 2010, Dr

Thomas Curtis identified 43 wrong-sided regional blocks, a reminder that even well-intentioned safety initiatives can't overcome system pressures. In one case, a repeat interscalene block resulted in bilateral phrenic nerve palsy and ICU admission for ventilatory support.

The contributing factors are familiar to all of us: time pressure, ergonomic challenges, patient positioning changes, and the simple human tendency to assume rather than verify. In 56% of cases, teams performed a second block on the correct side, potentially doubling the patient's risk of complications.

The path forward: systems solutions for human problems

These incidents aren't isolated failures, they're predictable consequences of complex systems under pressure. International data suggests that systematic approaches work: care bundles for central line insertion have reduced mechanical complication rates from an expected 4% to 0.41% across 60 hospitals in 13 countries.[3]

The solutions require both individual vigilance and organisational commitment. For cardiac arrest, this means honest preoperative discussions about limitations of care with high-risk patients. For drug errors, it requires redesigned storage systems and standardised equipment. For airway management, it suggests universal capnography, even for emergency intubations and neonatal resuscitation.

Learning from our experience

These webAIRS analyses illuminate the shadows of anaesthetic practice, the near-misses, complications, and system failures that rarely make it into textbooks but shape our daily reality. The voluntary reporting means we're seeing only the tip of the iceberg, the patterns are clear, and the lessons invaluable.

The value of webAIRS emerges from multiple dimensions: the analysis of trends reveals evolving patterns in clinical practice, frequency data identifies where risks concentrate, and associations between factors expose underlying system vulnerabilities. Equally powerful are the strong narratives provided by individual case summaries, offering rich contextual detail that brings these patterns to life and makes the lessons memorable and actionable.

Every anaesthetist will recognise themselves in these stories, the time pressures, the difficult cases, the moment when good intentions met system failures. The power of webAIRS lies not in blame but in collective learning, transforming individual incidents into shared wisdom and better patient outcomes.

For anaesthetists, these findings should prompt reflection on personal practice and departmental protocols. They remind us that patient safety isn't just about individual competence, it's about designing systems that make it easy to do the right thing and hard to make mistakes.

If you are not yet registered with webAIRS, you can register at webairs.com to start contributing. If you are interested conducting analyses on the growing dataset of over 13,000 incidents, contact the Australia and New Zealand Tripartite Anaesthetic Data Committee at anztadc@anzca.edu.au

Dr Pieter Peach and the ANZTADC Case Report Writing Group

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

DR JAMES HOSKING
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

THE AUSTRALIAN SOCIETY OF ANAESTHETISTS (ASA) IS LED BY A DIVERSE RANGE OF COMMITTEES IN ADDITION TO THE ASA BOARD AND COUNCIL. THESE COMMITTEES ARE DEDICATED TO ADVANCING THE FIELD OF ANAESTHESIA AND ENSURING THE HIGHEST STANDARDS OF CARE.

Role of the Professional Issues Advisory Committee

The role of the Professional Issues Advisory Committee (PIAC) is to provide advice to the ASA Board and members on professional issues including but not restricted to:

- Clinical practices and standards
- Clinical Credentialing and privileging issues
- Professional indemnity insurance
- Continuing professional development
- Professionalism
- Workforce and survey issues.

ASA NSC 2025

Congratulations to all those involved in organising the NSC in Canberra in October. I'd personally like to thank the 100 or so members who attended the *Business & Billings: All things ASA* breakfast session at 7:00am on the final day of the Congress.

I co-hosted and presented at this session together with the Chairs of the Public Practice Advisory Committee (PPAC) and Economics Advisory Committee (EAC), Dr Janette Wright and Dr Michael Lumsden-Steel respectively. It was great to see such large turnout of members for this session so early in the morning.

A recording of the session is available in the members area of the ASA website.[1] Look for *ASA NSC 2025 Canberra All Things ASA*. You can also watch recordings of previous ASA NSC Sessions from Darwin in 2024 and Melbourne in 2023.

I look forward to seeing as many members as possible at the Combined Scientific Congress in October next year in the Hunter Valley.

Set out below are several issues raised in my presentation at NSC.

Workforce

Expedited registration pathway for specialist international medical graduates

Members should be aware by now of the expedited registration pathway for specialist international medical graduates (SIMGs) who have an international specialist medical qualification on the Medical Board of Australia's *Expedited Specialist pathway: accepted qualifications list.* Specialist international medical graduates with a qualification on this list, and who meet other specialist registration requirements, can apply directly to AHPRA for specialist registration in Australia.

All qualifications on the list have been assessed by the Australian Medical Council (AMC) and approved by the Medical Board of Australia as substantially equivalent or based on similar competencies to an approved qualification.

Accepted qualifications for anaesthesia are currently a Fellowship of the Royal College of Anaesthetists (RCA) or Fellowship of the College of Anaesthesiologists of Ireland (FCAI), together with a Certificate of Completion of Training (CCT) or Certificate of Satisfactory Completion of Specialist Training (CSCST).

This expedited pathway requires six months supervision, including workplace-based assessments, and involves an AHPRA-appointed supervisor.[2] The ASA would like to make members aware that, unlike the ANZCA process, there is no indemnity provided by AHPRA for those performing this supervision. The ASA recommends members ensure they either are indemnified by their employer or medical defence organisation, and that they have evidence of such.

The Expedited Specialist pathway is currently open for general practice, anaesthetics, psychiatry, and obstetrics and gynaecology.

