

AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • SEPTEMBER 2026



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AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

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Cover photo

Anaesthetist with patient at St George Hospital, Kogarah, NSW, Australia

Would you like to contribute to the next issue?

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

- Intention to contribute must be emailed by 16 October 2026
- Final article is due no later than 23 October 2026

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



DR VIDA VILIUNAS OAM
PRESIDENT

FROM THE ASA PRESIDENT

THE DEVELOPMENT OF THE ROLE OF ANAESTHETISTS IN PAIN MANAGEMENT

Anaesthetists are not just pain technicians who infuse drugs, guide needle placement with ultrasound, or write scripts. We are all well aware that pain medicine has moved on considerably from being a prn prescription.

As specialists, we are involved with formulating tailored plans for our patients to ensure they are safe and comfortable throughout their hospital stay and beyond. For many of our increasingly complex and frail patients, that job starts before admission.

Our role has expanded enormously from addressing perioperative pain to creating hospital-based acute pain services and to establishing dedicated multidisciplinary pain clinics for chronic non-malignant pain, and cancer and palliative pain management. For decades now, the Faculty of Pain Medicine has been responsible for the training, standard-setting and accreditation of specialist pain physicians.

This background makes it clear that we are not just technicians and are not exchangeable with other providers. We are justifiably proud of our sophisticated training and credentials that meet the challenges of our patients. We participate in lifelong learning and continuous

improvement of our skills and knowledge to provide the level of service that our patients expect.

This deep professional involvement in the development of pain medicine is why ASA advocacy puts us at the tables where decisions are made about our training of specialists, resource allocation, remuneration, the Medical Benefits Schedule, and private health insurer involvement.

Our professional commitment in this area and others does not come without cost or consequences for us as practitioners.

I recently returned from the Melbourne Winter Anaesthesia meeting. The regional meetings are a great opportunity for us to hear about the latest in our speciality, acquire some useful CPD hours, and to catch up with colleagues. The morbidity and mortality roundtables and workshops were not only opportunities for learning from each other's clinical experiences but also access to some relief from the stress associated with adverse events by sharing those experiences with colleagues who understand the nuanced context of our work.

At the ASA we are always eager to hear members' views on how your work is being

impacted by any issues: safety, workforce shortages, work conditions, and contract or roster matters. We have maintained ASA advocacy at all levels with engagement of state and territory politicians around the country. We will continue to argue that the central role of anaesthetists deserves recognition, support, and resources. Please let us know if there is an initiative or direction we should be considering.

The Combined Scientific Congress is only weeks away. An important issue that will be raised at the AGM during the congress is Constitutional change for the ASA. The ASA's charitable activities are distinct from its professional ones and scrutiny from the Australian Charities and Not-for-Profits Commission (ACNC) is expected to increase. We have foreshadowed that modernisation of sections of the Constitution is required to ensure compliance with the ACNC requirements for organisations such as ours.

The CSC scientific program and workshops are a standout lineup. Come to engage with colleagues from around Australia and New Zealand in the relaxing Hunter valley – I'm looking forward to seeing you there!

■ **Dr Vida Viliunas OAM**



DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

FROM THE ASA CEO

ASA: A YEAR OF ADVOCACY, GROWTH, AND ACHIEVEMENT OVER THE PAST 12 MONTHS

Since July 1, 2025, the Australian Society of Anaesthetists (ASA) has been advancing its mission of supporting Australian anaesthetists and safeguarding high-quality patient care through a year of advocacy, member engagement, educational innovation, and strategic partnerships. We have engaged in important health policy reforms, expanded services for members, and pursued initiatives that enhance patient understanding of anaesthesia. Even though the theme of this edition of the Australian Anaesthetist is Pain Management, I am highlighting key achievements of the ASA, from advocacy and policy to evolving member support and collaborative ventures, to demonstrate how the Society is leading with purpose and preparing for the future.

From a numbers perspective, we currently have ~4,500 members, which is a growth of 3 per cent. We held a record number of events with under 4,000 participants and have expanded our educational videos and podcast that are free to members. We also conducted significant research on specialist fees and informed financial consent, where almost 25% of the specialty participated. Another highlight was the Morbidity & Mortality webinar

discussion with webAIRS, which had 674 attendees (which is over 10 per cent of the registered specialty) and is being replicated with our colleagues in New Zealand through NZSA.

Advocacy and policy

From our 2025 Member survey, we know that you value our advocacy and policy influence. Over the past year and projecting into the future, we are championing patient-centric policies through the experience of the anaesthetist, advocating for patient interests and ensuring specialist autonomy.

Over the past year, ASA has made significant contributions to legislative and regulatory debates. We engaged directly with governments and health departments across Australia. For example, in early 2026, we submitted a detailed response to a Senate inquiry on the Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026. This submission strongly supports measures to improve consumer information. It also calls for adequate indexation of Medicare rebates and private health insurance reimbursements to ensure fair funding for anaesthesia services.

From our independent research, the ASA highlighted the widespread use of no-gap and known-gap billing arrangements along with routine informed financial consent in private practice. This underscores the growing gap between insurer rebates and the real costs of providing safe and complex anaesthetic care. These evidence-based advocacies are positioning the ASA's voice to shape health policy and have deepened our engagement with key stakeholders.

We continue our public positioning on changes to the healthcare system. We emphasise the importance of preserving patient-clinician relationships and caution against insurer-driven vertical integration or aspects of managed care models in Australia's private health system. Our principled stance on these structural health system issues means that we maintain our role as an informed advocate for both practitioners and patients.

Our continued strategic priority has been shaping a more sustainable health system and anaesthesia workforce. The ASA's commitment to workforce planning and sustainable service provision is evidenced by our commissioning of robust data with expert input. This data has informed long-term strategies for workforce

sustainability. The Society continues to provide its expertise in the ongoing MBS review ensuring that any updates support evidence-based, high-quality care for patients.

These initiatives highlight ASA's core strategic themes. We focus on upholding patient safety and quality of care, advocating for health funding reforms like Medicare rebate indexation and transparency in specialist fees, and addressing workforce sustainability. This ensures that Australia continues to have a well-resourced and resilient anaesthesia workforce. The ASA's advocacy demonstrates our standing as a respected voice in health policy debates.

Membership engagement

The ASA has maintained strong engagement and modest growth in membership over the past year. By June 30, 2026, the Society's membership exceeded ~4,500, reflecting continued growth from members at the same point in 2025. This steady increase attests to ASA's enduring value and evolution, plus we see sustained growth in Ordinary and Trainee member categories. Feedback from you suggests high satisfaction and reinforces our focus: advocacy is perceived as the core value of ASA membership, and ASA's education services are highly valued. These insights have guided ASA's strategic priorities through 2025 to 2027, ensuring the Society's activities align with what matters most to you.

Over the past year, ASA has continued to invest in member-centric communication and support initiatives. Regular President's e-newsletters, policy updates, and a revamped communication strategy for 2025 to 2027 have helped keep you informed and engaged with the Society's work.

Our digital presence and member portal continue to be improved, making resources more accessible. For instance, ASA's patient information pamphlets, covering various procedures and available in multiple languages, are now easily downloadable without login as a direct response to member feedback.

Educational innovation

Events and networking opportunities have been another key focus to member engagement. Additionally, ASA's state and territory sections have been active in hosting member meetings and educational evenings. These events not only disseminate clinical knowledge and updates but also strengthen peer networks and relationships within the anaesthetist community.

We are continuing to expand our educational resources through our investment in AMA CPD Home, and member usage continues to grow. The ASA Education Committee and team have expanded its suite of learning materials with a growing library of on-demand resources of clinical videos and podcast episodes covering diverse topics.

Our journal, *Anaesthesia & Intensive Care*, led by Editor-in-Chief, Professor Philip Peyton, continues to improve its support and impact for the Australian research community. This blended learning approach, which combines in-person events, online webinars, CPD modules, podcasts, and journal content, reflects our commitment to key objectives of the Society as part of our charitable purpose.

The ASA's achievements are embedded in our public mission to ensure the safest possible anaesthesia for patients. The ASA continues to support and engage with ANZTADC's webAIRS and this makes it easier for anaesthetists to report and review near-misses and adverse events, thus facilitating continuous learning and safer practices.

Through these efforts, ASA ensures that member anaesthetists are not only well-supported professionally but continue to lead patient safety and quality initiatives. Importantly, the ASA promotes your continuing commitment to improvements in patient care which the broader public often does not understand, and policy makers seem to take for granted. From a patient perspective, we see growth in the access of our patient information website and pamphlets, along with an increasing number of downloads in languages other than English.

Strategic partnership

Collaboration continues to be a cornerstone of the ASA's approach. Our influence extends both domestically and internationally across the healthcare sector through ODEC, CIG, WFSA and ANZCA, ensures that Australia's voice is heard on global issues and that ASA members benefit from international knowledge exchange. Domestically, the Society worked constructively with government agencies and other specialist medical colleges and societies on issues of mutual concern to enhance our advocacy capacity and impact.

Over the past year, we stepped up our role as a public educator and voice on key healthcare issues through data-driven public engagement. A highlight included the launch of the ASA-commissioned survey on specialist fees and patient out-of-pocket costs. Drawing on responses from 1,121 anaesthetists (representing about one quarter of Australia's specialists in private practice), this report provided key insights into how anaesthetists set fees, engage in no-gap and known-gap insurer arrangements, and manage patient affordability concerns.

In April 2026, we released the report to the public, with a press release that highlighted the mounting financial pressures on patients due to an "outdated system under stress," emphasising that Medicare and private insurance rebates have failed to keep up. We used the opportunity to call for integrated reforms, noting that "without urgent reform to rebates and indexation, patients will continue to feel the pressure in their out-of-pocket costs." This approach helps correct misinformation and positions the ASA as an informed thought leaders on healthcare affordability, speaking up for patients and practitioners through credible data and experience.

We have actively engaged with the media and public to promote understanding of anaesthesia and the vital role of anaesthetists. The ASA, through its members, has contributed expert commentary and responded to press inquiries on issues ranging from surgical wait times to safety, ensuring that anaesthetist perspectives are represented

in public discussions. By advancing a coherent public narrative around quality anaesthetic care and system improvements, the ASA has strengthened our public standing and expanded our advocacy reach.

The achievements of the past year, from policy influence to member growth and improved professional support, reflect our reason for being: "To support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public."

These successes have been made possible by the hard work of ASA's members, volunteer leaders, committees, and staff, as well as the constructive support of partners across the health sector. As we look ahead, we remain committed to our forward-looking vision: continuing to champion an accessible and equitable healthcare system, addressing workforce challenges, and ensuring Australia's anaesthetists can practice at the highest standards of safety and quality.

