

# AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • MARCH 2026

ADVOCACY &  
ANAESTHESIA



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Australian Society of  
**Anaesthetists**



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### Would you like to contribute to the next issue?

If you would like to contribute a feature or lifestyle piece for the June 2026 edition of Australian Anaesthetist, the following deadlines apply:

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

Please email the editor at [editor@asa.org.au](mailto:editor@asa.org.au). Image and manuscript specifications can be provided upon request.



DR VIDA VILIUNAS OAM  
PRESIDENT

# FROM THE ASA PRESIDENT

Advocacy is central to the ASA's vision and mission.

**A**ustralian anaesthetists are very good at clinical care, training the next generation of specialists, and researching developments in our field. Increasingly, as we look up from the head of the bed, we see many other factors that impact on our working life. Matters of rosters that are hard to fill, protests about out-of-pocket costs or unindexed no gap and known gap contracts, to name a few.

## Strengthening our national voice – workforce sustainability and fees

The ASA Board and Council work closely with our policy and advocacy team. ASA CEO Dr Matthew Fisher leads the team that continues to represent the ASA at State, Territory and Federal levels on significant issues for anaesthetists.

It's not just about being at the table. The ASA attends with data. Our 2024 workforce survey informed projections for anaesthesia workforce sustainability into the future and will be updated to track progress with further research. We have generated data that supports our recommendations for short- and longer-term solutions and makes them persuasive, influential and in the interests of our ASA members.

Specialist International Medical Graduates are an important part of our specialist workforce. Expedited pathways are short-term workforce solutions that should be focused on cutting red tape and maintaining quality and safety.

The ASA is working closely with other groups to ensure that any changes to scopes of practice or other models of care prioritise patient safety, access to timely care and preserve anaesthesia as a medical speciality.

So let's talk about fees. A resounding thank you to all who participated in the ASA survey on specialist fees and patient out-of-pocket costs. That will bring relevant and current data to the conversations focused on anaesthetists' fees and billing transparency. It will move the discussion from sensationalist headline grabbers to what actually happens for the majority – supported by facts and numbers.

## ASA advocacy for members and advocacy for patients

Our advocacy efforts are not only aimed at policymakers and members. The ASA will be enhancing its public-facing content to reach the broader health community. Videos, podcasts and targeted messaging will be a focus for 2026.

The ASA has two intertwined responsibilities reflected in our mission and vision statements:

1. To support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public, and
2. To be a society that advocates for patients, patient safety and an accessible, equitable health system.

## Looking ahead

This March edition of Australian Anaesthetist has its theme as advocacy for good reason. For effective advocacy, our specialty must be proactive to be well-equipped to shape the environment in which we practise. I encourage all ASA members to explore the advocacy-focused pieces in this issue, contribute your views and insights, and remain engaged in our work and the future of the profession.

Let's do this together.

### ■ Dr Vida Viliunas OAM



# FROM THE ASA CEO

DR MATTHEW FISHER  
CHIEF EXECUTIVE OFFICER

## Advocacy: Driving Influence and Impact for the ASA

**ADVOCACY IS MORE THAN A STRATEGIC FUNCTION—IT IS AT THE CORE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS (ASA). IT ENSURES THAT THE VOICES OF ANAESTHETISTS RESONATE IN POLICY-MAKING, HEALTHCARE REFORM, AND PUBLIC DISCOURSE. IN AN ERA OF RAPID CHANGE AND INCREASING COMPLEXITY, ADVOCACY IS ESSENTIAL FOR SAFEGUARDING PROFESSIONAL STANDARDS, IMPROVING PATIENT OUTCOMES, AND SHAPING THE FUTURE OF ANAESTHESIA IN AUSTRALIA.**

**T**he ASA has committed to be an exemplary society of anaesthetists advocating for the specialty, patients, patient safety and an accessible, equitable health system. We will represent the anaesthesia specialty to stakeholders, and advocate for patient and community access, equity, and patient education.

The 2025 ASA Member Survey provided a comprehensive assessment of the value members derive from their association with ASA, how this value varies across different member segments, and where the organisation can focus its efforts to enhance member engagement and satisfaction. The core value proposition of ASA membership remains advocacy - both in terms of protecting the role of the profession and in influencing the broader healthcare landscape on behalf of all Australians.

I am exploring the ASA’s advocacy journey through our successes, the challenges encountered, and the initiatives that will define our future efforts.

### Defining Advocacy in Healthcare

Advocacy in healthcare involves influencing decisions within political, economic, and social systems to promote the interests of patients and professionals. For ASA, advocacy means:

- Championing patient safety and quality care.
- Ensuring fair remuneration and sustainable practice models.
- Representing anaesthetists in policy and regulatory discussions.
- Educating the public and stakeholders about the critical role of anaesthesia.

It is a dynamic process requiring persistence, credibility, and collaboration. We have utilised partnerships with specialist agencies such as the Civic Partnership, Health Consult and Survey Matters to advance our advocacy.

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## Successes Achieved

ASA's advocacy efforts have delivered significant momentum that underscore our influence and strategic foresight.

### 1. Government Engagement

ASA has established strong relationships with health leadership across all federal, states and territory jurisdictions. In the past year alone, ASA participated in more than 50 high-level meetings with federal and state members of parliament and health authorities. These engagements aim to position the ASA as a trusted adviser on issues such as workforce planning, funding models, and patient safety. This is aimed at bringing the clinician voice to the table and we utilised our 90th year celebrations as a platform to build further action.

### 2. Policy Influence

ASA has successfully contributed, both in the past and present, to key policy understandings and reforms, including:

- Relative Value Guide (RVG) negotiations, ensuring fair remuneration structures.
- MBS Review engagement, advocating for clarity and equity in billing practices.
- Private health insurer discussions, securing better outcomes for members and patients.
- Environmental sustainability.

These achievements reflect ASA's ability to combine evidence-based advocacy with strategic diplomacy and build on a relationship focussed approach.

### 3. Strategic Partnerships

Collaboration amplifies impact. ASA has strengthened ties with various organisations including:

- ANZCA (Australian and New Zealand College of Anaesthetists) for joint workforce initiatives.
- WFSA (World Federation of Societies of Anaesthesiologists) to influence global standards.
- Common Issues Group (USA, UK, Canada, New Zealand and South Africa) aligning with other anaesthesia bodies to address shared challenges.
- NRHA (National Rural Health Alliance) to forward the interests of healthcare in rural, regional and remote areas.

- AMA (Australian Medical Association) for joint initiatives impacting medicine, healthcare and the public.

Such partnerships ensure ASA's voice is heard nationally and internationally.

### 4. Public Profile and Communication

ASA's outward-facing advocacy has grown significantly through:

- Social media engagement, reaching thousands of viewers with patient-focused content.
- Media commentary, positioning ASA as an authoritative voice on anaesthesia-related issues.
- Educational campaigns, enhancing public understanding of anaesthesia's role in healthcare.

## Challenges Faced

Advocacy is complex and often fraught with obstacles. ASA's challenges include:

### 1. Fragmented Jurisdictions and Planning

Australia's healthcare system spans Commonwealth, state, and territory levels, creating overlapping responsibilities and often inconsistent policies. Navigating this complexity requires tailored strategies for each jurisdiction.

### 2. Workforce Sustainability

Persistent concerns about anaesthesia workforce shortages and wellbeing demand ongoing advocacy. Securing training positions, addressing burnout, and promoting flexible and supportive work models remain priorities.

### 3. Member Engagement

While advocacy is a core ASA value, perceptions of representation vary across career stages and work settings. Engaging younger members and those in diverse practice environments is essential to maintain unity and momentum.

### 4. External Environment

Globally, advocacy faces increasing scrutiny, funding limitations, and political volatility. These factors require ASA to remain agile, transparent, and authentic in its messaging appropriate to the Australian context.

## Future Initiatives

ASA's strategic plan outlines our ambitions and initiatives to strengthen advocacy and adapt to emerging trends.

### 1. Digital Advocacy

Technology is transforming advocacy and the ASA has invested in its platform for action. ASA will:

- Expand its social media presence to influence public opinion and policy debates.
- Use data analytics to target messaging and measure impact.
- Explore appropriate tools and channels for rapid response and stakeholder engagement.

### 2. Intersectional Partnerships

Healthcare challenges are interconnected. ASA will continue to collaborate with:

- Government agencies on workforce and funding reforms.
- NGOs on equity and sustainability initiatives.
- International bodies to align with global best practices.

### 3. Capacity Building

Advocacy requires expertise and resilience. ASA plans to:

- Invest in leadership development programmes.
- Engage external consultants for specialised campaigns.
- Build internal capability for continuous advocacy.

### 4. Diversity and Inclusion

Initiatives like the Women in Leadership (WELI) programme will promote diversity in advocacy leadership. ASA will also engage younger members through mentorship and networking opportunities.

### 5. Global Trends Alignment

ASA will embrace emerging trends such as:

- Authenticity in corporate communications, ensuring transparency and trust.
- Intersectional advocacy, addressing issues that span health, equity, and sustainability.
- Digital-led strategies, leveraging technology for maximum reach and impact.

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So, in conclusion, advocacy is the ASA's cornerstone for influence and impact. The successes achieved demonstrate the power of clinician informed, strategic engagement, but challenges demand innovation, adaptability and resilience. By embracing digital tools, fostering partnerships, and aligning with relevant trends, the ASA can continue to lead in shaping healthcare policy and advancing the profession on behalf of anaesthetists and the public.

The future of our advocacy is collaborative, informed, human centred and technology driven. ASA will continue to focus on this and influence the future – ensuring that anaesthetists' collective voice remain strong, your contributions recognised, and the Australian public continue to receive high quality, world leading care.

### ■ Dr Matthew Fisher

PhD DHlthSt (honoris causa)

## Contact

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# 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](mailto:committees@asa.org.au)

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**Professional Issues Advisory Committee**

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**Public Practice Advisory Committee**

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**Editorial Board of Anaesthesia & Intensive Care**

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**Overseas Development and Education Committee**

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**Trainee Members Group Committee**

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**General Practitioner Anaesthetists Group**

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**National Scientific Congress Committees**

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**History of Anaesthesia Library, Museum and Archives Committee**

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**ASA State Committees of Management**

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**Wellbeing Advocates Committee**

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**Science Prizes, Awards and Research Committee**

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**Education Committee**

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DR JANETTE WRIGHT  
IMMEDIATE PAST CHAIR,  
PUBLIC PRACTICE ADVISORY  
COMMITTEE

# PUBLIC PRACTICE ADVISORY COMMITTEE

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

## Dr Andrea Wojnicki – Evening Seminars and Online Workshops in 2026

The PPAC has been offering evening communication workshops since 2022 with Dr Andrea Wojnicki, covering topics such as dealing with difficult people, personal branding and demonstrating leadership. We are pleased to let members know that we will be continuing those evening workshops in 2026 and we will also be offering online courses by Dr Wojnicki with the first four topics available from early 2026 and the remaining five courses with staggered starts through 2026. The first four topics are as follows:

1. Leading Productive Meetings
2. Overcoming Imposter Syndrome & Communicating with Confidence
3. 5 Steps to Nail Your Personal Brand
4. Establishing Executive Presence

These courses attract CPD points under Knowledge and Skills and account for three hours of time per topic.

## Introducing the new Chair of PPAC

I will be stepping down as the Chair of the PPAC after holding that position for four years. It has been a fantastic experience working with all the other passionate and dedicated anaesthetists and support crew at the ASA. The incoming Chair is Dr Namrata Singh from Dubbo, NSW and as a way of introduction she agreed to a short interview.



DR NAMRATA SINGH  
INCOMING CHAIR,  
PUBLIC PRACTICE ADVISORY COMMITTEE

## Hi Namrata! Congratulations on your appointment for the next four years as the Chair of the Public Practice Advisory Committee for the ASA! I was wondering if you could tell members a little bit about yourself?

I was fortunate to grow up in India in a family that valued and supported women. I am the third generation of female doctors in my family, and my grandmother was one of the first 50 female doctors in the country. I studied medicine and trained at a Christian medical college (the same hospital where my grandmother trained), working in a mission hospital and providing healthcare in rural areas. I trained in anaesthesia to work with Smile Train and Mercy Ships, but life took me in a different direction. Twenty-one years ago, I came to Australia when my husband started a fellowship. I was on maternity leave and planned to stay for a few months to relax, but I quickly fell in love with the country, its culture, and the weather. Now, Australia is home, and my goal to make a difference in healthcare is still as strong as ever.

**You have already been having an impact on improving the workforce opportunities for anaesthetists in regional NSW. I was wondering if you could explain a little more about this initiative?**

I came to Dubbo for an accredited post to complete my final FANZCA exam and saw how rewarding the clinical work was, but also noticed the severe workforce shortage and tough working conditions. Many people told me it wasn't my problem since I had my Fellowship and could move on, but I remembered why I chose a career in healthcare. I saw great potential in the hospital. The colleagues were supportive, the patients were complex, and the staff were welcoming. The senior administrators also shared my vision. With my family's support, I decided to stay, and everything came together.

I was lucky to have senior anaesthetists as mentors who supported me as I worked to address the healthcare shortage. We started with just two regular local staff, and now our department has grown to 18 consultants and a few FIFO doctors.

During COVID, I had a great team, including one member from Tasmania who stayed in Dubbo throughout the pandemic because he knew we needed him and appreciated the strong support system here. Once I saw how well the team worked together, I applied for a two-year accreditation and a PF role to help make Dubbo a destination for registrars and PFs to work with us long-term.

After a few years, we realised the best way to address the shortage was to train our own anaesthetists. We partnered with Orange Hospital and worked together to make it happen. Our CEO, GM, and DMS were very supportive. Together with the Orange Hospital Anaesthesia Department, we submitted a business case to MOH, ANZCA, and the District. It took some time, but thanks to our dedicated team, it all came together. This year, we welcomed our first Scheme Trainee.

The goal of the PPAC Committee is to advocate for and represent the views of those working in public practice across Australia. What do you see as the main issues, and how the ASA will be able to best create an impact in those areas?

Since finishing my fellowship, I have mostly worked in public practice, with some private work as well. I have noticed that few people stay in the public sector long-term due to ongoing issues. In Dubbo, we have made many improvements, and most of our consultants now prefer public work, even though there are many opportunities in the private sector. The lack of interest in public work in Australia is mainly due to pay differences, longer work hours that affect clinical performance, and limited support from administration and colleagues. Staffing shortages and resource constraints are also concerns in public hospitals.

Many of these issues need to be addressed by the health ministry, but some can be tackled at the district and hospital levels. While the ASA cannot make all these changes directly, it can help by supporting public practice on a larger scale and encouraging hospitals to offer incentives. The ASA can promote public work to new consultants by working with ASMOF, State Health, and ANZCA to include incentives in contracts, making public hospital work more attractive. There should also be a special focus on supporting the well-being of anaesthetists in regional public hospitals.

The ASA offers workshops for new consultants, and we will encourage them to take on public work to maintain their skills, which can decline if they only work privately. We also aim to streamline the process for internationally trained staff to gain local qualifications through ANZCA and AHPRA, helping to address staff shortages, especially in public hospitals. The ASA already supports continuing professional development, leadership training, mentorship programs and opportunities for advancement and upskilling. I will continue to make sure these programs receive ongoing support. Many GP anaesthetists work in regional areas, but I have not seen many of them involved with the ASA. I would like to encourage their membership and support them in maintaining their anaesthesia skills. Since their Colleges do not provide this support, the ASA can fill this gap and help everyone work at the top of their scope of practice.

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

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

We support those in public practice through:

**1. Education**

- a. For residents and registrars:
  - i. Online Primary and Final Examination practice
  - ii. Part Zero and Part Three courses.
- b. For consultants:
  - i. Evening Communication and Leadership webinars four times per year
- c. For all:
  - i. The Australian Anaesthesia Podcast with Suzi Nou
  - ii. Australian Anaesthetist quarterly magazine
  - iii. *Anaesthesia and Intensive Care* journal
  - iv. ACE education events – Tripartite anaesthesia events governed by ANZCA/ ASA/ NZSA

**2. Advocacy**

- a. For ongoing improvement in Enterprise bargaining arrangements/ Awards for public hospital doctors-in-training and specialists.

