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

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CONTACT US:

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

DESIGNED BY:
Joanna Basile, Hopping Mad Designs

PRINTED BY:
Ligare Book Printers Pty Ltd

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

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

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

Australian Society of Anaesthetists®

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FROM THE ASA PRESIDENT

EDUCATION

DR VIDA VILIUNAS OAM
PRESIDENT

This edition features articles on the broad theme of education and reflects how that has evolved with the profession. Much of our education today occurs online and no longer face-to-face. Current focusses are on wellbeing, artificial intelligence, how we teach, and continuing professional development (CPD).

Wellbeing education

Wellbeing support and education is no longer just an add-on but a vital part of our awareness and commitment to our professional health as doctors. It is a part of our teaching, research, and support. Our workplaces promote policies and practices that are supposed to make them respectful and kind, yet that is where burnout, distrust and helplessness are reported[1]. Membership organisations such as the ASA have a responsibility to pastoral care at every level. Virtual and particularly face-to-face events provide an opportunity to offer support to colleagues with shared experiences. The ASA has partnered with Drs4Drs[2] to support members to care for themselves through a network of referral services that are independent, free, safe and confidential.

Education, AI and our specialty

Most of us have done it: googled the likely impact of artificial intelligence (AI) on anaesthesia and our future as specialists. Many are worried that 'transforming' the specialty is code for replacing it with several AI-driven systems in various operating theatres supervised by one actual human anaesthetist and calling it efficiency. Currently, the AI-and-the-specialty literature and research is dominated by speculation about effects on radiologists and pathologists[3] rather than anaesthetists.

The effect of AI on our specialty is not to be ignored. Professor Alwin Chuan has warned that "We aren't – cannot be – just users, we need to be informed stakeholders" so that we can advocate for the specialty with decision-makers. I recommend his recent primer on GenAI concepts published recently in Anesthesiology[4].

Artificial intelligence can be used to condense a lot of information without fatigue. This has implications for patient information summaries, risk stratification as well as for medical education.

However, capability is outpacing governance and the responsibilities of unfiltered and unacknowledged use of AI methods. There is no doubt that AI will augment and change our professional lives. Keeping abreast of and involved in developments and leadership in AI integration is our important responsibility. There is a host of skills that AI can contribute to education, but it cannot replace us. No amount of number-crunching or literature-summarising can replace an anaesthetist's skills in areas of judgement, crisis management, ethics, or the communication of empathy to patients at their most vulnerable. There is a t-shirt that says "Please do not confuse your Google search with my medical degree". Health information is easy to access but harder to synthesise and apply clinically. However, studies show that self-diagnosing patients might have better relationships with their doctors and are usually more involved with their health[5]. Rather than taking offence, we are much better off using patients' print-outs as a conversation starter in our consultations. Australian anaesthetists have millions of opportunities per year to educate their patients and communicate the value of what we do.

ASAEd and trainees

It's exam season. Many of us have flashbacks about studying during medical school and for specialist exams. All of us know that that was just the start of a lifetime of learning and teaching. The ASA's Education Committee has been busy with exam preparation with trainees – a shared load with many consultants in departments all over the country. It's a group effort from which we all benefit, and our greatest investment in the future of our specialty. By the time this Education- themed issue is out, Primary and Final exam candidates will have sat their exams and will be awaiting results. Best wishes for success to all.

CPD – is that education?

While they're not perfect, CPD programs are aimed at engaging doctors in medical education. Medical knowledge is expanding exponentially and is correctly called out as a 'tsunami'[6]. The Medical Board as regulator must demonstrate to the community that doctors participate in CPD. That's important for public trust as well as patient care. ASA education events are aimed at satisfying CPD requirements as well as actually being worthwhile and not just a tick-box exercise. That goes for domains of knowledge and skills as well as practice evaluation.

I am looking forward to reading the insights of the contributors to this issue on many facets of education!

Dr Vida Viliunas OAM

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DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

FROM THE ASA CEO

PUBLIC EDUCATION AND ETHICAL LEADERSHIP: THE ASA'S JOURNEY AND FUTURE STRATEGY

The ASA has long placed education of the public at the heart of its mission, recognising that an informed public is essential to patient safety and trust in the profession. For over 90 years, the ASA has steadily expanded its public-facing educational efforts. We have developed patient information resources to engaging in national health debates, all with the goal of being the primary, trusted source of ethical advice on anaesthesia and perioperative care.

Today, as healthcare information proliferates and misinformation able to spread rapidly, our role as an ethical communicator and leader in public health education is more vital than ever. This article reviews how the ASA has approached public education to date, mainly focusing on initiatives for the public, and how we continue to strengthen public trust and our reputation as a dependable authority on ethical medical advice.

Public education has been an integral part of the ASA's mandate since inception. Our constitutional objects embrace best practices, education, research and conduct, showing that early recognition on advancing knowledge benefits not only practitioners but the broader public. ASA's status as a charity means a core purpose is public education and our strategic plan includes a pillar on advocating for patient and community access, equity, and patient education.

In practice, much of the ASA's historical public education has occurred indirectly through your expertise as well as through published materials designed for patient understanding. The ASA regularly produces updates on plain-language patient information resources like the "Anaesthesia and You" pamphlet, which is widely distributed to patients facing surgery. This information reassures patients that Australia is one of the safest places in the world to have an anaesthetic, and it explains the role of the anaesthetist. Such resources help demystify anaesthesia, outline what to expect before and after surgery, and emphasise the expertise of specialist anaesthetists.

Another long-standing channel for public education is the ASA's website, which serves as an accessible portal of knowledge. It has a dedicated section for patients, providing reviewed and relevant information about anaesthesia and the work of anaesthetists. By positioning the ASA as a primary source of information about anaesthetic care and the role of anaesthetists, the ASA ensures that patients and the public have a reliable place to turn to for answers.

Today, as healthcare information proliferates and misinformation able to spread rapidly, our role as an ethical communicator and leader in public health education is more vital than ever. This article reviews how the ASA has approached public education to date, mainly focusing on initiatives for the public, and how we continue to strengthen public trust and our reputation as a dependable authority on ethical medical advice.

In recent years, we have used digital channels and social media to broaden our reach, sharing educational content on platforms like LinkedIn, Facebook, Instagram, and TikTok. This helps us engage the public and highlight the human side of anaesthetists. These efforts have contributed to a steady growth in our online audience, indicating a widening impact of our communications.

Crucially, the ASA's public education work has often extended beyond explaining medical facts – it encompasses clear communication about ethical practices, patient rights, and the healthcare system at large. For example, we have been active in addressing public concerns about medical costs and informed financial consent. Earlier this year, we conducted an independent survey on specialist fees and patient out-of-pocket costs, in response to confusion and misunderstanding about medical billing. The resulting report provided evidence-based insights on how anaesthetists determine fees, engage in insurer gap arrangements, and manage informed financial consent with patients. By presenting the facts as they are and advocating for greater fee transparency, the ASA helps educate the public and policymakers on healthcare costs. This reinforces that anaesthetists are committed to ethical practice and patients' informed choice. This kind of advocacy and public explanation of complex issues exemplifies our approach to ethical leadership, using research and data to clarify national health debates in the interest of the public.

The ASA also works with traditional media and public forums to spread our educational messages. We use press releases and media statements to provide expert commentary on topics ranging from anaesthesia safety to healthcare policy reforms. We recognise that your role is often behind the scenes, and that to build public trust, the ASA must actively highlight your value and address misconceptions. We have taken opportunities to reach out to the public and inform them about the profession's role in patient care. These efforts help to incrementally raise the ASA's profile, and to highlight your focus on patient outcomes and high-quality medical practice.

To improve our impact, we have focused our communications strategy on addressing public needs and affirming our status as a trusted authority. The ASA Communication Strategy 2025–2027 was created to align with our strategic vision and member insights. This framework prioritises raising public awareness of the ASA's work and ensuring that our messages are accessible, relevant, and credible to non-medical audiences. Key elements of the communications strategy include:

- Our core narrative focuses on patient centricity to guide our messaging. By emphasising your expertise and the trustworthiness of the ASA's information, we consistently communicate our commitment to ethical, patient-centred care.
- The communications framework identifies distinct audience groups and defines specific messaging goals for each. For the public, our messaging is designed to foster trust by showing that the ASA upholds high standards and that anaesthetists are compassionate, highly trained specialist medical practitioners who put patient safety and patient care first.
- We use a multi-platform approach to underpin our public education efforts. The ASA has expanded beyond traditional print and email newsletters to engage audiences on social media, recognising these as important channels for reaching the public and younger demographics.
- We use consistent branding and clear visuals to make ASA's educational content recognisable across platforms.
- We work in partnership with other organisations, understanding that broad alliances can amplify public education. Such collaboration also helps position the ASA as a key player in national healthcare discussions – an image that bolsters public confidence.

This structured framework is now yielding results. Our public engagement metrics have improved, with more people visiting ASA's online resources and interacting with our educational content. By speaking with one clear voice that reflects our values, we are reinforcing our identity as the leader in anaesthesia-related advice, trusted by both the public and professionals.

Being a trusted leader of ethical advice means not only delivering factual information, but also by exemplifying integrity, transparency, and accountability in all communications. The ASA has embraced this through:

- **Combating misinformation:** The ASA stands for evidence-based information in an era of misinformation and confusion. As a founding member of the Australian Ethical Health Alliance (AEHA), a coalition dedicated to upholding ethics and truth in healthcare communication, we collaborate with others to broader health literacy and anti-misinformation efforts, signaling to the public that the Society is committed to honest and science-backed advice.
- **Transparency and patient advocacy:** The ASA advocates for transparency in areas that directly affect public trust. An example is our work on informed financial consent and medical fee transparency. We acknowledge that surprise medical costs can erode public trust in healthcare, so in response we research billing practices and engage with government initiatives like the Medical Costs Finder. This demonstrates a commitment to clarity about fees and the principle that patients deserve to fully understand costs and options in their care.
- **Expert voices in public debate:** The ASA leverages the expertise of its members to contribute to public discussions on health policy and safety. We speak out on issues like workforce shortages, standards, pain management and perioperative care improvements presenting balanced, patient-focused perspectives. This visibility in policymaking circles not only leads to better health outcomes (through improved policies) but also signals to the public that the ASA is taking responsibility for ethical leadership.

The cumulative effect of these efforts is that the Society is wseen as the primary 'go to' organisation for public benefit about anaesthesia, providing a highly valued source of ethical, accurate content through best-practice channels.

Looking ahead, we will continue to build on our foundation in public education through:

- Broadening public outreach through digital innovation.
- Running public-facing campaigns.
- Strengthening alliances for greater impact.
- Continuing to demonstrate transparency and accountability.
- Emphasising ethical identity in our actions and branding.

In summary, the ASA's past and current public education initiatives have laid a strong foundation for public trust in anaesthesia and perioperative care. The Society has increasingly taken up the mantle of ethical leadership, confronting misinformation, demanding transparency, and collaborating widely to ensure that patients hear a consistent message: they are in safe hands with an ASA anaesthetist.

By continuing to evolve our strategy through embracing innovative communication, forging partnerships, measuring impact, and championing ethics, we can solidify our reputation as the trusted leader in advice on anaesthesia and patient safety for all Australians. With a clear vision and dedication to the public good, the ASA is poised to not only inform but also affirm trust in the critical care that anaesthetists provide every day.

Dr Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

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

Get involved in your ASA ...

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

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

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FEATURE ARTICLE

USING GENERATIVE ARTIFICIAL INTELLIGENCE FOR ANAESTHESIA EDUCATION

What is generative artificial intelligence?

Artificial intelligence is highly topical, emerging as a major disruptor in workplaces, promising to improve healthcare delivery, as well as creating fake images and news. In this article, we will focus on generative artificial intelligence (GenAI) and describe its architecture and limitations, before exploring novel uses of GenAI in anaesthesia education.

Generative Artificial Intelligence creates new human-like text, images, videos and content by learning statistical patterns from extremely large datasets. This is achieved using a generative pre-trained transformer neural architecture that analyse relationships within the training dataset, such as semantic and contextual meanings between words[1]. The recent breakthrough in the previous decade that has powered GenAI to its current prominence is self-attention, a mechanism that allows parallelised data processing, and an improved ability to understand semantics and context[1]. Furthermore, this process follows a power-law relationship that enables GenAI to enormously scale to trillions of parameters and terabyte-sized training datasets; leading to the term 'large language models' (LLM) to describe GenAI applications from vendors such as OpenAI (ChatGPT), Anthropic (Claude), and Google (Gemini)[2]. At sufficient scale, LLMs can exhibit previously unexpected capabilities including in-context learning, where the model can learn new skills through examples provided in a prompt[3].

GenAI training

Large language models are fundamentally probabilistic systems – they produce outputs by predicting the next most likely token based on the preceding words[1]. During pre-training, they are trained to produce responses on a large training dataset in a self-supervised manner, enabling the model to synthesise large volumes of text and form contextual relationships between words rapidly[4]. Pre-trained models are thus highly versatile and generalise well to new, unseen tasks, including few-shot and zero-shot learning[4]. However, pre-training can lead to model hallucinations – the generation of information that is contextually implausible and factually inaccurate[5]. Hallucinations are considered an intrinsic limitation of LLMs and are difficult to eliminate[6]. Large language models rely on statistical pattern matching over true reasoning, rewarding the generation of any answer even without ground truth or supporting context. This risk is exacerbated by poor quality training datasets and poor reinforcement learning[6]. The fine-tuning stage can help mitigate hallucination risks.

General-purpose LLMs are usually fine-tuned via instruction-tuning, where the model learns to perform various tasks in a supervised manner. This allows the model to generalise to unseen tasks without additional training and improve zero-shot performance[4]. These models can be further fine-tuned via reinforcement learning from human feedback (Figure 1), whereby human annotators rank model output quality[7]. This feedback is used for the development of a reward model that ranks the output to train the model to generate responses that better align with human preferences.

GenAI limitations

Figure 2 describes some practical limitations to LLM deployment in clinical settings. Model hallucinations and concerns surrounding privacy and bias will be further discussed below as these factors have the most significant clinical implications.

Trusting hallucinated responses can lead to misdiagnosis, inappropriate treatment and incorrect medical management. For example, LLM outputs often seem fluent and confident, leading patients to trust hallucinated information over accurate clinician-delivered advice[8]. Clinicians can also become over-reliant on LLM for model-generated recommendations which can also directly compromise patient safety[9]. Furthermore, LLMs inherit or even amplify harmful societal biases and stereotypes in the training dataset[10]. The lack of diverse datasets used for LLMs in current studies risks underrepresenting vulnerable or marginalised groups and perpetuating existing inequalities[11]. Anonymising patient data used for training will help mitigate privacy concerns, whereas the use of diverse training datasets is crucial to reducing bias[12].