■ 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

CHANGING CLINICAL PRACTICE TO INCREASE PATIENT ACCESS TO REGIONAL ANAESTHESIA SHOULD NOT BE SO DIFFICULT

I read a depressing article that said it takes an average of 17 years before research evidence becomes widely adopted in clinical practice¹.

The patient benefits of regional anaesthesia and analgesia have been well described, especially in the context of enhanced recovery following surgical procedures. As an anaesthetist, researcher and educator who specialises in regional anaesthesia, I would like to see clinical practice change happen faster, so all patients can have access.

When I was a resident, regional anaesthesia was not that complicated. We were not using ultrasound yet, and catheters were still experimental. Regional anaesthesia was just one part of anaesthesia, and there was a fairly limited set of blocks to offer patients. Besides spinals and epidurals, I was fortunate to learn how to do more peripheral techniques than most residents in my cohort: femoral nerve block; proximal and distal sciatic nerve block; brachial plexus blocks (interscalene, infraclavicular and axillary); ankle block; and paravertebral block. All of these blocks were performed using landmarks to guide needle placement, and we used needle tip position endpoints for confirmation (e.g. nerve stimulation or paraesthesia).

Recently, a consortium of 14 medical organisations representing anaesthesia, pain medicine, surgical specialties and hospitals in the United States unanimously agreed on a set of principles to guide acute peri-operative pain management, and included in these principles is access to a pain medicine specialist and the universal application of multimodal analgesia with regional anaesthesia techniques when indicated². The demand for better peri-operative pain control that minimises dependence on opioids has driven the development of advanced clinical fellowships in regional anaesthesia and acute pain medicine (RAAPM) for anaesthetists who want to become acute pain medicine experts, and there is a standardised one-year curriculum and a national accreditation process for these fellowships in the United States³.

As a former program director for two RAAPM fellowship programs, I am a big supporter of fellowship training. The modern RAAPM fellowship curriculum trains anaesthetists to become leaders within their healthcare systems with the knowledge and skills to perform a wide range of advanced regional anaesthesia procedures and manage acute pain services in any practice

As an anaesthetist, researcher and educator who specialises in regional anaesthesia, I would like to see clinical practice change happen faster, so all patients can have access.

setting. New procedures to extend the benefits of regional analgesia beyond the first few postoperative days are currently being developed, as are new models of care such as transitional pain services that can add significant value to healthcare systems⁴.

However, not all anaesthetists can or should do a RAAPM fellowship, and the small cohort of fellowship-trained regional anaesthetists will not change clinical practice and patient access to regional anaesthesia very quickly. Considering that physicians work for about 30 years or more after completion of training, we need basic regional anaesthesia training incorporated into core anaesthesia registrar training and continuing education targeted at consultant anaesthetists.

Changing physicians' behaviour is rarely easy. One study published in JAMA that focused on physician adherence to practice guidelines identified seven categories of change barriers: lack of awareness; lack of familiarity; lack of agreement; lack of self-efficacy; lack of outcome expectancy; inertia; and external barriers⁵.

Most of these barriers to change are internal. In healthcare, clinical practice continues to be dominated by dogma, which can be loosely defined as the non-scientific practice of doing what you have been told to do based on experiences or anecdotes (not evidence). Implementation experts suggest 'incremental, context-sensitive, evidence-based management strategies for change implementation' and the need for local champions to drive change⁶. The proposed change cannot be overly complex, or it will be perceived as just more work⁷.

When Drs. Lloyd Turbitt, Kariem El-Boghdadly and I first published our editorial proposing 'Plan A blocks' online in 2019, we challenged the world of regional anaesthesia by asserting the concept of 'a few blocks for the many' in opposition to 'many blocks for the few [experts]'⁸.

The rapid adoption of ultrasound in regional anaesthesia led to an explosion in the number of new block techniques in which local anaesthetic can be selectively deposited near nerves or in fascial planes. While these advances offered a wider variety of procedures to choose from, they arguably have not led to greater patient access to regional anaesthesia. Essentially, experts expanded their repertoire of blocks for their own patients.

The concept of having a 'Plan A' anaesthetic (i.e. the consistent, reliable technique that you can count on in the middle of the night) as well as back-up plans (e.g. B, C and D) is not foreign to anaesthetists. The Plan A blocks educational framework suggests a core set of blocks (one per indication) for the general anaesthetist who is not an expert in regional anaesthesia and has been incorporated into the Royal College of Anaesthetists training curriculum in the United Kingdom^{8,9}.

There has been some controversy with the original list of Plan A blocks provided in our editorial since its publication, with many experts in regional anaesthesia arguing about the individual blocks mentioned. However, the list itself is not a prescription. It is merely a suggestion and can be adapted to the needs of the training program or practice. In a new *Core Topics* article dedicated to Plan A blocks published in *Anaesthesia*, we have updated the list of suggested blocks in the Plan A/B/C/D table, provide the evidence supporting the use of the Plan A blocks educational framework, and suggest future steps to implementing the broader use of regional anaesthesia to improve patient care⁹.

For consultants in anaesthesia who have been practicing clinically for years and not employing regional anaesthesia techniques regularly for their patients, it is not difficult to pick up the needle and ultrasound transducer. There are a variety of Plan A block workshops offered by major medical societies as continuing professional development, and many practices have local ultrasound-guided regional anaesthesia champions who can serve as educators and mentors. The list of Plan A blocks to learn for a consultant anaesthetist also tends to be shorter than a trainee who is preparing for practice because the consultant in clinical practice already has established lists, surgical partners and patient populations.

Of course, I am biased as a RAAPM subspecialist, but I truly believe that practicing regional anaesthesia helps to prevent physician burnout. There is nothing more satisfying than preventing and treating pain for patients who are undergoing surgery or suffering from traumatic injury. Learning to deliver a timely block that consistently works allows you to: 1) take good care of patients; 2) continue to evolve your practice in innovative ways; and 3) be part of an incredible worldwide community of regional anaesthetists who can provide support and mentorship throughout your career.

Professor Edward R. Mariano

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References

1. Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. *J R Soc Med* 2011; 104: 510-20. 10.1258/jrsm.2011.110180
2. Mariano ER, Dickerson DM, Szokol JW, et al. A multisociety organizational consensus process to define guiding principles for acute perioperative pain management. *Reg Anesth Pain Med* 2021. 10.1136/rapm-2021-103083
3. Mariano E, Rosenquist R. The road to accreditation for fellowship training in regional anesthesiology and acute pain medicine. *Current Opinion in Anesthesiology* 2018; 31: 643-8. 10.1097/ACO.0000000000000639
4. Harrison TK, Mariano ER, Clark JD, Mudumbai SC, Hunter OO. Lessons learned from establishing a transitional pain service in the USA. *Reg Anesth Pain Med* 2025; 50: 184-7. 10.1136/rapm-2024-105610
5. Cabana MD, Rand CS, Powe NR, et al. Why don't physicians follow clinical practice guidelines? A framework for improvement. *JAMA* 1999; 282: 1458-65.
6. Rangachari P, Rissing P, Rethemeyer K. Awareness of evidence-based practices alone does not translate to implementation: insights from implementation research. *Qual Manag Health Care* 2013; 22: 117-25. 10.1097/QMH.0b013e31828bc21d
7. Grol R. Successes and failures in the implementation of evidence-based guidelines for clinical practice. *Med Care* 2001; 39: 1146-54.
8. Turbitt LR, Mariano ER, El-Boghdadly K. Future directions in regional anaesthesia: not just for the cognoscenti. *Anaesthesia* 2019. 10.1111/anae.14768
9. Turbitt LR, Mariano ER, El-Boghdadly K. Plan A blocks in regional anaesthesia: a narrative review. *Anaesthesia* 2026. 10.1111/anae.70182



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FEATURE ARTICLE

WHEN WORDS HURT: THE ROLE OF HYPNOSIS IN PAIN MANAGEMENT

Communication is not neutral. Anaesthetists influence patients' attention and experiences through their words, tone, non-verbal behaviour, and the clinical environment. Clinical hypnosis recognises that many perceptual, emotional, autonomic, and behavioural processes occur outside immediate conscious awareness. It provides a framework for understanding these effects and methods for communicating therapeutically. Greater awareness can help clinicians reduce avoidable nocebo effects and support patients as active participants in care.

Hypnotic practices involving focused attention, imagery, repetition, and ritual have been used to relieve pain across cultures for thousands of years. Modern clinical hypnosis developed from eighteenth-century mesmerism and, before pharmacological anaesthesia, was one of the few methods reported to be capable of facilitating pain-free surgery. Stage hypnosis, misconceptions about loss of control, and the ease of use and reliability of pharmacological anaesthesia have contributed to hypnosis being overlooked and to continuing medical scepticism about its clinical value.¹ Although occasionally used as the sole

anaesthetic technique, hypnosis more commonly complements multimodal analgesia, reduces anxiety, and empowers patients to participate in care. Every clinical interaction shapes expectation, whether towards fear and pain, or comfort, confidence, and relief.

What is clinical hypnosis?

Hypnosis is commonly defined as a state of consciousness involving focused attention, reduced peripheral awareness, and an enhanced capacity to respond to suggestion.² Clinical hypnosis uses these processes to facilitate therapeutic changes in perception, emotion, or behaviour. Some responses may feel automatic. Patients usually remain aware, can communicate, and can end the experience or reorient themselves when they choose.

Formal hypnosis generally involves induction, deepening, therapeutic suggestion, and reorientation. Hypnotic communication, sometimes termed conversational hypnosis, refers to the deliberate use of attention, expectation, imagery, and suggestion within an ordinary clinical interaction. Therapeutic

changes may occur within minutes or even seconds.

During preoxygenation, the anaesthetist might say:
"Each time you breathe out, you can notice yourself relaxing, and with every breath out, you can relax even more."

Brief encouragement such as *"That's right"* or *"Well done"*, paced with exhalation, can reinforce this association without delaying care.

Pain is more than nociception

The International Association for the Study of Pain defines pain as 'an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.'³ Attention, anxiety, previous experience, context, culture, and expectation all contribute to pain and suffering. Patients undergoing the same procedure may therefore report very different experiences. Neuroimaging studies show that hypnosis can alter activity and connectivity within networks concerned with attention, emotional processing, executive control, and sensory discrimination, including the

anterior cingulate, insular, prefrontal, and somatosensory cortices.⁴⁻⁶ Suggestions can influence the sensory intensity, emotional unpleasantness, and personal meaning of pain. The aim is not necessarily to remove sensation, but to alter how it is attended to, interpreted, and experienced.