**2. Support**

- a. Peer support – network of members who have been trained to provide peer support for other members in times of need.
- b. CRASH return-to-work scholarships – 50% discount for ASA members to attend an online or in-person CRASH Course.

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

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

■ **Dr Janette Wright**

Immediate Past Chair, Public Practice Advisory Committee



# PUBLIC ADVOCACY AND THE ASA

**FOR MORE THAN 90 YEARS, THE AUSTRALIAN SOCIETY OF ANAESTHETISTS (ASA) HAS PROUDLY REPRESENTED THE INTERESTS OF THE ANAESTHESIA PROFESSION. AT THE HEART OF THIS MISSION IS A COMMITMENT TO DELIVER SAFE, HIGH-QUALITY PATIENT CARE, HEALTH SERVICES, AND PROFESSIONAL STANDARDS, AS WELL AS PROTECT THE PERSONAL HEALTH AND WELLBEING OF OUR MEMBERS.**

**T**his is more than a set of words, but the lodestars that underpin much of the work we do advocating on the policy, economic, industrial and workplace issues that impact Australian anaesthetists and patients.

Governments determine the laws, funding, workforce policies, and regulatory frameworks that shape our healthcare system. When anaesthetists engage meaningfully with government, we help ensure that policy decisions reflect clinical realities, uphold patient safety, support workforce sustainability, and safeguard the future of our profession. In a rapidly evolving health environment, the voices of clinicians are more critical than ever. As specialists who are deeply embedded in perioperative care, critical care, pain management, and patient safety, advocacy to government is not a peripheral activity: it is a professional imperative, because our insights present opportunities to improve the health system for everybody.

Governments and policymakers often lack that ground-level insight. Clinical expertise gives a unique vantage point on how health services function in real time.

We see first-hand the impact of policy decisions on perioperative flow, critical care capacity, resource allocation, and patient outcomes. When the ASA speaks up through written submissions, parliamentary briefings, media engagement, or collaboration with health

departments we bring essential clinical wisdom into conversations that otherwise could be dominated by economic or political perspectives. This enriches policy outcomes, making them more effective, realistic, and patient-centred.

This is essential. The core of our work is safe anaesthesia and optimal perioperative care. Government policies that influence staffing models, funding for operating theatre resources, emergency response systems, and training pathways directly impact patient safety. Advocating for evidence-based standards, adequate resourcing, and thoughtful regulation helps ensure that patients receive safe, timely, high-quality care.

## The future of our workforce

Over the past two years, the ASA has advocated to government regarding a number of key issues. For example, the workforce modelling report that was commissioned by the ASA highlighted a predicted shortfall in the supply of anaesthetists relative to future demand.

A sustainable anaesthesia workforce is foundational to a functioning health system. Yet Australia face shortages of specialist anaesthetists, uneven distribution across regions, and burnout fuelled by high demand and limited support.

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**“Demand for anaesthetic services in Australia is expected to increase by 35.7% between 2017 and 2032, while the anaesthetist workforce is predicted to increase only 31.8% in this time, from 4,594 to 6,055 anaesthetists. This means there will be a 4 per cent shortfall between the forecast and required workforce.”**

**ASA Workforce Modelling Statement, August 2024**

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Crucially, when we presented the report to government (who had not done their own workforce modelling) the ASA filled this important information gap.

When advocating to government it's important not just to go with problems. Politicians and bureaucrats want to hear solutions too. We determined that ultimately, State and Territory governments must adequately fund new, additional trainee positions. Our report advocated a simple and cost-effective solution: Australia must increase the number of new anaesthetists entering the workforce by between 39 and 56 new graduating fellows each year.

When professional societies present evidence-based positions like this, they can - with appropriate engagement, pressure and collaboration - influence legislative processes, budget allocations, and government policy. Such victories are not abstract achievements, they translate into safer patient care and stronger services.

They also solidify recognition of anaesthetists' expertise, positioning the ASA as a trusted thought leader, voice, and partner to government. Sustained advocacy builds trust between clinicians and policymakers. When governments know they can rely on anaesthetists for accurate, practical advice they call on us during reform processes. This trust means anaesthetists have a seat at the table early, which dramatically increases the likelihood that outcomes reflect clinical realities.

The ASA will continue to leverage the expertise of its members, its reputation and relationships with key decision makers to advocate for policy solutions to address the issues affecting our profession.

## Out of Pocket Costs

Another important issue is out-of-pocket costs. As we all know, like everything we purchase, the pressures of inflation have increased the cost of delivering doctors' services, including specialist care like anaesthesia. Despite this, rebates from the Medicare Benefits Schedule (MBS) and private health insurance (PHI) have not kept pace.

For example, out-of-pocket specialist costs have doubled since 2004. Yet the MBS rebate has only increased by a third. Similarly, since 2015 the average cost of PHI premiums has cumulatively risen 30 per cent, yet often provide unclear or reduced coverage. Health insurance products have a known-gap arrangement, which have not been indexed since they were introduced. Where a doctor's fee is greater than the health fund's known gap limit, the health fund reduces the patient rebate, meaning patients receive less from the health fund. This dramatically increases the patient's insurance shortfall.

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**“The attention to indexation and rebates is at the heart of this matter... We already know that 95% of services provided in the private system are either no-gap or known-gap, that's a fact.”**

**Dr Vida Viliunas, ABC Radio,  
11 December 2025**

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Yet a number of recent media reports have attempted to lay the blame for out-of-pocket costs at the feet of specialists, including anaesthetists. It is the ASA's responsibility to ensure this narrative is countered and engage with government and other stakeholders to ensure policies are developed that mean patients can access the treatments they need. The bottom line is that out-of-pocket costs are rising not because of unfair billing practices, but because the proportion of costs that Medicare and wealthy PHI companies are willing to cover has declined, meaning out-of-pocket costs are rising for patients.

The ASA believes the government must revise the methodology it uses to determine rebates to ensure they reflect the cost of providing services. At the same time, in light of rising premiums, hospital closures, and PHI profitability, the government should seriously examine the PHI industry and whether it provides adequate funding for healthcare.

## We're not doing this on our own

On this and many other issues the ASA is not alone. Advocacy can and must be collaborative. Many policy challenges, such as hospital funding or rural workforce shortages, are shared across medical professions, communities and wider society. Unified voices are more likely to influence government action, and in this goal the ASA readily works and communicates with peak bodies, issue groups, Colleges and decision makers at all levels.

Without strong advocacy from organisations like the ASA, policy risks being disconnected from clinical reality; with it, healthcare professionals, service providers and government are better equipped to deliver high-quality, safe, and sustainable healthcare for the community.

### ■ Leon Beswick

Managing Partner  
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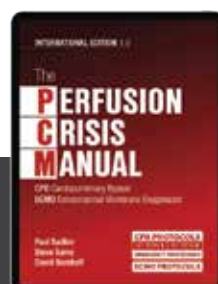
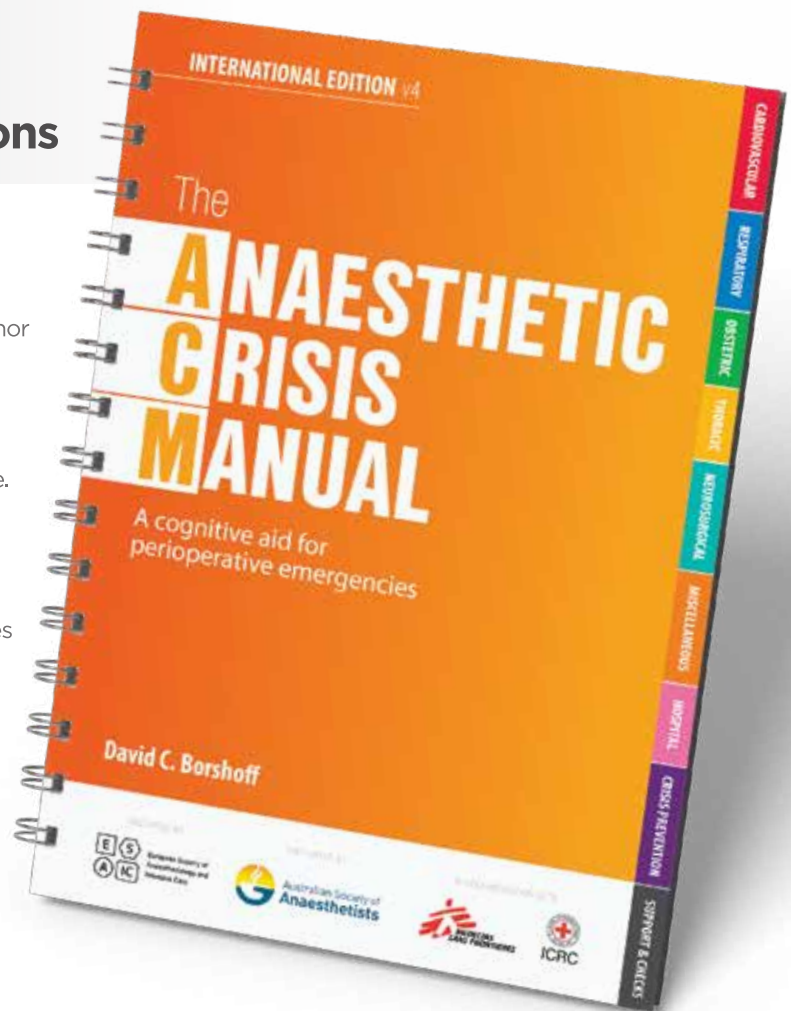
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# DR GABY BOLTON'S CLASS ACTION WIN AND DEDICATED ADVOCACY EFFORTS

ASSOCIATE PROFESSOR SUZI NOU CATCHES UP WITH DR GABY BOLTON IN BETWEEN STUDYING FOR HER PART 2 EXAM TO CHAT ABOUT BEING THE LEAD PLAINTIFF IN THE LANDMARK CLASS ACTION FOR UNPAID OVERTIME.

AT THE TIME THIS GOES TO PRINT, DR BOLTON WILL BE SITTING HER EXAMS. WE WISH HER LUCK!

## **Thanks for taking time out of your studying to chat with me.**

Thanks, I sat my primary four times, so I can't say exams are my favourite.

## **Sorry to hear that you sat it four times. Did that have anything to do with what was going on in this class action?**

I think so. The trial for the class action was about six weeks before my first sitting. And we'd spent months prior to that preparing me. We'd go through hours and hours of interrogation and cross-examination prep. I've always had really terrible performance anxiety since I was 9 or 10 years old, so it was quite a challenge.

## **There was quite a bit of media attention as well. How did you cope with that?**

Yeah, I got to the end of it and decided a life of fame in the media is one hundred percent not for me. I have absolutely zero interest in going anywhere near this again.

I think it's just one of those things you have to do, but it certainly wasn't something I enjoyed or felt very comfortable doing at all. I've never been

very comfortable in front of a camera or anything like that, so it was a learning curve. They had media managers help you learn but it still feels very unnatural.

## **Can I go back to how this all started? Because that was a few years ago, wasn't it?**

Yeah, it's coming up to about six years now from when I first started to get involved. It was right around the time that the pandemic started. I was a critical care, second year resident medical officer (RMO) at Frankston at the time. I'd just been elected as the HMO Society president, and we were plunged into this pandemic, which I think really uncovered the general underappreciation of clinicians and junior clinicians. It all started because Peninsula Health wouldn't pay the \$8.87 a week uniform allowance for staff. The hospital couldn't supply enough scrubs for all the junior medical staff who worked outside of theatres. We were coming to work, getting changed, wearing dirty scrubs at work, getting changed, then going home so as not to bring all the virus and whatever else back to our families.

## **I still do that now. I like not having to think about what to wear.**

Hospitals are not clean places, and I don't think people realize that. That's where all the sick people go.

At the time, we were having all these meetings and I was invited as a representative of the junior medical staff. Meanwhile all the decision makers were working from home, away from the germs and COVID.

In response to our request, they went around every single loophole they could to get out of paying for something that wouldn't even cover half a pair of scrubs. Prior to the pandemic, they never had to cover uniforms. We don't have to wear uniforms, but that almost became mandatory for our own protection and for the protection of other people. And they made it very clear from their glass houses that they didn't think that was a reasonable request from us.

It was also compounded because people were getting their leave cancelled. These are people who would normally come to work unwell unless they were dead and couldn't get out of bed.

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Hospitals are not clean places, and I don't think people realize that. That's where all the sick people go.

At the time, we were having all these meetings and I was invited as a representative of the junior medical staff.

Meanwhile all the decision makers were working from home, away from the germs and COVID.

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**Yeah, exactly. You never took a day of sick leave as a junior doctor.**

It just wasn't the done thing. And now you've got people having the two blue lines pop up on their RAT (Rapid Antigen Test) tests and being told you can't go to work. Their jobs couldn't be covered, so people were doing the jobs of two or three others, and so on. I was getting messages from people all the time who had their leave cancelled. They didn't want to put their name to it because it was too detrimental for their career. The people that are making decisions about their references and whether they pass rotations were potentially going to get annoyed if they buck the system.

**So, you were representing the other HMOs in the hospital. How did that lead to the class action?**

In March when the pandemic was kicking off, the AMA in Victoria sent out a survey. I can't even remember what it was, it was so long ago, but there was a little box right at the bottom that said, "tick this box if you would be happy for us to contact you about your survey results." And I thought, I guess if you want to call me and talk about it, I'm more than happy to do that.

I forgot about it but then a few weeks later, I got a call from Hayden Stevens, of Hayden Stevens and Associates, one of the major law firms involved in this class action. He raised what they were doing with ASMOF (Australian Salaried Medical Officers Federation) and this class action for the non-payment of unrostered overtime for junior doctors and asked would I be willing to be a part of it.

He did warn me quite heavily that it wasn't completely risk free, that it could impact my career, but that they needed representatives from each of the hospitals. He thought that I might be someone that would be good for that and somebody willing to do it.

**So, what was going through your mind at the time in terms of helping you decide whether to be involved or even to be the lead applicant?**

At that stage, I was not a protected trainee of anybody's college. I certainly knew applications were coming up. I also felt that maybe anaesthetics was one of the better specialties that might not look as negatively on this because traditionally we don't work the overtime our surgical colleagues do. So, I was hopeful that would turn out to be true. There was also a big push from the legal side of things that if I did do it, they would do their absolute best to suppress my name.

So, I kept it very quiet. I didn't speak to many people, just very trusted colleagues, friends and family. I didn't talk about it openly even if it was brought up. The lawyers felt confident in their argument. They believed negotiations and mediation would likely be the final steps, and going to trial seemed unlikely.

Ultimately, mediation went over 12 months, and it was very clear that a resolution was not going to be reached and it was going to go to trial. By that point I had gotten onto training. I was an introductory trainee when they rang me and said, "the trial is in June, how does that work for you?" I said, "that's not great

because my exam is in about six weeks after that. But you are going to subpoena me, so there's not much I can do."

**The first phone call with the lawyer was in early 2020. When did you go to trial?**

The first time it went to trial was in June of 2022. Then there's been further court hearings since. There was an appeal by Peninsula Health and then the most recent was the final settlement and calculation of costs.

**In that two and a half years between the initial call and going to trial, you've progressed in your career, from being an RMO to getting a training position, which is a busy time, a lot of things to learn, a lot of jobs to apply for. Very competitive. Whilst you're handling all of that, you were, I assume, helping to prepare the lawyers?**

In anaesthesia we have all our colour coded syringes, vials and everything lined up. I run my day-to-day life like that. I have my Google calendar in all its colour coding for my shifts, or my overtime. Everything has always been in there and at the time they were only looking at about two years of my working life.

I had to supply a dossier of my complete working life for the last two years to them. I had to go back through my work from my first day of internship with a fine-tooth comb and show: what my rosters were, what my payslips were, when I worked overtime, whether it was paid or unpaid?