The Board releases monthly summary reports of data on Expedited Specialist pathway applications and registrations.[3] As of 30 September 2025, 536 internationally qualified specialists had applied for registration in Australia

since the pathway opened in October 2024. Of these, 29 applications were for anaesthetics, 455 applications were for general practice, 12 applications were for obstetrics and gynaecology and 40 applications were for psychiatry. Three hundred and forty-three applicants have been registered through this pathway – 12 anaesthetists, 305 general practitioners, three obstetricians and gynaecologists and 23 psychiatrists.

Of note, the existing ANZCA pathway is currently processing significantly more overseas specialists than the expedited Medical Board / AHPRA pathway.

Task or role substitution

There is continued pressure on all areas of medicine by non-medical practitioners wanting to 'work to their full scope of practice'. Members are probably aware of the role of CRNAs in the US where some states allow independent practice and the use of Anaesthesia Associates in the UK.

The I*ndependent review of the physician associate and anaesthesia associate roles: Final Report* by Professor Gillian Leng CBE (the Leng Report) was published in July this year and is available on the GOV.UK website.[4]

Examples in Australia include the Queensland-based EDNAPS program, Endoscopist Directed Nurse Administered Propofol Sedation.

The ASA continues to advocate for the medical model of anaesthesia delivery, with our own modelling recommendations set out in the Anaesthetist Workforce Modelling Final Report which was updated in May 2025. You can download a copy of our report on the ASA website.[5]

The ASA placed this issue on the agenda of the Common Issues Group (CIG) meeting in Cape Town in September at the South African Society of Anaesthesiologists National Congress. The CIG is a representative group drawing its membership from the senior leadership of the American Society of Anesthesiologists, the Association of Anaesthetists [of Great Britain & Ireland], the Australian Society of Anaesthetists, the Canadian Anesthesiologists' Society, the New Zealand Society of Anaesthetists and the South African Society of Anaesthesiologists.

Private hospital ownership

At the time of writing there is still no resolution to the fate of the 37 hospitals operated nationally by Healthscope, which has gone into receivership. This may have changed by the time of publication.

These 37 hospitals treat over 600,000 patients each year and the ASA would like to see this continue. This is only one example of the many pressures facing private hospitals in Australia at the moment. We are particularly concerned for those communities with only a private hospital operated by Healthscope and the implications that an ownership change may have on these communities.

There are many private hospital ownership models in Australia, including some where private health insurers hold a significant share of the ownership. These hospitals may operate with a no gap or bundled model for the patient. In order to protect the Australian healthcare system from a transition to managed care, the following principles which are set out in ASA Position Statement 24 on US Styled Managed Care are suggested:

- Preservation of simple fee-for-service remuneration for doctors
- Preservation of a universal Benefit Schedule under Medicare
- Preservation of the Community Rating principle whereby all Australians pay a similar fee for private healthcare
- Avoidance of contracts between doctors and third-party payers
- Avoidance of preferred provider networks
- Prohibition of vertical integration in healthcare
- Prohibition of insurer coercion of private hospitals
- Recognition of the inherent conflict of interest held by publicly traded and for-profit health insurance companies.

Draft Emergency Laparotomy Clinical Care Standard

Earlier this year the Australian Commission on Safety and Quality in Health Care developed and published a draft Emergency Laparotomy Clinical Care Standard. Consultation on the draft Standard and related resources closed in October.

The ASA was asked to provide feedback about the draft standard during the public consultation period. I would particularly like to highlight two aspects:

- More than five per cent risk of mortality mandates Anaesthesia Specialist and Surgical Specialist presence (Quality Statement 6)
- More than ten per cent risk of mortality mandates ICU involvement (Quality Statement 7)

This clearly would have implications for units around the country and does not reflect current practice. We also believe that there should be no discrepancy between mandating Specialist presence and ICU involvement.

Minimum facilities for Pre-Anaesthesia Consultations

The ASA Position Statement on Minimum facilities for Pre-Anaesthesia Consultations (PS03) was recently modified to better reflect modern anaesthesia practice. The document now recognises that pre-anaesthesia consultations may be a combination of face to face, telephone, or teleconference review and/or use of preoperative surveys.

Dr James Hosking

PIAC Chair

References

1 https://asa.org.au/asaeducation/asaed-event-recordings
2 https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Expedited-specialist-pathway.aspx
3 https://www.medicalboard.gov.au/Registration/International-Medical-Graduates/Specialist-Pathway/Guides-and-reports.aspx
4 https://www.gov.uk/government/publications/independent-review-of-the-physician-associate-and-anaesthesia-associate-roles-final-report
5 https://asa.org.au/publications/anaesthetist-workforce-modelling
6 See https://www.safetyandquality.gov.au/standards/clinical-care-standards/emergency-laparotomy-clinical-care-standard#consultation-and-expert-advice

BACK TO WORK SUPPORT FOR ASA MEMBERS

Getting back to work can be a big challenge after a period away. 'CRASH' is a course designed to restore your confidence and support your return.

Attending ASA CRASH course helped me refresh some essential skills & knowledge (such as how to tackle different types of Anaesthetic Crises) whilst providing me a safe & conducive learning environment to make mistakes.

The faculty was welcoming & have a broad experience & presence at multiple major hospitals in Melbourne, which further enriched the day.

Having taken 6 months away from medicine & Anaesthesia training, I felt this full day course was very helpful in giving me confidence to return to work with confidence in my own abilities but also knowing when to escalate & ask for help.

Finally, the ASA scholarship was a very welcome financial bonus after 6 months of unemployment!"

~Dr Mayank Vasudeva

The Australian Society of Anaesthetists recognises the importance of ensuring that anaesthetists returning to work after a period away can do so with confidence. To this end, the ASA is offering scholarships to members who are returning to work after a period of leave to undertake the *"Critical Care, Resuscitation, Airway Skills: Helping You Return to Work* - CRASH Course."