Evidence for hypnotic analgesia

Although effects vary with population, setting, practitioner expertise and outcome, systematic reviews and clinical trials suggest beneficial effects of hypnosis for experimental and procedural pain and distress associated with surgery.^{7,8} Hypnotic responsiveness varies between individuals and is influenced by context, the therapeutic relationship, and the type of suggestion. In invasive radiological procedures, adjunctive self-hypnotic relaxation reduced pain and anxiety, improved haemodynamic stability, and shortened procedure time.⁹ A multicentre cannulation trial similarly found that hypnosis and therapeutic communication reduced pain and anxiety.¹⁰ Because studies use different methods and outcomes, benefits should be regarded as context-dependent.

When words hurt

Patients in pain subconsciously observe clinicians, equipment, and the environment for signs of threat. Communication promoting comfort, safety, and control can be therapeutic, whereas inadvertent negative suggestion may amplify distress through nocebo mechanisms.

Phrases such as “This will sting”, “Sharp scratch”, “Bee sting coming” or “Try not to move” are intended to prepare or protect the patient. They may instead direct attention towards pain or movement and contribute to the experience or behaviour the clinician intended to avoid. Negatively-framed language during invasive procedures has been associated with greater pain and anxiety.¹¹ Avoiding nocebo effects does not mean withholding information or offering false reassurance. Predicting that cannulation

“is going to hurt” or “it is going to be comfortable” may be inaccurate because experiences differ. An approach that accounts for difference include:

“People experience sensations differently. Knowing that the drip allows us to give fluid and medication to keep you safe can help you feel more comfortable.”

Before infiltrating local anaesthetic, rather than saying “Bee sting coming”, the anaesthetist might say: “In a moment, but not yet, I’ll place some local anaesthetic under the skin to numb the area so we can finish as comfortably and safely as possible.”

Non-verbal cues also matter. Placing a vomit bowl beside an asymptomatic patient may suggest that nausea is anticipated. Hurried movements, visible concern or apologising before a routine procedure can similarly suggest that something unpleasant is about to happen.¹²

Giving the patient a role

Patients are often treated as the ‘field of play’ on which clinicians perform procedures. Hypnotic communication instead recognises the patient as an active team member whose skills, preferences and resources can be utilised. Choice and permission restore control. “Can you show me your best vein?” invites expertise. Asking, “Is it all right if I look at the arm?”, “May I place the tourniquet?” and “Is it OK to finish up?” builds rapport, confirms ongoing willingness, and allows the procedure to progress in stages. If the patient says no, pausing enhances trust. “That’s OK, just let me know when you are ready to finish”. Bounded choices can preserve agency when both alternatives are acceptable. A child might be asked, “Would you prefer to breathe in the magic wind or blow it away?” Asking whether the child would like to climb onto the operating table independently or with a parent’s help similarly preserves agency.

A practical framework

GREAT describes the interaction: Greeting, Rapport, Expectations, Addressing concerns and Tacit agreement.¹³

Greeting the patient and asking how they would like to be called begins rapport. Expectations can then be explored, misunderstandings corrected, and goals aligned where possible. Concerns should be addressed before agreeing the next steps. Tacit agreement refers to a shared understanding of those steps before the interaction finishes; it does not replace explicit consent for anaesthesia, invasive procedures, or formal hypnosis.

LAURS describes the therapeutic process: Listening, Acceptance, Utilisation, Reframing and Suggestion. Listening checks that the patient feels heard and understood. Acceptance validates present symptoms and experience. Utilisation incorporates the patient’s words, interests, memories, and strengths. Reframing offers a potentially therapeutic interpretation, while suggestion directs attention towards an agreed goal.

If a patient says, “The pain is like a tight braid around my spine”, it is essential first to validate that experience before suggesting therapeutic change: “That tight braid around your spine must be difficult for you. Would it be OK to explore what might make it more manageable?” This acknowledges and utilises the patient’s exact metaphor without claiming to know precisely what the experience feels like.

Applications across pain management

Hypnotic communication can be incorporated into venepuncture, cannulation, regional anaesthesia, interventional radiology, and awake surgery. It may be useful when previous adverse experiences, needle phobia, or severe procedural anxiety make necessary procedures difficult.

Children often engage readily with storytelling, play, and imagery. In burns care, consistent communication can help interrupt anticipatory fear and procedural pain during repeated dressing changes and rehabilitation. Imagination can redirect attention towards a pleasant experience without denying clinical reality.¹⁴

During labour, hypnosis may support relaxation, confidence, coping, and control. Suggestions can give contractions meaning beyond “labour pain”: “Each contraction brings you closer to meeting your baby.” Alternatively: “As you focus on the rest between contractions, that rest can begin to seem longer than it really is.”

Hypnotic communication complements women’s choices about pharmacological and neuraxial analgesia.¹⁵

Evidence for hypnosis in persistent pain is still developing and is best considered one component of multidisciplinary care. Hypnosis and self-hypnosis may support sleep, activity, emotional regulation, and self-management. Asking, “Can you remember a time when the pain was least troublesome?” may identify strategies associated with better function. For patients who engage with imagery, asking whether the pain has a colour or shape may create psychological distance from the symptom. The focus can then broaden towards function, confidence, flexibility, and participation.¹⁶

Training, safety, and limitations

Hypnosis is generally safe when used appropriately. Formal hypnosis and teaching self-hypnosis require appropriate training, discussion with the patient and documentation. Routine therapeutic communication can be integrated into our usual interactions. Clinicians should remain transparent about any distinct hypnotic intervention they propose.¹⁷

Patients with active psychosis, significant dissociative symptoms or complex trauma-related presentations may require clinicians with appropriate mental health and hypnosis expertise. Not every patient will respond, and not every anaesthetist will feel comfortable using formal hypnosis. That does not diminish the relevance of hypnotic communication. All clinicians can identify harmful suggestions, ask permission, offer meaningful choices, and direct attention towards comfort and recovery.

Conclusion

Clinical hypnosis lies at the intersection of neuroscience, psychology, and clinical practice. Formal hypnosis remains an additional clinical skill requiring appropriate training. However, the principles of hypnotic communication are relevant wherever health professionals prepare patients for procedures, manage symptoms such as pain or distress, and support recovery. The evidence currently available, together with the ubiquity of inadvertent negative suggestion in clinical care, supports the integration of conversational hypnosis in health-professional education. Therapeutic communication can then become a recognised competency, taught, practised, and assessed alongside other patient-safety skills. Future clinicians should understand not only what treatment they provide, but how the way they communicate can alter the patient’s experience and outcome. The recognition of conversational hypnosis as a clinical intervention and core component of pain management is long overdue.

Five changes to use tomorrow

1. Avoid routinely predicting pain when the patient’s experience is uncertain.
2. Explain the therapeutic purpose of each intervention.
3. Ask permission before successive procedural stages.
4. Describe the response you want rather than the behaviour the patient should avoid.
5. When appropriate, pace calming suggestions with the patient’s exhalation.

■ Associate Professor Allan Cyna

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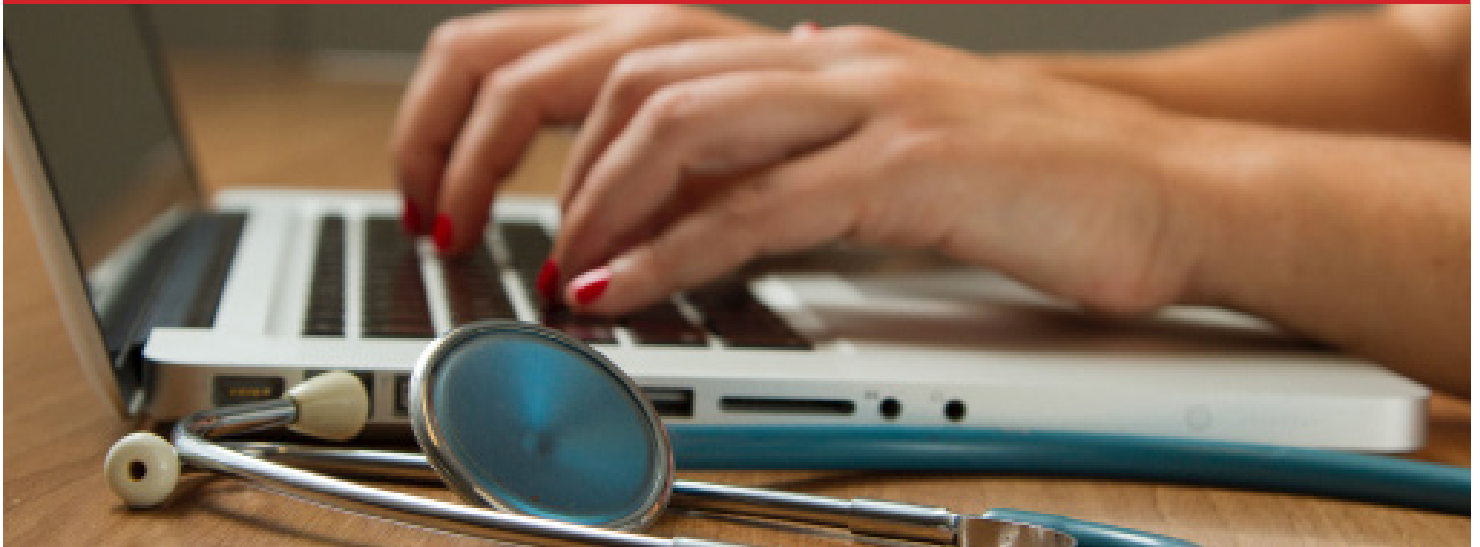
References