I sent contracts. I sent all our EBAs (Enterprise Bargaining Agreements), all our orientation documents, all my payslips, all my time sheets. I had to go back for years to whole WhatsApp chats and screenshot all of it and make huge documents full of everything that had happened, who they were, and supply all the contact details for all these people. At some point they were the people I was speaking to most. I'd come home from work at 8:30 - 9 o'clock at night and I'd be on the phone to them. They subpoenaed all my car parking records. They wanted to know what time I started work, what time I probably got into the car park. In the end, with everything that they had, there were tens of these big binders full of paperwork for their evidence.

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I think the one thing that really sticks in my mind is him (the opposing lawyer) saying, “you keep saying your patients, your patients. They’re not yours, you are not a consultant.” And I was like well no, but where is the consultant? The consultant’s gone to do their private clinic somewhere else. I’m the one that’s in there. I’m the one that’s doing all their paperwork, putting all their drips in, changing all the medicines, talking to their families that no one’s called for three days.

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Then at some point they said, “if and when we go to trial, Peninsula Health will be the first because it’s the one we have the most information on. The answer as to whether all the other hospitals go to trial or end in successful settlement depends on this case.”

#### **Did you feel the burden of pressure from that?**

I think in some ways, yes. I had other things going on. I just started my ANZCA training, I was studying for my primary. Also, these law firms have done class actions before and they’re experts in this, so I got to the point of just being a bit of a yes man for everything.

Certainly, leading up to the trial, it was very intensive preparation. I was going into the CBD at least once a week for hours on end, getting prepped by the barristers, who were lovely, but it was exhausting to sit in an office for hours and hours on end and getting asked mock questions like you will in court.

I’d be sitting in the offices waiting for the meetings, doing practice SAQs and getting interrupted all the time. I was trying to fit everything in, but I think in the end it was all a bit much.

#### **What was it like at work?**

The department itself was very good, even when it came out that it was going to trial. My director at the time was fantastic - I said, “I’m going to need a whole week of leave. I’m going to court. I know I’m about to take more leave to sit my exams, but I’m being subpoenaed.” I remember I was working one evening and one of my bosses said to me, “I don’t really get

it. I don’t know why this is necessary because if people work, why can’t you just pay them?”

It must have been an absolute nightmare from a rostering point of view, but they never at one point made my life difficult. I was extremely grateful because I know that would’ve been so frustrating.

#### **What was court like?**

A lot. I think in the end I spent three and a half days back-to-back in the witness box. The preparation was outstanding. I think I would’ve been nowhere near as articulate and not shaken if the barristers hadn’t prepared me.

I guess the cross examination was a bit more difficult, but my lawyers did anticipate things quite a lot. I think that part was very frustrating because they try and undermine everything you say. As an intern most people see you as a paperwork monkey but at the end of the day you are always there, you are always available. You’re the punching bag of everyone’s needs. If there’s an emergency, do you know how to handle it on your own? Probably not. But you’re still going to be the first person they call because you’re there.

I think the one thing that really sticks in my mind is him saying, “you keep saying your patients, your patients. They’re not yours, you are not a consultant.” And I was like well no, but where is the consultant? The consultant’s gone to do their private clinic somewhere else. I’m the one that’s in there. I’m the one that’s doing all their paperwork, putting all their drips in, changing all the medicines, talking to

their families that no one’s called for three days. If the nurses need something, I’m the one that’s there. If there’s a MET call, a code blue, I’m the one that’s the first one there. Am I making all the final decisions for these people? Absolutely not. But I’m also the most accessible and I’m probably the one that everyone knows by name because I’m always around.

#### **Do you see yourself as a natural spokesperson?**

I don’t think I’m good at public speaking about myself or things that I’ve done. But I’ve always thought that you must use your privilege for good. I thought, well, I’m in a position to do it. It’s something that I think I won’t suffer consequences as badly as probably some other people would. And somebody must do it, so I guess that’s me.

#### **Thank you so much for speaking up for your colleagues and for speaking with me today. Good luck for your exams.**

Thank you so much for having me, Suzi. I’ve had a lovely chat.

### **■ Associate Professor Suzi Nou**

Chair, Communications Committee  
and Past President



Australian Society of  
**Anaesthetists**

**Is it time to quit?**



Concept by Dr Nathan Chin



DR MARYANN TURNER  
CO-FOUNDER  
AUSNZ WELI

## AUSNZ WELI UPDATE

# GENDER INEQUITY IN THE SPECIALTY OF ANAESTHESIA

2026 International Women's Day

**INTERNATIONAL WOMEN'S DAY OFFERS A TIMELY OPPORTUNITY TO ASK WHAT MEANINGFUL CHANGE SHOULD LOOK LIKE FOR OUR SPECIALTY AND TO CANVAS PRACTICAL STEPS WE CAN ALL TAKE TO ENSURE OUR PROFESSION IS ONE IN WHICH EVERYONE BELONGS.**



**G**ender inequity in the specialty of anaesthesia persists as it has been normalised and tolerated. Every leadership role filled without transparency, every pay gap left unexplained and every “flexible” career quietly penalised represents a collective failure to act. International Women’s Day offers a timely opportunity to ask what meaningful change should look like for our specialty and to canvas practical steps we can all take to ensure our profession is one in which everyone belongs.

Here is a quick reminder of the issues. In remunerated leadership positions, only 26 per cent of Heads of Department are women<sup>1</sup>. A gender pay gap of \$67,000 per annum persists which is not explained by hours worked or experience<sup>2</sup>. Women are under-represented as first and last authors compared to men<sup>3</sup>. Not a single Editor-in-Chief of a major anaesthesiology journal is a woman<sup>4</sup>. A study of ANZCA trainees showed that male trainees performed more procedures and rated themselves as more competent than female trainees at similar levels, while women were more likely to report gender bias from both patients and in training environments<sup>5</sup>. Approximately half of women anaesthetists felt that their gender is a barrier to a career in anaesthesia<sup>2</sup>. Anecdotally, women anaesthetists are more likely to be

interrupted or spoken over in meetings and be negatively judged for behaving assertively. Certain work performed in the large majority by women in anaesthesia continues to be invisible, underpaid and undervalued.

Not all women experience inequity in the same way and I acknowledge my privilege as a cisgender white woman who does not live with a disability. Equity initiatives need to move beyond gender alone while adopting an intersectional lens and I acknowledge the unique barriers faced by many socially marginalised groups of people including our First Nations colleagues, LGBTIQ+ anaesthetists and the doctors living with disability amongst us.

The theme of 2026 International Women’s Day is ‘Give to Gain’. There is power in reciprocity and support and when women thrive, we all rise<sup>6</sup>. The Australia and Aotearoa New Zealand Women’s Empowerment and Leadership Initiative – AUSNZ WELI (<https://ausnzweli.org>) – embodies this philosophy. With the support of US WELI, the ASA, SPANZA and ANZCA, our purpose is to empower women and non-binary anaesthetists and pain medicine specialists in Australia and Aotearoa New Zealand to achieve their leadership goals. We do this through a program of personalised pairings of proteges with experienced



advisors of all genders, workshops and our popular networking events, usually held at the ASA NSC, the SPANZA ASM and the ANZCA ASM. Come and join our welcoming community!

And what else can you do? Actively sponsor women into career and leadership opportunities. Challenge the biases and inequities that pervade our organisations, institutions, board rooms and change rooms. Be a mentor. Normalise diverse career paths, flexible work options and return-to-work programs. Train supervisors in bias-aware feedback. Act as an ally. Highlight assumptions and address microaggressions. Re-assess the metrics by which we evaluate success in anaesthesia. Ensure adequate lactation facilities and safe sleeping spaces for staff required to work after hours. Stop and disrupt gender stereotyping. Collect and distribute gender data. Stay accountable. Recognise and remunerate teaching, supervision, mentoring and wellbeing work. Implement the ANZCA Gender Equity Resource Kit<sup>7</sup>. Appreciate that women leaders may have different but equally effective communication styles and approaches. Implement structural change to create fair systems. Endorse inclusive leadership models.

International Women's Day should prompt more than just reflection – it is a call to action. Gender inequity is the predictable outcome of systems that have failed to evolve alongside the workforce. If we are serious about patient care, sustainability, and fairness for the next generation of anaesthetists, equity cannot remain optional or symbolic. We must lead change – consistently, transparently and beyond one day a year. It's time to build a specialty where all anaesthetists can thrive.

### ■ Dr Maryann Turner

Co-founder, AUSNZ WELI

**Thanks to Dr Tanya Farrell (AUSNZ WELI co-founder) and Associate Professor Gianni Lorello for their feedback. Written with the assistance of ChatGPT.**

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# JOURNEY INTO ANAESTHETIST ADVOCACY

## My role as an Executive Councillor at the ASA

**MY JOURNEY TO THE ADVOCACY ROLE I'M PRIVILEGED TO BE IN AS EXECUTIVE COUNCILLOR FOR THE ASA BEGAN WITH AN UNEXPECTED PHONE CALL FROM DR SUZI NOU BACK IN LATE 2023. SUZI IS SOMEONE I DEVELOPED GREAT RESPECT FOR AS A LEADER NAVIGATING THE ASA THROUGH THE IMPACT OF COVID, WHEN I AT THE TIME WAS TASKED WITH THE MUCH(!) SMALLER ROLE OF WORKING OUT WHAT TO DO WITH A DISRUPTED QUEENSLAND-BASED NATIONAL SCIENTIFIC CONGRESS.**



**S**o, I took the approach I try to take if asked to volunteer to do things - surely if they think I can do this I may as well give it a go. It also helped that the timing was not when I was completely overwhelmed with other life events, as happens to all of us.

I love my day job giving anaesthetics and being part of our profession, seeing firsthand the impact we can have on our patients' experiences of healthcare. I aspire to see the highest quality anaesthetic care available for every patient. I like being surrounded by great anaesthetists doing incredible work every day.

Having now worked on numerous continents I also have a strong belief that the health care system we have here in Australia still is the best in the world.

Despite the significant, and at times seemingly insurmountable challenges we're facing this is something worth preserving and sharing. I'm also still optimistic this might be possible. So, this is a way I see myself as trying to be part of the solution and not just someone who notices and complains about all the problems. I value the opportunity to learn from and collaborate



with similarly motivated individuals and never underestimate the benefit I get from this. Things are rarely achieved by one person's 'thought bubbles', but rather hearing and considering different perspectives. I'm also conscious that I'm just spending a period of time trying to build on what has been achieved by many others over the years. It doesn't come completely naturally to me to always feel like I'm 'value adding', but I'm choosing to see this as just another skill to learn and continue to practice. If this is something holding anyone back, I'd say it's more common than we all think, so if the timing is right, just jump in and see how an advocacy role might fit for you.

### ■ Dr Peta Lorroway

ASA Board Member and Executive Councillor

## UP CLOSE WITH

# ASSOCIATE PROFESSOR MAGDALENA SIMONIS AM

Dr Magdalena Simonis talks with Associate Professor Suzi Nou about why even doctors need doctors too.



### Biography

**MBBS (University of Melbourne),  
FRACGP, DRANZCOB, MHHS**

Associate Professor Magdalena Simonis AM is a leading women's health expert and advisor. She is a Senior Honorary Research Fellow University of Melbourne Department of General Practice and a long-standing member of the RACGP Expert Committee for Quality Care. She is on several National Expert Advisory Groups, a GP, Board Director, medical educator and examiner.

#### **As a GP with a focus in women's health, what is it like consulting with patients who are from the medical field?**

Although I am an expert in women's health, I see an equal number of males and females. I see a lot of male colleagues, most of whom will get to sixty, sixty-five and have never had a GP visit. And in fact, they're rather proud of it and I think that is one of the difficulties. For women it's quite different because they'll need to have various health check-ups that force them to see a doctor more whereas men don't have those prompts throughout that phase of family building.

#### **One of the barriers I find as a medical professional is that I consider some of my health problems are too small and it is not worth troubling a busy GP. What do you recommend?**

Well, I treat my doctor patients as much as the way I do everybody else. I say, you must schedule a booking and dedicate a regular health appointment once a year with your GP, schedule it when you are well and you probably have nothing to talk about. Let the GP guide the consultation by asking you some questions that you might not have thought about. In general practice we refer to the preventative guidelines according to the phase of life that you're in. We look at doctors in the same way. We consider the different

phases of life and professional careers and the demands that imposes on your life and the potential impacts on health.

#### **This is mind blowing to me, that we should make a health appointment when we are well and not sick?**

Yes, because prevention happens when you are well. It doesn't happen when you have a symptom or a condition, and this is a great opportunity to talk about things from vaccinations to skin screening. For women, knowing your breasts and making sure that you have a breast screening and knowing your family history. Things like mental health, what are your triggers, how are things at work and coping with stress are good to talk about when you are well.

Doctors are humans too and I think we impose high expectations on ourselves to always be at the top of our profession and do well. Every interaction we have with a patient we must be switched on regardless of our personal life and wearing that mask can really take its toll.

Family planning is particularly important. For professional women, preconception counselling is key. Unexpected pregnancies can disrupt life stages and family plans. I also discuss family planning with my female patients who are doctors and not in a relationship.

I ask them about freezing their eggs and other options. I just plant that seed.

And then of course knowing what stage of life you are at – are you at risk for diabetes, cholesterol or low iron. We need to have that baseline at some point.

### **At what age do you need to start thinking about doing baseline testing?**

Where there's a family history, I'd even suggest that in their thirties. Prevention happens when you're early, before the disease occurs. We know that atheroma, by the time you're forty, forty-five, could still be significant, so it is worth knowing.

### **A lot of anaesthetists are fit and healthy, exercise, eat well. Why would we want to start screening?**

This is the other difficulty. Anaesthetists are experts in physiology and biochemistry and like many of our colleagues, they will manage this on their own and prescribe their own medication.

### **It's very easy for us to slip into work and check our own blood pressure.**

These are the sorts of conversations I have often with my patients who are doctors. I try not to be judgmental because it's important not to be. I understand. It's the pressure we're under and time is pressure. Time is money. Why see a GP for something simple like blood pressure? This ties back to my earlier point. It's like, well, if it's my blood pressure, I can take a tablet, and I don't have to waste someone else's time. This is simple. I can handle this. That's the kind of mentality I deal with doctors.

Preventative medicine picks up the warning signs. As we approach forty, we conduct the forty-plus health screen, which serves as the baseline - looking for diabetes and cholesterol. These are government funded MBS item numbers and yes you can book a longer appointment and do the full adult health check.

### **So, we should be getting to our GPs in our forties?**

Yes, for women it is about breast cancer risk depending on their family history – again because waiting until your fifty is

quite a long time. If your baseline tests are all clear at forty to forty-three you don't really need to do another blood test if everything is fine.

At ages forty-five to forty-nine, you have another health check. This check includes a visit to the doctor for a health screening. In this screening, you'll check your cholesterol, sugar levels and other heart disease risks. We also have the faecal occult blood test (FOBT), which is available from forty-five onwards.

And although you will not receive the prompt from the government in the mail, you can just Google "order poo test" and click on that.

From fifty onwards with both men and women, we've got the regular health checks, which include the FOBT.

I do maintain men should have a prostate-specific antigen (PSA) test. If under sixty and if there is a positive family history particularly of the father and brother, I recommend doing a test somewhere around forty-five or even earlier as a baseline. The MBS rate is about \$50 or \$60, but I think it's a worthwhile test to have as I have detected early prostate cancer in younger men and it can become aggressive if left for another ten-years.

### **We all have a friend, probably some of the listeners out there, who might be at an age between fifty and sixty, who have not completed their screenings and do not visit their GP regularly. They receive letters from the government requesting a poo test or recommending breast testing or reminding them to schedule their cervical pap smear. They probably have a lot of things on their to-do-list - how can they prioritise this list?**

That's a good question, Suzi, because it takes a lot of time to have a fasting blood test as you must take time out in the morning to do it. So, if you're an anaesthetist and you have early lists, eight in the morning might be too late and hopefully you can find a place close to home on Saturday morning. So, with bloods I try to take them opportunistically and do them even though they're not fasting. Then if there is something abnormal, we can talk about that and investigate further.