One approach to reducing hallucination risk is the adoption of a retrieval augmented generation (RAG) vector database. Retrieval augmented generation supplements the LLM's parametric memory with non-parametric memory in the form of an external database for information retrieval[13]. Documents in the RAG database are first parsed to extract raw data which is converted to clean text, then chunked into digestible components. Chunks are then encoded into vector representations using an embedding model that captures the semantic meaning of each piece of text and stored in a vector database (Figure 1). At query time, the user's input is encoded by the same embedding model and compared against the vector database, facilitating the retrieval of contextually relevant information that grounds the LLM's output[14]. This reduces the LLM's reliance on its parametric memory and can mitigate some of the hallucination risk.

Additionally, there are regulatory concerns of the security and privacy of confidential patient data shared with cloud-based GenAI. Commercial LLMs increase the exposure risk of private medical information stored on external cloud servers with unverified and potentially unenforceable data protection policies[15]. Sensitive patient information may therefore be disclosed to unintended audiences. Compliance with local data protection laws is important, and where feasible, storing sensitive patient information on-premise (behind local hospital firewalls) or in a sovereign data centre (located within national borders) may mitigate cross-jurisdictional differences in data protection regulations.

Using GenAI for anaesthesia education

Once these limitations are understood, GenAI can be utilised in novel ways to enhance anaesthesia education. As examples, a regional anaesthetist wants to critically analyse the literature on the evidence for blocks in shoulder surgery to minimise the risk of hemidiaphragm paresis; while an anaesthetic trainee wants to create a study aid for postgraduate examinations. Both have done a literature search and downloaded over 30 randomised controlled trials, meta-analyses, and textbook chapters into a peer-reviewed curated collection.

Example 1: Literature review

Traditional literature reviews can be laborious, requiring our regional anaesthetist to read through all documents and manually synthesise information. This process is accelerated, and related but dispersed information across multiple documents easily merged, by instructing GenAI to provide answers from within our curated collection.

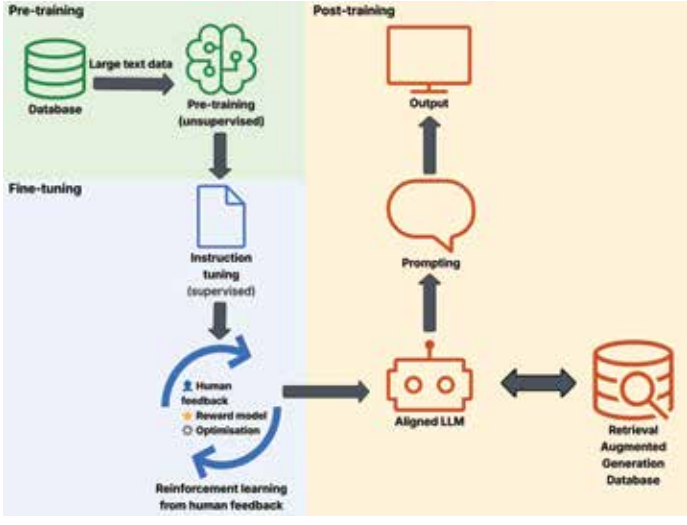

Figure 1. Flowchart of the training pathway of language models. This consists of both the pre-training and post-training stages before prompts are provided by the user to generate responses.

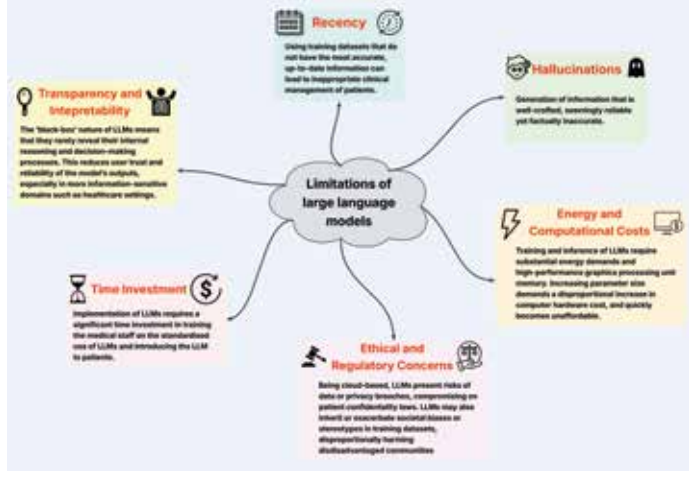

Figure 2. Mind map describing the limitations of large language models.

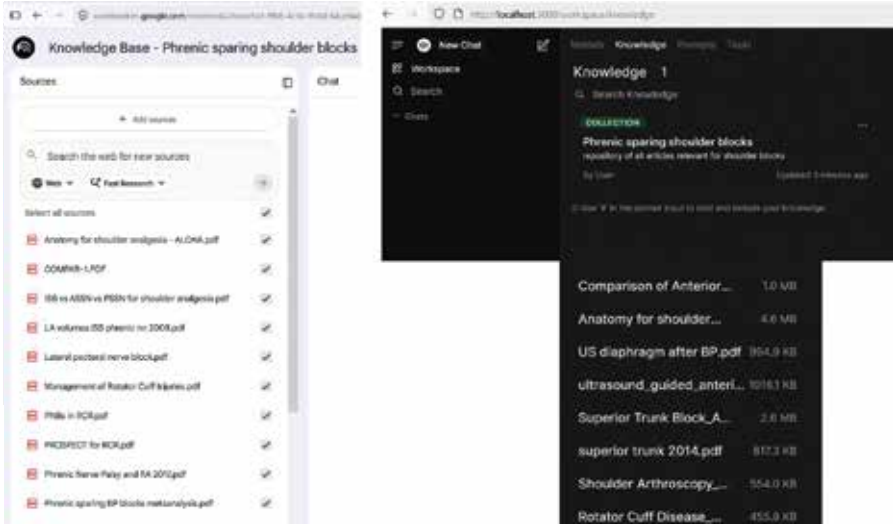

Figure 3. Montage of screencaps of the NotebookLM (left) and OpenwebUI (right) user interfaces. In both applications, a curated collection of relevant documents has been uploaded and converted into a RAG knowledge base.

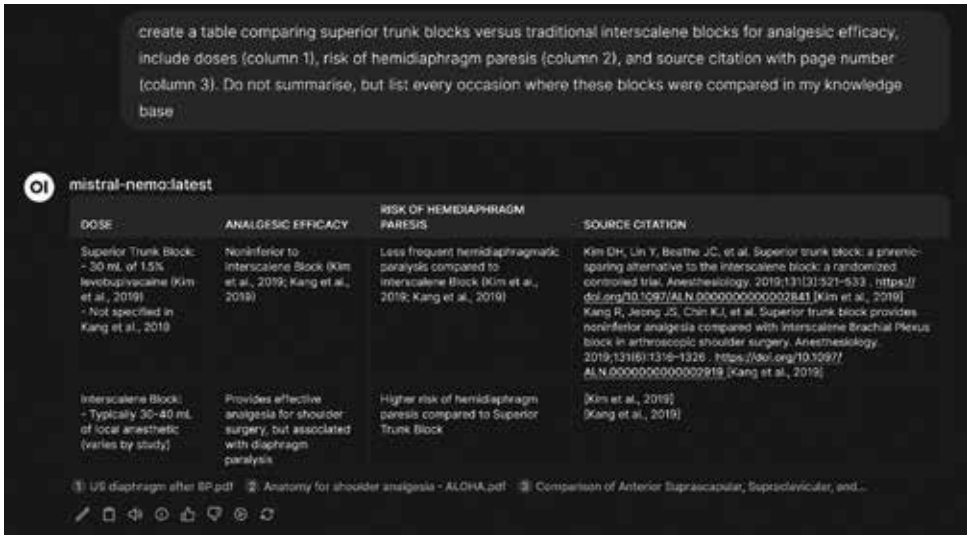

Figure 4. Screencap of an example query of the knowledge base during a literature review, using the OpenwebUI application. Note the specific question phrasing to structure the answer. This allows human-in-the-loop cross-referencing to confirm factuality.

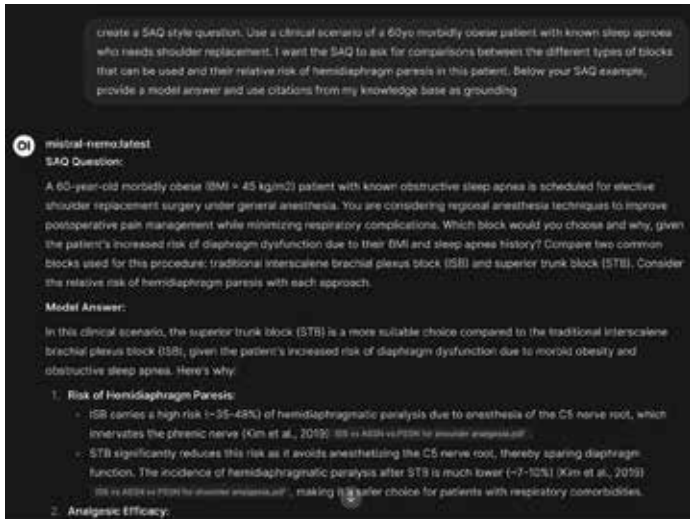

Figure 5. Screencap of a query to the knowledge base acting as a study aid, asking OpenwebUI to create a short answer question and provide a model answer with cross-references.

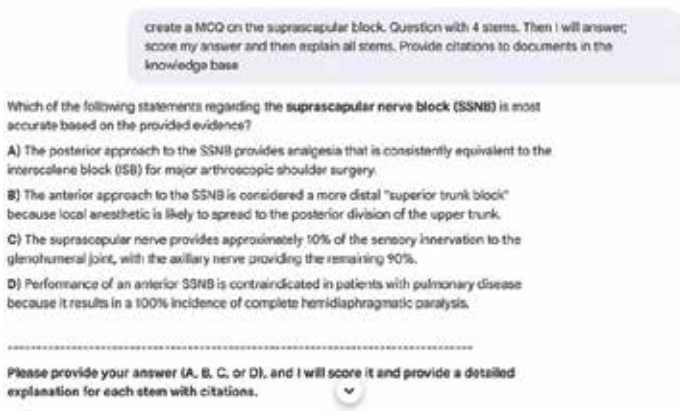

Figure 6. Screencap of using NotebookLM to create multiple choice questions to test knowledge, score the trainee's response and then provide citation-backed rationale for each stem.

It is tempting to simply use the document upload function offered in the GenAI chatbox. However, most GenAI applications have a limit (often less than five) on document uploads; moreover, these documents are treated as simple context injections rather than having proper parsing and embedding. Chatbox document uploads can saturate the context window, ironically resulting in an increased risk of hallucinations rather than more accurate answers. This is particularly true in scientific fields such as anaesthesia, as our documents tend to be technically dense, table- and image-intensive.

We must therefore use a commercial option (NotebookLM, Google, Mountain View) or open-source alternative (OpenwebUI, OpenwebUI Inc, San Francisco) that permits upload of larger number of documents, and are designed for RAG-based workflows. NotebookLM is powered by Google's GenAI commercial model Gemini, while OpenwebUI is powered by a GenAI local model chosen by the user – in the illustration used in this article, the open-source Mistral-Nemo-12B (Mistral AI, Paris). Another difference is that NotebookLM is cloud-based, with the previously discussed ethical and regulatory risks if your documents contain privileged information, versus OpenwebUI which is run on your own hardware and is private. Finally, the free version of NotebookLM does cap the number of documents it will process, while the paid subscription version unlocks larger upload limits. By comparison, OpenwebUI has unlimited upload.

In either application, the curated collection is uploaded into the source window, and this is converted into a RAG knowledge base (Figure 3). Subsequently this knowledge base can be interrogated with queries that return rapid, precise, synthesised answers that substantially reduces the friction of literature review (Figure 4). The authors have found that GenAI is very adept at finding relationships and retrieving relevant information within large databases, such as all files contained in our Endnote/Zotero reference manager.

Example 2. Study aid

In this second example, the same knowledge base can be used by a trainee wishing to supercharge their exam preparation. There are numerous and valid possibilities that GenAI can assist with: ask GenAI to create a structured study guide for a new topic, ask to explain concepts in more detail, and to produce multiple choice questions, viva questions, and short answer questions based on the knowledge base (Figure 5). In all instances, we recommend that all answers are cross-referenced to the source documents as this allows spiral reading to improve learning of that topic and related topics.

Alternatively, to test recall of learnt material, the trainee could upload their finalised study notes and ask GenAI to create a bank of multiple choice questions and short answer questions that can be attempted under exam conditions, or to produce study note cards. These can be accompanied by model answers (Figure 6).

Conclusion

GenAI can be a powerful tool for anaesthesia education. Using it effectively requires a knowledge of the neural architecture of current GenAI applications, and an understanding of its limitations as well as its strengths. We believe that hallucinations and privacy risks are two major limitations, which can be mitigated respectively by a RAG vector database and on-premise system to reduce leakage of private data to the cloud. Careful structuring of queries and forcing the use of only uploaded documents combines the twin strengths of the tuned GenAI model supplemented by a RAG. Finally, we recommend that all answers provided by a GenAI model are cross-referenced to citations, so that factuality can be confirmed.

- **Professor Alwin Chuan**

  Science Prizes, Awards and Research Committee Immediate Past Chair

- **Mr Eric Ho**

  UNSW Medical Student BSc (Med) Hons Candidate

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FEATURE ARTICLE

THE POWER OF THE TEAM: REDEFINING SURGICAL TRAINING FOR SAFER CARE

NABEELAH MCKECHNIE
TRAINING COORDINATOR, LIFEBOX

In the operating room, patient safety rarely depends on one person alone. It depends on how well a team communicates, anticipates risk, and acts together when every second counts.

A drop in oxygen saturation.

An unexpected bleed.

A sudden change in a patient's condition.

In these moments, technical skill matters. But skill alone is not enough. Outcomes are often determined by teamwork: clear communication, shared situational awareness, and the ability of every member of the perioperative team to respond in sync. At its core, this is what patient safety demands, collective reliability not isolated excellence.

Increasingly, global surgery education is reflecting this reality. At Lifebox, the global safe surgery and anaesthesia non-profit organisation, this principle is central to our work. Multidisciplinary teamwork is not an adjunct to training; it is the foundation of how we support surgical and anaesthesia programs in low-resource settings to improve patient safety.