1. Cyna AM, Hewson DW, Hardman JG. Clinical hypnosis: implications in anaesthesia and perioperative care. *Br J Anaesth*. 2023;130:647–650.
2. Elkins GR, Barabasz AF, Council JR, Spiegel D. Advancing research and practice: the revised APA Division 30 definition of hypnosis. *Int J Clin Exp Hypn*. 2015;63:1–9.
3. Raja SN, Carr DB, Cohen M, et al. The revised International Association for the Study of Pain definition of pain: concepts, challenges and compromises. *Pain*. 2020;161:1976–1982.
4. Wolf TG, Faerber KA, Rummel C, Halsband U, Campus G. Functional changes in brain activity using hypnosis: a systematic review. *Brain Sci*. 2022;12:108.
5. Landry M, Lifshitz M, Raz A. Brain correlates of hypnosis: a systematic review and meta-analytic exploration. *Neurosci Biobehav Rev*. 2017;81:75–98.
6. Faymonville ME, Laureys S, Degueldre C, et al. Neural mechanisms of antinociceptive effects of hypnosis. *Anesthesiology*. 2000;92:1257–1267.
7. Thompson T, Terhune DB, Oram C, et al. The effectiveness of hypnosis for pain relief: a systematic review and meta-analysis of 85 controlled experimental trials. *Neurosci Biobehav Rev*. 2019;99:298–310.
8. Holler M, Koranyi S, Strauss B, Rosendahl J. Efficacy of hypnosis in adults undergoing surgical procedures: a meta-analytic update. *Clin Psychol Rev*. 2021;85:102001.
9. Lang EV, Benotsch EG, Fick LJ, et al. Adjunctive non-pharmacological analgesia for invasive medical procedures: a randomised trial. *Lancet*. 2000;355:1486–1490.
10. Fusco N, Bernard F, Roelants F, et al. Hypnosis and communication reduce pain and anxiety in peripheral intravenous cannulation: a multicentre randomised trial. *Br J Anaesth*. 2020;124:292–298.
11. Lang EV, Hatsiopolou O, Koch T, et al. Can words hurt? Patient-provider interactions during invasive procedures. *Pain*. 2005;114:303–309.
12. Arrow K, Burgoyne LL, Cyna AM. Implications of nocebo in anaesthesia care. *Anaesthesia*. 2022;77(Suppl 1):11–20.
13. Cyna AM. A GREAT interaction and the LAURS of communication in anaesthesia. *Acta Anaesthesiol Belg*. 2018;69(3):131–135.
14. Cyna AM. Little words BIG impact: perioperative communication for children with burns. *Anaesth Intensive Care*. 2020;48(2):123–128.
15. Madden K, Middleton P, Cyna AM, Matthewson M, Jones L. Hypnosis for pain management during labour and childbirth. *Cochrane Database Syst Rev*. 2016;2016:CD009356.
16. Pulling BW, Braithwaite FA, Moseley GL, et al. Suggestions in Hypnosis to Aid Pain Education in people with chronic low-back pain: a pilot feasibility randomised controlled trial. *Int J Clin Exp Hypn*. 2022;70:251–276.
17. Häuser W, Hagl M, Schmierer A, Hansen E. The efficacy, safety and applications of medical hypnosis. *Dtsch Arztebl Int*. 2016;113:289–296.

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UP CLOSE WITH

THE BLOCK ROOM ADVANTAGE: LESSONS FROM TORONTO ON BUILDING A HIGH-PERFORMING REGIONAL ANAESTHESIA SERVICE

Professor Ki-Jinn Chin talks with Associate Professor Suzi Nou about regional anaesthesia and block rooms in Canada.



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PROFESSOR KI-JINN CHIN IS THE PROGRAM AND CLINICAL DIRECTOR AT TORONTO WESTERN HOSPITAL. HE SPECIALISES IN REGIONAL ANAESTHESIA, ACUTE PAIN MANAGEMENT AND ULTRASOUND-GUIDED PROCEDURES, WITH FELLOWSHIP TRAINING IN NEUROANAESTHESIA AND REGIONAL ANAESTHESIA. A WIDELY PUBLISHED AUTHOR AND INTERNATIONAL SPEAKER, DR CHIN PROMOTES BROADER ACCESS TO REGIONAL ANAESTHESIA THROUGH TECHNOLOGY, EDUCATION AND ONLINE RESOURCES FOR HEALTHCARE PROFESSIONALS WORLDWIDE.

I have been hearing about block rooms for years. The concept surfaces whenever clinicians discuss theatre efficiency, enhanced recovery pathways, same-day arthroplasty, workforce pressures or the expanding role of regional anaesthesia. Yet despite growing interest, the model here in Australia often remains more talked about than understood.

What exactly does a mature block room service look like? How does the patient move through the system? What makes it work day after day? And perhaps most importantly, could Australian hospitals realistically adopt the same approach?

To answer those questions, I spoke with Professor Ki-Jinn Chin, Director of the Regional Anesthesia Fellowship Program in Toronto, Canada. His institution has operated a dedicated block room service for more than two decades, building on foundations established by Dr Vincent Chan, one of the pioneers of ultrasound-guided regional anaesthesia.

What became clear very early in our conversation was that the success of the model has remarkably little to do with physical space. The enduring lesson from Toronto is that a block room is not a room at all: it is a workflow.

That distinction matters because the greatest benefits are not architectural. They are operational. By shifting regional anaesthesia out of the operating theatre and into a dedicated preparation area, the service improves patient flow, creates opportunities for assessment and troubleshooting, and allows operating rooms to function more efficiently.

What is a block room?

Professor Chin offers a refreshingly simple definition.

"A block room is really a dedicated space in which regional anaesthesia happens."

The space itself can be surprisingly modest. Some hospitals begin with a single bay in the Post Anaesthesia Care Unit (PACU), an induction room or another area within the theatre complex. Toronto currently utilises repurposed operating room space, but Professor Chin emphasises that infrastructure is only part of the equation.

The fundamental principle is parallel processing. While one patient is undergoing surgery, the next patient receives a spinal anaesthetic or peripheral nerve block elsewhere. By the time an operating room becomes available, the

The fundamental principle is parallel processing. While one patient is undergoing surgery, the next patient receives a spinal anaesthetic or peripheral nerve block elsewhere. By the time an operating room becomes available, the block has been performed, assessed and given time to develop.

block has been performed, assessed and given time to develop.

For clinicians, this may sound like a relatively small change in geography. In practice, however, it transforms how patients, staff and resources move through the perioperative environment.

The patient journey starts early

One of the most striking features of the Toronto model is that the block room journey begins well before the day of surgery. Many patients first hear about regional anaesthesia from their surgeon. Those discussions are reinforced during subsequent anaesthetic review and preoperative assessment. By the time patients arrive for surgery, the offer of a regional anaesthesia technique has become a discussion of something familiar rather than novel or unexpected. For procedures such as hip and knee arthroplasty, regional anaesthesia has become an established part of the pathway. For many upper limb procedures, it is frequently presented as the default approach by the surgeon, anaesthetist and others in the care team.

Professor Chin believes these early conversations are critical. When the first discussion about a nerve block occurs on the morning of surgery, clinicians may spend valuable time correcting misconceptions and addressing anxieties that could have been managed weeks earlier. Toronto's approach allows education to occur gradually, creating a smoother experience for both patients and clinicians. Importantly, patient autonomy remains central throughout the pathway. Regional anaesthesia is recommended and discussed, but never imposed.

Consent as an ongoing conversation

Consent is revisited when patients arrive in the block room. The team reviews risks, benefits, alternatives, postoperative analgesia plans and expected block duration. Temporary weakness, sensory changes and the possibility of supplemental sedation or general anaesthesia are also discussed. A particularly important question is clarified early: is the block intended as the primary anaesthetic or as an analgesic adjunct? The answer influences theatre planning, recovery expectations and the overall perioperative pathway.

Professor Chin noted that many patients worry they will be fully awake during surgery. Addressing that concern early often improves acceptance.

"You will be asleep. However, it is not a coma. It is a light sleep and we'll freeze your elbow."

The explanation is simple, memorable and patient-centred.

Inside the block room

On a typical day, the block room functions like a carefully choreographed transit hub. Patients move steadily through the area while operating theatres continue running in parallel. Standard monitoring is applied. Intravenous access is established when required. Nursing checklists are completed and patient identification confirmed. Correct-site verification receives particular attention. "You have to make sure you're performing the block on the correct surgical location and the right side," Professor Chin explained. Multiple safeguards are used, including consent review, direct confirmation with patients

and procedural marking systems. Only once these steps are complete does the procedure begin.

Who keeps the system moving?

Building a reliable block room service requires more than ultrasound machines and procedure trays. The success of the model depends on people. Professor Chin describes three key workforce groups: the first is a dedicated coordinating nurse who manages patient flow, liaises with theatres and ensures patients arrive at the appropriate location at the appropriate time, the second is an anaesthesia assistant who supports procedural setup and delivery, the third is the procedural team itself, comprising consultants, fellows and residents.

The coordinating role becomes particularly valuable when multiple theatres are involved. Lists often run ahead or behind schedule. A spinal performed too early may wear off before surgery begins. A block performed too late may contribute to delays. Managing these moving parts is an essential element of the model and highlights a recurring lesson from Toronto: successful block rooms rely on systems thinking.

There is more to a block than the needle

Many specialist anaesthetists recognise that performing a procedure is, in itself, often the shortest part of the process. The real work occurs before and after needle insertion. Patients must be positioned, monitored, educated and reassured. Safety checks and

Building a reliable block room service requires more than ultrasound machines and procedure trays. The success of the model depends on people.

documentation must be completed. Afterwards, clinicians need time to evaluate block performance.

This perspective challenges the common tendency to focus only on technical proficiency. A well-functioning regional anaesthesia service depends just as much on workflow design as procedural skill.

Time to test the block

One of the major advantages of the block room model is the opportunity to assess whether a block is actually working before surgery begins. Traditional workflows sometimes compress block placement and surgical start times so tightly that limited opportunity exists to evaluate effectiveness. Toronto deliberately creates space between block completion and transfer to theatre. Professor Chin estimates that around thirty minutes is often appropriate. During this period, clinicians assess sensory changes, monitor progression and identify incomplete coverage. Supplementary blocks can be performed when necessary.

As Professor Chin pointed out, no regional anaesthesia service achieves perfect success rates and it is important that potential problems become apparent before the patient is draped and surgery has commenced.

Theatre handover

Once the block has been evaluated, patients proceed to theatre. A separate anaesthesia team assumes intraoperative care. Some patients receive sedation alone, while others undergo general anaesthesia combined with regional techniques.

The handover process is structured and deliberate. The block room team remains available throughout the day, allowing expertise and continuity to follow the patient journey even after transfer. Again, the defining characteristic is workflow. Preparation and delivery occur in separate but closely linked environments, with each team focused on a specific component of care.

The reverse PACU

Perhaps the most fascinating concept discussed by Professor Chin was what some clinicians have called the 'reverse PACU'. Traditionally, intensive monitoring occurs after surgery in the PACU with patients being nursed in a 1:1 ratio. However, many patients receiving regional anaesthesia have already undergone substantial assessment and observation before entering the operating room. Patients who receive only light sedation frequently emerge comfortable, alert and physiologically stable.

As a result, some can bypass Phase 1 PACU. For example, following hand surgery, patients may be transferred directly from the operating table to a wheelchair and then to Phase 2 PACU. Similar pathways are increasingly being explored for same-day arthroplasty patients when clinically appropriate. For hospitals struggling with PACU capacity, the implications are obvious.

Follow-up after discharge

Professor Chin is especially passionate about what happens after patients leave hospital. Historically, many regional anaesthesia services concentrated heavily on block placement while

collecting relatively little information about the patient's post-discharge experience. Toronto deliberately follows patients beyond the immediate perioperative period.

Telephone follow-up provides safety surveillance, quality improvement data and opportunities for education. Discussions commonly focus on block resolution, rebound pain, neurological symptoms and analgesic requirements. Perhaps most importantly, these conversations provide direct insight into the patient experience.

Professor Chin believes hearing patients describe their postoperative journey helps clinicians become better communicators and set more realistic expectations.