The poo test is easy to do. It is harder for those with irregular bowel patterns, because you need to have three separate samples and it can be a drawn-out process.

Skin checks are also important to have every single year. I encourage self-checking. Examine your skin, know your skin and your GP can help you do that. You don't need to go to a dermatologist. I still remove lesions. Making it easy for the patient is important. I do a quick biopsy and if there is need for further excision I refer the patient on to a plastic surgeon.

### **I love that perspective as a GP because I think as doctors, we can be tempted to bypass our GPs.**

Many of my colleagues end up in my room. They admit they've had a colonoscopy or a stress echocardiogram, but they've never seen a GP. No one is taking care of their health in a complete way or tracking how their condition is changing. There are other aspects to health other than diagnostic investigations. It's about knowing what else is potentially going to go wrong or how you can support your health better.

For example, a lot have been on medication without ever having to see a GP and that shouldn't be the case. You need to have renal function checks. You can do these through telehealth. However, you must have an in-person visit once a year.

Adding to that to-do-list is screening mammograms. Yes, having breast screenings are great. Many colleagues prefer the 3D tomosynthesis and ultrasound. However, these can have a high false positive rate. This means you might end up needing a fine needle biopsy that isn't necessary.

As a GP and expert on the BreastScreen Australia advisory group, we focus on breast density. What we now know is that women who have very dense breasts cannot detect lumps in their breasts. Density is only determined by radiological classification.

There are four categories of density. If you have category C or D, then you have more dense breasts and the two-dimensional breast screen does not have the same level of sensitivity.

There's also a higher association with breast cancer. Hormone replacement therapy increases the density of breasts. So, we need to take all of this into consideration as it makes it harder to detect things in dense breasts. Remember, density is a radiological classification. It can't be detected by palpation. With all our patients and colleagues, we will be having this conversation, and it will all come back to the GP because these are the recommendations issued by BreastScreen Australia.

**As an anaesthetist I wasn't aware of these nuances. This is fantastic to know and reinforces why you need a good GP. You mentioned PSA before, is there anything else you want to add about PSAs and prostates?**

Basically, just do them. It's a disease that is so common and I know the older you are and if it's positive and you develop prostate cancer the less likely you are to die of the consequences of it. I have patients who are living well into their eighties and nineties and are thriving. That's when they get into their other phase of life, writing their books, being Emeritus Professors and doing all sorts of exciting things. I certainly recommend doing them at that life phase and if it's elevated outside of the range, we certainly need to have that conversation.

**Okay, so we've talked about breast screening, poo screening, prostate screening with PSAs. Is there anything else that we should be thinking about?**

Yes, for everyone osteoporosis is important and we need to know about bone density. If you're starting menopause, have a family history of early osteoporosis, or conditions like coeliac disease, thyroid disease, or autoimmune disorders, your bone health may be at risk. Long-term steroid use or treatment for connective tissue disorders can also affect it. If you've been on medication for these conditions, get bone screening for osteoporosis sooner rather than later. If

you have an eating disorder like anorexia nervosa and experience amenorrhea than it's especially important for younger women and men.

Cervical screening is important for women. You can now do it every five years, and there's a self-test option available. However, I tell my female patients that if you feel discomfort, burning, itching, or any vaginal symptoms, it's important to get a physical exam. This is especially true for checking vulva changes.

I want to highlight immunisations. Pertussis is a topic I bring up when I can. So, make sure you're up to date on your booster since it's spreading. Also, don't forget the COVID vaccine; it's important too.

**Pertussis is an interesting one because we're often vaccinated as teenagers and you might be reminded when you're in your childbearing years that it's time for a booster. But then after that we don't often get another prompt and it's likely that immunity wanes.**

Look we don't really know when the pertussis antibodies last and we suspect somewhere around the ten-year mark. I put that automatically on the recall list for a boost.

**It is a bit of a checklist, but can you get through it all? Is it manageable with the support of your GP?**

When it comes to your patients, you understand that you really want to protect your patient and do the best you can. But when it comes to you, all your other biases can interfere, so it's good to have that objectivity of someone like your GP.

**I think this leads nicely into what I've been thinking in the back of my mind. We can be reluctant trusting someone with this decision making. What are the things we are looking for in a good GP? How do we find them?**

I think it's word of mouth. Ask colleagues that have got a good GP. Say, "Hey, do you have someone that you could recommend?" Most of us will open an appointment for a colleague.

**Speaking of the chat, you must have a huge network. You've been president of the Victorian Women's Medical Society, you're on multiple boards, you've been involved with the AMA at so many levels. Do you come across your patients in your network?**

All the time, I don't find that disturbing. I say hello. No one needs to know I'm their GP. But often, they mention it. This puts me in an awkward spot. I want to be seen as more than just their GP, especially since we're professional friends. They don't need to disclose I am their GP. Unless there's a conflict of interest or another reason, like a research project.

**I want to come back to this point about booking an annual wellness check with your GP, even when we are well. At what age should we start?**

I say from eighteen onwards. I get that drummed into teenagers. I enjoy seeing students. I want them to feel they can come in during a crisis. They also have telehealth options for urgent help. I encourage that through the parents. As a GP I'm so lucky. I see young women in their forties that I've known since they were fourteen for their acne.

**Absolutely inspiring having a chat with you this morning and thank you for your time.**

Lovely to see you in this context too. Thank you.

**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.**

with Associate Professor

**Suzi Nou**





# ADVOCATING FOR ANAESTHESIA IN THE PACIFIC ISLAND NATIONS

## Advocating for Anaesthesia Training

Fiji National University (formerly Fiji School of Medicine) provides post graduate anaesthesia specialty training for Fiji and many small island nations of the South Pacific.

There are currently trainees from Fiji, Samoa, Tonga, Cook Islands, Kiribati, Tuvalu, Vanuatu, Solomon Islands and Timor Leste completing their speciality anaesthesia training at Fiji National University (FNU).

Anaesthesia registrars initially complete a one year Post Graduate Diploma of Anaesthesia. Most will continue training and studying for a further three years to graduate with a Masters of Medicine (Anaesthesia).

When speciality training began in 1995 all 6 trainees were based at Colonial

War Memorial Hospital (CWMH) in Suva, Fiji. The numbers of trainees entering anaesthesia has steadily increased since this time. In 2025 there were 33 anaesthesia trainees.

The WFSA recommends at least 5 anaesthetists per 100 000 population. Most of the small Pacific Island nations fall far short of this target. See table 1 and map 1. This shortage of anaesthetists means that FNU plays a critical role in working towards adequate workforce numbers in the future.

FNU currently employs 4 anaesthetists/intensivists who are responsible for all undergraduate and post graduate anaesthesia and ICU training.

Dr Apaitia Goneyali has recently joined the School of Medicine in Suva. Dr Apaitia has worked as a consultant anaesthetist in Fiji, Tonga and American Samoa, and brings a wealth of experience to his new role of Assistant Professor of Anaesthesia.

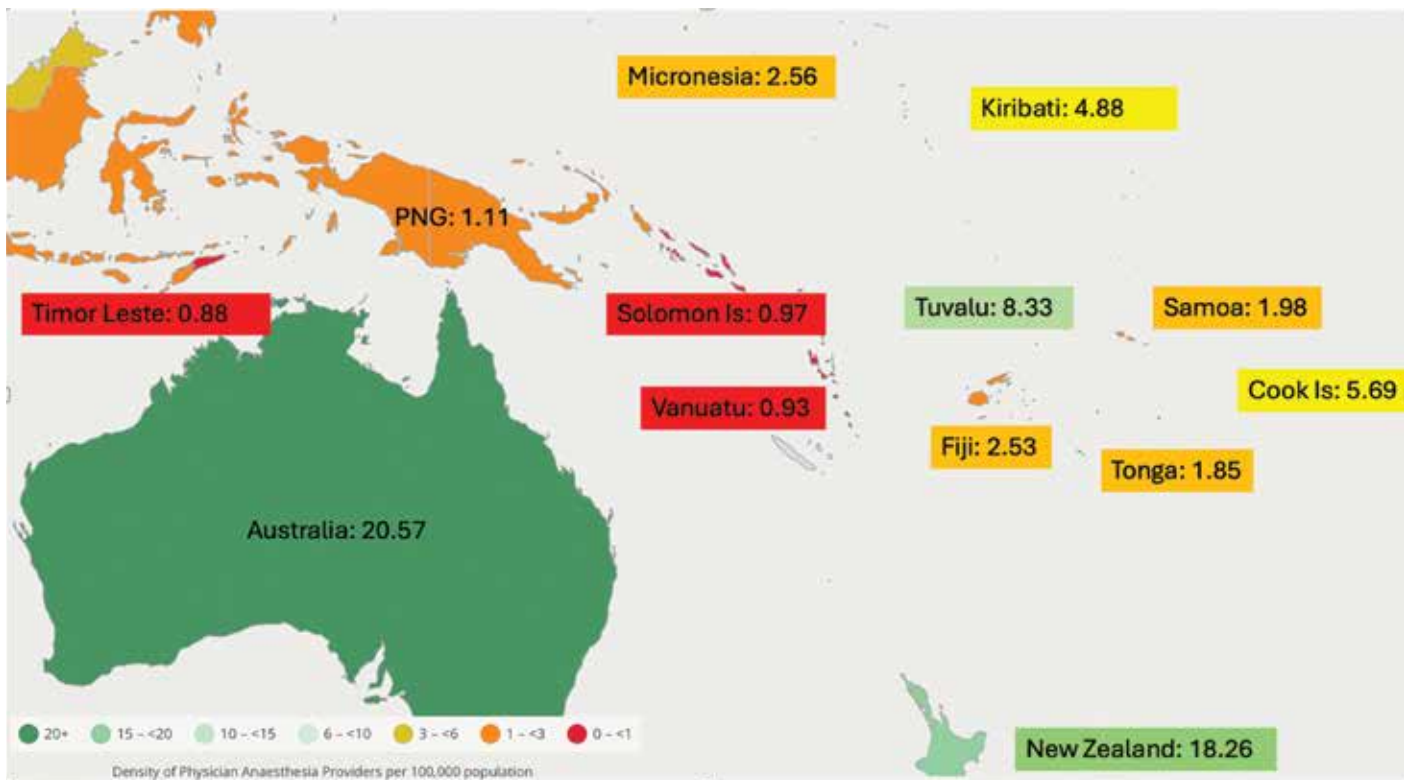


Dr Apaitia Goneyale Assistant Professor of Anaesthesia at FNU and Dr Lisa Akelisi Yockopua

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**Fiji National University (formerly Fiji School of Medicine) provides post graduate anaesthesia specialty training for Fiji and many small island nations of the South Pacific.**

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**Source:** WFSA Workforce Survey Map. 2024 Update. <https://wfsahq.org/resources/workforce-map/>

When asked about his new role in advocating for anaesthesia training in the Pacific, he said:

'I have been employed at FNU for 8 months have just begun to understand the vision that FNU has in supporting anaesthesia in the broader Pacific region. It is a vision and goal aimed at training in anaesthesia and critical care skills for the countries in the Pacific region. It is a role that has many facets:

As a TEACHER the role involves presenting a curriculum that has been developed and moulded over the years. While it is based on the ANZCA curriculum, it has been augmented to better suit the health systems and needs in the greater Oceania region. It is a robust program heavily steeped in theory and clinical skills modules.

As a MENTOR, my role in FNU entails keeping a close watch on graduates, encouraging them during challenging or uncertain times and nurturing their professionalism. I believe it is the mentoring that the anaesthesia faculty has provided over the years that has

made the anaesthesia graduates highly sought after as managers outside their anaesthesia departments.

As a COLLEAGUE, my role in the FNU faculty involves working alongside the graduates. This includes teaching and assessing, as well as highlighting that even though across the Pacific we have critical shortages in drugs and equipment, the provision of safe and reliable anaesthetic care is possible and should always be strived for.

As ADVOCATES for the graduates, we ensure that they are supported in the hospital, FNU academic meetings, regional and international symposiums, ensuring that their "voice" is heard and acknowledged.

Every year Fiji and the region relies on FNU to train and equip anaesthetists to meet the growing health needs in the Pacific. It is a task that we take seriously. It is made possible with support from our fellow colleagues and the family from the ASA, NSZA and ANZCA.'

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## Advocating for Anaesthesia

Despite relatively small workforce numbers, the Pacific is lead by a strong and dynamic Pacific Society of Anaesthetists (PSA). The PSA plays a key role in both advocating for patient safety and in advocating for the specialty of anaesthesia.

Dr Nikish Narayan is one of Fiji's newest fully qualified anaesthetists having graduated with his MMED (anaesthesia) in December 2025. He was awarded

Every year Fiji and the region relies on FNU to train and equip anaesthetists to meet the growing health needs in the Pacific. It is a task that we take seriously. It is made possible with support from our fellow colleagues and the family from the ASA, NSZA and ANZCA.'

the ASA prize for being the top student of his year. When asked about his role in advocating for both the speciality of anaesthesia and for his patients, he said:

"I am a recently graduated anaesthetist practising in Fiji, where my clinical work spans anaesthesia and intensive care at a public tertiary referral hospital.

Advocacy for patients is intrinsic to my daily work, but it also extends well beyond the individual patient encounter. While my role begins with reassuring patients during some of their most vulnerable moments, it also involves advocating within health systems where resources are limited and safety margins are narrow. At times, this means speaking up when processes, pressures, or expectations place patients at risk. Many of the patients I care for face geographical and cultural barriers to accessing safe surgery, and healthcare is often delivered within a traditionally paternalistic framework. I view advocacy as helping patients feel informed and empowered to participate in decisions about their care, while also advocating for equitable access to safe anaesthesia.

In the Pacific, anaesthetists form a critical backbone of hospital care, with responsibilities that extend across operating theatres, intensive care units and emergency responses for deteriorating patients. Advocacy therefore also involves raising the visibility of anaesthesia—both to patients and within healthcare systems—by articulating the breadth, complexity, and centrality of our role in patient safety and hospital resilience. This is not an individual endeavour, but a collective responsibility of the profession, strengthened through teaching, mentorship, and a shared commitment to building a sustainable anaesthesia workforce for the region."

## The Role of ODEC in Advocating for Anaesthesia in the Pacific

The ASA's Overseas Development and Education Committee has a long history of working with the Pacific Society of Anaesthetists and supporting training and education in the region.

ODEC currently supports three Australian anaesthetists each year to spend three months each in Suva working at Colonial War Memorial Hospital through the ASA Sereima Bale Pacific Fellowship program. They play a key role in registrar supervision, support, training and exam preparation. (<https://asa.org.au/overseas-development-and-education-committee/odec-events-sereima-bale>)

A similar program has recently commenced in Timor Leste, with one Australian anaesthetist spending three months in Dili each year to support anaesthesia training.

ODEC runs short teaching trips to Solomon Islands, Timor Leste, Micronesia, Mongolia and Cambodia. The Essential Pain Management Course is run in several Pacific Island countries. ODEC has collaborated with the PSA to

introduce simulation training into Fiji with the VAST course (Vital Anaesthesia Simulation training). ODEC also works with the PSA to support the annual Pacific Society Refresher Course. The next PSA conference will be held from August 31-Sept 4, 2026. For more information see: <https://www.psaonline.info/>.