What is CRASH?

1. CRASH has been designed by critical care specialists and educators to form part of a structured return to work process after a period of leave.
2. It is facilitated by a dedicated faculty, with a high faculty: participant ratio
3. CRASH meets the ANZCA requirements for two emergency responses plus additional Continuing Medical Education (CME)
4. CRASH is recommended by CICM as part of a return to work process, providing simulation (face-to-face), emergency scenarios, skills practice and clinical decision-making support to refresh knowledge, as well as practical tips on returning-to-work.

CRASH face-to-face (which may be half or full day) has two emergency responses.

CRASH virtual is accredited for one emergency response.

What is the ASA CRASH Scholarship?

The scholarship is a contribution designed to partially offset the registration costs of undertaking the CRASH Course. CRASH Virtual $200 CRASH face-to-face $400.

Who can apply for an ASA CRASH Course Scholarship?

Any ASA member returning to work after a period of leave be it parental (including maternity and paternity), overseas fellowship, cross-specialty training, research, or wanting to refresh their skills after a break in practice, may apply for a scholarship.
Applicants must have been a financial ASA member for a minimum of one year to be eligible for the scholarship.

How do I apply?

Book and pay for your CRASH Course online. Save your registration receipt.

Complete the online ASA CRASH Course Scholarship application and attach your receipt.

Should your application be successful, you will be informed by the ASA and scholarship funds will be paid into your nominated bank account. All successful applicants must use the scholarship within one year (12 months) of it being awarded.

Please note that the financial scholarships are dependent on applicants attending the CRASH Course. Therefore, if you are unable to attend the course for any reason, you'll be expected to refund any monies received from the ASA.

20 CRASH scholarships available per year

For ASA CRASH Course Scholarship information please scan the QR code

DR MICHAEL
LUMSDEN-STEEL
EAC CHAIR

ECONOMICS ADVISORY COMMITTEE

Anaesthesia Relative Value Guide Review

Introduction

The ASA Relative Value Guide (RVG) is a comprehensive guide to billing for anaesthesia services, and aid to the Medicare Benefits Schedule (MBS). The Anaesthesia RVG was introduced into the MBS in 2001, after many years of ASA representation to ensure that patients had access to medicare rebates which reflected their clinical anaesthesia care, as opposed to rebates derived from the surgeons MBS items.

In the MBS, the RVG groups anaesthesia services within anatomical regions. These items are listed under Group T10, Subgroups 1-16 and include detailed descriptors and notes to help you determine the correct MBS item. If you are uncertain about the correct MBS item to use from several possibilities, you can review the relevant notes for an MBS item using the "Search the MBS" function in MBS Online at https://www.mbsonline.gov.au.

All ASA members can access a current, digital version of the ASA RVG in the members' area of the ASA website, and in the ASA RVG App. Members are also encouraged to listen to ASA podcasts as these contain many of the answers to common questions we receive regarding anaesthesia billing.

Finally, note that there are several ASA items with no clearly equivalent MBS items, and that there are ASA items which may have a different unit value to MBS items. ASA members can contact the ASA with questions or to seek guidance.

Medicare eligible anaesthesia services

Medicare benefits for anaesthesia services are only payable where anaesthesia is performed in association with an eligible service, and the patient is Medicare eligible. The exception to this is item 21997, if there is a clinical need for anaesthesia, and this has been documented.

Where the anaesthetist has initiated anaesthesia for an eligible service, Medicare benefits are payable for anaesthetic services found in Group T.10 (Relative Value Guide for Anaesthesia) under Category 3 (Therapeutic Procedures of the MBS). Group T.10 is comprised of Subgroups 1-26 which is often simply referred to as the "Anaesthesia RVG".

The RVG provides a clear and logical way to derive an estimate of what you fee is likely to be. An Anaesthesia episode will consist of a base Item (known as an initiation of Anaesthesia Item) AND Time. There may also be patient modifiers, and other services as clinically indicated (such as therapeutic and diagnostic items in Subgroup 19). Each clinical service is allocated a unit value which will be the total of RVG units multiplied by your unit value.

Informed Financial Consent (IFC) represents an estimate of your fee only. It should be clearly communicated to patients when providing IFC that the actual cost may change depending on factors such as the need for additional clinical services or variations in anaesthesia time during the procedure.

All ASA members can access a current, digital version of the ASA RVG in the members' area of the ASA website, and in the ASA RVG App. Members are also encouraged to listen to ASA podcasts as these contain many of the answers to common questions we receive regarding anaesthesia billing.

The ASA Relative Value Guide on the other hand has Subgroups 1-26 organised as "Divisions" (A-W), with Time and Modifiers listed independently.

The RVG Review - broad scope and principles

In my preface to the 2025 ASA RVG, I noted the ASA would be engaging in discussions with the Health Department's Medicare Policy Team over the course of 2025 to discuss an Anaesthesia RVG Review and proposals for potential changes. It has often been observed for example that many newer interventional and minimally invasive procedures are first introduced and established in

public hospitals. When subsequently adopted in the private hospital system, this often occurs before the necessary anaesthesia MBS arrangements have been adequately addressed.

This review of the RVG is the result of many years of ASA engagement with the Department of Health and calls for a clinician-driven update to ensure the RVG continues to reflect contemporary anaesthesia practice. Updating the MBS has traditionally been a complex process, involving lengthy submissions via the Medical Services Advisory Committee (MSAC) or MBS Review Advisory Committee (MRAC). It's worth noting the last significant review, the MBS Review Taskforce which ran from 2015–2020, did not deliver meaningful modernisation of the RVG. In fact, the initial recommendations of that review focused heavily on removing or devaluing many MBS anaesthesia RVG items.