Lessons for implementation

Could every Australian hospital establish a dedicated block room tomorrow? Realistically, no. Space constraints, workforce shortages and funding pressures remain significant challenges across the healthcare system. Yet Toronto's experience suggests that waiting for perfect conditions may be unnecessary.

Professor Chin's advice is simple: start small. A single procedural bay can demonstrate proof of concept. One engaged surgeon can become a champion for change. One dedicated nurse can improve coordination and flow. Early successes create credibility. Credibility creates momentum. As the benefits become visible to clinicians, administrators and surgical colleagues, support often grows organically.

Conclusion

What resonated most strongly throughout our discussion was how relevant the Toronto experience might be to Australian practice. Our hospitals face many of the same challenges: increasing surgical demand continues, operating theatre time remains expensive and the need to deliver high-quality care with finite resources. At the same time, regional anaesthesia is becoming an increasingly important component of enhanced recovery and ambulatory surgery programs.

The block room model sits at the intersection of these challenges and opportunities. Importantly, Toronto's experience suggests that success depends less on constructing new facilities and more on creating a culture that supports collaborative perioperative care. Surgeons, anaesthetists, nursing staff, recovery teams and administrators all contribute to the outcome. Ultimately, the model succeeds because everyone participates in the same workflow.

By the end of my conversation with Professor Chin, it became clear that block rooms are about far more than regional anaesthesia. They represent a different way of organising perioperative care, one that extends from preoperative education and consent through to recovery and post-discharge follow-up.

As Professor Chin reflected, "The block room environment is a very rich learning area." It is also an environment that fosters collaboration, efficiency and continual improvement. For Australian departments considering the next evolution of their regional anaesthesia service, Toronto offers an important reminder. The most meaningful innovations do not always come from new technology or additional infrastructure.

They come from rethinking the way care flows.

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with Associate Professor

Suzi Nou



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UP CLOSE WITH

DR MICHELLE CHONG: EMBRACING CHANGE, FINDING PURPOSE, AND BUILDING A RESEARCH LEGACY

Dr Michelle Chong talks with Associate Professor Suzi Nou about regional anaesthesia and winning an ASA research grant.



DR MICHELLE CHONG
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DR MICHELLE CHONG IS A STAFF ANAESTHETIST AT ST VINCENT'S HOSPITAL MELBOURNE AND PHD CANDIDATE IN CRITICAL CARE AT THE UNIVERSITY OF MELBOURNE. HER RESEARCH EXPLORES TARGETED PERIPHERAL NERVE BLOCK STRATEGIES FOR SHOULDER SURGERY, INCLUDING SELECTIVE COMBINATIONS OF THE SUPRASCAPULAR, AXILLARY AND LATERAL PECTORAL NERVES, TO IMPROVE PAIN RELIEF, REDUCE COMPLICATIONS AND SUPPORT RECOVERY.

For many clinicians, attaining a consultant position represents the culmination of years of hard work and sacrifice. For Dr Michelle Chong, however, becoming a consultant anaesthetist was not the end of the journey. Instead, it became the starting point for a series of professional and personal transformations that would reshape her career, challenge her assumptions, and ultimately position her as an emerging leader in regional anaesthesia and clinical research.

From obstetrics to regional anaesthesia: A career pivot

Today, Dr Chong is a full-time consultant anaesthetist at St Vincent's Hospital Melbourne. She received her FANZCA in 2018 and trained at Monash Health, where she completed a provisional fellowship in obstetric anaesthesia shared between Monash Health and the Royal Women's Hospital. Like many young specialists, Dr Chong initially imagined this would become the primary focus of her consultant career. She loved obstetric anaesthesia and spent several

years building her clinical portfolio in the specialty, caring for women during pregnancy and childbirth.

Yet careers rarely follow a straight line. Alongside her interest in obstetric anaesthesia, Dr Chong had always been fascinated by regional anaesthesia. The interest was present from early in her training, but it grew significantly after she joined St Vincent's Hospital Melbourne as a Visiting Medical Officer. There, she became increasingly aware of the potential of regional anaesthesia to improve recovery, reduce opioid requirements, and contribute to broader perioperative care pathways.

The turning point came several years into consultant practice. While she continued to enjoy obstetric work and valued her time at Monash, she found herself increasingly drawn toward regional anaesthesia as a field in which she could make a broader impact. The opportunity to undertake a regional anaesthesia fellowship in Toronto ultimately forced a choice: Pursuing that path would mean stepping away from the career trajectory she had originally envisioned in obstetric anaesthesia and committing fully to a new professional direction.

Looking back, the decision represented one of the most significant pivots of her career. It involved leaving behind an established area of expertise and re-entering a fellowship environment in a different subspecialty years after becoming a consultant. What might have appeared from the outside as a risk became the catalyst for a new chapter defined by academic research, international collaboration, and leadership in regional anaesthesia.

A leap into the unknown

Dr Chong's move to Toronto was unconventional. Most overseas fellowships are completed immediately following specialist training, not four or five years into consultant practice. The seeds of this change were planted during the COVID-19 pandemic. Like many healthcare professionals, she experienced a period of reflection during those difficult years. Originally from Malaysia, Dr Chong found herself far from home while simultaneously navigating the professional and emotional challenges of the pandemic. She began asking herself questions that many clinicians eventually face: Is there something more I could be doing? Am I fulfilling my potential? What impact do I want to have over the course of my career?

Around this time, she reached out to Professor K.J. Chin, the internationally respected regional anaesthetist based in Toronto. Initially, her intentions were modest. She wanted to learn more about regional anaesthesia, discuss some of the educational videos and resources he had produced, and seek advice on how she might further develop regional anaesthesia services in her own hospitals. The conversation also carried a personal dimension. As fellow Southeast Asians living and working far from home during the pandemic, they shared common experiences and perspectives.

What began as a simple Zoom meeting quickly evolved into something much more significant. After a lengthy discussion about regional anaesthesia, innovation and clinical practice, Professor Chin unexpectedly asked her a life-

changing question: why not come to Toronto and join the fellowship program for a year? Dr Chong said yes almost immediately, before fully appreciating just how much her life was about to change.

Understandably, the prospect was intimidating. She admits that one of her greatest fears was re-entering a fellowship environment after years of working independently as a consultant. It was not the learning she feared; she has always loved learning. Instead, she worried about whether she could meet the expectations placed upon senior fellows and whether she could still work at the intensity demanded by the role.

Toronto: A transformational year

What she discovered in Toronto quickly reassured her. Rather than being an outlier, she found herself surrounded by other experienced consultants who had also chosen to leave established careers in pursuit of further learning. Her fellowship cohort were almost all specialist anaesthetists and came from diverse backgrounds such as Colombia, Brazil, Wales, and included a military anaesthetist from the British Army. This diversity created an extraordinarily rich learning environment and friendships that now span the globe.

More importantly, Toronto exposed her to a deeply academic culture. Beyond learning advanced regional anaesthesia techniques, Dr Chong found something equally valuable: mentorship. During her fellowship she developed professional relationships with internationally respected leaders including Professor Philip Peng, Professor K. J. Chin, and Professor Anahi Perlas. These mentors continue to support her work long after her return to Australia.

Finding a voice through scholarship

The experience also gave her something she had been searching for professionally: confidence and credibility. She believed that undertaking advanced fellowship

training and pursuing higher academic qualifications would help her develop the authority needed to advocate effectively for new ideas and innovations.

Exposure to internationally recognised academic leaders also prompted reflection on her own career aspirations and how she might establish a voice within academic anaesthesia.

Dr Chong spoke candidly about her feeling that women often need to accumulate additional credentials before being taken seriously in leadership roles. Although she acknowledges that progress is being made, she felt that pursuing a fellowship and a PhD became necessary steps in establishing herself within the academic community.

Returning to Melbourne in 2024, Dr Chong consolidated her practice at St Vincent's Hospital and embarked on perhaps her most ambitious challenge yet: a PhD through the University of Melbourne.

The origin of her doctoral research demonstrates the power of curiosity-driven medicine. Dr Chong approached Professor Jason Ivanovic, an anatomy expert at the University of Melbourne, with an idea regarding a novel shoulder nerve block. Rather than dismissing the concept, he immediately recognised its potential, suggesting that the project contained enough material for multiple significant publications and encouraging her to consider a PhD.

Her research journey began in the anatomy laboratory. Through cadaveric studies, dye injections, dissections, systematic reviews, and early clinical investigations, she sought to develop and validate a new technique for blocking the axillary nerve.

Winning the ASA's research grant

Crucially, this work was supported by the ASA Small Grant, now known as the ASA Research Grant, one of the awards designed to help emerging researchers transform promising ideas into meaningful projects. For Dr Chong, the grant arrived at exactly the right moment.

While she had secured access to the anatomy laboratory and support from collaborators, the cadaveric component of her research carried significant costs. The funding allowed her to obtain the specimens required to complete the anatomical studies that formed the foundation of her project.

The impact of the grant extended well beyond financial support. It provided an important vote of confidence at an early stage of her research career, helping validate an ambitious idea that would go on to become one of the central pillars of her PhD. The work subsequently resulted in the publication of a paper describing a novel approach to blocking the axillary nerve, contributing new knowledge to the field of regional anaesthesia.

Looking back, Dr Chong regards the ASA Small Grant as a critical stepping stone. Like many clinician-researchers beginning their academic journey, she learned that every successful project depends not only on good ideas but also on securing the resources needed to bring those ideas to life. The grant has become a springboard for the next phase of her research, which will involve larger clinical studies and applications for more substantial research funding.

Like many clinician-researchers, Dr Chong has had to balance research with ongoing clinical responsibilities. She credits much of her success to the support she has received from St Vincent's Hospital Melbourne, particularly departmental leadership who actively encouraged her academic pursuits.

From research idea to clinical impact

The influence of Toronto became particularly evident when Dr Chong returned to Australia armed with new ideas about perioperative care and patient recovery. Drawing on the experience she had gained in Canada, she recognised opportunities to rethink traditional approaches to joint replacement pathways and explore ways to help suitable patients recover more efficiently and reduce length of

stay while maintaining excellent clinical outcomes. Rather than simply importing a model from overseas, she worked collaboratively with colleagues at St Vincent's to adapt those concepts to the Australian healthcare environment and local patient population.

What emerged was Project 24 Arthro, a multidisciplinary initiative designed to safely discharge suitable joint replacement patients within 24 hours of surgery. The program was not simply an anaesthesia project. Dr Chong recognised that success depended upon aligning everyone involved in patient care, including surgeons, physiotherapists, pharmacists, ward staff, administrators, and patients themselves.

Her approach reflected a key lesson she had learned throughout her career: meaningful change requires understanding other people's workflows and priorities. Months were spent building consensus, refining protocols, and establishing common discharge goals. The results exceeded expectations, leading to significant reductions in length of stay and earning the St Vincent's Hospital Association Excellence in Service Award.