**For further information of ODECs activities please visit: <https://asa.org.au/overseas-development-and-education-committee>**

### Dr Megan Walmsley

Vice Chair, Overseas Development and Education Committee

### References

Law, Tyler J. MD, MSc, FRCPCT;†; Lipnick, Michael S. MD\*†; Morriss, Wayne MBChB, FANZCA‡;§; Gelb, Adrian W. MBChB, FRCPCT\*†;§; Mellin-Olsen, Jannicke MD, DPHS‖; Filipescu, Daniela MD, PhD§¶,##; Rowles, Jackie DNP, MBA, CRNA, FAANA\*\*††; Rod, Pascal RN, RNA, BSEd††; Khan, Fauzia MBBS, FCPs, FRCAS,‡‡; Yazbeck, Patrica MD, MHMS,§§; Zoumenou, Eugene PhD‖‖; Ibarra, Pedro Acad§¶¶; Ranatunga, Kumudini MBBS, MD, FRCAS,##; Bulamba, Fred MMed\*\*\*; Collaborators. The Global Anesthesia Workforce Survey: Updates and Trends in the Anesthesia Workforce. *Anesthesia & Analgesia* 139(1):p 15-24, July 2024. | DOI: 10.1213/ANE.0000000000006836

Country	Number of Anaesthetists/ 100 000 population
Australia	20.57
New Zealand	18.26
Fiji	2.53
Samoa	1.85
Solomon Islands	0.97
Vanuatu	0.93

**Table 1.** Pacific Anaesthesia Workforce

# Sereima Bale Pacific Fellowship

3 month teaching fellowship aiming to support training in partnership with Fiji National University. Teaching involves both clinical supervision and classroom based tutorials. The ASA supports fellows with \$12,500 and FNU provides financial support for accommodation

Please contact the fellowship co-ordinator  
Dr Andrew Downey [Andrew.Downey2@nh.org.au](mailto:Andrew.Downey2@nh.org.au)

COLONIAL WAR MEMORIAL  
HOSPITAL, SUVA, FIJI



## ASA Timor Leste Fellowship

- ▶ Spend 3 months in Dili at Hospital Nacional Guido Valadares providing both clinical supervision and supporting education and training for anaesthesia registrars
- ▶ Living allowance AUD \$1000/week provided by ASA
- ▶ Dates flexible
- ▶ Please contact Dr Meg Walmsley for further information [megan.walmsley@act.gov.au](mailto:megan.walmsley@act.gov.au)





# EDUCATION COMMITTEE

DR KAYLEE JORDAN  
CHAIR, EDUCATION COMMITTEE

## EVENTS ON THE HORIZON FOR 2026

**FOLLOWING ON FROM A VERY BUSY AND SUCCESSFUL YEAR OF MEMBER EVENTS IN 2025, WE ARE PLEASED TO SHARE WITH YOU SOME OF THE EVENTS THAT ARE PLANNED OR IN PLANNING FOR 2026. THIS YEAR IS SHAPING UP TO BE A STANDOUT EVENT CALENDAR, BETWEEN ONGOING AND NEW INITIATIVES FOR FELLOWS AND TRAINEES, REFLECTING OUR COMMUNITY'S COMMITMENT TO CLINICAL EXCELLENCE AND PROFESSIONAL DEVELOPMENT. MANY THANKS TO THOSE WHO CONTINUE TO DEDICATE THEIR TIME AND EFFORT TO PLANNING AND HOSTING THESE EVENTS, AND TO MEMBERS FOR THEIR ENTHUSIASTIC AND ENGAGING PARTICIPATION.**

### The Big One: Combined Scientific Meeting 2026 – Hunter Valley (8–11 October)

Mark your calendars for CSC26 at Rydges, Hunter Valley, NSW (8–11 October 2026). Planning of the program, speakers and social functions are well underway, with this jewel of the ASA/NZSA calendar being one not to be missed!

### The Practice Wise ASA Business Series

We are pleased to announce a new initiative, the Practice Wise ASA Business Series, a series of online events offering regular practical help for anaesthetists across several practice-focused topics. These started with Stay Ahead: Recent Changes to Privacy Law Explained on 26th February, closely followed by Billing Conundrums Unlocked, the first in a series focused on ensuring Medicare compliance with challenging scenarios, on Tuesday 3 March. The next Practice Wise event will be held on 26th March.

### Practice Evaluation Sessions

Following the success of our popular online Morbidity and Mortality evening meetings in 2025, we are planning to continue these in 2026, this year with the assistance of the WebAIRS team. If you are involved in a case where you think de-identified discussion would provide learning opportunities for other anaesthetists, either:

1. Submit a WebAIRS incident, and note in the beginning of the narrative "Review at ASA M&M", or
2. Email us at [events@asa.org.au](mailto:events@asa.org.au)

2026 ASA Morbidity and Mortality meeting dates will be announced soon.

### Emergency Response Workshops

Along with a multitude of Emergency Response workshops on offer at various conferences throughout the year, we will continue to run Acute Severe Behavioural Disturbance workshops online. This enables members to gain Emergency Response CPD points online, a flexible route for busy clinicians.

## Regional Anaesthesia Cadaveric Workshop

It was no surprise that this full-day workshop, that was held in Brisbane on 28th February, once again sold out immediately after registrations opened. This hands-on workshop focused on upper limb, lower limb, truncal and eye blocks, and continues to gain in popularity. Look out for the 2027 workshop dates.

## PPAC Communication Workshops

A new series of PPAC Communication Workshops is planned for 2026, expanding beyond the well-received 2025 series and addressing everyday clinical communication challenges. The first of these, Using AI to Improve Communication, is planned online for the evening of 14th April.

## Wellbeing and Support

The ASA's wellbeing focus continues to evolve, with updated resources on the ASA website and dedicated wellness events planned across the year. The first of these events is planned for 31st March. The ASA now has a partnership with Drs4Drs, which includes the offer of 3 free counselling services for ASA members. More information can be found at <https://asa.org.au/wellbeing-of-anaesthetists>.

## Trainee Events

Another busy year of Primary and Final SAQ and VIVA Exam Support Sessions is ahead, with evening online sessions planned every 1 – 2 weeks across the year, including additional dedicated sessions for SIMG Final Exam candidates. These sessions cover written and VIVA preparation and technique, with regular involvement from past and current examiners. ASA membership, unlocking access to these events, is free for ANZCA Basic Trainees. Please consider sharing information about these Exam Support Sessions with your trainees.

Additionally, a Trainee Wellness Webinar, titled Exams Preparation: Surviving and Thriving will be held online on the evening of 24th March, exploring how emotional intelligence (EQ) can enhance exam performance. Attendees will learn to recognize and befriend negative self-talk and anxiety, transforming them into sources of awareness rather than obstacles.

Later in the year several of the state committees will host Part 3 events around the country, aiming to help senior trainees to prepare for life as specialist anaesthetists.

## Prevocational Medical Education And Training (PMET) Support

PMET trainees are invited to a dedicated support event on 12th March, featuring practical advice and insider insights on gaining entry to the Training Scheme. Learn from recent successful applicants and connect with your state representatives.

## ASA/AMA CPD Home

Members are reminded that ASA/AMA CPD home is now complimentary with ASA membership. This is a valuable foundation for monitoring and reporting your CPD compliance across the year.

## Get In Touch

**If you have feedback or suggestions, please take a moment to share your thoughts with us at [events@asa.org.au](mailto:events@asa.org.au).**

### ■ Dr Kaylee Jordan

Chair, Education Committee



**Register now for ASA Events**

## MEMBERS

### MARCH

# 03

Tuesday  
19.00–20.00 AEDT

#### Practice Wise - ASA Business Series

##### Billing Conundrums Unlocked.

**Ensuring Medicare Compliance with Challenging Scenarios** is the first in this three-part series focused on the anaesthetic billing system in Australian anaesthetic practice & MBS structure.



# 26

Thursday  
20.00–21.00 AEDT

#### Practice Wise - ASA Business Series

##### Stay Ahead: Recent Changes to Privacy Law Explained.

Keeping up with evolving privacy regulations is essential, especially with the introduction of new penalties.

Join us for an exclusive Practice Wise-ASA Business Series session, where a legal expert will unpack the latest changes to privacy law, what they mean for you & how you can stay compliant with confidence.



# 31

Tuesday  
19.30–21.00 AEDT

#### Wellness Series

##### Peer supporters & Wellbeing Advocates.

The ASA, in partnership with Hand-n-Hand, presents its first wellness series event for 2026 for **ASA members who are wellbeing advocates or peer supporters**, providing a dedicated space to connect & support one another.

This forum is also a great way to learn or refresh on how to organise, facilitate & participate in a peer-to-peer support meeting.



### APRIL

# 14

Tuesday  
20.00–21.15 AEDT

#### Communications Workshop

##### Using AI to Improve Communication.

Whether new to ChatGPT or a daily AI user, we can all use AI to elevate our communication. Learn a framework to help you prompt AI, plus important do's and don'ts to help you leverage this emerging technology.



### MAY

# 26

Tuesday  
20.00–21.15 AEDT

#### Communications Workshop

##### How to ACE your Interview.

Whether you're seeking a promotion or a career change, interview skills are important life skills. Learn how to effectively prepare for the interview, how to answer common questions and other research based tips to help you succeed.



# TRAINEES

## MARCH

### 03

Tuesday  
19.30–21.00 AEDT

### Final Exams VIVA Support Session

Boost your confidence and sharpen your VIVA skills in this focused online session. Work through realistic scenarios, refine your communication under pressure, and gain practical tips to enhance clarity and structure. Join us to feel more prepared and exam ready.



### 10

Tuesday  
19.30–21.00 AEDT

### SIMG VIVA Exams Support Session

A focused online session designed for SIMG candidates to strengthen VIVA communication, build exam confidence, and practise structured verbal responses. Join us for practical strategies and supportive preparation to help you perform at your best.



### 12

Thursday  
19.30–21.00 AEDT

### Real talk: How I got onto training

Join current anaesthesia trainees for a practical, honest session designed to help PMETs navigate the pathway into anaesthesia training. Gain insights into the application process, hear firsthand experiences, and pick up useful tips to strengthen your preparation and stand out as a candidate.



### 18

Wednesday  
19.30–21.00 AEDT

### Primary Exams VIVA Support Session

Strengthen your VIVA technique with targeted practice, clear frameworks, and practical exam strategies. This focused online session helps primary candidates refine reasoning, communicate confidently, and perform under pressure.



### 24

Tuesday  
19.30–21.00 AEDT

### Trainee Wellness – Exams Preparation: Surviving and Thriving

Boost Your Exam Readiness with Emotional Intelligence & Mindfulness. Join this interactive webinar to explore how EQ and mindfulness can enhance focus, reduce anxiety, and shift unhelpful selftalk. Walk away with simple, practical tools to support calm, clarity, and resilience throughout your exam preparation.



## APRIL

# 07

Tuesday  
19.30–21.00 AEDT

### Final Exams VIVA Support Session

Boost your confidence and sharpen your VIVA skills in this focused online session. Work through realistic scenarios, refine your communication under pressure, and gain practical tips to enhance clarity and structure. Join us to feel more prepared and exam ready.



# 20

Monday  
19.30–21.00 AEDT

### Primary Exams VIVA Support Session

Strengthen your VIVA technique with targeted practice, clear frameworks, and practical exam strategies. This focused online session helps primary candidates refine reasoning, communicate confidently, and perform under pressure.



# 21

Tuesday  
19.30–21.00 AEDT

### SIMG VIVA Exams Support Session

A focused online session designed for SIMG candidates to strengthen VIVA communication, build exam confidence, and practise structured verbal responses. Join us for practical strategies and supportive preparation to help you perform at your best.



**To register or find out more about any of these events, scan the QR code.**

# A CPD Home Program and Tracker

## A CPD Home Program and Tracker

Did you know as our member you can claim a free or discounted subscription to a fully AMC-accredited CPD home?

An AMA CPD Home Subscriber plan complies with the Medical Board of Australia's (MBA) Registration Standard: Continuing Professional Development (the Standard) for an Anaesthetist to have a 'CPD home'.

Each year, ASA members can claim their **Free** or discounted CPD Home subscription by :

- 1 Logging into the ASA member portal
- 2 Click on the AMA CPD Home tile
  - Have an account with CPD home? Choose **'Renew'**
  - Don't have an account with CPD Home? Choose **'Subscribe'**
- 3 Enter your details and start tracking your CPD in 2026

Start treading your own learning pathway and achieve CPD compliance with ease. Keep track of all your CPD, anywhere, any time. Find out more on [cpdhome.org.au](http://cpdhome.org.au)



Easy to use and upload. *Dr Elizabeth, QLD*

Well organised and convenient.  
*Dr Virginia, NSW*

Professional and efficient. *Dr Len, NT*

Flexible in allowing CPD certified by other homes.  
Broad program allowing for CPD plans that are tailored to the individual's CPD goals.  
*Dr Mahalakshmi, QLD*



### Exclusive ASA Member Benefit



**FREE** ~~\$220~~  
per calendar year

Home Subscriber

You do the CPD.  
You do the paperwork.



**\$594** ~~\$880~~  
per calendar year

Home Subscriber  
with Concierge

You do the CPD.  
We do the paperwork.



CPD Home Subscriber Exclusive ASA Member Benefit



# New year, New learning

CPD Home has devised an easy Stepwise plan to support you in meeting your annual CPD requirements.



1. **Subscribe** to AMA CPD Home



2. **Read the AMA CPD Home Program Guide 2026**



3. **Complete the 'Planning for Learning in 2026'** online CPD activity (optional) to learn how to write your CPD Plan.



4. **Write your CPD Plan**



5. **Browse our Catalogue.** Enrol in activities that suit your needs and interests.



6. **Complete CPD activities** that meet the mandated learning domains including the CAPE aspects



7. **Upload any supporting evidence into your CPD Tracker** for completed activities external to our Catalogue



8. **Watch your progress** on your CPD Tracker Dashboard



9. **Reflect** on your completed CPD at the end each year



10. **Download progress reports** and an annual Statement of Completion

## Need assistance or an extension?

Get in touch by completing our online form: [cpdhome.org.au/contact](https://cpdhome.org.au/contact)





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

# SCIENCE PRIZES, AWARDS AND RESEARCH COMMITTEE REPORT

**2025 has been a year of change for the ASA's Science Prizes, Awards and Research Committee (SPARC), and it is my pleasure to highlight these modernisations going forward.**

The ASA's suite of research prizes has undergone a significant and strategic refresh, following extensive consultation with members, reviewers, and SPARC leadership. The goal was to simplify the prize structure, and ensure that each award continues to support high-quality anaesthesia research across Australia.

**FURTHER INFORMATION CAN BE FOUND ON THE SPARC WEBSITE AT:**



**All grants and prizes will continue to be adjudicated and awarded according to NHMRC guidelines in an independent peer-reviewed manner. We look forward to continuing to receive high-quality submissions from our members, and to fostering the next generation of impactful anaesthesia research across Australia and New Zealand.**

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## The new ASA Research Grant

Historically, the ASA has offered four Small Grants per year, each valued at \$3,000. Feedback was that the amount was too limited and few projects fell under this narrow budget. To increase visibility and impact, the Small Grants have been combined into one annual award worth up to \$12,000. This larger, consolidated grant will support a broad range of project types and allow applicants greater flexibility in designing meaningful research.

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## The Kevin McCaul Prize (Obstetrics)

This prize commemorates the late Dr Kevin McCaul who was for many years the Director of Obstetric Anaesthesia at the Royal Women's Hospital, Melbourne. He had a major and lasting influence on obstetric anaesthesia throughout Australia. The prize was instituted in 1978 on the occasion of his retirement as Director. This prize, awarded for outstanding research in obstetric anaesthesia, has traditionally been offered annually at \$11,000. To enhance the prestige and impact of the award, the prize will now transition to a biennial cycle. Fitting with this, the revised value is now up to \$22,000. This biennial structure allows for higher-value support to obstetric research projects.

Under the updated structure, the ASA's research funding portfolio now comprises:

- ASA Research Grant (general, no limitations on topics within anaesthesia) - \$12,000 annually.
- Jackson Rees Prize (general) - awarded biannually to the value of \$27,500.
- Jeanne Collison Prize (pain) - awarded biannually to the value of \$11,000.
- Kevin McCaul Prize (obstetrics) - awarded biannually to the value of \$22,000; alternating with the Jackson Rees Prize. This will re-open in 2027.
- ASA Annual Research Grant and Scholarship (PhD support)- awarded to the value of \$75,000.