For generations, surgical training has focused largely on the individual; the precision of the surgeon, the expertise of the anaesthetist, the mastery of the technique. But modern perioperative care tells a different story. Preventable harm in surgery is often linked not only to gaps in clinical knowledge, but to breakdowns in communication, unclear roles and fragmented systems. As Atul Gawande, co-founder of Lifebox and author of *The Checklist Manifesto*, observes, "Success in medicine requires not just individual excellence but systems that support teamwork and communication."

It was this insight that underpinned the development and global spread of the WHO Surgical Safety Checklist; a simple yet transformative intervention that sits at the heart of Lifebox's origin and mission. More than a checklist, it introduced a structured pause in care: a moment for the entire perioperative team to come together, communicate, anticipate risk and align before proceeding. In doing so, it established a shared language for safety, clarified roles and created space for every voice to be heard. Surgical safety was no longer viewed as an individual responsibility, but as a collective practice.

Building on this foundation, surgical education has undergone a broader paradigm shift: training the team, not just the individual. Because safe surgery is not delivered by individuals working in parallel; it is delivered by teams working together. Training programs developed by Lifebox in collaboration with key partners – including the World Federation of the Societies of Anaesthesiologists, the Association of Anaesthetists, the Royal College of Surgeons and Smile Train among many others are grounded in this principle of multidisciplinary teamwork. Surgeons, anaesthetists, nurses, and perioperative staff learn together in shared environments that reflect the realities of the operating room. This is not incidental; it is intentional. Because when teams train together, they develop a shared language for safety, build mutual respect across roles and hierarchies, and learn to listen to every voice in the room. This matters especially in settings where hierarchy can silence the voices that first recognises when something is wrong.

Lifebox's training programs actively work to create space for every team member to speak up for patient safety. As Belinda Karimi Mbaadu, Registered Nurse and

For generations, surgical training has focused largely on the individual; the precision of the surgeon, the expertise of the anaesthetist, the mastery of the technique. But modern perioperative care tells a different story. Preventable harm in surgery is often linked not only to gaps in clinical knowledge, but to breakdowns in communication, unclear roles and fragmented systems.

Lifebox Training Facilitator, notes, "the training helps to flatten hierarchy and create an environment where every voice is heard, valued and expected to contribute to patient safety". Programs such as the Nursing Leadership for Surgical Excellence , SAFE OR and Team Cleft place a strong emphasis on nursing empowerment; recognising nurses as central to perioperative safety, not peripheral to it. Because a safe operating room is one where any team member can raise a concern and be heard.

In one training simulation described by Dr Naima Yusuf Zakaria, Medical Director of Tanga Regional Referral Hospital, Tanzania, the lead nurse initially hesitated to escalate concerns because of hierarchy, contributing to delayed intervention. When the scenario was repeated with an emphasis on open communication, the same nurse spoke up decisively, prompting earlier action and a better outcome. The contrast showed how these workshops can break down barriers and empower nurses to act with confidence in life-saving moments.

What further distinguishes the Lifebox approach is that it goes beyond knowledge transfer. We seek to work with teams to shift behaviours and strengthen the culture of safety that underpins good care every day. At its heart are the practical human-factor skills that help teams function effectively under pressure: structured communication, crisis resource management, role clarity, mutual accountability, and systems thinking across the perioperative pathway. These are not abstract ideas. They are repeatable behaviours that teams can apply immediately in their daily work.

Their impact becomes most evident in complex clinical situations, where these skills directly influence patient outcomes. As described by Dr Jyoti K C Khatri, Anaesthesiologist at Tribhuvan University Teaching Hospital, Nepal, in the management of a high-risk elderly patient undergoing emergency laparotomy, a brief multidisciplinary discussion prior to surgery enabled early risk identification, alignment on the operative plan and proactive coordination with critical care. This shared planning and communication were central to stabilising the patient and supporting recovery; illustrating how structured teamwork translates into safer clinical outcomes.

Participants in Lifebox training programmes consistently highlight the value of learning together as a full team. Practising together strengthens accountability, improves communication, and creates a more sustainable path for change. One participant reflected that training as a complete team ensures that "we hold one another accountable to

What further distinguishes the Lifebox approach is that it goes beyond knowledge transfer. We seek to work with teams to shift behaviours and strengthen the culture of safety that underpins good care every day.

implement the skills and tools learned," capturing the shift from individual learning to collective responsibility.

The strength of team-based training lies in its immediate relevance to real-world care. Training scenarios are grounded in the realities teams face every day, particularly in low-resource settings where the margin for error is narrow and teamwork may be the most powerful tool available. Through simulation and guided reflection, teams build not only competence but trust. That trust translates into practice: faster responses to complications, stronger communication across disciplines and safer care for patients. As Dr Alok Sagtani, Oral and Maxillofacial Surgeon at Vayodha Hospital, Nepal, reflects, "I no longer proceed with surgery when anaesthetic concerns are raised. This has contributed to fewer intra-operative events."

Team-based training is also most effective when it does not stand alone. Within Lifebox's model, training is embedded within broader quality improvement efforts at both facility and system level. Training is linked with safer workflows, quality improvement initiatives and support for teams to identify and address system gaps in their own settings. The result is not only better-trained individuals, but stronger and more resilient systems of care. Because systems do not function on paper; they function through people.

The rise of interdisciplinary training reflects a shift in how excellence is defined in global surgery. It is no longer measured solely by individual skill, but by how well teams communicate, manage crises and deliver safe care together. That is especially true in low-resource settings, where advanced equipment may be limited and patient safety depends heavily on how well the team functions. As Dr Zakaria observes, in such environments, teamwork is not an added advantage; it is essential for patient safety.

Every Voice, Every Role, Every Patient

At its core, team-based training is about recognition; recognising that every member of the perioperative team plays a vital role in patient safety.

The Nurse who notices a subtle change.

The Anaesthetist who anticipates a complication.

The Surgeon who pauses to ensure alignment before proceeding.

These moments collectively define outcomes.

That is why Lifebox training programmes are more than teaching skills. It is about helping build safer systems of care that last. Every team trained creates a ripple effect: knowledge is shared, behaviours change, and safer practices spread within operating rooms and across hospitals. Yet many surgical teams still lack access to this kind of interdisciplinary training. Greater support can help expand these programmes, equip more local facilitators and ensure that more patients benefit from teams trained to work together when it matters most.

The ASA is a proud supporter of Lifebox. To make a tax-deductible donation and support the work of Lifebox in the Asia-Pacific region, please visit: https://www.anzca.edu.au/safety-and-advocacy/globalhealth/lifebox-australia-and-newzealand

Nabeelah McKechnie

Training Coordinator, Lifebox


Australian Society of
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Concept by Dr Nathan Chin

DR SEBASTIAN KARALUS
ANAESTHETIST
CAIRNS HOSPITAL
RWAC GRADUATE

FEATURE ARTICLE

REAL WORLD ANAESTHESIA COURSE

Group photo on boat Aft Deck.

The uncharted

Feeling stagnant, unchallenged, and unfulfilled in the operating theatre?

Seeking new purpose in your professional life but aren't sure what to do?

The 'real world' might just be the challenge you didn't know you were looking for.

Global burden of surgical disease

The inequities in global health care are not new and no secret. The lack of access to safe surgery has come into the spotlight over the last 30 to 40 years and new initiatives are having a major effect on reducing this surgical disease burden. Past initiatives were focussed on prevention of infectious diseases and took a single disease approach, but it is now understood that around ten to 15 per cent of the global disease burden is treatable with surgery.[1] The Lancet Commission on Global Surgery 2030 published in 2015 sets out the evidence and solutions to promote development in this area.[1] Economic analysis from this commission found that there would be an incredible return on investment with improved surgical services which has helped dispel the myth that surgical care is a costly luxury of high-income countries.

The provision of surgical services involves a complex system of human and financial resources, infrastructure and utilities, logistics, support services, supplies and equipment including, dare I say it, supply chains, systems, and governance. Improving a health-systems surgical service takes political commitment, ministerial ownership, strategic resource and finance distribution, workforce sustainability, and data and performance analysis. Acknowledging this, work in this space has seen a shift from the old model of isolated 'medical missions' to a newer sustainable 'partnership model'. It is obvious to us that safe surgery requires safe anaesthesia, but this is not understood universally. We only need to take a short flight to one of our beautiful neighbouring Pacific Islands to see the understaffed conditions our anaesthetic colleagues are working in over there. This is the real-world anaesthesia we are talking about.

A founder's story

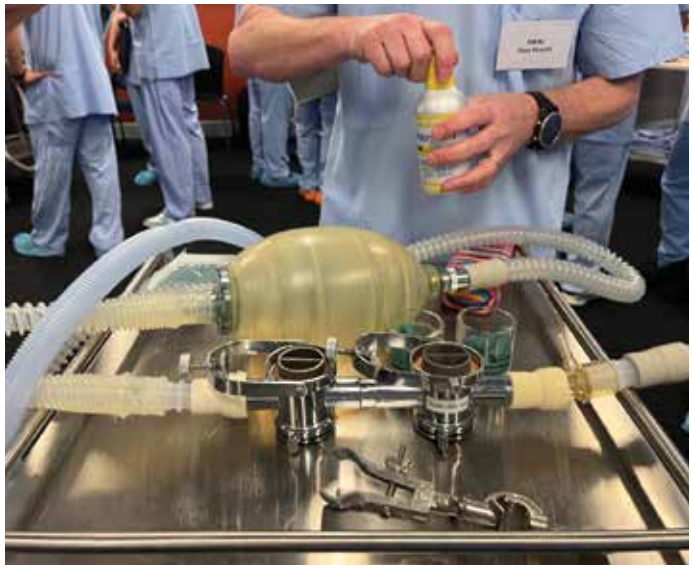
The 31st Real World Anaesthesia Course was hosted for the first time at the Gold Coast University Hospital (GCUH) in October 2025. As a participant, I can confirm that this is the best post-fellowship education I have been involved in and this sentiment is echoed by many before me.

The course was founded in the late 1990s by Dr Haydn Perndt and Dr George Merridew as the *Remote Situations, Difficult Circumstances, Developing Country Anaesthesia* course and was successfully directed by them for many years. Building on that extensive history and refinement, the current iteration has been enriched by the contributions of a wide and ever-changing group of experts who have added new content and experience to match the ongoing progress of global anaesthesia. It also continues to address anaesthetic practices across vast landmasses, particularly in low- and mid-resource settings, and highlight the global reality that the overwhelming demand for surgery is tragically left unmet.

Having experienced these real-world situations firsthand, Dr Perndt and Dr Merridew, identified a crucial need to share the lessons of their experiences among like-minded anaesthetists. This was essential to prepare others for the unique challenges of working abroad in these settings and in various humanitarian aid and military situations. While anaesthetic practice in comfortable, well-equipped theatres of the late 1990s was like today, featuring piped gases and plenum vaporisers, this was starkly different in less developed locations. Dr Perndt, reflecting on the early days of the course's establishment, stated, "Our goal was simple, to enthuse and empower

The caretakers: Dr Phil Blum (Darwin), Associate Professor Dr Wayne Morriss (Christchurch), and Dr Chris Bowden (Gold Coast).

Dr Eunice Onisimo based at Lautoka Hospital, shares her experience training, working and managing her department as an Anaesthetist in Fiji.



Dr David Pescod, Melbourne, prepares his anaesthetic circuit for theatre

Steve Threlfo, Newcastle, testing our troubleshooting abilities on various anaesthetic machines.

anaesthetists to step out of their comfort zones and challenge themselves. We wanted the participants to be able to replicate the successes while avoiding the challenges we first navigated". And this vision still flows through the faculty and is shown by their strong desire for their peers to benefit from their valuable experiences. Having Dr Perndt, now retired, attend the course inspired the faculty and participants with his real-world wisdom. During the breaks in between sessions, we were able to gain insights into his years of experience which went far beyond the technical material of the course.

Last year marked a new chapter for the course, meticulously organised to the minute by Dr Chris Bowden at the GCUH. As one of the caretakers of the course, Dr Bowden had previously run the event in Melbourne at Frankston Hospital, so he was well up for the challenge. The course usually rotates between Darwin, Christchurch, and the Gold Coast, and will return to Melbourne this year at the Northern Hospital.

Rediscovering our roots

The Real-World Anaesthesia Course (RWAC) is rare for two distinct reasons. Firstly, it defies logic and delivers low-tech anaesthesia in a state-of-the-art tertiary referral centre. Secondly, it maintains a high level of participant engagement over five intensive days made possible by a refined and evolving format adapted over decades. So, say goodbye to your high-end integrated care-station anaesthetic systems and embrace a world where you can deliver anaesthesia without electricity or pressurised gases.

The curriculum is delivered with an interactive approach:

- Diverse formats: The course features engaging interactive lectures, small group case-based discussions, and hands-on practical equipment sessions.
- Practical skills: You will gain experience in the in-theatre delivery of draw-over anaesthesia for patients presenting for surgery using a variety of equipment you may encounter in resource-limited settings.
- Real-world scenarios: Low-fidelity simulation scenarios and reflections from a wide variety of global experiences shared by seasoned professionals provide invaluable context.

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Real world simulation training - adapting to unfamiliar environments.

Dr Eunice Onisimo reunites with Dr Nina Loughman, Hobart, a past Sereima Bale Pacific Fellow.

Another major feature of the course that keeps you captivated is the excellent instructor-to-participant ratio. Dr Bowden reinforced the importance of this ratio to "foster a strong networking opportunity and allow for personal connections with like-minded peers". And on this course, the instructors aren't just teachers, they are all highly qualified practitioners with genuine, extensive experience in the field of global anaesthesia. Despite this, their humble nature cultivated a supportive, genuinely welcoming, and nurturing atmosphere that carried through to the exceptional social program. They represented a broad spectrum of industries and backgrounds including biomedical technicians and an engineer who is the founder and managing director of Diamedica (UK) Ltd who make anaesthetic machines for these environments that we were able to practice with. There were practicing anaesthetists from Africa, Nepal, Fiji, Australia and New Zealand. The faculty also included powerhouses like the immediate past president of the World Federation of Societies of Anaesthesiologists, Associate Professor Wayne Morris, Dr Phil Blum, and Dr Meg Walmsley who is heavily involved and active in the ASA's Overseas Development and Education Committee partnerships across the Pacific.