Looking ahead

Looking ahead, Dr Chong's ambitions remain firmly focused on research. Her published cadaveric work and early clinical studies represent only the beginning of a larger research program. The next phase involves securing funding for randomised controlled trials that will formally compare her novel nerve block technique against existing standards of care.

In an era when healthcare increasingly relies on innovation, collaboration, and evidence-based practice, Dr Chong represents a new generation of clinician-scientists who bridge the worlds of patient care and research. Her willingness to take risks, seek mentorship, and embrace lifelong learning has already transformed her career. More importantly, it is generating tangible improvements in patient care and creating opportunities for future advances in regional anaesthesia.

Throughout the interview, she returned to the importance of mentors. At the same time, she has begun to consider her own role as a mentor. Recognising the relative scarcity of women in academic anaesthesiology and research leadership, she expressed enthusiasm about supporting the next generation of clinician-researchers.

For Dr Chong, the decision that once seemed "crazy" now appears to have been exactly the right one. By stepping outside her comfort zone, she discovered a new direction, a stronger professional voice, and a platform from which she can help shape the future of our specialty.

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with Associate Professor

Suzi Nou



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DR SARAH LEE
STAFF ANAESTHETIST,
EASTERN HEALTH

FEATURE ARTICLE

METHADONE: MENACE OR MISUNDERSTOOD? FOUR DECADES OF DEBATE, REDISCOVERY AND REINVENTION

First introduced into perioperative practice more than four decades ago by the pioneering Australian work undertaken by Geoffrey Gourlay and colleagues^{1,2} methadone remains one of the most debated drugs in modern anaesthesia. Few perioperative medications have experienced such repeated cycles of enthusiasm, rediscovery and reappraisal³.

While recent systematic reviews and meta-analyses have demonstrated improved postoperative analgesia and reduced opioid consumption across a range of surgical populations^{4,5} questions regarding patient selection, postoperative monitoring and safety continue to divide opinion⁶. As interest in enhanced recovery pathways and opioid stewardship has grown, methadone has once again become a topic of discussion^{7,8}. The story of perioperative methadone is not simply one of a drug. Rather, it reflects that the translation of evidence into clinical practice is influenced by multiple factors, including local culture, perceptions of risk, and familiarity with the agent.

Recent discussion during the ADVANCE (Anaesthesia Discussion, Views and Contemporary Evidence) methadone webinar hosted by the Australian Society of Anaesthetists (ASA) highlighted that many of the questions surrounding methadone are not just centred on whether the drug provides effective analgesia but rather how it should be implemented safely in modern practice. Topics frequently raised by clinicians included optimal dosing strategies, postoperative monitoring requirements, patient selection and the implications of methadone's long elimination half-life. Notably, considerable variation existed in how practitioners approached these issues, reflecting a broader uncertainty that persists despite an expanding evidence base. Importantly, such variation is not unique to Australia. A recent nationwide survey of anaesthesiology residency programs and practitioners in the United States similarly demonstrated substantial heterogeneity in perioperative implementation, suggesting that uncertainty regarding its optimal use remains an international phenomenon⁹.

The Australian origins

The modern story of perioperative methadone began in Australia. During the early 1980s, Gourlay and colleagues undertook a series of methadone related studies. Their work helped define the perioperative pharmacokinetic and pharmacodynamic profile of methadone, highlighting an observation that continues to shape contemporary practice: despite a long elimination half-life, methadone has a relatively rapid onset of action and favourable distribution kinetics that support its use as a single-dose perioperative analgesic^{1,2,10,11}.

This distinction remains important. Effect-site concentrations decline substantially during the early distribution phase, while analgesic benefits persist well into the postoperative period. More than three decades later, these observations inspired renewed interest in methadone among a new generation of investigators, including many of those leading the contemporary resurgence.

While recent systematic reviews and meta-analyses have demonstrated improved postoperative analgesia and reduced opioid consumption across a range of surgical populations^{4,5} questions regarding patient selection, postoperative monitoring and safety continue to divide opinion⁶.

In many respects, the concept was ahead of its time. A single opioid administered during anaesthesia that continued to provide analgesia throughout the period of greatest postoperative pain represented an attractive proposition. Yet despite these early insights, methadone failed to gain widespread acceptance within routine perioperative practice. For many clinicians, methadone's long elimination half-life became equated with increased risk of delayed respiratory depression, perhaps erroneously.

Why did methadone fall out of favour?

The decline of perioperative methadone cannot be attributed to a single factor. Concerns regarding respiratory depression, long elimination half-life, difficult titration and interindividual pharmacokinetic variability all contributed to caution. Educational resources from the Australian and New Zealand College of Anaesthetists and publications from the Acute Pain Management Scientific Evidence group have consistently emphasised methadone's long duration of action, substantial pharmacokinetic variability and the importance of appropriate patient selection and postoperative monitoring¹². Such guidance has appropriately encouraged caution. At the same time, anaesthesia was increasingly embracing short-acting opioids, patient-controlled analgesia, regional anaesthesia and neuraxial techniques.

Stigma may also have played a role. For many clinicians, methadone became synonymous with opioid substitution therapy and chronic pain management rather than perioperative analgesia.

Of note, methadone remains one of the least expensive long-acting analgesic options available to anaesthetists. Paradoxically, its low cost has been proposed as one factor contributing to limited familiarity and slower uptake, as generic medications may attract less investment in research dissemination and educational initiatives than newer proprietary agents¹³. Consequently, much of methadone's contemporary resurgence in perioperative medicine has been driven by investigator-initiated research and academic interest³.

Concerns regarding respiratory depression continue to represent the greatest barrier to widespread adoption. Recent observational studies have generated debate regarding postoperative respiratory events following methadone administration^{14,15}. Interpretation of these findings requires caution. In the study by Dunn and colleagues, methadone recipients represented a clinically distinct cohort characterised by greater comorbidity burden and higher rates of pre-existing analgesic requirements. Concurrent use of central nervous system depressants, including gabapentinoids and benzodiazepines, was common and there was no comparator control group. Furthermore, planned postoperative intensive care admission may have influenced clinician dosing decisions and monitoring practices. Consequently, causal inferences regarding methadone itself remain difficult to establish¹⁴. Emerging evidence, although not without limitations, suggests that when appropriate patient selection, dosing and monitoring are employed, methadone can be administered safely within perioperative pathways^{16,17}.

Fears regarding corrected QT interval prolongation and arrhythmias may have further contributed to cautious uptake. However, much of the literature underpinning these concerns originated from patients receiving chronic oral methadone therapy, where daily doses exceeding 100 mg were common and treatment occurred over prolonged periods¹⁸. In contrast, perioperative methadone is typically administered as a single intravenous dose, substantially lower than cumulative doses used in chronic methadone maintenance therapy, under continuous physiological monitoring and has not been shown to be associated with increased clinically significant arrhythmias¹⁹. The distinction between chronic high-dose oral methadone therapy and single-dose intraoperative administration is not always clearly appreciated, and safety concerns derived from one population may have influenced perceptions of the other.

Concerns regarding serotonin toxicity have also been raised because methadone inhibits serotonin reuptake. However, clinically significant perioperative serotonin syndrome appears uncommon and is typically associated with concomitant serotonergic medications rather than methadone alone^{20,21}.

The variability in uptake is unsurprising. Unlike fentanyl, morphine or oxycodone, methadone has historically occupied a relatively limited role within anaesthesia training and many clinicians report less familiarity with its perioperative use.

The resurgence

Yet methadone has again re-emerged as a topic of international interest, driven largely by the work of investigators, such as Evan Kharasch, Glenn Murphy and colleagues, whose studies have expanded understanding of its role in perioperative practice.

Ironically, the increasing emphasis on regional anaesthesia, multimodal analgesia and later opioid-minimisation strategies may have contributed to methadone's decline before simultaneously creating conditions for its resurgence. In major spine, cardiac and abdominal surgery,

For many clinicians, methadone became synonymous with opioid substitution therapy and chronic pain management rather than perioperative analgesia.

postoperative pain remains substantial and regional techniques may not always provide complete coverage. In these circumstances, methadone has re-emerged as a pragmatic compromise between opioid avoidance and effective analgesia. In fact, methadone has been described as the “opioid sparing opioid”, reflecting its association with a reduction in postoperative opioid consumption and in some patients, opioid requirements beyond hospital discharge^{3,22}. Intravenous methadone may provide comparable postoperative opioid consumption and functional recovery outcomes while avoiding the procedural limitations associated with regional and neuraxial techniques²³. Importantly, caution is warranted when profound postoperative analgesia abolishes nociceptive input, as this may unmask opioid-induced ventilatory depression. This principle is particularly relevant when dense neuraxial or major regional techniques are combined with systemic opioid analgesia, including methadone^{24,25}.

Contemporary studies in cardiac, spine and major abdominal surgery have renewed attention on its potential to improve postoperative analgesia, reduce opioid requirements and enhance recovery^{4,26-28}. The timing coincided with growing interest in enhanced recovery pathways where healthcare systems were increasingly focused on quality of recovery, early mobilisation and opioid stewardship.

Clinical applications and special populations

As evidence expands, methadone's use has extended beyond the cardiac and spine populations that initially drove renewed interest. Dose-finding studies demonstrated that carefully selected patients undergoing ambulatory and next-day discharge surgery may achieve

improved analgesia with relatively modest methadone doses^{22,29}.

Interest has expanded into paediatric practice where emerging studies have reported improved analgesia, reduced postoperative opioid requirements and emergence delirium without a corresponding increase in adverse events³⁰⁻³³.

Australia again contributed important data during the next phase of methadone's evolution. In 2011, Russell, Paech and colleagues reported the use of intravenous methadone during general anaesthesia for caesarean delivery³⁴. Although intrathecal morphine remains the dominant analgesic strategy for caesarean section, methadone continues to attract interest in carefully selected obstetric patients, particularly where neuraxial opioids are unavailable or undesirable. Notably, breastfeeding data derived from methadone maintenance populations have been reassuring, with low infant exposure reported through breast milk^{35,36}. While these data derive from a different clinical setting, they provide additional reassurance when considering a single perioperative dose.

Interestingly, discussion during the ADVANCE webinar suggested that uptake remains highly variable even within Australia. While some institutions report little or no perioperative methadone use, others have incorporated methadone into selected pathways such as major abdominal surgery, complex spine surgery or general anaesthesia caesarean delivery. Together with the findings of Razak and colleagues⁹, these observations suggest substantial variation in perioperative methadone practice. More broadly, variation in clinical practice is well recognised within anaesthesia, where differences in clinician training, institutional protocols and interpretation of evidence may influence decision-making³⁷⁻³⁹.

What is methadone's role today?