### ■ Associate Professor Indy Lin

Chair, Science Prizes, Awards and Research Committee



# webAIRS

Dr Monique Pisaniello,  
Dr Nathan Strugnell, Dr Jonathan Begley  
and Dr Anna Steer, and the ANZTADC  
Case Report Writing Group

## PERIOPERATIVE NEONATAL INCIDENTS REPORTED TO WEBAIRS



## Introduction

Neonatal anaesthesia presents unique anatomical and physiological challenges. Adverse anaesthesia events in the neonate, whilst rare, are more likely to be serious and life threatening.<sup>1,2</sup> This review examines all perioperative neonatal incidents reported to webAIRS. It highlights common issues when caring for the neonate and the importance of maintaining currency of practice in neonatal advance life support (ALS).<sup>3</sup>

## Methods

In this analysis, a search was conducted using the demographics filter for all incidents involving patients less than 28 days old reported to webAIRS to June 2025. A narrative analysis to review for eligibility for inclusion was completed independently by two authors Dr Monique Pisaniello and Dr Nathan Strugnell. All queries were reviewed by a third analyser Dr Anna Steer and discussed by all three authors until consensus was reached. The narratives and demographic data of the included incidents were then reviewed in detail by all authors. Categories were formed based on the type of incident reported (airway/ respiratory, cardiac, medication error, equipment).

## Results

The final detailed analysis involved 48 reports (Figure 1).

The majority of neonatal patients were American Society of Anesthesiologists Physical Status classification (ASA) 3 or 4 (n=19, 40% and n = 12, 25% respectively) including 19 ex-premature infants. Most incidents occurred during daylight hours (n = 34, 71%) and were under the care of a specialist anaesthetist (n = 41, 86%). A number of surgical procedures were required (Table 2). Eleven cases were included where the anaesthetist was called upon to assist in neonatal resuscitation in settings such as caesarean delivery or in other hospital locations, i.e. emergency department and labour ward (Table 3).

Incidents were classified as either airway/ respiratory, cardiovascular, equipment issue, or medication issue and sub-classified as being a neonatal resuscitation issue (n = 11, 22%), in comparison to a perioperative anaesthesia issue (Table 3). The most common reported events involved airway/ respiratory, (n = 22, 46%) including oesophageal intubation, accidental extubation, obstructed endotracheal tube (ETT), apnoea, desaturation and hypoxic cardiac arrest. Cardiovascular incidents (n = 9, 19%), included line complications (arrhythmia, arrest), difficult intravenous access and hypovolaemia. Equipment issues (n = 7, 14%), included three related to use of the neonatal resuscitation systems (Resuscitaire™, Atom™). Issues with the neonatal resuscitation systems involved an oxygen monitor not being available, oxygen not connected, and faulty bag-mask ventilator. Anaesthesia-related equipment issues included monitoring issues with blood pressure recordings and general monitoring, and a circuit leak secondary to a faulty heat and moisture exchange device. Medication issues (n = 10, 21%) were predominantly dose errors and local anaesthetic systemic toxicity (LAST) (Table 3).

## Discussion

Neonatal anaesthesia is most often provided by a paediatric anaesthetist in a specialist institution with neonatal intensive care support.<sup>2</sup> This review however demonstrates that anaesthetists may be called upon to assist in emergency neonatal resuscitation outside of the perioperative setting such as during caesarean delivery or in locations 'off-the-floor' including the labour ward and emergency department. The National Audit Project 7 review of perioperative cardiac arrest recommends all anaesthesia providers maintain proficiency in paediatric and neonatal resuscitation.<sup>4</sup>

Paediatric perioperative cardiac arrest is rare, however the incidence is substantially higher in the neonatal and infant subgroup and most commonly due to airway and/or respiratory issues as the precipitating cause.<sup>4</sup> Twelve neonatal cardiac arrests were reported on in this analysis, four at time of birth during neonatal resuscitation and eight perioperatively. Two cases resulted in death and were considered not preventable.

Fifty per cent of cases involved complications of intubation leading to severe hypoxaemia, bradycardia, and resulting cardiac arrest. Complications reported included oesophageal intubation, accidental extubation, pneumothorax, and ETT obstruction (kinked). In all cases the issue was promptly recognised. Despite this, rapid desaturation occurred due to known anatomical and physiological challenges of the neonatal airway complicated by equipment issues. Difficult intubation incidence in neonates is higher than the general paediatric population and is often unanticipated.<sup>2</sup> The routine use of video laryngoscopy, apnoeic oxygenation, muscle relaxation and end-tidal carbon dioxide etCO<sub>2</sub> monitoring with continuous waveform is recommended.<sup>5</sup>

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Two cardiac arrests from LAST occurred following caudal neuraxial anaesthesia. The correct dose, i.e. dose not exceeding the recommended maximum weight based dose, was administered in both cases. Cardiac arrhythmias presented immediately post-caudal, raising concern for intravascular injection. Successful outcomes were reported in both cases with advanced paediatric life support (APLS) and intralipid. Local anaesthetic systemic toxicity is a rare yet well recognised cause of perioperative cardiac arrest in paediatric anaesthesia, with an incidence of eight per 100,000 blocks.<sup>6</sup> It is notably more common in infants compared to other age groups, likely due to age-specific pharmacokinetic and pharmacodynamic profiles, and unique ultrasound images in infants, despite not exceeding the recommended dose range.<sup>7</sup>

In all cases of neonatal cardiac arrest, the APLS algorithm was followed, reinforcing the importance for all staff involved in the provision of perioperative care of neonates and infants to maintain currency of APLS practice.<sup>4</sup>

Medication errors pertained to ten (21%) incidents in this analysis. Three cases related to incorrect doses of medication, of these, two related to confusion between 'mg' and 'ml' and one anaesthetist self-reflected that fatigue and recent failed procedures to be contributing factors. Other human-factor issues cited included a last-minute theatre change contributing to an oxytocin infusion inadvertently commenced instead of phenylephrine in an elective caesarean section where neonatal resuscitation was required post-delivery. Two cases attributed frequent interruptions during critical moments on delivery of care which resulted in a drug error and residual paralytic agent being flushed in the post anaesthesia care unit followed by a period of apnoea. Cognitive load is high when delivering neonatal anaesthesia. Implementing human factor strategies to mitigate this can improve performance and patient safety.<sup>8</sup>

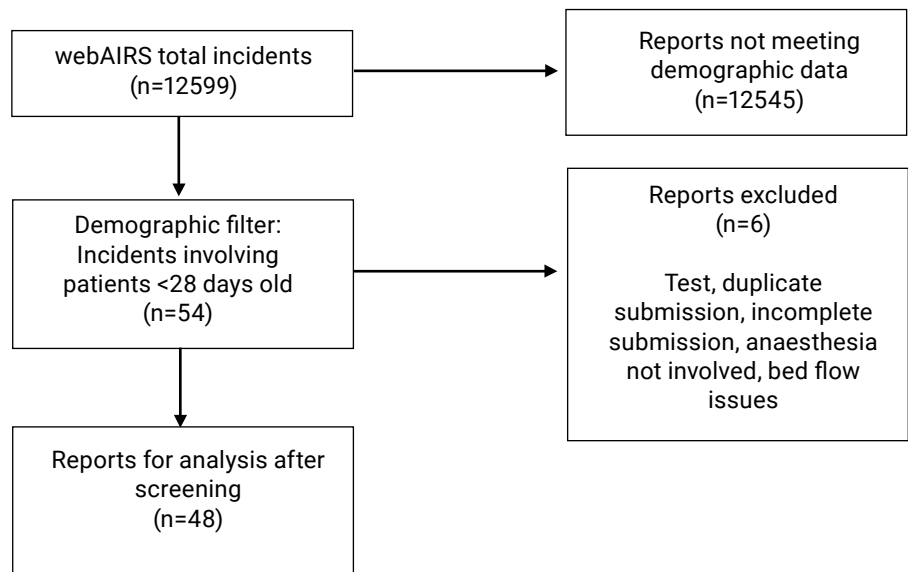
One third (16 of 48) of the cases were related to intubation. This included difficult intubation, oesophageal

intubation, endobronchial intubation and inadvertent extubation. In one case, repeat laryngoscopy after a prolonged period of cardiac arrest identified that the ETT was not in the trachea. This occurred despite previously normal etCO<sub>2</sub> readings and auscultation of the chest. The decision to perform repeat laryngoscopy was consistent with the consensus guideline from the Project for Universal Management of Airways and international airways societies, which recommend actively excluding oesophageal intubation where there is an inability to detect sustained etCO<sub>2</sub>.<sup>9</sup> These recommendations have been established because preventable mortality and serious morbidity continue to occur worldwide.<sup>10,11</sup>

## Conclusion

This webAIRS review captures the unique and complex anaesthetic challenges faced when caring for neonates. Perioperative airway, respiratory and cardiac issues are the most common adverse events reported. Equipment and drug errors also feature as preventable contributing factors escalating care needs, specifically ETT incidents. This report supports the requirement for anaesthetists to maintain skills and currency of practice in neonatal resuscitation and highlights the common error traps when caring for this vulnerable population subgroup.

**Figure 1: Search Results**



**Table 1: Demographic data**

ASA	n	n/48 (%)	Sex	n	n/48 (%)
1	6	12%	Male	27	56%
2	6	12%	Female	14	29%
3	19	41%	Not reported	7	15%
4	12	25%			
5	2	4%			
6	1	2%			
Not reported	2	4%			

Urgency	n	n/48 (%)
Emergency	29	60%
Elective	19	40%

**Table 2: Surgical and anaesthetic data**

<i>Time of day</i>	<i>n</i>	<i>n/48 (%)</i>	<i>Hours on duty</i>	<i>n</i>	<i>n/48 (%)</i>
08.00-18.00	34	71%	0-10	38	79%
18.01-22.00	5	10%	>10-16	2	4%
22.01-07.59	4	9%	>16-24	2	4%
Not specified	5	10%	Not specified	6	13%
<i>Specialty</i>	<i>n</i>	<i>n/48 (%)</i>	<i>Anaesthetist in charge</i>	<i>n</i>	<i>n/48 (%)</i>
General	19	40%	Specialist	41	86%
Obstetrics	8	17%	Trainee	3	6%
Nil procedure	5	11%	Other	1	2%
Cardiac	2	4%	Not specified	3	6%
Otolaryngology	2	4%	<i>Location</i>	<i>n</i>	<i>n/48 (%)</i>
Radiological	2	4%	Operating theatre	28	58%
Neurosurgery	1	2%	Recovery room	3	6%
Thoracic	1	2%	Anaesthetic room	2	4%
Urology	1	2%	Cardiology	2	4%
Other	4	8%	Other	7	15%
Not specified	3	6%	Not specified	6	13%

**Table 3: Classification of Incidents**

	<i>n</i>	<i>n/48 (%)</i>
<i>Airway/respiratory</i>	22	46%
<i>Medication issue</i>	10	21%
<i>Cardiovascular</i>	9	19%
<i>Equipment issue</i>	7	14%
<i>Subcategory</i>	<i>n</i>	<i>n/48 (%)</i>
<i>Anaesthesia</i>	37	78%
<i>Neonatal resuscitation</i>	11	22%
<i>Arrest V no arrest</i>	<i>n</i>	<i>n/48 (%)</i>
<i>No cardiac arrest</i>	36	75%
<i>Cardiac arrest</i>	12	25%

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DR MICHAEL LUMSDEN-STEEL  
CHAIR, ECONOMICS ADVISORY  
COMMITTEE

# ECONOMICS ADVISORY COMMITTEE

## Anaesthesia, the MBS and the Relative Value Guide

**IN AUSTRALIA PATIENTS ARE FORTUNATE THAT ANAESTHESIA IS OVERWHELMINGLY DELIVERED BY MEDICALLY TRAINED SPECIALIST ANAESTHETISTS, ENABLING CARE THAT IS TAILORED AND OPTIMISED FOR EACH PATIENT AND PROCEDURE. WHERE ANAESTHESIA IS PROVIDED FOR ELIGIBLE SERVICES, PATIENTS RECEIVE A REBATE THROUGH THE MEDICARE BENEFITS SCHEDULE (MBS).**

**T**he incorporation of the Anaesthesia Relative Value Guide (RVG) into the MBS (Category 3, Group T.10, Subgroups 1–26) has been well documented in *Australian Anaesthetist*<sup>1</sup> and ASA podcasts<sup>2</sup>. When it was first introduced in November 2001, the MBS RVG unit value was **\$17.15**. Prior to the RVG's introduction, anaesthetists' fees were derived from surgeons' fees.

By June 2025 – more than 24 years later – the RVG unit value had increased to **\$23.10**, representing a total increase of **\$6.05 per unit** over that period. The Reserve Bank of Australia has an Inflation Calculator tool on its website which calculates the change in cost of purchasing a representative 'basket of goods and services' over a period of time. Using this calculator, a basket of goods and services valued at \$17.15 in calendar year 2001 would, in calendar year 2025, cost \$32.78, well above the current \$23.10.

### MBS indexation

At the time of its introduction into the MBS, the RVG was subject to intense cost scrutiny and was adjusted to maintain overall cost neutrality. Anaesthesia RVG items are remunerated at 100% of the schedule fee. In contrast, surgical services (Group T8) are subject to the Multiple Operations Rule (MOR), as outlined in MBS Note TN.8.2.

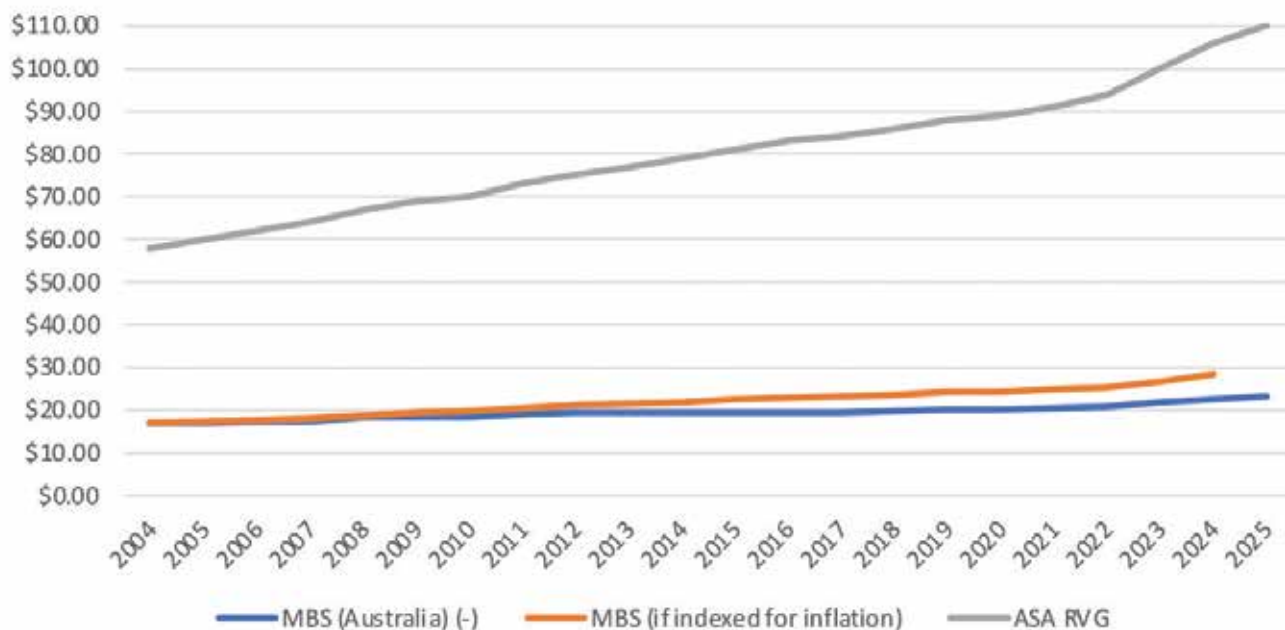
**At the time of its introduction into the MBS, the RVG was subject to intense cost scrutiny and was adjusted to maintain overall cost neutrality. Anaesthesia RVG items are remunerated at 100% of the schedule fee.**

Early adjustments to the RVG unit value include a reduction to **\$16.50** for both 2002 and 2003, followed by an increase to **\$16.85** in 2004. The original 2001 value of **\$17.10** was only restored on 1 November 2005. From November 2012 to November 2019, indexation was frozen as part of the broader MBS rebate freeze.