Making sense of it

As we have heard, safe anaesthetic and surgical care is not a guarantee across the planet. During a working trip to a low- or middle-income country, this reality can be confronting. Having delivered anaesthetics in Samoa myself, I can tell you firsthand that this course will prepare you well. It teaches you how to manage your expectations, approach complex clinical dilemmas, ethical challenges and injustices, and the moral distress caused by the inability to always provide the 'gold standard' of care we are used to. It explores strategies to navigate your work relationships and understand the local culture and your place as a visiting 'expert'. The course ensures you are mentally and emotionally prepared for this vital work. My own experience confirms the course's value; most importantly for me it helped me to rationalise and explain situations I had previously encountered abroad which I am grateful for.

Global health needs you

The RWAC course will open your mind to the real possibility to make an impact to global health. Whether you have experienced the real world, are planning to, or are simply unsure if this work is right for you, RWAC will give you the confidence you need to take that initial leap of faith and link you with a support network of pioneers in the field. This course is always oversubscribed so make sure you keep a close eye on the course announcements on the ASA website.

Dr Sebastian Karalus

Anaesthetist, Cairns Hospital
RWAC graduate

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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




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

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Australian Society of Anaesthetists®

DR MEGAN WALMSLEY
ODEC COMMITTEE
VICE CHAIR

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

EDUCATION IN TIMOR-LESTE: BUILDING BRIDGES THROUGH THE ASA TIMOR-LESTE FELLOWSHIP

DR ALISON JARMAN
ASA TIMOR LESTE
FELLOW

DR ALISON JARMAN IS A CONSULTANT ANAESTHETIST BASED AT THE AUSTIN HOSPITAL IN MELBOURNE. SHE HAS INTERESTS IN MEDICAL EDUCATION, COMMUNICATION AND GLOBAL HEALTH, WITH PREVIOUS EXPERIENCE IN NAMIBIA AND ZAMBIA. IN 2025, ALISON COMPLETED THE ASA TIMOR-LESTE FELLOWSHIP AND SPENT THREE MONTHS AT HOSPITAL NACIONAL GUIDO VALADARES IN DILI, TIMOR-LESTE. BEFORE STUDYING MEDICINE, ALISON WAS INVOLVED IN THE CAMPAIGN FOR AN INDEPENDENT TIMOR-LESTE.

Timor-Leste has a population of 1.3 million people and currently has six consultant anaesthetists, all of whom are based in Dili, the capital city. The local consultant anaesthesia workforce is supplemented by Cuban and Chinese anaesthetists as well as by locally-trained nurse anaesthetists. The workforce density is less than 1 anaesthetist per 100,000, which falls short of the World Federation of Societies of Anaesthesiologists recommended five per 100,000, and is far short of Australia's greater than 20 anaesthetists per 100,000. Timor-Leste is one of Australia's closet neighbours, being just over a one-hour flight from Darwin.

The ASA Timor-Leste Fellowship was re-established in 2025 and aims to provide clinical and educational support for Timorese anaesthesia registrars for a total of three months each year.

"It is cold in Theatre 4. The aircon units are finally working and pumping out air chilled to a malae (foreigner) level of comfort. Theatre 4 is also spacious and mostly empty. Unfortunately, theatre lights weren't installed when it was built a few years ago, so it makes for a poor operating theatre but an excellent tutorial room.

As an ASA Fellow undertaking the three-month fellowship at the Hospital Nacional Guido Valadares (HNGV) in Dili, Timor-Leste in 2025, I got used to teaching in different spaces. We sometimes squeezed into the Head of Department's office and once squeezed even further into the anaesthesia storeroom.

In Timor-Leste, it's good to be flexible. It's also good to accept that no Timorese doctor can learn whilst freezing. As the anaesthetic registrars arrive in Theatre 4 and set up plastic chairs in a polite semicircle around the projector, I find the remote for the aircon and press a few buttons to take off the chill.

Dr Colom da Silva, a senior anaesthetist in Dili and graduate of the MMed anaesthesia program in Fiji, had asked me to re-start regular tutorials for the group of anaesthesia registrars who have had little or no protected teaching time throughout the course of their medical careers. So, we met twice a week, after the start of the Monday afternoon list and during the Friday lunch break.

It is hard to pitch the teaching to a diverse group of learners. Dr Filomena (Mena) was the last graduate of the pre-Covid Timorese Diploma of Anaesthesia, run with support from the Royal Australian

Timor Leste craft basket

Drs Filomena Monica, Dulce Seran Calado, Boaventura Sarmento and Alda Araujo

College of Surgeons and long-term coordinator, Dr Eric Vreede. Also in the room are Drs Boaventura, Abrão, Dulce, Caetano and Alda. Without an in-country training program, they all learn on the job, essentially as unaccredited registrars.

Dr Mena will start anaesthesia training in Fiji in 2026, and she is a little worried about the transition. Previous Timorese candidates have found it challenging to step into a training program as well as working in a role that covers intensive care and a range of higher acuity medicine they haven't had exposure to in Timor-Leste.

One of the key goals of the ASA Fellowship is to help prepare doctors in Dr Mena's position. I aim to be a bridge: to re-familiarise the registrars with formal teaching and regular participation in a training program taught in English. Dr Colom lets me know what topics to cover, when the teaching is landing right, and what the educational expectations are.

Some of the registrars speak English well and some are less confident. Tetum is the main language spoken in Timor-Leste (along with 30 other indigenous languages), but it is not an easy language in which to express complicated medical concepts. Most

Drs Dulce Seran Calado, Filomena Monica and Boaventura Sarmento

Drs Alison Jarman, Boaventura Sarmento, Alda Araujo and Colom da Silva

Sunset at Lecidere, Dili

Mangroves at sunset, Metiaut, Timor Leste

Timorese doctors, depending on where and when they trained, also speak Bahasa Indonesian, Portuguese, or Spanish. The Cuban government has supported the development of medical care and education in Timor since 2004 under a 'solidarity aid' program. Cuban anaesthetists are still seconded to HNGV and the peripheral hospitals, and early Timorese graduates of nurse anaesthetist training form the backbone of the workforce, continuing to work with and teach junior anaesthetists.

My own language skills consist of passable French, Duolingo Spanish and basic greetings in Tetum. Because my role at HNGV was not directly clinical and the senior Timorese anaesthetists were mostly fluent in English, this wasn't a major obstacle. I did discover, when assisting one of the Cuban anaesthetists with an unwell emergency patient, that a common understanding of anaesthesia and a willingness to mime are also useful international languages.

I decide early on to translate my teaching slides into Spanish using an AI tool (Claude). The slides are busy, but hopefully it eases the cognitive load of learning and translating at the same time. Google translate has recently included voice to text translation from English to Tetum, but not yet the other way around. It's another option for real-time translation, if the notoriously slow data network coverage allows.

Dr Colom asks me to start teaching with investigations and critical care topics. I create some tutorials blending ECGs and CXRs with clinical cases, then move on to ABGs and sepsis, introducing more questions and participation into the presentations as I go. After a few weeks, I figure the registrars are ready for simulation and I set up in a spare theatre on Friday lunchtime.

Simulation education happens infrequently in Timor-Leste, largely limited to the annual one-week intensive teaching workshops supported by the ASA/ANZCA. So, like most sim participants, the registrars are nervous. Maybe low-fidelity simulation is less intimidating, or my banter helps smooth things over, but the registrars buy in enthusiastically. With an intubation torso draped in a hospital gown and the invaluable SimMon app, they show me teamwork and troubleshooting. They finish the scenarios to applause and probably a little relief.

For me, the ASA Timor-Leste fellowship was an incredible opportunity. I learnt so much about the medical system, the strengths of the doctors and the challenges they navigate every day. I stretched my own skills when a request to teach pharmacology brought me to re-discover long-buried knowledge and to try different educational approaches to make that particular bridge a little easier to cross. And, as I figured out how best to fit into and build upon the existing network of anaesthesia education, I discovered that flexibility was one of my greatest strengths."

The ASA Timor-Leste Fellowship program supports Australian and New Zealand anaesthetists to spend a total of three months in Dili each year. Dr Jarman chose to spend her time in two blocks. The focus is on clinical and educational support of the local anaesthetists. A living allowance of $1000 per week is provided by the ASA. Applicants should be flexible, adaptable and have an interest in education and experience in working in low resource environments.

For further information please contact: megan.walmsley@act.gov.au

- **Dr Alison Jarman**
  ASA Timor Leste Fellow
- **Dr Megan Walmsley**
  ODEC Committee Vice Chair

DR MERREDITH CULLY
TMG COMMITTEE CHAIR

TRAINEE MEMBERS GROUP COMMITTEE

GETTING TO KNOW YOUR COMMITTEE

Artwork by Dr Merredith Cully with the assistance of AI tools.

Getting to know your TMG committee

What is your...? *Level of training, Hospital, Favourite textbook, Dream job if not anaesthesia, TIVA or Gas?, Cuisine of choice if you could only have one for the rest of your life*

Merredith	Daniel
pF (Obstetrics + Regional)	AT2
KEMH + Royal Perth	Royal Hobart
Petkovs	Petkovs
Dinner party business	Vegetable Gardner
Dirty TIVA	Dirty TIVA
Pasta	Lean Cuisine

Rachael	Shubh	Ellie	Mila
pF (General + Upper GI)	IT	pF (Trauma)	pF (Paeds + Head & Neck)
Canberra Hospital	Canberra Hospital	Royal Adelaide	Royal Adelaide
Peck & Hill	Kam & Power	Wests Respiratory	Vanders Renal
Behavioural ecologist	Architect	Own a dog daycare	Lawyer
TIVA	MIVA	TIVA	Both have their place!
Thai	Japanese	Chinese	Japanese

Ash	Praba	Brendan	Ben
pF (Education + Paeds)	AT1	BT2	AT2
RCH	Northern Hospital	John Hunter	Royal North Shore
Peck & Hill	Deranged Physiology	Nunns Respiratory	Hemmings & Egan
Pilot	Cake decorator	Startup founder	Baker
MIVA	Gas	Dirty TIVA	MIVA
Japanese	Thai	Mediterranean	Japanese

Kennia	Siobhan	Lachlan	Clare
AT2	BT2	AT2	AT1
Royal Perth	Royal Perth	Princess Alexandra	RBWH + TPCH
Kam & Power	Kam & Power	Wests Respiratory	The Cynical Anaesthetist
Marine biologist	Travel blogger	Gelato store owner	Wedding Planner
TIVA and gas A/H	TIVA	MIVA	Dirty TIVA
Hot chips	Thai	Thai	Italian

ANZCA Primary Exam

A “How to” Guide from the TMG: Personal Recommendations from the Committee Members

Useful Websites

John West Original Lectures

https://pulmonary.ucsd.edu/research/labs-centers/west/video-lectures.html

“Speed up on 1.5-2x!”

Deranged Physiology

https://derangedphysiology.com/main/home

“More detail than needed but if you ever want more info it will be here”

Electrical Safety Explained Simply

https://www.howequipmentworks.com/electrical_safety/

“Great easy explanation!”

Alfed ICU Youtube

https://www.youtube.com/@alfredicu8359/videos

“ICU and critical care concepts taught and explained well”

Primary LO of the Day

https://primarydailylo.wpcomstaging.com/

“Blog of a previous examiner - one learning outcome focus per day!”

SAQ Bank Resources

MAK 95

"Invaluable and essential computer program that organises all past questions and exam reports, suggests a study plan, includes notes and can generate MCQ papers!"

Ketamine Nightmares

“Aspirational "best answers" if you had ample time! Great study tool but unrealistic to expect to be able to handwrite it all in 10 minutes”

Adrenaline Memories

“Paid subscription but interactive lectures from Stan Tay breaking down how to most efficiently answer questions”

Propofol Dreams

Previous trainees OneNote

"Handy resources if you can find a colleague willing to share!"

Contact the TMG: trainees@asa.org.au

Continue on for more resources

Textbooks: Our Favourites

Physiology

Chambers et al
"Succinct, really great for the essentials"

Pappano & Wier
"The "West's" of Cardiology"

Nunn's Respiratory
"Gold Standard but lengthy, anaesthesia chapter is a must read"

Hemmings & Egan
"Well laid out explanations and graphics"

Kam & Power
"Great graphs and explanations"

Vander's Renal
"Core textbook for those tricky topics"

West's Respiratory
"Consice and high yield, a good place to start or a recap of the essentials prior to sitting"

Pharmacology

Petkov's
"Concise, easy read, small and easy to carry in your scrub top pocket!"

Evers & Maze
"Good for those deep dives"

Peck & Hill
"Clear, concise and nicely laid out"

Equipment

Equipment in Anaesthesia and Critical Care

Physics Clinical Measurement and Equipment of Anaesthetic Practice for the FRCA 2e

How Equipment Works

Anatomy

Ellis & Lawson - Anatomy for Anaesthetists

ANZCA Primary Exam

A “How to” Guide from the TMG: Personal Recommendations from the Committee Members

Study Tools

Mak95

“Must have! Use random question generator when you don't know what to study before the exam.”

Ace your Medical Exams by Patsy Tremane

“Delves into the psychology of how to study effectively; suggested reading early on or prior to starting study.”

Long Course Lecture Series

“Often contains pearls for SAQs when presentations are structured by LOs and SAQs”

AI: Large Language Models Notebook LM.

“Upload the "Highly Recommended" textbooks and train it purely on those. MCQ answers in less than 10 seconds. With reasons for and against. Good to consolidate knowledge and concepts for SAQs.”

Anki

“Start MCQs earlier than you think - helps with SAQ knowledge too!”

Contact the TMG: trainees@asa.org.au

Brainscape Decks

"Train how you play! Useful flashcard resource."

Refresher Course

"Many states run these - great opportunity for a tax deductible trip and to experience another perspective. Great refresher lectures. The SA Course focuses on SAQ practice, scattered with pearls of wisdom!"

ASA Primary Exam Sessions

"Great live and interactive sessions with past examiners, award winners, and passionate educators from across Australia"

The TMG Committee wishes you Good Luck with your Primary Exam!

Top Trainee Podcasts

"A great way to make use of commute time to and from work, or for some passive learning when you need a break from written study"

- Anaesthesia Coffee Break Podcast
- ABCs of Anaesthesia
- Count to 10
- Listen to videos of Adrenaline Memories
- Primary FRCA Physiology / Pharmacology / Physics /
- Primary Cast
- BJA Education
- "ANZCA Part 1 SAQs" - Podcast by WA Trainee

EDUCATION COMMITTEE

TRAINEE EXAM PREPARATION: I WANT TO HELP BUT I DON'T KNOW HOW

DR KAYLEE JORDAN
EDUCATION COMMITTEE CHAIR

Twice yearly, we watch our trainees go through the lead-up to the Primary and Final Examinations. Although the anxiety associated with once going through this process ourselves will always remain sharp in our memories, we may feel that we are losing touch with the relevant content and technique over time. This may lead us to question our ability to help our trainees during their examination preparation, despite both requests for help and a wish to assist them. So how can we better support our trainees through this time?