Methadone is not a panacea. Its greatest value may lie in selected clinical contexts where prolonged analgesia is desirable and alternative strategies are limited. The concept remains appealing: a single intraoperative intervention that continues to provide meaningful analgesia throughout the period of greatest postoperative pain.

More than 40 years after Geoffrey Gourlay's seminal work, methadone remains one of the most fascinating drugs in perioperative medicine.

Conceived through pioneering Australian pharmacological research, embraced by international investigators, overshadowed during the rise of short-acting opioid techniques and subsequently rediscovered in the era of enhanced recovery, methadone has repeatedly challenged conventional thinking.

Future studies may further clarify patient selection, dosing strategies and long-term recovery outcomes. Until then, methadone remains neither menace nor marvel, but rather an evolving agent whose role in contemporary perioperative care continues to be defined. As international interest grows once again, it is worth remembering that the contemporary methadone story began in Australia, where investigators first explored whether a single intraoperative opioid could provide prolonged postoperative analgesia.

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References

- Gourlay GK, Willis RJ, Wilson PR. Postoperative pain control with methadone: influence of supplementary methadone doses and blood concentration--response relationships. *Anesthesiology*. 1984;61(1):19-26.
- Gourlay GK, Wilson PR, Glynn CJ. Pharmacodynamics and pharmacokinetics of methadone during the perioperative period. *Anesthesiology*. 1982;57(6):458-67.
- Kharasch ED. Intraoperative methadone: rediscovery, reappraisal, and reinvigoration? *Anesth Analg*. 2011;112(1):13-6.
- Machado FC, Vieira JE, de Orange FA, Ashmawi HA. Intraoperative Methadone Reduces Pain and Opioid Consumption in Acute Postoperative Pain: A Systematic Review and Meta-analysis. *Anesth Analg*. 2019;129(6):1723-32.
- D'Souza RS, Gurrieri C, Johnson RL, Warner N, Wittwer E. Intraoperative methadone administration and postoperative pain control: a systematic review and meta-analysis. *Pain*. 2020;161(2):237-43.
- D'Souza RS, Esfahani K, Dunn LK. Pro-Con Debate: Role of Methadone in Enhanced Recovery After Surgery Protocols-Superior Analgesic or Harmful Drug? *Anesth Analg*. 2023;137(1):76-82.
- Garcia S, Mali M, Grewal A. Pro: Methadone Should Be Used as a Part of Enhanced Recovery After Cardiac Surgery Protocol. *J Cardiothorac Vasc Anesth*. 2024;38(5):1268-71.
- Ramaiah VK, Kharasch ED. Methadone and Enhanced Recovery After Surgery: Concepts and Protocols. *Anesth Analg*. 2024;139(3):670-4.
- Razak A, Al Bizri E, Fardos Y, Romeiser JL, Bennett-Guerrero E. Nationwide survey of intraoperative methadone administration for perioperative analgesia. *Regional Anesthesia & Pain Medicine*. 2026;51(1):104.
- Gourlay GK, Plummer JL, Cherry DA, Cousins MJ. Does intravenous methadone provide longer lasting analgesia than intravenous morphine? *Pain*. 1990;42(3):383-4.
- Gourlay GK, Willis RJ, Lamberty J. A double-blind comparison of the efficacy of methadone and morphine in postoperative pain control. *Anesthesiology*. 1986;64(3):322-7.
- Schug SA PG, Scott DA, Alcock M, Halliwell R, Mott JF; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. *Acute Pain Management Scientific Evidence* 5th edition. Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. 2020. Available from <https://www.anzca.edu.au/safety-advocacy/advocacy/college-publications>.
- Ripamonti C, Bianchi M. The use of methadone for cancer pain. *Hematol Oncol Clin North Am*. 2002;16(3):543-55.
- Dunn LK, Yerra S, Fang S, Hanak MF, Leibowitz MK, Alpert SB, et al. Safety profile of intraoperative methadone for analgesia after major spine surgery: An observational study of 1,478 patients. *J Opioid Manag*. 2018;14(2):83-7.
- Carlé N, Nikolajsen L, Uhrbrand CG. Respiratory Depression Following Intraoperative Methadone: A Retrospective Cohort Study. *Anesth Analg*. 2025;140(3):516-23.
- Lumsden S, Kharasch ED, Speer B, Kwater A, Gan TJ, Cata JP. Intraoperative Methadone Administration Is Not Associated With an Increase in Perioperative Use of Naloxone: A Retrospective Study. *Anesth Analg*. 2024;138(5):1145-7.
- Nunez-Rodriguez E, Mazzinari G, Lumsden S, Cortes-Mejia NA, Krause KJ, Kharasch ED, et al. Respiratory Depression after Perioperative Methadone Administration: A Systematic Review and Meta-analysis. *Anesthesia & Analgesia*. 9900:10.1213/ANE.0000000000008077.
- Alinejad S, Kazemi T, Zamani N, Hoffman RS, Mehrpour O. A systematic review of the cardiotoxicity of methadone. *Excli j*. 2015;14:577-600.
- McClain MR, Subramaniam K, Cheema R, Lavage DR, Lin H-HS, Sultan I, et al. Intraoperative Methadone in Adult Cardiac Surgical Patients and Risks for Postoperative QTc Prolongation. *Journal of Cardiothoracic and Vascular Anesthesia*. 2025;39(2):406-13.
- Baldo BA, Rose MA. The anaesthetist, opioid analgesic drugs, and serotonin toxicity: a mechanistic and clinical review. *British Journal of Anaesthesia*. 2020;124(1):44-62.
- Peranathan V BN. Opioids and antidepressants: which combinations to avoid. *Aust Prescr* 2021;44:41-4. doi:10.18773/austprescr.2021.004
- Kharasch ED, Brunt LM, Blood J, Komen H. Intraoperative Methadone in Next-day Discharge Outpatient Surgery: A Randomized, Double-blinded, Dose-finding Pilot Study. *Anesthesiology*. 2023;139(4):405-19.
- Lim ZJ, Rough K, Dubey H, Lee S. Intravenous methadone versus regional and neuraxial analgesic techniques in the peri-operative period: a scoping review. *Anaesthesia Reports*. 2026;14(1):e70070.
- Borgbjerg MF, Nielsen K, Franks J. Experimental pain stimulates respiration and attenuates morphine-induced respiratory depression: a controlled study in human volunteers. *Pain*. 1996;64(1):123-8.
- McQuay HJ. Potential problems of using both opioids and local anaesthetic. *Br J Anaesth*. 1988;61(1):121.
- Murphy GS, Szokol JW, Avram MJ, Greenberg SB, Marymont JH, Shear T, et al. Intraoperative Methadone for the Prevention of Postoperative Pain: A Randomized, Double-blinded Clinical Trial in Cardiac Surgical Patients. *Anesthesiology*. 2015;122(5):1112-22.
- Murphy GS, Szokol JW, Avram MJ, Greenberg SB, Shear TD, Deshur MA, et al. Clinical Effectiveness and Safety of Intraoperative Methadone in Patients Undergoing Posterior Spinal Fusion Surgery: A Randomized, Double-blinded, Controlled Trial. *Anesthesiology*. 2017;126(5):822-33.
- Pontes JJP, Braz FR, Módolo NSP, Mattar LA, Sousa JAG, Navarro ELLH. Intraoperative methadone effect on quality of recovery compared with morphine following laparoscopic gastropasty: a randomised controlled trial. *Anaesthesia*. 2021;76(2):199-208.
- Komen H, Brunt LM, Deych E, Blood J, Kharasch ED. Intraoperative Methadone in Same-Day Ambulatory Surgery: A Randomized, Double-Blinded, Dose-Finding Pilot Study. *Anesth Analg*. 2019;128(4):802-10.
- Barnett AM, Machovec KA, Ames WA, Homi HM, Turi JL, Koo J, et al. The effect of intraoperative methadone during pediatric cardiac surgery on postoperative opioid requirements. *Paediatr Anaesth*. 2020;30(7):773-9.
- Martin DP, Samora WP, 3rd, Beebe AC, Klamar J, Gill L, Bhalla T, et al. Analgesic effects of methadone and magnesium following posterior spinal fusion for idiopathic scoliosis in adolescents: a randomized controlled trial. *J Anesth*. 2018;32(5):702-8.
- Pan SJ, De Souza E, Anderson TA. Intraoperative Methadone Versus Other Opioids: A Retrospective Review of Postoperative Outcomes in Pediatric Surgeries. *Anesth Analg*. 2026;142(4):720-9.
- Einhorn LM, Hoang J, La JO, Kharasch ED. Single-dose Intraoperative Methadone for Pain Management in Pediatric Tonsillectomy: A Randomized Double-blind Clinical Trial. *Anesthesiology*. 2024;141(3):463-74.
- Russell T, Mitchell C, Paech MJ, Pavy T. Efficacy and safety of intraoperative intravenous methadone during general anaesthesia for caesarean delivery: a retrospective case-control study. *Int J Obstet Anesth*. 2013;22(1):47-51.
- Methadone Bethesda M. National Institute of Child Health and Human Development; [updated January 15, 2024 Available from: <https://www.ncbi.nlm.nih.gov/books/NBK501233/>.
- Sachs HC. The transfer of drugs and therapeutics into human breast milk: an update on selected topics. *Pediatrics*. 2013;132(3):e796-809.
- Atsma F, Elwyn G, Westert G. Understanding unwarranted variation in clinical practice: a focus on network effects, reflective medicine and learning health systems. *Int J Qual Health Care*. 2020;32(4):271-4.
- Biro J, Neyens DM, Jaruzel C, Tobin CD, Alfred M, Coppola S, et al. "One size" doesn't "fit all": Understanding variability in anesthesia work practices. *Human Factors in Healthcare*. 2022;2:100026.
- Kennedy PJ, Leathley CM, Hughes CF. Clinical practice variation. *Medical Journal of Australia*. 2010;193(S8):S97-S99.
- Davis AM, Inturrisi CE. d-Methadone blocks morphine tolerance and N-methyl-D-aspartate-induced hyperalgesia. *J Pharmacol Exp Ther*. 1999;289(2):1048-53.
- Tognoli E, Proto PL, Motta G, Galeone C, Mariani L, Valenza F. Methadone for postoperative analgesia: contribution of N-methyl-D-aspartate receptor antagonism: A randomised controlled trial. *Eur J Anaesthesiol*. 2020;37(10):934-43.
- Kharasch ED, Clark JD. Methadone and Ketamine: Boosting Benefits and Still More to Learn. *Anesthesiology*. 2021;134(5):676-9.
- Murphy GS, Avram MJ, Greenberg SB, Benson J, Bilimoria S, Maher CE, et al. Perioperative Methadone and Ketamine for Postoperative Pain Control in Spinal Surgical Patients: A Randomized, Double-blind, Placebo-controlled Trial. *Anesthesiology*. 2021;134(5):697-708.