The goal of this review is to ensure the RVG remains fit for purpose, and that relativity remains between initiation of anaesthesia MBS items. The review will be led by the ASA's Economics Advisory Committee in collaboration with the Department. While other stakeholders will have opportunities to provide their input, the ASA will act as the primary representative body for anaesthetists. To gather a broad range of perspectives, the ASA will invite input from special interest groups, and we encourage all members who would like to provide any feedback and comments to provide this directly to the ASA.

Increasing unit values of specific MBS items, to raise patient rebates to a level that individual anaesthetists might deem appropriate, is not an objective of this review. We recognise however that, at the time of writing, the current MBS unit value ($23.10) equates to less than 22 per cent of the ASA unit value ($106). Ultimately, your fee is set by the unit value that you allocate for your services.

The ASA RVG unit value was indexed on 1 November, increasing to $110. The lack of appropriate indexation to the MBS RVG unit value, as well as lack of indexation to private health insurance known gap limits, remains the major determinant for patient insurance shortfalls or out of pocket costs.

In late October we met with the Department and agreed to a broad scope and principles for this RVG Review, which we can now share with members.

Principals of the Review

1. The RVG review will align MBS billing of RVG items with current best clinical anaesthetic practice and where possible, future proof to minimise ongoing maintenance to the RVG, i.e. MBS items
2. Recommendations to amend the RVG resulting from the review, and, pending Government approval, will be implemented on a cost-neutral basis
3. Further noting we are aiming to achieve cost-neutrality, careful consideration must be given to how identified 'saves' should be redistributed across the RVG
    a) Identified 'saves' within a Sub-group would ideally be redistributed within that Sub-group
    b) Identified 'saves' across the RVG, e.g. recommendations to amend consultation or time items that result in 'savings' must be redistributed across the RVG
4. Any identified inappropriate or opportunistic billing by anaesthetists of MBS items, either deliberately or otherwise, does not represent a 'save' to be redistributed across the RVG – rather this will align with the principles outlined in '1' above
5. To avoid creating additional RVG items, where possible, priority should be given to amending existing items to achieve the intended outcome. The same principle applies to Explanatory Note/s
6. A succinct rationale must be provided for each change suggested and should, as much as possible, consider the impact on other anaesthetists/ anaesthesia practice
7. In addition to the specific Sub-group (Division) allocated to each review (special interest) group, it is anticipated all groups will review:
    a) RVG Group T6, Sub-Group 1 – Anaesthesia Consultations
    b) RVG Group T10, Sub-Group's 18 – 26
    c) Other Sub-groups of the RVG where applicable, e.g. potential crossovers between Sub-groups
8. While Sub-groups (or Divisions) of the RVG are being split out into special interest groups for review, a coordination/reconciliation exercise will be required to ensure fair representation for all anaesthetists billing the MBS
9. Where data is required to inform the Review, a link to Services Australia service numbers has been provided to the ASA in an RVG Review Template prepared by the Department. All data generated for this review will be from the 2023/24 financial year.

In conclusion

The ASA will continue to advocate for a robust RVG that reflects the complexity and variability of the intraoperative anaesthesia and perioperative care provided by anaesthetists. The ASA Relative Value Guide requires significant investment of ASA resources and finances and should not be shared with and/or used by non-members. ASA members are encouraged to refer non-members to join the ASA.

Finally, feedback from ASA members regarding the ASA Relative Value Guide is encouraged and should be directed to policy@asa.org.au.

Dr Michael Lumsden-Steel

EAC Chair

Australian Society of Anaesthetists®

ASA Trainee Members

Embarking on international opportunities:

The ASA Common Interest Group Scholarship

$5K*

How the Common Interest Group Scholarship opens doors for trainee anaesthetists

The Australian Society of Anaesthetists (ASA) continues to champion the professional development of its Trainee Members through the Common Interest Group Scholarship. Each year, this initiative enables three ASA Trainee Members to broaden their horizons by attending an annual meeting or conference hosted by one of our respected overseas partner societies. Through this unique opportunity, recipients gain exposure to pioneering research and innovative practices in anaesthesia, fostering invaluable connections across the global medical community.

Dr Harry Pearce, recipient of the 2024 CIG Scholarship, reflects on his experience:

"The ASA enthusiastically launched my foray into the international anaesthesia community via the Common Interest Group Scholarship. It's available to eligible Trainee Members and takes advantage of the strong ties between the Society and its international counterparts – in my instance, the Association of Anaesthetists at their annual trainee conference in Glasgow. Representing our Society at this forum means I see and learn from academic firsts and system advances at the coalface, and my trip is supported financially by the ASA. As I move into the next phase of my career, I look forward to finding my place amongst the common interest groups and continuing education arms inherent to the ASA's structure."

Successful applicants receive $5,000 to assist with their airfare and accommodation costs. In addition, each participating overseas society generously provides one complimentary registration for the scholarship winner to attend their meeting. Eligibility is exclusive to ASA Trainee Members who have maintained financial membership for a minimum of 12 months prior to applying.

Upcoming opportunities for 2026 include:

CANADIAN ANESTHESIOLOGISTS' SOCIETY

Destination: **OTTAWA**
Date: **5–7 JUNE 2026**

ASSOCIATION OF ANAESTHETISTS

Destination: **NEWCASTLE**
Date : **17–18 JUNE 2026**

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Destination: **SAN DIEGO, CA**
Date: **16-20 OCTOBER 2026**

The ASA Common Interest Group Scholarship is more than financial support – it is a gateway to international collaboration, professional growth and lifelong learning. For eligible trainee members seeking to make a mark in the world of anaesthesia this is an opportunity not to be missed.