Giving practice vivas

Giving practice vivas may be daunting. You may worry that your lack of knowledge may be exposed while asking questions that you might not remember the answers to as well as you once did. This tends to have particular relevance to the Primary Examination. Most of us still have some of our own recalled vivas written down. Suggesting that trainees book a time with you for viva practice in a week or so (rather than immediately), gives you time to read around the topics. You may be surprised how quickly the knowledge comes back to you. There remains some utility in asking questions from recalled vivas, even if you may no longer have the knowledge to explore understanding as well as the examiners do. The trainees will still be able to practice forming succinct definitions and explanations on-the-spot, and can recognise 'black holes' in their knowledge to guide independent learning.

If you do not have access to a bank of practice vivas, other trainees or consultants may be able to share some with you. Alternatively, the ANZCA Examination Reports are available on their Training Resources website. For the Final Examination, these include not only viva opening stems but also the topics of focus of the three five-minute (approximately) sections of each viva, along with the minimum standard of answer expected for each of these. These may be used to generate practice vivas. For example, using the example "assessment and management of postoperative distress and loss of IV access in a paediatric patient" it is reasonably straightforward to form a likely scenario and questions to ask the trainee.

The ASA's Practice Examination video resources, found in the Trainee Resources page of the ASAEd website, include Primary and Final Examination viva questions along with discussion of their answers. You may use these questions to generate and give practice vivas, then direct your trainees to the videos for their discussion.

Please scan the QR code to access the ASA's Practive Examination video resources.

Support in theatre

The theatre environment provides ample opportunity for practice of knowledge and technique, without giving complete vivas. This may be as simple as asking a registrar to tell you about a piece of equipment or a medication they have drawn up (Primary Examination), or asking about their management of a hypothetical situation in which your current patient were to have a

sudden change in haemodynamics/respiratory status, an airway crisis etc (Final Examination).

A previous hospital I worked in had a copy of the *Anaesthetic Crisis Manual* by David Borshoff in every theatre. This is a useful aid that provides a structured approach to some of the crises that might arise in the Final Examination vivas. Version 4 of this book has recently been released, is complimentary for ASA trainee members, and is offered at a 20 per cent discount for ASA consultant members. In my current hospital, every theatre has been stocked with a copy of Petkov's *Essential Pharmacology for the ANZCA Primary Examination*. This assists those who feel out of touch with the Primary Examination in asking primary-related pharmacology questions during quieter moments in theatre. Kerry Brandis' *The Physiology Viva: Questions and Answers* serves a similar purpose covering physiology topics, and Cross and Plunkett's *Physics, Pharmacology and Physiology for Anaesthetists* provides useful definitions, graphs and brief explanations about core topics relevant to the Primary Examination.

Practice examiners as a finite resource

Enthusiastic teachers are a precious resource, and most departments have a limited number of consultants and Provisional Fellows with an interest in Primary and/or Final examining. This can make it challenging for trainees to receive the amount of practice that they need without putting undue pressure on those offering exam practice. Although 'round-robin' viva nights are the gold standard in viva practice, they may quickly exhaust the precious resource of enthusiastic teachers. As an alternative or additional suggestion, at my hospital we run online after-hours practice primary and final viva sessions during examination lead-up times. These are group sessions that are led by a single practice examiner, where two vivas are given, and the group of exam candidates take turns answering the five-minute viva sections, followed by discussion. There is benefit not only in practising answering exam questions, but also in watching others and reflecting on their answering techniques and key phrases.

ASA examination support sessions

On a regular basis, the ASA runs both Primary and Final Examination Support sessions. These are online after-hours sessions, which focus on Short Answer Questions in the leadup to each written examination, and viva practice following this. During these sessions, we regularly invite guest examiners who are current or past examiners, previous examination prize winners or others heavily involved in exam teaching, courses or resource production. We also hold separate Specialist International Medical Graduate-specific Final Examination Support Sessions, which provide the additional benefit of connecting this smaller network of doctors who would be otherwise geographically distanced from one another. All of these sessions are complimentary for ASA members.

For upcoming Examination Support Session dates, please refer to the ASA Events Page at asa.org.au/asaeducation/events.

Anxiety as a performance obstacle

For many trainees, knowledge is not the barrier to passing the exams. Preparing for and sitting examinations can be very stressful, and this can have implications on examination performance. For those where this anxiety may be a barrier to optimising performance, assistance from a performance psychologist may be useful. There are some with specific expertise in medical examination preparation and performance.

Wellbeing support

It can be difficult to know how to support our trainees during this challenging period of their lives and careers. The ASA has recently launched its updated Wellbeing webpage at asa.org.au/wellbeing-of-anaesthetists. Here you will find information about wellbeing assistance, resources, and events available to support our members, some of which are trainee-specific. Our partnership with Drs4Drs continues, offering members free, confidential support.

Dr Kaylee Jordan

Education Committee Chair

Register now for ASA Events

MEMBERS

JUNE

04
Thursday
19.30–20.30 AEDT

Wellness Series

Wellness on-the-fly. Pause for a Cause with Emotional Intelligence.

Mindfulness of speech resets and harmonises our physiological stress responses and anchors oneself to neutralise negative verbal or written speech when received. Evidence-based benefits with mindfulness practice are plenty including lowering blood pressure, stress and anxiety. It aids in conflict resolution and improves work performance.

15
Monday
19.30–21.00 AEDT

Exam Support Session – SIMG

These interactive sessions provide targeted exam preparation for SIMG candidates across Australia, offering a supportive environment to practise key components of the exam while connecting with consultants, examiners and peers who understand the SIMG pathway.

16
Tuesday
19.00–20.30 AEDT

Practice Wise-Business Series

Mandatory Reporting Requirements – Navigating Making or Receiving a Notification

This session unpacks the practical, legal and ethical responsibilities involved in mandatory reporting. Participants will explore what triggers a report, how to respond when receiving a disclosure, and the steps required to make a notification confidently and correctly.

23
Tuesday
19.30–21.00 AEDT

Exam Support Session – Primary SAQs

These interactive sessions provide targeted preparation for Primary SAQ candidates, focusing on structured written responses, exam technique and refining clinical reasoning, alongside opportunities to connect with consultants, examiners and fellow trainees.

29
Monday
19.30–21.00 AEDT

Morbidity & Mortality Discussion Evening

Join us for a focused Practice Evaluation session designed to support your continuing professional development. This session will feature Morbidity and Mortality (M+M) highlights from recent webAIRS submissions, offering valuable insights into incidents and the lessons learned from them. Through the discussion of real cases, attendees will have the opportunity to reflect on clinical decision-making, patient safety considerations, and strategies for improving practice.

JULY

6
Monday
19.30–21.00 AEDT

Exam Support Session – SIMG VIVAs

These interactive sessions provide focused viva preparation for SIMG candidates, helping to strengthen structured communication, build confidence and practise verbal exam performance in a supportive, examiner-led environment.

13
Monday
19.30–21.00 AEDT

Exam Support Session – Final SAQs

These interactive sessions provide targeted preparation for Final SAQ candidates, supporting advanced clinical reasoning, answer structure and exam technique, with opportunities to engage with experienced consultants, examiners and peers.

16
Thursday
20.00–21.15 AEDT

Communications Workshop

Gender Differences in Communication.

Yes, gender differences in communication are real. However, there are some misperceptions that we'll clear up. Then we'll shift to vocabulary and strategies to help you call out sexism, whether you're an ally, a victim or an observer.

20
Monday
19.30–21.00 AEDT

Exam Support Session – Primary SAQs

These interactive sessions offer targeted exam training for candidates across Australia and provide valuable opportunities to connect with consultants, examiners, and fellow trainees as part of your exam preparation.

29
Wednesday
19.30–21.00 AEDT

Part 4 – Planning for Retirement

Calling All Anaesthetists: It's Time to Plan for Life Beyond Clinical Practice.

Retirement from clinical anaesthesia may feel far off, but the smartest time to prepare is now.

AUGUST

03
Monday
19.30–21.00 AEDT

Exam Support Session – Final SAQs

These interactive sessions provide targeted preparation for Final SAQ candidates, supporting advanced clinical reasoning, answer structure and exam technique, with opportunities to engage with experienced consultants, examiners and peers.

AUGUST

10
Monday
19.30–21.00 AEDT

Exam Support Session – SIMG VIVAs

These interactive sessions provide focused viva preparation for SIMG candidates, helping to strengthen structured communication, build confidence and practise verbal exam performance in a supportive, examiner-led environment.

11
Tuesday
19.00–20.00 AEDT

Practice Wise- Business Series

Medicolegal Issues.

Join us for an enlightening discussion on the medicolegal aspects of anaesthesia. This session will explore current concerns, legal considerations, litigation, safe practice, and documentation in the field, offering participants valuable insights and practical tips to support their clinical practice. This session is anticipated to be both informative and engaging.

19
Wednesday
19.30–21.00 AEDT

Morbidity & Mortality Discussion Evening

Join us for a focused Practice Evaluation session designed to support your continuing professional development. This session will feature Morbidity and Mortality (M+M) highlights from recent webAIRS submissions, offering valuable insights into incidents and the lessons learned from them. Through the discussion of real cases, attendees will have the opportunity to reflect on clinical decision-making, patient safety considerations, and strategies for improving practice.

26
Wednesday
19.30–21.00 AEDT

Exam Support Session – Primary VIVAs

These interactive sessions offer targeted exam training for candidates across Australia and provide valuable opportunities to connect with consultants, examiners, and fellow trainees as part of your exam preparation.

26
Thursday
19.00–20.30 AEDT

Practice Wise- Business Series

Billing Conundrums Unlocked. Third in the Series.

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

TRAINEES

Trainee Exam Support Sessions

The ASA continues to support trainees nationwide through its Trainee Exam Support Sessions, offering structured, online preparation for the ANZCA Primary and Final examinations.

There are eight sessions that feature SMIG, primary, SAQ and viva exam practice with direct access to experienced consultants and examiners. These sessions provide practical strategies, real time feedback and focus on performance guidance. Delivered in a supportive environment, the program also enables trainees to connect with peers across Australia during an intensive stage of training, reinforcing the ASA's ongoing commitment to high quality, accessible exam preparation and trainee wellbeing.

Trainee Wellbeing events

Recognising the unique pressures of anaesthetic training, the ASA delivers a dedicated program of Trainee Wellbeing events focusing on mental health, resilience and sustainable practice. These online sessions explore practical approaches to managing stress, anxiety and high pressure situations such as examinations, while creating a safe, non-judgemental space for reflection and conversation.

Bringing together expert facilitators and experienced clinicians, the program reinforces the importance of wellbeing as a cornerstone for training and long-term professional practice.

Part 3 Courses

The ASA's Part 3 Courses continue to support trainees as they transition from training to independent specialist practice, with programs delivered nationally in both face-to-face and virtual formats. Designed for trainees who have completed the Part 2 examinations, these courses focus on the practical and professional aspects of early consultancy, including public and private practice, professional responsibilities, medico legal considerations, and career sustainability. Consistent delivery across all states, together with valuable opportunities for peer connection, reflect the ASA's commitment to supporting trainees through this critical transition and preparing them for confident, sustainable specialist practice.

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

EDUCATION & EVENT HIGHLIGHTS

Regional Anaesthesia Cadaveric Workshop

The 2026 Regional Anaesthesia Cadaveric Workshop, held in Queensland earlier this year, was a highly successful event.

Designed for specialist anaesthetists, advanced trainees and GP anaesthetists, the course delivered an intensive, hands-on learning experience focused on key single shot and catheter techniques for the trunk, upper limb and eye blocks.

A highlight of this year's workshop was the addition of a dedicated eye block station, which replaced the previous catheter station and provided valuable new learning opportunities. Participants benefited from practical training using both live models and fresh cadavers, offering an unparalleled chance to deepen their anatomical understanding and build procedural confidence in a realistic setting.

We would like to thank all attendees, as well as the convenor Dr Dougal Miller and the facilitators, Drs Cat Bella, Craig Daniel, Robert Gray, Jonathon Lau, Sam McCormack, Libby McLellan, Graham O'Connor, Andrew Peart, David Scott, Andrew Souness, Chaminda Wijeratne and Bryan Cook, for their countless hours of planning and preparation that made this workshop possible.

Regional Anaesthesia Cadaveric Workshop Attendees

Communications Workshop

The ASA is delighted to continue the Communications Workshops in 2026, with four additional workshops facilitated by Dr Andrea Wojnicki, a renowned executive communication coach, speaker & podcaster.

Andrea holds a Doctor of Business Administration from Harvard Business School, where her research focused on consumer psychology & interpersonal communication. Andrea founded "Talk About Talk" to help ambitious executives catapult their careers by improving their communication skills through one-on-one coaching, corporate workshops and online courses. She also shares her thought leadership, as the host, of the popular "Talk About Talk" podcast, with over 150 episodes & counting.

Dr Andrea Wojnicki, Penny Harrisson, Dr Namrata Singh & Dr Vida Viliunas

Morbidity & Mortality Discussion Evening

The ASA is pleased to announce that the M&M events will continue in 2026, featuring highlights from recent webAIRS submissions that provide valuable insights into incidents and the lessons learned. This year's program includes three workshops facilitated by Dr Vida Viliunas, with the first one now open for registrations with over 540 registrants received thus far.

New Zealand SOCIETY OF Anaesthetists | Ngā Ringa Tauwhiro o Aotearoa

te aka tauwhiro

AOTEAROA ANAESTHESIA TRAINEE MEETING

27-28 NOVEMBER 2026
QUEENSTOWN, NEW ZEALAND

All anaesthesia trainees are invited

Register now
tauwhiro.anaesthesia.nz

RHIAN FOSTER
ASA EDUCATION AND EVENTS MANAGER

INSIDE YOUR SOCIETY

BEYOND THE LECTURE HALL: FUN THINGS TO DO AT CSC2026 IN THE HUNTER VALLEY

The 2026 Combined Scientific Congress is being held in the Hunter Valley, a favourite getaway spot in Australia. As you take a break from sessions, you'll find yourself surrounded by the beauty of spring in a perfect getaway location. You can expect vineyard views, fresh country air, and a hotel that makes it easy to shift from "conference mode" to "holiday mode" in no time. Whether you're travelling solo, catching up with colleagues, or bringing the family, there are plenty of ways to spend your downtime and a good reason to add on an extra day or two.