Over the same period, MBS values indexed to CPI and Health CPI, as well as the ASA RVG (which is indexed in line with the AMA RVG, using ABS wage price and practice cost indices), diverged substantially from the MBS anaesthesia RVG. The graph below shows actual indexation of the MBS RVG, indexation of the MBS RVG (if indexed to CPI) and indexation of the ASA RVG between 2004 and 2025.

In February 2026, the MBS RVG unit value is just 21 per cent of the ASA RVG unit value.

RVG indexation 2004 - 2025  
Actual MBS RVG; MBS RVG (if indexed to CPI); ASA RVG



## Private health insurers

The Health Legislation Amendment (Gap Cover Schemes) Act 2000<sup>3</sup> enabled private health insurers to introduce no-gap and known-gap schemes to reduce patient out-of-pocket costs. The ASA supported informed financial consent to patients for known gap schemes.

However, private health insurer rebates have been inconsistently indexed, and known-gap limits have not been indexed at all. Health funds have also shifted from applying known-gap limits per item to applying a single limit for the entire episode of care (i.e. all item numbers). When a specialist's fee exceeds an insurer 'known gap' limit, the insurer reverts to only paying 25 per cent of the MBS fee, which is the minimum amount they are legally required to pay. The effect of this is to increase out-of-pocket costs for patients.

Bupa, currently the largest private health insurer in Australia, consolidated previously state-based RVG unit values into a single national value in 2021, adopting the lowest existing rates rather than uplifting higher ones. In 2018, Bupa

attempted to restrict no- and known-gap payments to contracted hospitals, irrespective of specialist participation; this was reversed following strong medical and political opposition.

Since 2002, health funds have also introduced a range of opaque local schemes offering higher payments in exchange for no-gap or maximum known-gap arrangements. Various schemes have been introduced to anaesthetists at the last minute; while many have failed, others have quietly become entrenched. They are often poorly disclosed, tied to specific surgeons, funds, or hospitals, and may exclude patients based on clinical or administrative criteria. As a result, some patients do not benefit from the doctor's uplift fee reducing their out-of-pocket costs. Finally, it remains unclear how the uplift in fees paid to doctors is captured and reported by the Australian Prudential Regulation Authority (APRA), with respect to doctors' fees, known gap data, and patient out of pockets.

## Specialist fees and out-of-pocket costs

In 2025, the Grattan Institute published *Special Treatment: Improving Australians' Access to Specialist Care*<sup>4</sup>. The report found that average out-of-pocket costs for specialist services increased from **\$45 to \$78 per service** between 2010 and 2025, faster than for other Medicare Services. The report also defined "extreme billing" as fees exceeding three times the MBS schedule, without modelling MBS indexation against CPI or Health CPI.

The report recommended measures to control specialist fees, including clawing back the value of all Medicare rebates paid to a specialist who charges "extreme fees" for their services that year and publicly identifying those practitioners.

While the report included several constructive recommendations – such as workforce planning, investment in public specialist clinics, improving clinic efficiency, and supporting GPs – there was limited acknowledgment of rising private practice costs, inadequate

indexation of MBS and private health insurance rebates, and the absence of indexation of known-gap limits.

The report found there had been no clear or coordinated planning to identify and train the specialist workforce required to meet demand in the public hospital system. The National Health Reform Agreement—which funds public hospitals across states and territories—was only finalised on 30 January 2026. It therefore remains unclear whether the Agreement will drive meaningful changes in health service planning, workforce training, or system investment to meet growing public hospital demand.

The ASA workforce survey<sup>5</sup> indicates that addressing the projected shortfall of 224 anaesthetists would require an increase of just 56 additional trainees per year between 2024 and 2027. The survey also recommends maintaining the current medical model of anaesthesia care, without task substitution.

## Recent public commentary and transparency

Recently specialist fees have become a focal point of public commentary, with doctors portrayed as “greedy” and their fees described as a “barbecue conversation stopper.” This occurred despite limited recognition of escalating practice costs and prolonged rebate stagnation.

The Government’s Medical Costs Finder website<sup>6</sup> – costing more than \$20 million and with minimal clinician participation – has been flagged for reform, making it mandatory to report specialist billing data. How this will be implemented, and with what accuracy, remains uncertain at this point in time.

Recognising the wide variation in fees, the ASA conducted a member survey in January 2026, with analysis ongoing, and continues to respond to media commentary on the issue.

## MBS Review Taskforce 2015 - 2018

Many anaesthetists may be unaware of the 2015–2018 MBS Review Taskforce and the Anaesthesia Clinical Committee (ACC) report<sup>7</sup> released in 2017. The ASA was not formally represented on the ACC. The ACC recommended substantial changes to anaesthesia items, framed around concerns regarding inappropriate use of public funding.

ASA modelling demonstrated that the proposed changes would have resulted in:

- An **85% reduction** in Subgroup 19 expenditure
- Impact on **80% of anaesthetic services**
- Rebate reductions for **1.4 million patients annually**
- Combined annual reductions in MBS and PHI rebates exceeding **\$64 million**

Following strong ASA advocacy, many of the ACC’s recommendations were not adopted, and a liaison group, which included the ASA, was established to implement more measured reforms.

## ASA RVG Review

The ASA is now undertaking a comprehensive review of the Anaesthesia RVG in partnership with the Department of Health. The review aims to modernise the RVG, reduce compliance risk, and ensure it reflects contemporary clinical practice. Importantly, this is not a **cost-cutting exercise**; any identified savings are to be reinvested within the subgroup.

Key principles include updating item descriptors and unit values, introducing new items for contemporary procedures, reducing ambiguity, reviewing time units, capturing public hospital activity, and addressing ASA items without MBS equivalents.

The ASA continues to advocate for appropriate recognition of anaesthetists’ care and fair patient rebates. Updating the RVG, alongside education and compliance activity, remains the appropriate and proportionate approach to safeguarding the integrity of the MBS.

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## ■ Dr Michael Lumsden-Steel

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# PROFESSIONAL ISSUES ADVISORY COMMITTEE

## PRIVATE HOSPITAL OWNERSHIP

**A NEW MODEL OF PRIVATE HOSPITAL OWNERSHIP AND GOVERNANCE IS EMERGING AROUND THE COUNTRY. ADENEY PRIVATE HOSPITAL IN VICTORIA IS ONE SUCH EXAMPLE, WHILE SIMILAR MODELS HAVE ALSO BEEN DEVELOPED IN NEW SOUTH WALES AND SOUTH AUSTRALIA. THE AUSTRALIAN SOCIETY OF ANAESTHETISTS UNDERSTANDS THAT THE ADENEY OWNERSHIP MODEL CURRENTLY ENSURES DOCTORS HOLD A MAJORITY 51% OWNERSHIP STAKE, WITH THE REMAINING 49% OWNED BY AMPLAR HEALTH, A SUBSIDIARY OF PRIVATE HEALTH INSURER, MEDIBANK PRIVATE. PATIENTS BENEFIT FROM SIGNIFICANTLY ENHANCED REBATES WHICH ARE PAID TO THE HEALTH PROFESSIONAL AT THESE HOSPITALS UNDER NO GAP ARRANGEMENTS THAT REDUCE OR ELIMINATE PATIENT OUT-OF-POCKET COSTS.**

In January the ASA published a new Position Statement in response to this emerging model of private hospital ownership and governance. This article discusses the pros and cons of these hospital models.

### The case for the affirmative

These models have reintroduced something that for a long time had been diminishing in healthcare in Australia, significant medical involvement in the ownership and governance of hospitals. This has the potential to place clinical decision making ahead of financial decisions, with focus on efficiency and patient outcomes. Like all private businesses however, there will still be a need to make a profit.

Adeny Private Hospital currently promotes itself as Australia's first purpose-built gap-payment-free private hospital, meaning patients who meet the hospital's admission criteria, and who have eligible hospital cover, have zero out-of-pocket costs across its full suite of hospital services.

This means eligible patients can expect no additional charges for:

- Surgeon and Surgical Assistant fees
- Anaesthetist fees
- Perioperative Physician fees
- Onsite Radiology costs
- Inpatient Pathology fees and
- Inpatient Pharmacy charges

During the last federal election, the Government heavily promoted the campaign slogan, "*Under Labor, all you'll need is your Medicare card, not your credit card*". In this instance, perhaps its more accurate to say all you'll need is your Medicare card and your Health Insurance card.

Clinical remuneration is enhanced at parity for both Surgeons and Anaesthetists, demonstrating equal positioning of all specialties at the hospital. There are enhanced rebates for all specialties at multiples of the usual fund rebate levels, demonstrating an acknowledgement that current rebate levels are inadequate. This also shows that if health funds so wish it, they are able to pay increased rebates, more in line with AMA rates. This also demonstrates

that the RVG and AMA rates are an excellent indicator of the needs of modern clinical practice. These rates have also been agreed to be indexed at rates more in line with inflation. At present, both Medibank Private and Bupa have agreed to this funding model (for eligible patients). Clinicians and patients still have full autonomy for choice of pathology, pharmacy, or radiology services.

## The case for the negative

Admission to these facilities appears to be restricted to low risk, privately insured patients undergoing a defined set of procedures and managed according to pre-defined clinical pathways. Patients deemed higher risk however are excluded from receiving surgical care at these facilities. Consequently, these patients must seek treatment at fully resourced private hospitals. The absence of increased rebates means these patients can incur significant out-of-pocket expenses due to the insurance shortfall.

There is a departure from community rating principles and legislation. The Private Health Insurance Act 2007 ensures that health insurance in Australia is community rated. This means:

- everyone pays the same price for a particular policy, regardless of their underlying health status or age
- a health insurer can't refuse to insure someone or sell them the policy they want to buy
- everyone is guaranteed the right to renew their policy.

In the model being discussed higher risk members of the same health insurance fund however are prevented from accessing the hospital due to the hospital's admission eligibility requirements. Furthermore, fund members who do not reside close to one of these hospitals in NSW, Victoria or South Australia are also prevented from accessing this type of care.

The model establishes the placement of a third party, the health insurer, between the patient and clinician. It is a form of vertical control with the health funder

also being a 49% owner of the hospital. There is the potential for ownership arrangements like this one to unduly influence conditions moving forward. These arrangements may result in an erosion of conditions should the hospital run at a loss, and a progression to managed care where a health insurer can direct patients to facilities it owns and for care or treatment provided only by specialists who agree to "No Gap". Patient choice and doctor independence may be sacrificed in favour of insurer control over the therapeutic process.

This model of care is also an example of "cherry picking" healthy patients over complex patients with multiple comorbidities. There is also the risk of targeted selection of specialist on the basis of efficiency/productivity, the profitability of procedures, and a business model based purely on the profitability of the caseload as opposed to patient need. This will result in more complex patients and or procedures being directed to other private hospitals, which already struggle with inadequate funding by private health insurers, or movement of patients into the already overburdened public healthcare system.

## Protecting the Australian healthcare system

To safeguard Australia's healthcare system from a shift toward managed care, the ASA recommends the following principles.

- Preservation of simple fee-for-service remuneration for doctors
- The right for doctors to set their own fees – when the financial relationship between patient and doctor is lost the health insurer can determine which patients are treated, what operations are performed and how much doctors are paid
- Preservation of a universal Benefit Schedule under Medicare
- Preservation of the Community Rating principle whereby all Australians pay a similar fee for private health insurance

- Recognition that the indexation of patient rebates must be aligned with healthcare inflation
- Avoidance of contracts between doctors and third-party payers
- Avoidance of preferred provider networks
- Prohibition of vertical control 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
- Transparency of all arrangements where enhanced schedules and non-standard remuneration agreements are in place
- Open disclosure by doctors who have financial interests and conflicts of interest with respect to investment/ownership in health facilities where they are working.

## ASA Position Statements

The ASA publishes "position statements" to outline its stance on various aspects of anaesthesia services. These statements, including the new Position Statement on Private Hospital Ownership, are available on the ASA website at <https://asa.org.au/policy-and-advocacy/position-statements>.

### ■ Dr James Hosking

Chair, Professional Issues Advisory Committee



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# EXCLUSIVE MEMBER OFFER

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## ASA-BRANDED SCRUBS AVAILABLE FOR ORDER



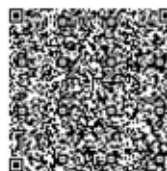
We're excited to introduce ASA-branded scrubs, now available for members to personalise with your name and position alongside the ASA logo.

In partnership with Infectious Clothing Co, ASA members receive an exclusive ten per cent discount on a selected range of high-quality scrubs plus free personalised embroidery on scrub tops.

**To order, simply complete the online form from the ASA website, [asa.org.au](http://asa.org.au), and Infectious Clothing Co will issue an invoice (incurs shipping costs).**

**Please allow up to three to four weeks for delivery, depending on stock availability.**

**Scan the QR code to complete the online order form.**





“Hello my name is...” is a simple phrase that should be used at the start of a healthcare relationship. It recognises, above all, that healthcare is an interaction and relationship between two human beings.

“Hello my name is...” starts a collaboration that promotes learning, flexibility and the trust that is essential for providing human-centred care.

The key to the success of “Hello my name is...” lies in its simplicity. Introducing yourself takes very little time, it is relatable, costs little, helps build trust and shows respect.

When patients know who you are and what your role is they feel respected and are more likely to have less anxiety, increased trust in you, ask questions and share important information about themselves.

## Who is this tool for?

All staff, both clinical and non-clinical. “Hello my name is...” works best when introduced as a health service wide initiative, in all departments and across all disciplines.

## When should you use this tool?

Starting conversations with “Hello my name is...” can be used anytime and anywhere. It is particularly important when you meet a patient, their family or carers for the first time. Also if you are re-establishing your relationship with them after some time has passed or within high stress environments: for example in emergency or ICU.

## Good practice

- 1. Be ready** to use “Hello my name is...” in any situation. Think about non-verbal and verbal cues. Be friendly and warm. Be aware of your facial expressions, eye contact, gestures and postures, they should be open, warm and friendly. Little things like sitting down next to a patient, if appropriate, so you are at the same eye level. It also makes a big difference to a patient to look at them, not your notes or devices.
- 2. Start the conversation.** Upon approaching a patient, start the conversation with “Hello my name is...”. Don’t rely on your name tag. While you may have a name badge on – it is often hard for patients to see or read them “in the moment”.
- 3. Extend** your introduction to include your role or purpose so the patient is aware of the reason for your visit. “I’m the...” or “I’m here to talk about...”
- 4. Ask** a question that is not clinically related e.g. “Can I call you <first name>? How did you sleep? How did you get here today?” Take some time to learn about them as a person.
- 5. Share** – as the patient shares personal details be ready to share a few personal things about yourself that you feel comfortable with, “Yes I have a dog too”, “I am also a runner...” As the patient shares more about themselves, continue to listen and ask questions to build the relationship.

# **hello** my name is...



## Why it works

You will notice patients, families and carers are more relaxed in your care. This may be displayed in their body language and by the relaxed way they sit or hold themselves. They will become more open to share who they are, their beliefs and behaviours in the context of the clinical situation.

For those from different cultures and circumstances you will initiate the opportunity to understand their values and beliefs, which may influence how you speak or interact with them, maximising their understanding and communication<sup>1</sup>. You will quickly understand the importance of social and cultural influences for your patients.

If you notice that the communication, verbal or non-verbal, is not more open, consider cultural and situational influences. For example, cultural positioning and power of health professionals as experts, the patients' domestic situations, language barriers, socioeconomic & demographical influences.

Consider involving other health care professionals, support agencies or family members that may relate better to this person and support them in the next appointment.

## Principles of this concept



### COMMUNICATION

is of paramount importance. Timely and effective communication which is bespoke to the patient makes a huge difference and starts with a simple introduction.



### THE LITTLE THINGS

really do matter – they aren't little at all. They are indeed huge and of central importance in any practice of healthcare and in society. This could be someone sitting down next to you rather than looming over you or holding the door open for someone coming through.



### PATIENT AT THE HEART OF ALL DECISIONS

"No decision about me without me". These words ring true in healthcare as the most important person is the patient and everything should be done with them in mind.