AROUND AUSTRALIA

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

HBF health fund survey results

Thank you to all who took the time to fill in the HBF survey sent out earlier this year. The ASA WA Committee is working with the Policy team and EAC to present these findings to WA members and HBF, opening negotiations on HBF rates and the 'HBF-preferred' scheme.

ACE CICO Workshop

Dr Jingjing Luo led a fully-subscribed CICO Emergency Response workshop on Monday 22nd September at the WA ANZCA Office in Osborne Park. Many thanks to Dr Luo and colleagues from the Royal Perth Hospital Anaesthesia and Intensive Care departments for facilitating this essential CPD activity.

Cocktail Party

On Saturday September 13th, Lum's Subiaco hosted our annual ASA WA Cocktail party. It was wonderful to catch up with colleagues both new and seasoned in a warm, intimate setting that kept out the terrible weather. The event, open to both members and non-members, was a fabulous opportunity for networking and connecting with friends with excellent food and beverages.

Many thanks to our WA TMG representatives Dr Kennia Lotter and Dr Merredith Cully for organizing this delightful evening.

Part 3 Course

The always-popular WA Part 3 Course will be held on Friday 14th November at the University of Western Australia University Club. Popular sessions such as the Heads of Department panel, Financial Planning, and Private Billings are planned and will no doubt be a valuable experience for all attendees. We thank the sponsors and Drs Merredith Cully and Kennia Lotter for their work organising this.

New South Wales

Dr Simon Martel

Chair of the New South Wales Committee of Management

VMO Determination

Members of the ASA continue to work with AMA(NSW), to pursue improvements of the VMO Determination.

Evidence was submitted to the Industrial Court on 26 September and included:

1. Results of a VMO Survey - thank you to the many anaesthetists who participated in the VMO Survey – 20% of completed surveys were by anaesthetists.
2. 25 detailed witness statements that included several anaesthetists
3. An accountancy report
4. A health economist report

This incorporates a significant amount of work, with a work value case last being prosecuted by the AMA in the early 1990s.

AMA claims for sessional VMOs include payment for services provided remotely, payment for private patients where a VMO does not agree to treat privately, loadings for after-hours and weekend work, increased loadings for call-backs,

more straight forward progression to senior VMO, increasing the Professional Support Payment for regional VMOs and changing it from reimbursement to an allowance, payment for travel time for regional VMOs, recognition of general practitioners as specialists, and increased rates of remuneration.

The government will have an opportunity to review and respond to the claims and collate their own evidence, which is due to be submitted by 6 February 2026.

Hearing dates are planned between April and June 2026.

The AMA has requested an interim pay rise whilst this process plays out, but as of mid October has yet to receive a response from the Ministry. The last increase to pay rates in the Determination was in July 2023.

Staff Specialist / Doctor in Training Awards

ASMOF NSW continues to prosecute their campaign to achieve award reform in NSW.

A recent IRC ruling has resulted in psychiatrists being award an interim 20 per cent increase in salary.

NSW doctors recently rejected an interim pay offer of three per cent per annum, with almost 6000 doctors voting, and 75 per cent of ASMOF members voting against the deal. This offer would have resulted in a three per cent per annum interim pay offer but would have removed the ability of doctors to undertake industrial action.

Hearing dates for arbitration in the NSW Industrial Relations Commission are currently scheduled for November and December, and are expected to run over eight to ten weeks.

Healthscope/Northern Beaches Hospital

The ASA continues to monitor the ongoing attempt to sell off the assets of Healthscope, which went into receivership earlier this year. In particular, the NSW government has expressed a desire to take over the operation of Northern Beaches Hospital. Intel would suggest that the government is keen to take over the whole hospital, and there are significant concerns regarding the ongoing operation and viability of private work that currently occurs at the hospital, and the downgrading of current services.

Single Digital Patient Record

Planning for the SDPR continues with the first local health district, Hunter New England LHD, looking to implement this in early 2026. More information is available at https://www.health.nsw.gov.au/single-digital-patient-record/Pages/staff.aspx .

Part III Course

The ASA NSW Part III course will be held virtually on Saturday 22 November. We look forward to educating our recent and future consultants on the transition from trainee to consultant practice.

Harry Daly Museum and Richard Bailey Library

NSW members remain apprehensive whilst the Board continues to review the operations of the museum and library. The NSW Committee continues to monitor the situation and support affected members.

Our next meeting is on Wednesday 26 November.

Australian Capital Territory

Dr Valerie Quah

Chair of the Australian Capital Territory Committee of Management

A highlight of the recent quarter was the National Scientific Meeting superbly convened by Drs Girish Palnitkar and Adam Eslick. Over 700 delegates were privy to a stellar cohort of international and Australian speakers. There were workshops aplenty run by our ACT colleagues, not to mention superb networking and socialising opportunities including a gala dinner at Parliament House.

Thanks to the organising committee members Freya Aaskov, Shruti Krishnan, Elizabeth Merenda, Jennifer Herrick, Julia Hoy, Mark Skacel, Vida Viliunas, David Elliott and Rhian Foster. Last but not least, we also congratulate Dr Vida Viliunas on her formal appointment as ASA president.

Tasmania

Dr Alice Mulcahy

Chair of the Tasmanian Committee of Management

After a short hiatus, the Tasmanian state committee has re-convened this year, with members actively addressing issues regarding private obstetric anaesthesia following the withdrawal of maternity services at Hobart Private Hospital. We have supported members through concerns regarding the future of the Healthscope Hospital in Hobart, and are working closely with private hospital anaesthetic subcommittees to support members and ensure that their concerns are clearly articulated and conveyed to the appropriate stakeholders.