Wine tasting

Thursday 8 October 2026 (13:30-15:00pm) at Usher Tinkler Winery
Tickets: $75pp

Discover Usher Tinkler Wines and how this third generation Hunter Valley winemaker family has changed the way people taste wine in the Hunter Valley. In this workshop, they will share their unique approach, pairing their wines with artisan cheeses to create a richer and more immersive tasting journey. Outside of wine tasting, you can book a variety of tours, such as local food excursions, historical walks, or scenic bike rides.

Wine tasting

Helicopter tours

Hunter Valley Helicopter Tours

Aero Logistics offers delegates a breathtaking way to see the region from above. For CSC2026, we have arranged exclusive discounted scenic helicopter flights, giving you the chance to take in the sweeping vineyard landscapes and rolling hills for a truly unforgettable perspective.

Please scan here to learn more about Optional Activities

Kids waterpark

Hunter Valley Gardens

Sydney to Hunter Valley map

Hit the fairways: Golf at The Vintage

Thursday 8 October 2026 (13:00–17:00pm) at Rydges Hunter Valley Tickets: $55pp

If you like networking with fresh air and some friendly competition, the CSC2026 golf outing is a great choice. The relaxed afternoon is perfect for both golfers and those who play once a year.

What to do in the Hunter Valley with the kids?

Rydges, Hunter Valley Water Park

Next to the main pool is the Water Park, a family favourite at Rydges Hunter Valley. The kids splash, slide and play while the parents can kick back on sun loungers and soak up the relaxed resort vibe. Lovedale Bar + Grill is just steps away offering chef-made meals and refreshing drinks delivered straight to your poolside seat from the dedicated menu.

Hunter Valley Gardens

The Hunter Valley Gardens have eight kilometres of walking paths winding through 14 hectares of gardens which include over 6000 trees, 600,000 shrubs and over 1 million ground cover plants, man-made waterfalls, statues from around the world and murals designed and painted by local artists. The gardens are divided into 10 themed areas, each showcasing gardens from different parts of the world and using a mix of both native and exotic plants.

Getting to the Hunter Valley

Reaching the Hunter Valley is simple, whether you're travelling from interstate or just up the road. The region is a two-hour drive north of Sydney. If you're flying, Newcastle Airport is the closest major hub, about an hour from the heart of the valley, with direct flights from major Australian cities. For something a little different, you can also take the scenic train from Sydney's Central Station to Newcastle, which passes the beautiful Hawkesbury River along the way.

If you don't want to drive, we'll be offering three shuttle services between Newcastle Airport and the Rydges Hunter Valley. For more details, including timetables and bookings, please refer to the Destination Hunter Valley page on the CSC 2026 website.

Please scan here to learn more about Destination Hunter Valley.

Rhian Foster
ASA Education and Events Manager

Understanding the differences between CPD Domains

Understanding the requirements of the Continuing Professional Development (CPD) Standard* can feel complex at first. At its core, however, it is simply about what we learn and how we improve. When doctors approach CPD in this way, it becomes a practical framework for maintaining confidence, strengthening skills, and delivering safe, effective care throughout their careers.

To maintain medical registration, the Medical Board of Australia* requires doctors to complete at least 50 hours of CPD each year, spread across two domains.

Domain 1
- Educational Activities

Domain 2
- Reviewing Performance
- Measuring Outcomes

medicalboard.gov.au/Registration/Obligations-on-Medical-Practitioners.aspx

Within the AMA CPD Home Program, these requirements are organised into **Domain 1** and **Domain 2**, creating a practical cycle of learning and improvement.

Domain 1: Educational Activities

Educational Activities focus on building knowledge and capability. Examples include, but are not limited to:

- conferences
- courses
- webinars
- professional reading
- research participation
- structured learning such as grand rounds or post-graduate study

Answers the question: "What did I learn about?"

These activities are primarily ***input-focused***, helping you stay current with clinical advances, strengthen diagnostic reasoning and broaden professional skills.

Mandatory Requirement: **12.5 – 25 hours per year**

Domain 2: Reviewing Performance & Measuring Outcomes

Reviewing Performance (RP) and Measuring Outcomes (MO) translates your learning into real-world application. These components are linked into one domain because genuine improvement depends on both analysing and evaluating your professional practice and its impact.

Reviewing Performance activities often involve reflection and feedback on how clinical care is delivered. This may include:

- CPD Plan
- peer review
- case discussions
- performance appraisal
- procedural logbooks

Extends the learning: "How am I practising — and where can I improve?"

These activities help you identify strengths, address learning gaps and refine professional behaviours.

This component is ***output-focused***. CPD activities should analyse your current actions and behaviours for improving safety, efficiency or patient experience.

Measuring Outcomes goes further by assessing real-world impact. Example activities include, but are not limited to:

- clinical audit
- analysing patient outcomes
- multi-disciplinary team meetings
- quality improvement incentives
- patient feedback study

Answers the question: "What difference has my learning made to me, to my practice or with my patients?"

This component is ***results-focused***. It demonstrates whether learning and performance changes are improving safety, efficiency or patient experience.

Mandatory Requirement: **25–37.5 hours per year (RP + MO combined)**

Together, these domains foster a cycle for professional growth: ***learn, reflect, improve*** and ***demonstrate impact***. Engaging in learning across both domains helps doctors:

- maintain clinical confidence
- meet regulatory expectations at registration renewal
- contribute to better patient outcomes

With the AMA CPD Home Tracker, maintaining compliance is simple.

Exclusive ASA Member Benefit

FREE

~~$220~~

per calendar year

Home Subscriber

You do the CPD.
You do the paperwork.

$594

~~$880~~

per calendar year

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You do the CPD.
We do the paperwork.

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

SCIENCE PRIZES, AWARDS AND RESEARCH COMMITTEE REPORT

2026 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.

Annual Research Grant & Scholarship

Inline with ASA recognising the need for research support in areas of interest to the Society, and to encourage an increase in higher degree completion in clinical anaesthetists, application is open to ASA members only, including Trainee Members, who are currently engaged in anaesthesia.

Research Grant

Applicants must have been financial members of the ASA for over 12 months. Applications from trainee members, and members within 5 years of full membership are strongly encouraged.

Applications from teams of researchers are also welcome. The grant will support original research into the current ASA Research Priority areas:

- Environment & Anaesthesia
- Innovation & Anaesthesia
- Safety in Anaesthesia or research related to anaesthesia, intensive care or pain management.

Jackson Rees Research Grant

Application is open to ASA members only, including Trainee Members, who are currently engaged in anaesthesia or research related to anaesthesia, intensive care, or pain management.

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.

Associate Professor Indy Lin
Science Prizes, Awards and Research Committee Chair

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

Australian Society of Anaesthetists®

members for members

Peer Support Programme

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

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

Benefits of peer support

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

Are you looking for peer support?

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

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

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

Contact the ASA Wellbeing Advocates Subcommittee

ASApeersupport@asa.org.au

webAIRS

webAIRS

Dr Shrey Sinhal, Dr Craig Morrison, Dr Indy Lin, Dr Yasmin Endlich and the ANZTADC Case Report Writing Group

MANAGEMENT OF THE LEADLESS PACEMAKER

Leadless pacemakers

A traditional transvenous pacemaker consists of a palpable subcutaneous generator implanted in the chest wall connected to transvenous leads placed in the right atrium, right ventricle, coronary sinus or a combination of locations. Leadless pacemakers are a newer technology, where the entire capsule-shaped device is implanted within the right ventricle via a femoral venous catheter (Figure 1). They are considered a type of permanent pacemaker (PPM); they do not currently have defibrillation capacity and cannot provide resynchronisation therapy. Due to their small size, they are not necessarily explanted at the end of battery life, and a patient may have a number of these pacemakers in situ.

Case overview

There have been recent reports to the WebAIRS platform regarding difficulties with the management of the leadless pacemaker.

A deidentified excerpt is included below:

> *"Did you know there are wireless pacemakers now? They can't have a magnet on them. The patient told me this AFTER I'd put a magnet on it. […] We are apparently supposed to reprogram them.*
> *I for one have no idea what the pacemaker numbers are at our private hospital with no cardiology. It was incredibly painful to organise and delayed my theatre two full hours while I made phone calls and read up on them."*

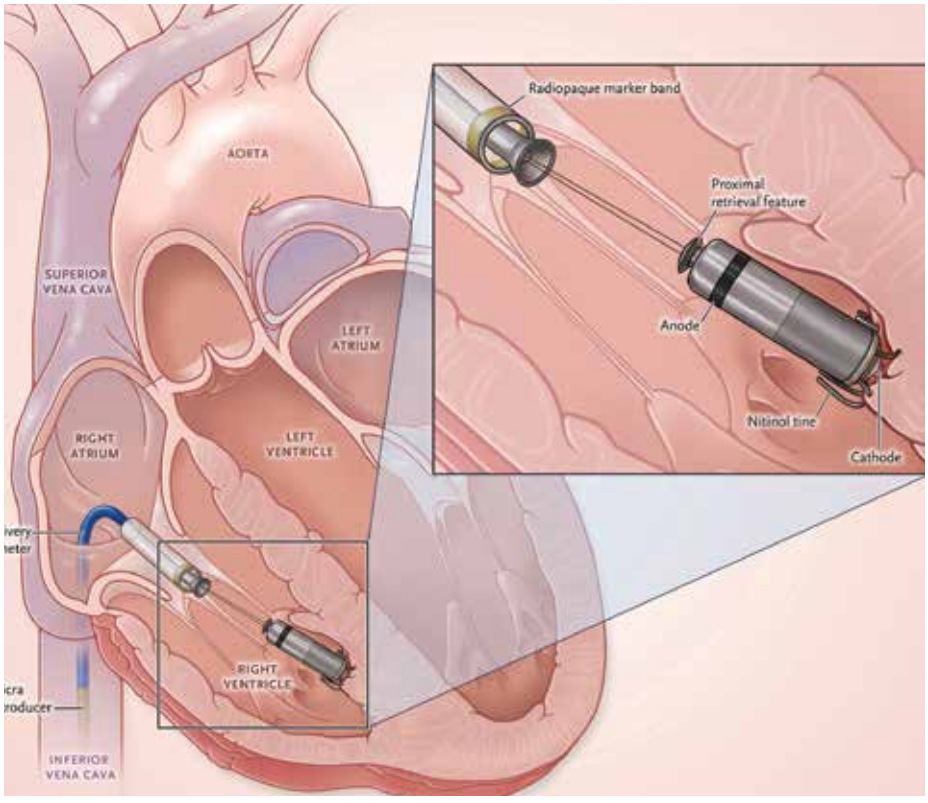

Figure 1. Diagram of the Micra leadless pacemaker system, showing transcatheter delivery through the femoral vein and implantation within the right ventricle.[1] Reproduced with permission from Reynolds D, Duray GZ, Omar R, et al. *N Engl J Med.* 2016;374:533-541. © Massachusetts Medical Society.

Leadless pacemakers are often the preferred device in cases where there is high infection risk, poor upper limb venous access or tricuspid valve dysfunction risk.[4] This may include patients with poorly controlled diabetes mellitus, prior endocarditis, on immunosuppressive therapy, or on haemodialysis.

Leadless devices currently used in Australia

There are two major leadless pacemaker platforms in current clinical use internationally.

The Medtronic 'Micra' Transcatheter Pacing System was the first leadless system to receive Therapeutic Goods Administration (TGA) approval in late 2016.[2] The original Micra VR device provided ventricular paced/ ventricular sensed/ inhibited response (VVI) or ventricular paced/ ventricular sensed/ inhibited response with rate modulation (VVIR) pacing, with fixed-rate ventricular paced (VOO) and not paced/ ventricular sensed/ no response (OVO) modes also available. A newer Micra AV device capable of detecting atrial mechanical activity using accelerometer algorithms was approved in 2022. Since then, updated versions of both devices called the VR2 and AV2 have been introduced.[3]

The Abbott Aveir platform is a newer system that only received TGA approval in 2022.[2] It represents a redesigned version of an earlier device, the NanoStim, which is no longer in use. The ventricular device (Aveir VR) provides similar pacing options to the Micra VR, while the newer Aveir DR system incorporates separate atrial and ventricular leadless devices capable of communicating wirelessly to achieve full dual-chamber pacing.[3] Due to the recent introduction of this platform, most leadless devices encountered in current clinical practice are likely to be the Micra devices.

Prevalence and use of leadless pacemakers

Leadless pacemakers are often the preferred device in cases where there is high infection risk, poor upper limb venous access or tricuspid valve dysfunction risk.[4] This may include patients with poorly controlled diabetes mellitus, prior endocarditis, on immunosuppressive therapy, or on haemodialysis. The evidence base for leadless devices is not yet robust enough to provide blanket indications, and so the decision to use largely remains clinician-driven. However, the use of leadless devices is increasing, with now more than 200,000 Micra devices implanted globally.[5] With rapid development in the technology, and increasing evidence to suggest lower complication rates, the use of leadless pacemakers is likely to further increase.

Perioperative considerations for leadless devices

The considerations around perioperative management of leadless pacemakers are similar to those of transvenous pacemakers, the key difference being that magnet application does not change the pacing mode. Micra devices do not contain a magnet-responsive switch, whilst Aveir devices usually enter a temporary asynchronous mode lasting five beats only, provided this feature has not been switched off.[3] Therefore, if electromagnetic interference (EMI) is likely and reprogramming to asynchronous mode is required, then a pacemaker technician needs to be involved.

The considerations around perioperative management of leadless pacemakers are similar to those of transvenous pacemakers, the key difference being that magnet application does not change the pacing mode.

Preoperative care

The preoperative check should focus on identifying 1) device details, 2) pacing dependency, and 3) procedural EMI risk.

Device details can be found on the patient pacemaker card, including the brand, model and serial number of the device, along with the implant date, magnetic resonance imaging (MRI) safety information, and contact details of both the manufacturer and follow-up physician or clinic.