### SEE ME

See me as a person first and foremost before disease or bed number. Individuals are more than just an illness, they are human beings, they are a family member, they are a friend etc and we should all remember to see more of an individual than just the reason they are using healthcare.

### Safety Fundamentals and Accreditation

Implementing this Safety Fundamental for Person Centred Communication will support healthcare organisations to demonstrate they are meeting actions in *National Standards 2: Partnering with Consumers* and *6: Communicating for Safety*.

### Acknowledgement and source

The CEC consumer partners for their input and support

<https://www.hellomynameis.org.uk/>

[AHHA \(2018\)-Deeble Institute for Health Policy Research - Perspective Brief](#)

### Footnote

<sup>†</sup><https://ahha.asn.au/news/%E2%80%98hello-my-name-%E2%80%A6%E2%80%99-should-be-starting-point-all-healthcare>

## HISTORY OF ANAESTHESIA, LIBRARY, MUSEUM AND ARCHIVES COMMITTEE UPDATE



ASSOCIATE PROFESSOR  
MICHAEL COOPER AM  
INCOMING CHAIR,  
HALMA COMMITTEE

# HALMA CHAIR STEPS DOWN AFTER A DECADE

**AFTER TEN YEARS, DR REG CAMMACK HAS STEPPED DOWN AS THE CHAIR OF THE ASA'S HISTORY OF ANAESTHESIA, LIBRARY, MUSEUM AND ARCHIVES (HALMA) COMMITTEE.**

**B**ut this has been only a small part of his ongoing voluntary work within the ASA, especially in the economic representation of anaesthetists. He has been an ASA member for nearly fifty years.

His past significant involvements include:

- Member of the NSW State Committee
  - NSW Economics Advisory Officer 1993-2008
  - Assistant Fees Advisory Officer 1993-2008
  - Vice Chair 2006-2007
  - Chair 2008-2009 including being on Federal Council and a Director
  - Immediate Past Chair 2010-2011
- Member of the Federal Economics Advisory Committee (1993-2008) which with colleagues Greg Deacon and Peter Hales involved settlement of the DVA dispute and introduction of the RVG into the Medicare schedule.

Since being Chair of HALMA, Reg has overseen many initiatives to preserve our heritage, including

- Ongoing annual history seminars at the ASA
- Support of the Retired Anaesthetists Group
- Maintaining ASA's corporate history
- The restoration of the museum collection and its move with the library and the archives to the superb new ASA headquarters at Naremburn. This was made more difficult coinciding with the pandemic and occurred without a loss.



Dr Reg Cammack

- The ASA library reclassification project which is now mostly completed
- Acquisition of many unique books and equipment relating to our history
- Cataloguing of the Harry Daly Museum
- The extensive History of Anaesthesia Timeline on the ASA website.

Dr Cammack exemplifies the long-term commitment of many ASA office bearers and committee members. His tireless work, sage counsel and commitment to the ASA has been invaluable. He received the ASA President's Award in 2006.

The ASA and the HALMA Committee thank Reg for his ongoing enthusiasm, diligence and work in preserving the heritage and history of the ASA and anaesthesia in Australia. We are fortunate that he will remain on the committee.

Without the preservation of our heritage, we cannot move forward.

### ■ Dr Michael Cooper AM

Incoming Chair, HALMA Committee



Drs Greg Deacon (former ASA President) and Reg Cammack



Drs Reg Cammack and Michael Cooper AM  
Incoming Chair, HALMA Committee

UNCONVENTIONAL CONVENTIONS  
NORTHERN LIGHTS

# ANAESTHESIA UNDER ARCTIC SKIES - KEEPING COOL IN A CRISIS -

Scientific convenors: Dr Anthony Padley & Dr David Elliott  
Keynote speakers: Prof Andrew Klein (UK) & Dr Jo Irons (Aus)

JANUARY 2027

- 26 hours of Anaesthetics CPD
- 7 nights in the Arctic Circle
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- Reindeer & dog sledding
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# ASA MENTAL HEALTH AND WELLNESS





DR LAN-HOA LÊ  
CHAIR, WELLBEING  
ADVOCATES COMMITTEE

# WELLBEING ADVOCATES COMMITTEE

## 1. ASA partners with Drs4Drs

The ASA is pleased to promote our partnership with Doctors' Health Services (Drs4Drs) to strengthen wellbeing support for anaesthetists and trainee members across Australia.

Drs4Drs is a not-for-profit charitable organisation dedicated to supporting the health and wellbeing of doctors and medical students nationwide. The program focuses on prevention, early intervention and timely access to help, working with partners who understand the unique demands of medical practice – including stress, burnout, and mental health challenges.

Through this collaboration, ASA members will have access to free, independent, confidential support available 24/7 via the doctors' health support line (1300 374 377). This national service links callers to State and Territory Doctors' Health Advisory Services. It offers confidential telehealth counselling and support for both minor and major personal or professional issues.

ASA members can contact services outside their State or Territory if they wish, stay anonymous, and receive free psychology and counselling consultations. Also, they can ask about cash and various payment options for ongoing services.

As part of this partnership, Drs4Drs will contribute to educate and raise awareness with activities across ASA. They will host events, workshops and podcasts to help normalise help-seeking and promote a

culture where wellbeing is recognised as integral to good medical practice.

Together, ASA and Drs4Drs are committed to supporting anaesthetists and trainees to stay well and seek help early when needed.

**To learn more or speak with a doctor or counsellor, call 1300 374 377 (available 24/7) or visit [www.drs4drs.com.au](http://www.drs4drs.com.au).**

## 2. The new ASA Wellbeing webpage is live

Discover quick resources, podcasts and many more evidence-based events. Use these for your wellbeing practice evaluation and to earn knowledge and skill CPD hours this calendar year:

- We have audio videos on how to set up a Wellbeing CPD Plan. Check them out at <https://asa.org.au/asaeducation/wellness-resources>.
- Beyond Blue provides tools to measure burnout and distress levels. You can find them at <https://www.beyondblue.org.au/mental-health/tools-and-quizzes/k10>.
- Explore mindfulness in courses like 'Mindfulness in Health – CPD Course' at <https://centralcoastmeditationcentre.com/events/>.

The 2026 Wellbeing series of events is kicking off with an evening that will help trainees and SIMGs tap into their emotional intelligence and self-compassion, making exam preparation more manageable.

**To register for "Exam Preparation: Surviving and Thriving", please visit <https://asa.org.au/event/trainee-wellness-webinar-exams-preparation-surviving-and-thriving>.**

**Check out more wellbeing events and resources here <https://asa.org.au/wellbeing-of-anaesthetists>. You can also learn how to reach your state and territory ASA Wellbeing Advocates Committee Representatives.**

## 3. The ASA also partners with HandnHand for peer support

Your HandnHand supporter doesn't need to be an anaesthetist. They just need to have experienced or witnessed something similar. If you prefer an anaesthetist as your peer supporter, then the ASA can connect you with a trained member.

**Visit [www.handnhand.org.au](http://www.handnhand.org.au) or contact [ASApeersupport@asa.org.au](mailto:ASApeersupport@asa.org.au).**

For workplace wellbeing officers and advocates, and peer supporters, mark your calendar for 31 March. Join us for the next HandnHand peer support education and networking event. It's a trusted forum to support your role and to refresh on how to peer-support your colleagues.

### ■ Dr Lan-Hoa Lê

Chair, ASA Wellbeing Advocates Committee  
[ASAwellbeing\\_chair@asa.org.au](mailto:ASAwellbeing_chair@asa.org.au)

# DRS4DRS

## Doctors Health Services (DRS4DRS)

Call 1300 374 377 (1300 DR4DRS) for assistance

Supporting doctors and medical students to care for themselves, their colleagues and their patients

### WHO ARE WE:

Doctors Health Services Pty Ltd (Drs4Drs) is a national not for profit organisation dedicated to the well-being of doctors and medical students. Established by the medical profession for the medical profession.

### HOW WE DO THIS:

Through a network of advisory and referral services, independent, free, safe, supportive and confidential services are available across Australia.

### WHO WE ARE HERE FOR:

Drs4Drs provides support for any doctor, medical students and their families.

### GET IN TOUCH

VISIT: [www.drs4drs.com.au](http://www.drs4drs.com.au)

EMAIL: [enquiries@drs4drs.com.au](mailto:enquiries@drs4drs.com.au)

PHONE: 1300 374 377

FIND US ON:



### EDUCATION AND TRAINING:

Deepen your understanding of doctors' health needs with our educational module, designed to help you care for yourself and others in the medical field.

Find out more visit:

[drs4drs.com.au/being-a-dr4drs](http://drs4drs.com.au/being-a-dr4drs)

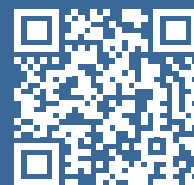
### EDUCATION AND WORKSHOPS:

Find out how we can assist with providing access to workshops and educational resources tailored to the needs of doctors and medical students.

### WE CAN ASSIST YOU FIND THE RIGHT SUPPORT SERVICE TO SUIT YOUR NEEDS INCLUDING:

- Physical health
- Mental health
- Substance use disorder
- Financial stress
- Acute/chronic stress
- Bullying
- Harassment
- Sexual Harassment
- Discrimination

If you, a colleague, or family member needs support please reach out, call 1300 374 377 or visit our website [www.drs4drs.com.au](http://www.drs4drs.com.au)



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



Australian Society of  
**Anaesthetists**<sup>®</sup>

*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 SubCommittee**

**[ASApersupport@asa.org.au](mailto:ASApersupport@asa.org.au)**





# AROUND AUSTRALIA

## Australian Capital Territory

### Dr Valerie Quah

*Chair of the Australian Capital Territory Committee of Management*

The last quarter of 2025 was bookended by a final ASA-sponsored CME event - the ACT Morbidity and Mortality discussion evening. Chaired by Dr Vida Viliunas, it was well attended by both local and interstate participants. Cases were presented across a diverse spectrum of elective and trauma scenarios, in both private and public clinical practice settings. We thank the presenters for their participation.

Also of note, it has been announced that National Capital Private Hospital, a flagship Healthscope facility, will be acquired by Ramsay Healthcare, subject to regulatory approval.

Looking to 2026, ACT ASA Vice Chair Dr Liz Merenda will help welcome new trainees to the ACT in the Canberra Health Services Part Zero/ Orientation course and Dr Dharan Sukumar is taking the lead in organising a Part Three course for our Advanced Trainees and recent FANZCAs.

## New South Wales

### Dr Simon Martel

*Chair of the New South Wales Committee of Management*

The NSW Committee last met on Wednesday 26 November.

#### VMO Determination

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

Evidence was submitted to the Industrial Court on the 26 September. The government has had 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.

Meanwhile, VMOs in NSW have not had a pay rise since July 2023. The ASA is aware that the AMA has requested an interim pay rise whilst this process plays out, but as of mid-January, no wage increase has been announced. It is therefore unsurprising that lists continue to be cancelled in NSW public hospitals due to a lack of anaesthetists.

### Staff Specialist/ Doctor-in-Training Awards

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

There were hearings during December, where both anaesthetists and GP - anaesthetists gave evidence. Further hearing dates are scheduled for January and February, with findings not expected until at least June.

In the interim, ASMOF NSW has accepted an interim backdated pay increase, with three per cent from July 2024 and another three per cent from July 2025. They have also accepted some improvements in employment conditions around fatigue management, paid parental leave, Training Education and Study Leave, and Trade Union Leave, in return for settling certain claims made in their Industrial Relations Commission case.

### Healthscope/ Northern Beaches Hospital

The ASA continues to monitor the ongoing attempt to sell off the assets of Healthscope, which went into receivership last year. The NSW Government has purchased Northern Beaches Hospital for \$190 million, with the hospital transitioning to full public ownership on

29 April. With full public ownership, the role of existing private services at the hospital remains uncertain. Mr David Swan, a former CEO of St Vincent's Health, has been appointed by the NSW Government to provide advice about the future of private services.

### Part Three Course

The ASA NSW Part Three course was held virtually on Saturday 22 November. Trainees were provided with an excellent program provided by many experienced ASA members, and other clinicians. Many thanks to those who volunteered their time to make this an insightful and informative day.

## Western Australia

### Dr Archana Shrivathsa

*Chair of the Western Australian Committee of Management*

2026 is shaping up to be a busy and productive year for the ASA WA Committee. I'd like to take this opportunity to thank all our Committee members, Heads of Departments and the ASA support staff in WA for your ongoing hard work and dedication.

Our WA ACE Committee is putting together an exciting program for 2026 to fulfil CPD requirements, registrations will be opening soon.

We will soon be opening nominations for the Committee for 2026 – please keep an eye on your inboxes!

### ASA Part Three Course, Friday 14 November 2025

The annual Part Three course was held at the UWA Club on Friday November 14 with an audience of both local and SIMG Advanced Trainees and Fellows. Opening with a session on Getting Started in Private Practice and Billing essentials, the day included consultant application advice and career planning, CPD, and the annual Heads of Department Panel. Rounding out the day was a session on financial planning presented by NOR Financial, indemnity and medicolegal hot topics from Avant and MDA National, and future challenges in anaesthesia from the ASA.

Thank you to our generous sponsors and our Trainee Member Group representatives Dr Kennia Lotter and Dr Meredith Cully for organising such an informative and enjoyable day.

## South Australia / Northern Territory

### Dr Nicole Diakomichalis

*Chair of the South Australia / Northern Territory Committee of Management*

### Wishing everyone a happy New Year from the SA Committee.

As we look back on 2025, the Committee members are proud of our achievements. We secured an excellent outcome in work cover remuneration, which has now been in effect for six months, and we delivered several successful events, including the

joint ACE evenings, covering topics such as gastric ultrasound and cultural safety.

We also hosted our Part Three course at the end of the year, which was well attended by trainees and supported by our President, Dr Vida Viliunas, and CEO, Dr Matt Fisher. Feedback has been very positive, and we extend our sincere thanks to our Trainee Representatives, Dr Mila Sterbova and Dr Evelyn Timpani, for their outstanding contribution throughout the year. We are also pleased to welcome Dr Ellie Cheah as our new Trainee Representative.

Looking ahead to 2026, we are planning additional social engagement opportunities, including our Bright Young Things event for new consultants.

We have also received interest from anaesthetists wishing to join our regional committee. As a result, we are considering a restructure to support greater diversity, succession planning, and the continued strong representation of our anaesthetic community. We welcome all who are interested in contributing to reach out to us.

We are excited for the year ahead and remain committed to representing our profession with enthusiasm and integrity.



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



**Join Now**

Contact the Membership Team ☎ 1800 806 654 ✉ [membership@asa.org.au](mailto:membership@asa.org.au)

[www.asa.org.au](http://www.asa.org.au)

# Join now and connect with your community



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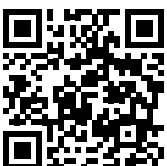


FREE CPD Home

Dr Nicole Diakomichalis  
ASA Member since 2014



The benefits of my membership that I value most include all of the educational videos. I use a lot of pamphlets and things available to patients as well and particularly the RVG, I use that almost every single day, and I just take so much from the social connections and the interactions with other members."



[www.asa.org.au](http://www.asa.org.au) | 1800 806 654 | [membership@asa.org.au](mailto:membership@asa.org.au)

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

#CSC26

# CSC2026

COMBINED SCIENTIFIC CONGRESS  
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8-11 OCTOBER 2026



## KEYNOTE SPEAKERS



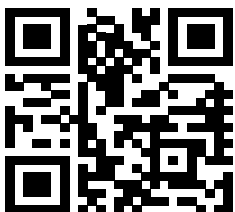
**Professor Paul Bowie**  
Programme Director (Safety & Improvement) NHS Education for Scotland Glasgow, UK

**Professor Marcy Rosenbaum**  
Family and Community Medicine  
University of Iowa, Carver, USA

**Associate Professor Andrew Lumb**  
Consultant Anaesthetist (Retd.)  
St James's University Hospital, Leeds, UK

**Professor Denny Levett**  
Director Centre for Perioperative Care (CPOC)  
University Hospital Southampton, UK

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\* Speakers confirmed at time of publication