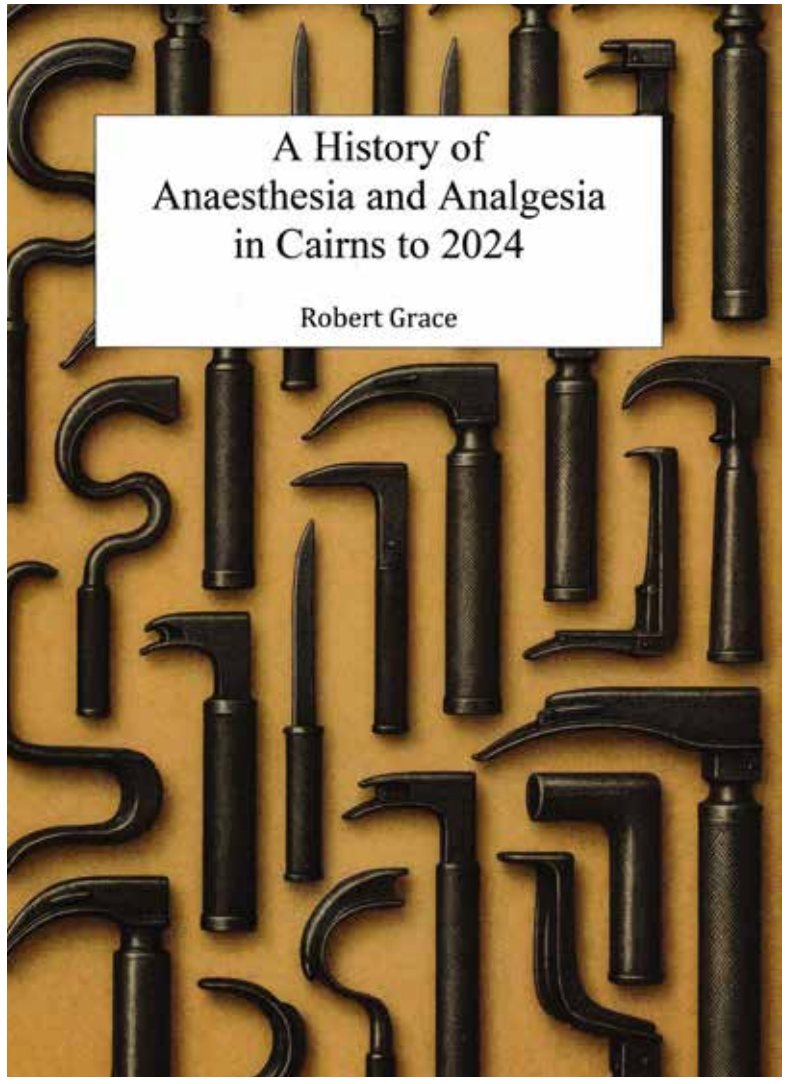
Events

In August, we held the ACE Tasmania Combined Winter CME Meeting at the beautiful Josef Chromy Wines in Launceston; this was a highly successful event with fantastic feedback from attendees. Looking forward, we are preparing to host the biennial Part 3 day in November for advanced trainees across the state, as well as a trainee social function to follow on from the Tasmanian Statewide Trauma Day in December.

HALMA UPDATE

BOOK DONATION

THE RICHARD BAILEY LIBRARY AT THE ASA HAS RECENTLY BEEN DONATED A WONDERFUL BOOK. IT IS *A HISTORY OF ANAESTHESIA AND ANALGESIA IN CAIRNS TO 2024*, WRITTEN BY DR ROBERT GRACE, A SENIOR ANAESTHETIST IN CAIRNS FOR MANY YEARS.



The book is a large hardcover with many colour illustrations, and I only wish that there were more departmental and regional histories of anaesthesia, intensive care and pain medicine like this in Australia. They are exceedingly rare and our specialty has grown - in many hospitals we are the biggest department.

We have many unique areas of practice in this country and this book reflects the diversity and challenges of Far North Queensland (FNQ). It starts appropriately with indigenous pharmacology and leads into a regional history of medicine with many unusual characters that FNQ attracted. There is extensive newspaper material from that wonderful resource Trove. It is not just a department history, it is a regional history of medicine.

There is mention of early opium dens and addiction, the impact of polio on small communities with life-saving iron lungs being deployed, and the all too frequent deaths under anaesthesia that occurred less than a century ago. It would not be FNQ without mention of the health impacts of cyclones, the first live captured taipan to be milked (the herpetologist died), research on the box jellyfish and anaesthetising crocodiles - with registrars sitting on them for the photo!

This book shows the development of one of the few major regional hospitals in the northern half of our country. It specifically relates to training, equipment, innovations, research and the challenges these professionals faced. In some ways, it is a 'family album' of what is obviously a close-knit department that has progressed to a cohesive and outstanding group that hosted the outstanding ANZCA ASM this year.

The history of medicine is intricately related to the history of a society. In the next few years, the early departments of anaesthesia in Australia will be approaching their centenary, with many more following in the next one to two decades. Now is the time for us all to be recording a 'family album' of how our departments, hospitals and regions developed and progressed – before those resources are lost. This book is a great model for others to follow. A few copies are still available from Dr Grace.