A device check within the preceding 12 months is generally recommended for pacemakers, including leadless systems. Both the Aveir and Micra pacemakers have capability to communicate wirelessly, allowing information to be transmitted via a device at the patient's home; however, this method cannot be used to reprogram or to test for pacing dependency.[4] Pacing dependence lacks a universal definition but broadly refers to the absence of a clinically adequate intrinsic rhythm such that pacemaker inhibition would be poorly tolerated. An example includes a pacing burden of more than 90 per cent, no, or only a very bradycardiac (less than 30 beats per minute), intrinsic rhythm when pacing is discontinued, or clinical symptoms of bradycardia when pacing is discontinued.[6] Current leadless pacemakers use accelerometer-based rate-adaptive algorithms rather than the minute ventilation sensors used in some transvenous systems, and therefore generally do not require perioperative adjustment of rate-response settings.

The risk of EMI is greatest in procedures above the umbilicus with the use of monopolar diathermy, and the significance of EMI is greatest in pacemaker-dependant patients.[3] Most patients undergoing procedures below the umbilicus are low-risk and can be managed with conservative intraoperative measures. For patients deemed high-risk, temporary conversion to an asynchronous pacing mode may be appropriate. This is generally safe, although there will be a loss of atrioventricular synchrony, and the asynchronous pacing may rarely trigger a malignant arrhythmia via the R-on-T phenomenon. If an asynchronous pacing mode is desired, this will require formal device reprogramming, as magnet application will not maintain a sustained asynchronous mode in current leadless systems.[3]

Other considerations include continuation of anti-arrhythmic agents, and normalisation of electrolyte, acid-base, or blood gas disturbances as these can influence capture thresholds.[6] The ECG may provide a baseline rhythm, whilst a chest X-ray may help visualise the device. It should be noted that a pacemaker box or overlying scar will not be seen on examination.

Intraoperative management

Intraoperative monitoring should include both an ECG for electrical monitoring, as well as a plethysmographic or an arterial line to assess for mechanical capture. If paced, the displayed heart rate should be interpreted cautiously, as pacing spikes may mistakenly be captured as QRS complexes.[6]

Intraoperative strategies for reducing EMI should be considered for all patients. These include avoiding diathermy, using bipolar in preference to monopolar, using short bursts of one to two seconds separated with pauses, minimisation of diathermy power, preferencing the cutting rather than coagulation current, and placement of the return electrode such that the current pathway does not pass near the thorax. The diathermy cables should also be distanced from the device. External pacing and defibrillation capacity should be immediately available, given the risk of EMI or ventricular arrhythmia. Arrhythmias should be treated by following standard advanced life support procedures.

Additional attention should be given to fluid balance and haemodynamics as the ability to mount a physiologic tachycardia is lost in pacemaker patients. The rate-responsive feature in current leadless models is accelerometer-based and is unlikely to function in the intraoperative setting.

As with other cardiovascular implantable electronic devices (CIEDs) there are certain procedures requiring special

consideration. Radio-frequency ablation and electroconvulsive therapy may both cause oversensing and pacing inhibition, the latter largely due to seizure activity.[6] Electromagnetic interference precautions should be taken. Radiation therapy is usually feasible, but ionising radiation may damage device electronics and most commonly causes device reset, or reversion to a backup pacing mode; management centres on minimising direct device dose and arranging appropriate pre- and post-treatment assessment. Rare case reports describe similar effects with modern multi-slice computed tomography scanners.[6] Most modern leadless pacemakers are MRI-conditional, meaning that MRI can be performed under specific conditions relating to scanner strength, device programming, and monitoring protocols.[3] Extracorporeal shock wave lithotripsy appears low-risk with modern systems, but the beam should be kept distant from and focussed away from the device, with further precautions as necessary. Transcutaneous electrical nerve stimulation should be approached cautiously and only with specialist advice. The evidence-base for these considerations lies largely with traditional CIEDs, though it appears appropriate to apply the same precautions to leadless pacemakers.

Post-operative management

Patients with a CIED should ideally be managed in a high-dependency recovery setting, with continuous monitoring available until such time as normal device function is resumed. Any temporary programming changes should be reversed postoperatively, and device interrogation arranged as appropriate.[6]

Key points

1. Leadless pacemakers are a relatively new technology and their use is increasing.
2. They may be missed on examination as they do not require a subcutaneous generator box and are inserted via the femoral vein.
3. Most current devices function as single-chamber ventricular pacemakers, although newer systems are capable of dual-chamber functionality.
4. Magnet application will not induce sustained asynchronous pacing in leadless pacemakers.
5. Most other principles of management are similar to traditional CIED management.

Dr Shrey Sinhal, Dr Craig Morrison, Dr Indy Lin, Dr Yasmin Endlich and the ANZTADC Case Report Writing Group

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PROFESSIONAL ISSUES ADVISORY COMMITTEE

WE NEED TO TALK

DR JAMES HOSKING
PROFESSIONAL ISSUES ADVISORY COMMITTEE CHAIR

The private practice breakup no one warns you about

I write this report following the second major breakup in my career. Fortunately, I am not talking romantic break-up, as I enter the 21st year of my marriage. No, I'm talking of a surgeon-anaesthetist breakup, something unique to private practice. Public hospital relationship breakdowns usually just mean moving to another room, as opposed to losing your regular income. My last private practice breakup was about 15 years ago, which was conveyed rooms to rooms, with a "He doesn't want to use you anymore".

This year's breakup was a one-on-one basis via phone. As per most surgeon-anaesthetist conflicts it was related to patient care, but then all the things they had suppressed came out, like lines from a Taylor Swift song:

You don't put the bed down fast enough

You took too long to do that spinal

You gotta maintain the momentum on the list

I'm not your resident

It got me thinking of all my colleagues who have had 'break-ups' and the reasons they were given:

You're too slow – after working together for 10 years

I've decided to continue using your replacement – after the regular anaesthetist went on a holiday

I don't like blocks

You don't do blocks

My wife/ husband doesn't like me working with you

We like to believe there is no power imbalance in surgeon-anaesthetist relationships but there clearly is. The surgeon controls their lists and who they offer work to.

Power imbalances between surgeons and anaesthetists have been consistently identified in the literature as a function of entrenched hierarchical structures within the operating theatre. Lingard et al[1] demonstrated that communication failures were both frequent and consequential, often occurring across professional boundaries and contributing to delays and increased patient risk.

Similarly, Sutcliffe et al[2] identified communication breakdown, exacerbated by hierarchical differences, as a key contributor to adverse events, noting that lower-status clinicians may hesitate to challenge decisions made by senior surgeons. This reluctance to 'speak up' has been further substantiated in simulation and behavioural studies, where clinicians frequently failed to question incorrect or unsafe surgical decisions, even in critical scenarios (e.g. Bould et al[3]). Importantly, the impact of hierarchy is not merely theoretical; the World Health Organization-led Safe Surgery Saves Lives initiative demonstrated that interventions designed to flatten authority gradients, such as the surgical safety checklist evaluated by Haynes et al[4], significantly reduced morbidity and mortality. Together, these findings suggest that traditional surgeon-led authority structures can inhibit open communication from anaesthetists, reinforcing a power imbalance that has measurable implications for patient safety.

Recent PIAC activity

Emergency Laparotomy Clinical Care Standard

In May 2026, the Australian Commission on Safety and Quality in Health Care will release a new Emergency Laparotomy Clinical Care Standard. The ASA has provided feedback to the draft with a specific focus on the use of tools for risk assessment, frailty assessment, and delirium screening, and consultant anaesthetist involvement in laparotomy cases.

Review of ASA patient information pamphlets

PIAC is currently reviewing each of the ASA's 11 Patient Information Pamphlets. The paediatric pamphlet in particular has undergone an extensive revision and rewrite. Next, the ASA Policy Team will incorporate all edits into the revised documents and run an artificial intelligence-supported plain language readability check, before the documents return to PIAC for a final review and republication.

Specialist International Medical Graduate registration pathways document

A concise new resource has been developed for Specialist International Medical Graduates (SIMGs) who might be considering a move to Australia to practise as specialist anaesthetists. Rather than duplicating existing guidance from the Medical Board of Australia, the Australian Medical Council, Ahpra, or ANZCA, our document is designed as a practical signposting tool. It outlines, at a high level, the key elements of the registration journey, including:

a) the requirement for SIMGs to apply for registration through AMC/Ahpra

b) the role of ANZCA in conducting specialist college assessments where applicable

c) where to find authoritative, up-to-date information through official channels.

> Power imbalances between surgeons and anaesthetists have been consistently identified in the literature as a function of entrenched hierarchical structures within the operating theatre.

Mandatory police checks for anaesthetists

PIAC has noted a growing expectation for members to repeatedly supply evidence of their own police checks to multiple organisations as part of credentialling processes. This is an administrative burden that continues to escalate. These checks are in addition to Ahpra registration requirements, adding an extra and often duplicative layer of compliance.

We have a clear preference for a streamlined, standardised 'once-and-done' police check model that would satisfy requirements across multiple hospitals or workplaces. Any such approach, however, must be accompanied by strong safeguards around the handling and retention of sensitive personal data.

ASA Statement on Private Hospital Ownership

The ASA recently published a Statement on Private Hospital Ownership. This is now available for members on the ASA website.[5]

The statement was developed in response to a new model of private hospital ownership and governance which is emerging around the country, including in New South Wales, South Australia and most recently at Adeney Private Hospital in Victoria.

While the ownership model at these hospitals currently ensures doctors hold a (slim) majority ownership stake (commonly 51%), the remainder is owned or controlled by private health insurers.

Dr James Hosking

Professional Issues Advisory Committee Chair

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ASSOCIATE PROFESSOR MICHAEL COOPER AM
HALMA COMMITTEE CHAIR

HISTORY OF ANAESTHESIA, LIBRARY, MUSEUM AND ARCHIVES COMMITTEE

SOME MILESTONES IN ANAESTHESIA EDUCATION IN AUSTRALIA

Ongoing education has been pivotal to the development, safety, and quality of anaesthesia in Australia. The first meetings where anaesthesia featured, however, were held well before even the 1934 founding of the ASA.

Over a century ago there were meetings every few years of the Australasian Medical Congress (by 1911 the majority of Australian doctors, over 90 per cent of those in NSW and Victoria for example, were members of Australian State Branches of the British Medical Association). These meetings were held in different cities in Australia and New Zealand with many delegates from both countries attending, almost always travelling by ship. In 1929, the Congress was held in Sydney with over 2,500 delegates. Several years before that, Dr Francis McMechan of the USA had written to the Medical Journal of Australia (MJA) inviting interested Australians to attend anaesthesia meetings in the USA. The editor of the MJA replied this was timely, as "an active body of skilled anaesthetists has arisen recently in this country". McMechan suggested that a Section of Anaesthesia be included in the Australasian Medical Congress, and this occurred in September 1929 in Sydney.

The President of the Congress, Dr GH Abbott of Sydney, said in his opening address: "… we still welcome any agent that will make operations more safe and comfortable and any improvements in the methods of producing anaesthesia are hailed with pleasure. The presence of a section of anaesthesia for the first time in an Australasian Medical Congress indicates the increasing interest in the subject and should be the means of further reducing the sufferings of mankind."

The President of the Section was Dr Gilbert Brown (first President of the ASA) from Adelaide, and his address was titled 'Anaesthesia in relation to lung disease'. Brown stated that it was 83 years since Morton's public demonstration of ether anaesthesia in Boston, "… but it is only in the last few years that the importance of careful scientific anaesthesia has been recognised". Brown discussed the challenges and mortality of anaesthesia in active tuberculosis, especially for the operation of thoracoplasty with avulsion of the phrenic nerve to collapse the cavity at the apex of the lung. This procedure involved operating supine then prone, and has not been performed for years. This would have been performed without double lumen tubes, muscle relaxants, invasive monitoring or intensive care – not for the faint-hearted!

McMechan, speaking from a wheelchair, had travelled to Sydney from Ohio to give his presentation on 'The Evaluation of Surgical Risk'. Other papers were on local anaesthesia by a surgeon, spinal anaesthesia by a gynaecologist, and intra-tracheal ethylene by someone who described themselves as an 'amateur anaesthetist' and 'a novice in the art of gas anaesthesia'! I think we have progressed.

Even though this meeting was nearly a century ago, we still talk about the same issues. Predominant disease processes have changed with drug therapy, public health measures, and immunisation, but disease severity and its relevance to anaesthesia has not. In a report from Adelaide Hospital, a medical registrar discussed six deaths within two hours of anaesthesia from 6,062 general anaesthetics over 16 months. The speaker concluded

> *that no patient died from asphyxia, and deaths will continue to occur during anaesthesia when the gravity of the condition needing operation is fully understood.*

The ASA has always sought to maintain international relations with other Societies, and this was explored through the annual Overseas Visitor. This enabled good international relations and networking for Australian anaesthetists to train overseas. The first official ASA visitor, 70 years ago, was Dr John Gillies from Edinburgh. He was followed by Sir Geoffrey Organe from London in 1957, Prof Lucien Morris from Seattle in 1958, and then Prof William Mushin from Cardiff in 1959.

In many states there were Continuing Education Day seminars organised by regional committees of the ASA and the Faculty of Anaesthetists, Royal Australian College of Surgeons. In NSW for example, next year will see the 50th anniversary of these meetings which started with New Drugs and Techniques in Anaesthesia at Prince of Wales Hospital in July 1977, and Obstetric and Peri-Natal Care at St Margaret's Hospital, in November 1977.

Some topics in our work do not change.

Thirty years ago, the ASA and the World Federation of Societies of Anesthesiologists hosted the 11th World Congress of Anaesthesiologists in Sydney. This was then the largest medical meeting ever held in Australia with over 10,000 attendees and was extremely successful at all levels.

Education is not just about conferences, networking, and comparing notes with our colleagues. Although now we look to Google, YouTube and artificial intelligence for immediate information – assuming it is correct – this was not always the way.

Older anaesthetists would remember going through the enormous Index Medicus volumes to do a literature search in their hospital library when reviewing a specific topic – only then to have to find the articles in printed journals - many of which took ages to come from overseas. We now have excellent services from ANZCA and institutional libraries providing online textbooks, journal access, and fast article retrieval.

Textbooks were the norm until the 1990s and Australian anaesthetists have contributed to many fields. One component of the Richard Bailey Library at the ASA is the collection of textbooks written by Australians in anaesthesia, pain medicine, intensive care, equipment, and many other areas. Many of these have been donated by the authors themselves and constitute a valuable collection of developments in this country.

Some landmark books are:

- *Practical Anaesthesia* 1932 by the Anaesthetic Staff of the Alfred Hospital, Melbourne, was the first general anaesthesia textbook produced in Australia. This book was awarded the Congress Trophy of the International Society of Anaesthetists. A great compliment to Australian anaesthesia.
- *Regional Analgesia for Intra-Abdominal Surgery*, 1943 by Norman R James. Although written while working in England during World War 2, James was Australian and returned becoming the first Director at Royal Melbourne Hospital then later moving to Dallas, Texas.
- *Anaesthetic Methods*, 1946, Melbourne, by Geoffrey Kaye, Robert Orton and Douglas Renton – the last two names being known to prize and medal winners!
- *A Surgeon's Guide to Local Anaesthesia*, 1948 by Cyril Corlette. Although a surgeon, this book was the first book on regional anaesthesia in Australia. He had published it as a descriptive manual for residents seven years earlier.

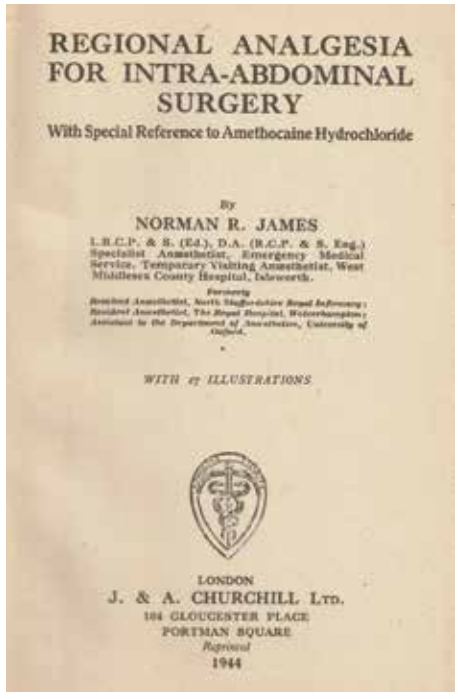
Other more recent but still landmark books that many will remember include:

- *Anaesthesia for Children*, 1979 by Kester Brown (Melbourne) and Graham Fisk (Sydney).
- *Neural Blockade in Clinical Anaesthesia and Management of Pain*, 1980 by Michael Cousins and Phillip Bridenbaugh.
- *Intensive Care Manual*, 1981 by TE Oh, Perth.
- *Equipment for Anaesthesia and Intensive Care*, 1983 by WJ Russell, Adelaide

How we continue to learn through our professional lives will change with technology and time but we will always need to do it.

Dr Michael Cooper AM

HALMA Committee Chair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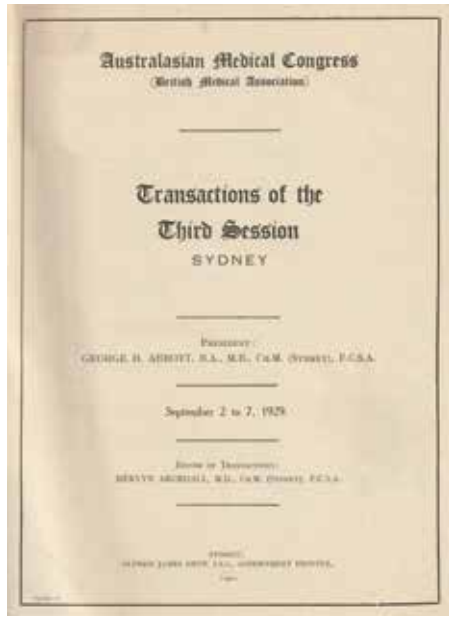
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INSIDE YOUR SOCIETY

AROUND AUSTRALIA

Australian Capital Territory

Dr Valerie Quah

Chair of the Australian Capital Territory Committee of Management

We warmly welcome our trainee members from the incoming registrar cohort.

The ASA continues to prioritise improvements to primary and final examination resources, both online and in person for our candidates.

Looking forward to the year ahead, key ACT ASA CME activities to note in your diary include Scan and Ski in July, Art of Anaesthesia in October, and the ACT Part 3 course in May.

Advocacy efforts continue apace including meetings with the ACT health minister and ASA representation to the Senate Committee on medical specialist access and affordability.

New South Wales

Dr Katherine Jeffrey

Chair of the New South Wales Committee of Management

Transitioning into the leadership role as ASA New South Wales State Chair could have been a daunting prospect. With more committee meetings, more emails and a new level of responsibility, it would have added a lot to your normal daily life as a human being. As a practising anaesthetist, in a healthcare system that's already under strain, it might have felt like a rather large mountain popped into view.

There is the added pressure of taking over the role from Dr Simon Martel, a colleague who is a successful leader. All while raising a family and managing a busy anaesthetic career. These are big shoes to fill. I would like to give a large thanks to Simon, who has led the NSW committee for the last four years with grace and exceptional knowledge of the profession especially in times of major reforms to clinical practice.

How do you take on the task, you might ask? You find inspiration in the people around you. Then you ask yourself what do I want to achieve for my profession.

A quote from Ruth Bader Ginsberg came to mind:

> *"Fight for the things that you care about. But do it in a way that will lead others to join you."*

I am not new to the role of a Chairperson or advocating for my profession. I have been on the ASA NSW committee since 2020, serving as education/welfare officer and deputy chair of the committee. I currently hold the North Western Metropolitan councillor position for NSW AMA and have previously held the Chairperson of the NSW AMA DITC during my training years. I have also sat on the ANCZA NSW Trainee Committee whilst a trainee. As an anaesthetist, I hold VMO/staff specialist and private appointments in the NSW system, so I am at the coalface, seeing the daily issues that we face as anaesthetists.

As I start to climb the mountain in front of myself, I will have some goals straight from Ruth's mouth:

- I will fight for the things I care about:
  - anaesthetists, trainees, patients and other professional colleagues
- I will lead in a way where others will join me:
  - I will encourage my colleagues to join in advocating for our profession
  - I will liase with other professional organisations to help show the importance of the medical profession in the care of patients
  - I will help in training the next generation of anaesthetists
  - I will show our colleagues that ASA NSW is worth the membership fee

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

WA Patient Anaesthetic Fee Awareness Survey

In mid March the ASA (WA) Committee sent out links to a patient survey for anaesthetists and their rooms to send out to patients post-operatively. The survey is designed to collect information on patients' understanding of how fees for anaesthesia services are set by insurers, and where gaps or shortfalls arise. We hope that the data gained from this survey will assist in future ASA engagement with health insurers by presenting a patient perspective on the frequently opaque and confusing nature of specialist fees.

Thanks to Dr David Kingsbury for designing this important survey.

Emergency FONA a roadside to resus perspective: Preparation, Prevention and Performance of CICO - 24 March 2026

Held on the 24 March at 6.30pm, and hosted by Dr Simone Cooper FANZCA and Dr Andrew Challen FANZCA, the workshop was delivered by experienced instructors from prehospital care, emergency medicine, and anaesthesia.

The multidisciplinary team provided a broad, practical perspective on managing airway emergencies as emergency anaesthesia can present a uniquely complex challenge for anaesthetists. Unlike controlled operating theatre environments, these procedures are often performed in unfamiliar settings, alongside ad hoc "swarm teams," and involve patients who are unfasted and physiologically unstable. These factors were noted to significantly increase the risk of complications, including front-of-neck airway (FONA) events.

This workshop combined focused discussion with hands-on training. Key discussion topics included the 2025 DAS guidelines, the AMAX approach, and strategies to optimise human factors using the Zero-Point Survey. These frameworks were presented as practical tools to improve decision-making and team performance in high-pressure environments.

The practical skill stations allowed participants to develop and refine critical techniques. These included ventilator-assisted preoxygenation, suction-assisted laryngoscopy airway decontamination (SALAD), and the scalpel–finger–bougie technique for FONA. Participants were given repeated opportunities to practice, helping to build muscle memory and procedural confidence, with each clinician performing multiple supervised attempts.

All participants also got to take home a Cric trainer!

Thank you to the facilitators for their knowledge, time and effort into making this workshop a success. This workshop was fully subscribed from its initial release, demonstrating that the ACE WA Lecture Series continues to be popular in 2026.

Save the date! WA ACE Country Conference 13-15 November 2026

Accommodation bookings have now opened for our annual country conference, to be held at the Pullman Bunker Bay Resort from 13-15 November 2026. Programs and registration will be available very soon!

South Australia / Northern Territory

Dr Nicole Diakomichalis

Chair of the South Australia / Northern Territory Committee of Management

The SA/NT ASA committee continues to support our members by continuing to connect with key stakeholders in both South Australia and Northern Territory. So far, we have had quite a productive year.

In the NT, our representative Dr James Corcoran is still awaiting another meeting with the Chief Minister for the Northern Territory, Hon Lia Finocchiaro to discuss the sale of Darwin Private Hospital. We await more news regarding this.

Bernard Rupisinghe, Matthew Fisher and I as the state Chair, met with the Chief Medical Officer, Dr Michael Cusack to discuss issues such as workforce sustainability, task substitution, informed financial consent, professional wellbeing, conditions and disputes. This was a positive interaction with a follow up email from Dr Cusack thanking us for the meeting and inviting the ASA to be a part of both the rural workforce committee and the elective surgical reform committee.

Dr Tristan Adams and I attended the first elective surgical reform committee meeting with Dr Adams continuing to attend the subsequent meetings with thanks. The meetings are chaired by Dr Michael Cusack and have representatives from various departments within SA Health. We have been asked to take part in the discussions around Public in Private cases and remuneration, and have welcomed this invitation. We look forward to making some good progress in this space this year.

As the Chair of the SA/NT ASA Committee, I was invited to attend the International Women's Day Breakfast by the South Australian Salaried Medical Officers Association (SASMOA) president, Dr Laura Willington. It was a great event with over 3000 guests. Very interesting talks by the Senator, Honorable Penny Wong and Australian on the Year, Katherine Bennell-Pegg.

Dr Ellie Cheah, Dr Vida Viliunas and I attended the Part Zero course. Both Dr Cheah and Dr Viliunas gave great presentations about the ASA. A special thank you to Dr Vida Viliunas for visiting SA and attending the course. We have had interest from some of the trainees to become the new junior representative on our state committee of management.

We thank Dr Mila Sterbova for all her hard work as our Trainee representative as she moves on to a consultant role. She will remain on our committee as the welfare representative.

Queensland

Dr Brett Segal

Chair of the Queensland Committee of Management

Changes in major private hospital ownership is upcoming with Mater Misericordiae Ltd acquiring Healthscope's

Gold Coast Private Hospital. This will be a new venture for the Mater Group with a facility on the Gold Coast. There is a not insignificant volume of public-in-private work done at this facility and there have been concerns that the current arrangements between Healthscope and anaesthetists may be adjusted. I have reached out to the Mater Executive to relay our concerns, and they have connected and started discussions with our local ASA representative on the ground there. There has been some assurance of maintaining the status quo following completion of the acquisition later this year and I should be able to report back on what has resulted.

By the time of publication, key members of the Queensland Committee of Management along with the ASA's CEO, Dr Matthew Fisher would have met with the Queensland Minister of Health, The Hon Tim Nicholls to discuss ongoing issues in the State. I will report back on how this meeting went in the next edition of *Australian Anaesthetist.*

We continue to support our trainees at various events including Primary and Final Practice Viva events and we hosted the post-course drinks following ANZCA Queensland Trainee Committee's Introduction to Anaesthesia (Part 0) Course that was held at the start of the Queensland Hospital Employment Year in February. Our next local event will be the Part 3 Course for Advanced Trainees and Provisional Fellows. This is scheduled for Saturday 15th August at ANZCA Queensland Regional Committee Offices in West End and we look forward to welcoming Dr Vida Viliunas AOM to this event. We will be having our annual member's cocktail reception following this course, with location details to follow through State e-communication.

Tasmania

Dr Alice Mulcahy

Chair of the Tasmania Committee of Management

Tasmania ASA Committee

The Tasmania ASA Committee are looking for new members. If you are interested in obtaining more information, please contact our Tasmania ASA Chair, Dr Alice Mulcahy. The Committee meets four times a year in Hobart at the ASA/ANZCA Tasmania Office and via zoom in a hybrid meeting format.

ASA presents at Tasmania Trainee Day

The ASA President Dr Vida Viliunas completed a final exam preparation session at the recent Tasmania Trainee Day in Hobart on Friday 27 February 2026 at the ASA/ANZCA Tasmania office.

A specialised 90 minute final exam preparation session was completed by 8 trainees with the ASA president.

Twenty-four trainees from around the country attended the Tasmania Trainee Day which was a full day scientific program covering topics such as primary/final exam preparation, trauma/retrieval, perioperative communication and airway management.

2026 Tasmania ACE Summer CME Weekend

One hundred and forty-three delegates and trainees attended this year's Tasmania ACE Summer CME Weekend which was held between Saturday 28 February and Sunday 1 March at the Hotel Grand Chancellor in Hobart.

A full day scientific program was presented on the Saturday over four sessions which covered Airway, Trauma, Perioperative Medicine Updates and AI in Healthcare.

Highlights from the feedback received included the presentations by Dr Jo Kippax on the Franklin River Rescue, a Story of Survival, Dr David Bertoni on ECMO in Trauma, and Associate Professor Kwang Yee on AI in Healthcare, Brave New Adventure of Brewing Storm.

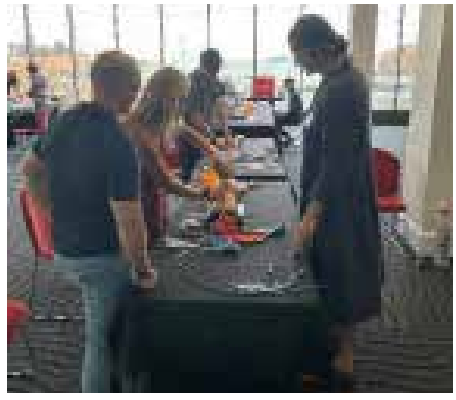
Eleven workshop sessions were available on the Sunday morning. These included CICO, OIVI, ASBD, Clinical Hypnosis, Gastric Ultrasound and Audit – Dexmedetomidine use in Contemporary Anaesthesia.

The organising committee thanks all attending delegates and trainees for their attendance. They also wish to thank all presenters, facilitators and operational staff for their expertise and time in delivering a very successful event.

ASA Poster Prize – 2026 Tasmania ACE Summer CME Weekend

The ASA sponsored poster prize was presented by ASA President Dr Vida Viliunas to Dr Rhys Rumley from the Royal Hobart Hospital in Tasmania.

The Judging panel commended all entries on their incredibly high standard of posters.



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

#CSC26

CSC2026

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8-11 OCTOBER 2026

Early Bird Registrations Now Open

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