Dr Michael G Cooper AM

Honorary Curator
Harry Daly Museum

HALMA UPDATE

INTERNATIONAL SYMPOSIUM FOR THE HISTORY OF ANAESTHESIA 2025 REPORT

THE SUCCESSFUL 11TH INTERNATIONAL SYMPOSIUM FOR THE HISTORY OF ANAESTHESIA (ISHA) WAS HELD RECENTLY IN PARIS IN SEPTEMBER. THIS MEETING IS HELD EVERY FOUR YEARS AND, AS USUAL, AUSTRALIA WAS WELL REPRESENTED. THIRTEEN AUSTRALIANS ATTENDED, WITH 7 PRESENTING A TOTAL OF 9 PAPERS. THERE WERE ABOUT 70 PAPERS PRESENTED IN ENGLISH FROM OVER 11 DIFFERENT COUNTRIES.

The first two days were spent at the historic University Paris Cité. Then the meeting moved to the Palais de Congrés for combined sessions with the Société Française d'Anesthésie et de Réanimation (SFAR) and the World Veterinary Anaesthesia Association, a fascinating intersection of interests.

The excellent cultural program included a visit to the Institut de France, the Armed Forces Medical Corps Museum at the Val-de-Grâce Army Hospital, and a superb historic anaesthesia display at the Musée d'Histoire de la Médicine titled, 'Il était une fois l'anésthesie,' which translates as 'Once upon a time in Anaesthesia'. The social night including a wonderful dinner cruising the Seine with all of Paris on display in clear autumn weather.

Of note, Dr Jun Parker from Portland in Victoria was the recipient of the Young Historian Prize for the best presentation at the Symposium. He received an original early French Ombrédanne inhaler from the President of ISHA, Dr Dominique Simon.

Representatives from many international museums were present including the Wood Library Museum in the Illinois, the Heritage Centre in London and the Japanese Museum of Anesthesiology in Kyoto. The ASA library, museum and archives were promoted at the meeting.

Dr Michael G Cooper AM
Dr Christine Ball AM

ASA MENTAL HEALTH AND WELLNESS

Central Coast Meditation Centre

Central Coast Meditation Centre provides teachings focused on Mindfulness and offers Calm Abiding (Shamada) Meditation Course **nationally on-line** in addition to being in-person.

Scientific evidence and in-depth guide with benefits to quieten the mind and cultivate inner peace. Enhance clarity in your daily life

Improved Sleep
Lower blood pressure
Adjunct management of depression, stress & anxiety and burnout
ADHD management
Pain management
Improved focus and concentration

For over twenty years, the Central Coast Meditation Centre has been a secular (non-religious) vital part of the Central Coast NSW Australia. We are a not-for-profit organisation dedicated to sharing medical mindfulness and over 2,500 years of Buddhist philosophy on compassion and wisdom.

"Emotional intelligence and wisdom cannot be fully obtained without ultimate compassion"

Wellbeing CPD hours (practice evaluation and knowledge & skills)

Contact Dr Lê asalanhoale@gmail.com

centralcoastmeditationcentre.com

Australian Society of Anaesthetists

Eligible for CPD hours

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.

DR. LAN-HOA LÊ

ASA WELLBEING ADVOCATES COMMITTEE CHAIR

WELLBEING ADVOCATES COMMITTEE

CHRISTMAS BLUES

PEER SUPPORT ARTICLE CONTAINS EXCERPTS FROM THE AUSTRALIAN SOCIETY OF ANAESTHETISTS (ASA) WELLBEING ADVOCATES, SANE (MENTAL HEALTH PEER SUPPORT), AND LIFELINE ORGANISATIONS.

"We can be alone and not feel lonely, but we can also be surrounded by lots of people, yet feel extremely lonely."

Coming towards the end of year's stress, pressure, and feelings of loneliness or grief can be overwhelming. High expectations, financial worries, and family dynamics can all contribute to higher stress levels, which can then trigger or exacerbate mental health conditions.

Factors that can worsen depression during the holidays:

- **Unrealistic expectations:** The media often portrays an idealised version of the holidays, which can lead to disappointment and higher stress levels when reality doesn't match.
- **Loneliness and grief:** For those who have lost a loved one or who cannot be with family, the holiday season can amplify feelings of loneliness and loss.
- **Financial pressure:** The costs associated with purchasing gifts, travel, and other holiday activities can be a significant source of stress.
- **Family dynamics:** Stressful or difficult family gatherings can create strain and anxiety, even for those without diagnosed mental health conditions.
- **General stress:** The holiday season is often packed with extra tasks such as shopping, decorating, and social events, which can lead to higher stress levels and a feeling of being overwhelmed. Memories and aversions, loneliness and feelings of hopelessness and distress can be triggered at the end of each year.

What can I do? What can I work with?

- **Manage expectations including financials:** Remind yourself holidays are not perfect. Focus on what is most important to you right now and don't put pressure on yourself to meet unrealistic ideals.

"Set a firm budget and being honest with friends and family about what you can and can't afford is a strategy for dealing with financial stress."

- **Prioritise self-care including mindfulness:** Plan to ensure you get enough sleep, eat balanced meals, and take time for yourself to de-stress. And that doesn't have to be big goals, an example is a simple walk, so you can be at the 'now' with colours of nature and UV sunlight.
- **Seeing the lightness of things:** *"Acknowledging that this is a hard time, and it's a hard time for a lot of people as well".* A creative exercise can be watching yourself from above and give a kind smile or laugh wholeheartedly. This allows a space between you and when something comes up, recognise and understand the impermanence and interdependence nature of how negative thoughts and feelings come and go... *"Realising we don't have to take things too seriously, or feel like we're a failure, and allow thoughts and feelings flow, so we can feel lighter in our minds."*
- **Set boundaries:** It's okay to say 'no' to invitations, and when you do attend, do limit your time spending at stressful events particularly with some family members or friends.
- **Dealing with loneliness:** When struggling with loneliness, increasing meaningful connections with other people can aid. *"The key here is 'meaningful' connections — so it's about quality, not quantity. This is why strategies like helping others, volunteering, joining a group around a shared interest can be helpful for combating loneliness because it's increasing the strength of those meaningful social connections. Other strategies can be to reinvigorate relationships that you've been thinking of for a long while. Tap into those existing friendships or relationships that we have and trying to reconnect with people that way."* Sane peer support.
- **Seek support:** If you are struggling, reach out to friends, family, or a mental health professional for support. Organisations like Lifeline 24/7, peer support live online chats or phonelines, are set up with extra volunteers during the holiday season to offer help; especially during times like New Year's when health professionals can be on holidays too, and thus making appointments to see them can be delayed. *"Having support plans in place for who to contact if you notice your mental health getting worse, or a list of self-care strategies you can follow, is also important to get ready before Christmas and New Year".*

"We will listen without judgement. We will listen with empathy, and we will listen with compassion what's happening to you."

Lifeline peer support

Online mental health and peer support resources:

- **Lifeline's self-support toolkit**
  https://www.lifeline.org.au/resources/fact-sheets/
- **Mensline Australia phone and online counselling**
  https://mensline.org.au/advice-support-referral-resources-for-men/
- **Drs4Drs peer support**
  https://drs4drs.com.au/support-us
- **Hand-n-Hand peer support**
  https://www.handnhand.org.au/receivesupport
- **SANE information and forums**
  https://www.sane.org/
- **Black Dog Institute resources**
  https://www.blackdoginstitute.org.au/resources-support/
- **Embrace multicultural resources**
  https://embracementalhealth.org.au/
- **QLife LGBTI+ peer support**
  https://qlife.org.au/
- **Headspace online support**
  https://headspace.org.au/online-and-phone-support/
- **BeyondBlue website and forums**
  https://www.beyondblue.org.au/mental-health/tools-and-quizzes/k10

Australian Society of
Anaesthetists®

Let's be serious and address the elephant in the room. Prioritise your mental health and wellbeing today.

Scan the QR code to access ASA free wellness resources

Let us know how we can best support you! Contact your ASA Wellbeing Chair
asapeersupport@asa.org.au.

Australian Society of
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Drs4Drs supports doctors and medical students to care for themselves, their colleagues and their patients.

Scan the QR code to visit the Drs4Drs website

Let us know how we can best support you! Contact your ASA Wellbeing Chair
asapeersupport@asa.org.au.

In partnership with psychiatrists at Hand-n-Hand, the Australian Society of Anaesthetists proudly present the launch of

Australian Society of Anaesthetists®

members for members

Peer Support Programme

Simply put, peer support is a way of providing emotional and wellbeing assistance where both the facilitator and participant are equals. Through this, people can connect through shared experience. It's not mentorship or career guidance - your facilitators are peers you can relate to.

When you sign up, you're linked in with a facilitator from the same profession and similar level of training. Our facilitators are trained and experienced in providing peer support.

Benefits of peer support

- 1-on-1 or group support available.
- Meet as often or as little as you like, at times that suit your schedule.
- Withdraw at any time, for any reason.
- Involves no clinical psychiatric treatment.
- Supported by evidence as a pre-clinical mental health intervention.

Are you looking for peer support?

Are you a peer support facilitator, or interested in becoming a trained facilitator?

By volunteering as a peer support facilitator, you can help others in your position navigate the ups and downs of the health profession.

Our triage method is guided by Hand-n-Hand to best suit you

Contact the ASA Wellbeing Advocates Committee

ASApeersupport@asa.org.au

Join now and connect with your community

Australian Society of Anaesthetists®

EDUCATION

ADVOCACY

SCHOLARSHIPS AND GRANTS*

EVENTS

PUBLICATIONS

RESOURCES

FREE CPD Home

Dr Justin Burke
ASA Member since 2010

I was inspired to become an ASA member by my senior colleagues and mentors. I attended a Real World Anaesthesia Course when I was an Anaesthetic Fellow. And in the course of the week, I met a lot of really inspirational people who had done amazing international work. Much of which had been sponsored by the ASA."

www.asa.org.au | 1800 806 654 | membership@asa.org.au

*Applicants require a minimum of 12 months ASA membership to be eligible.

50 years Membership

Dr Stephen Aseervatham

Dr Kanag Baska

Dr Alan Bradshaw

Dr Ian Dugan

Dr Peter Freeman

Dr Martin Greer

Dr Roger Henderson

Dr Timothy Hunt

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Australian Society of Anaesthetists®

On the road to becoming an anaesthetist? The ASA is here to support you at every step of your journey.

Junior Consultant

RVG
Medicare Compliance
Advocacy
Education

Provisional Fellow

DISCOUNTED MEMBERSHIP
Career Development

Advanced Trainee

DISCOUNTED MEMBERSHIP
Exam support, resources

Introductory/Basic Trainee

FREE MEMBERSHIP
Exam support and an independent voice for trainees

Intern/Resident/SRMO

FREE MEMBERSHIP
Support to get on the program

Join Now

www.asa.org.au

Contact the Membership Team 1800 806 654 membership@asa.org.au

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CSC2026

COMBINED SCIENTIFIC CONGRESS
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8-11 OCTOBER 2026

Key Dates for Abstract Submission

Save the date

Call for Abstracts Launch

Tuesday 2 December 2025

Deadline for Submission of Abstracts

Monday 15 June 2026

Authors Advised of Submission Result

Friday 31 July 2026

WWW.CSC2026.COM.AU

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