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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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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
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- ▶ Please contact Dr Meg Walmsley for further information megan.walmsley@act.gov.au





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PAIN MANAGEMENT IN THE PACIFIC



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Pain is one of the commonest reasons people seek health care, yet it remains one of the most undertreated health problems in many low- and middle-income countries (LMICs). Across the Pacific, many patients recovering from surgery or injury continue to experience unnecessary pain, largely because of limitations within healthcare systems rather than a lack of effective treatments. As populations age and the burden of non-communicable diseases such as diabetes continues to increase, improving pain management will become an increasingly important priority for health services throughout the region.

Despite its importance, few published studies have examined the prevalence of pain or its impact on Pacific communities. The available evidence from the Pacific is limited but concerning. Studies from Timor-Leste and unpublished work from Fiji have consistently demonstrated that many patients experience moderate to severe postoperative pain, significant functional limitation, and dissatisfaction with their pain management following surgery. Although evidence-based multimodal analgesia is recognised as best practice for postoperative pain management, it is not consistently prescribed or available in many Pacific settings.

The reasons for this are complex. Limited availability of analgesic medications is only one component of a much broader systems issue. Workforce shortages, competing clinical priorities, limited nursing capacity, inconsistent drug supply, inadequate staffing to assess pain on the wards, and restricted access to equipment all contribute to suboptimal pain management. Improving pain management therefore requires more than increasing access to medications; it depends on education, clinical leadership, nursing engagement, practical protocols, and organisational commitment. Better access to locally-driven research would help define both the magnitude of the problem and the interventions most likely to improve patient outcomes across the region.

Pain management education for healthcare professionals remains inadequate throughout much of the world and is certainly not unique to the Pacific. In a survey of doctors from 49 LMICs, 90 per cent considered their undergraduate education in pain management to be insufficient. These educational gaps have important consequences. Pain education not only improves knowledge but also changes attitudes and builds confidence to prescribe appropriate analgesics safely. Education also supports advocacy for



Drs Moira Rush (far left), Apaitia Goneyali (far left back row), and Sherene Prasad (far right) with 5th year medical students in Suva, Fiji



Drs Maria Jose A. Da Piedade, Dulce Seran Calado, Roger Goucke, Moira Rush, Mingota da Costa Hurculano in Dili, Timor Leste

better access to essential medicines and encourages the development of institutional pain management systems, policies, and clinical practice.

Educational barriers are most evident in relation to opioid prescribing. One of the clearest examples of global inequity in pain management is access to opioid analgesics. In 2024, approximately 82 per cent of the world's population - predominantly those living in LMICs - consumed only 14 per cent of the total morphine used worldwide for pain management. This imbalance persists despite the long-standing United Nations Single Convention on Narcotic Drugs recognising opioid analgesics as indispensable for the relief of pain, and requiring governments to ensure their adequate availability for legitimate medical use.

While morphine, fentanyl, and pethidine are included on Fiji's Essential Medicines List, reliable access cannot always be guaranteed across all healthcare facilities, and confidence in prescribing these medications appropriately often remains limited. However, concerns regarding opioids should not overshadow the broader principles of multimodal analgesia. Effective pain management depends on selecting appropriate combinations of pharmacological and non-pharmacological strategies tailored to the individual patient and the resources available.

International organisations including the International Association for the Study of Pain and the World Federation of Societies of Anaesthesiologists have

supported a range of initiatives to improve pain education in LMICs, including educational grants, scholarships, and the development of regional training centres. These initiatives have been valuable, but systemic barriers continue to limit widespread implementation. Sustainable improvements ultimately depend on strengthening local capacity and supporting clinicians to lead change within their own healthcare systems.

One such initiative is the Essential Pain Management (EPM) course, developed by Drs Roger Goucke and Wayne Morriss with support from the Australian and New Zealand College of Anaesthetists (ANZCA). Introduced in 2010, EPM is a one-day multidisciplinary program designed specifically for resource-limited settings. Importantly, the course incorporates instructor training, enabling local clinicians to continue delivering the program independently and fostering long-term changes in attitudes, knowledge, and clinical practice.

The impact of this educational model is increasingly evident across the Pacific. One notable example is Fiji, where the EPM has been incorporated into the final-year undergraduate medical curriculum at Fiji National University. As many medical graduates who ultimately practise throughout the Pacific complete their training at Fiji National University, the potential influence of this initiative extends well beyond Fiji itself. Local anaesthetists including Drs Sherene Prasad, Apaitia Goneyali and Yogen Deo have successfully delivered the course for several years.



Dr Roger Goucke (left) leading a role play scenario in Dili, Timor.

While responsibility for postoperative pain management has traditionally rested with surgical teams in many Pacific hospitals, anaesthetists are increasingly assuming leadership roles throughout the perioperative period. The expansion of specialist anaesthesia training across the region has been instrumental in this change. Pain management features prominently within both the Diploma and Master's curricula, positioning anaesthetists to become important advocates for improving perioperative pain care.

Dr Emily Fuakilau has been pivotal in the development of Fiji's national Pain Management Guidelines. The guidelines provide an important framework for promoting safe, evidence-based pain management throughout the country. Their introduction has supported initiatives such as the use of intrathecal morphine for postoperative analgesia following lower uterine segment Caesarean section. As elsewhere in the Pacific, however, reliable access to essential medications remains an ongoing challenge.



Ms Nicole Gauthier and Dr Moira Rush with nurses in Lautoka, Fiji



Middle back row - Dr Colombianus da Silva, Front row far left - Dr Dulce Seran Calado, middle - Dr Roger Goucke, Dr Moira Rush, far right - Dr Maria Jose A, Da Piedade, Dili, Timor

Formal acute pain services remain relatively uncommon across much of the Pacific. Nevertheless, innovative models are beginning to emerge that reflect local workforce and resource constraints. All three major teaching hospitals in Fiji have developed acute pain services that function effectively within existing resources. Dr Priyanka Shristy leads the Pain Service at the Colonial War Memorial Hospital in Suva, while Dr Yogen Deo, following completion of a Pain Management Fellowship in India, leads the Pain Service in Lautoka. Supported by the Pacific Society of Anaesthetists, they also deliver regular educational webinars on a range of pain management topics, often highlighting the expanding role of regional anaesthesia techniques.

The next important step in developing pain services across the Pacific is strengthening nursing involvement. Nurses play a central role in assessing pain, monitoring response to treatment, educating patients, and ensuring continuity of care. To support this development, the Overseas Development and Education Committee (ODEC), through the Australian Society of Anaesthetists (ASA), has assisted in delivering EPM courses specifically for nursing staff across Fiji. These courses have generated considerable enthusiasm, particularly through the involvement of Nicole Gauthier, Pain Nurse Practitioner from The Northern Hospital in Melbourne, whose practical experience has been highly valued by participants.

More recently, ODEC sponsored one of the emerging nurse pain champions from the Colonial War Memorial Hospital in Suva to attend the World Congress of Nurse Anaesthetists in Brisbane, together with an observership in the Acute Pain Service at the Royal Brisbane and Women's Hospital. It is hoped that the knowledge, skills and professional networks developed through these experiences will further strengthen local nursing leadership and contribute to the continued evolution of pain services throughout Fiji.

The ODEC has also proposed the establishment of a pain management observership in Melbourne for Pacific anaesthetists. With in-principle support from The Northern Hospital, Alfred Health, and the Royal Children's Hospital, we hope to expose participants to a variety of multidisciplinary pain services, organisational models and clinical approaches that can be adapted to local healthcare settings.

Essential Pain Management is currently undergoing its first major revision since its introduction. The revision will ensure that the program remains contemporary while retaining the practical, resource-appropriate approach that has contributed to its success.

The first course using the revised program was delivered successfully in Timor-Leste in March 2026 through the outstanding efforts of Dr Ming Da Costa and her team. Although interactive teaching methods and simulated patient role-play were initially unfamiliar to many

participants, they quickly became one of the most valued aspects of the course. This experience reinforced the value of practical, multidisciplinary education that encourages discussion, teamwork, and clinical decision-making rather than simply delivering information.

Further courses are planned in the Solomon Islands, Papua New Guinea, Samoa, and potentially Tonga, reflecting the growing regional demand for structured pain management education. These initiatives continue to be supported through partnerships between the ASA, ANZCA and Interplast, collaborating with local clinicians to strengthen education and service development.

Perhaps the greatest lesson from the Pacific has been that sustainable improvements in pain management depend less on sophisticated technology or external expertise than on local leadership, multidisciplinary collaboration, and long-term partnerships. Identifying enthusiastic local champions, developing practical guidelines, engaging nurses, and embedding pain education within existing training programs have all proven more important than isolated educational visits or the introduction of new medications alone.

For further information regarding EPM, please contact: Moira.Rush@nh.org.au

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UP CLOSE WITH

PAIN MEDICINE DISCHARGE PLAN

**ASSOCIATE PROFESSOR
SUZI NOU**
COMMUNICATIONS
COMMITTEE CHAIR
ASA PAST PRESIDENT

**Associate Professor Jennifer Stevens talks with
Associate Professor Suzi Nou about post-discharge pain care.**



**ASSOCIATE PROFESSOR
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IN PERIOPERATIVE AND CRITICAL
CARE ECHOCARDIOGRAPHY.**

**HER PAIN MEDICINE TRAINING
BEGAN AT PRINCE OF WALES
HOSPITAL, SYDNEY, IN ONE
OF THE FACULTY'S EARLY
FORMAL COHORTS.**

Closing the loop on post-discharge pain care

The Pain Medicine Discharge Plan gives patients practical instructions after hospital discharge and helps anaesthetists, surgeons and GPs communicate more consistently about opioid reduction and recovery.

Leaving hospital with pain medicines can be confusing for patients and challenging for General Practitioners (GPs) when discharge information is delayed, incomplete or unclear. The Pain Medicine Discharge Plan was developed to help bridge that gap by providing patients with practical instructions and supporting more consistent communication between anaesthetists, surgeons, pharmacists, nurses and primary care clinicians.

Developed by the Opioid Stewardship Working Party in 2022, the plan forms part of a broader suite of opioid stewardship resources available through the Australian Society of Anaesthetists (ASA). It provides patients with written guidance for managing pain medicines after discharge while clearly outlining the intended treatment strategy for GPs.

The information is presented in a simple traffic-light format, with regular analgesics highlighted in green, higher-risk medicines grouped in red, and clear guidance that only one opioid should be prescribed at a time.

The plan also includes advice on opioid reduction, safe storage and disposal of unused opioids, constipation management, non-pharmacological pain management strategies, and what patients should do if their pain is not adequately controlled.

For patients, the form serves as a simple take home reference that supports safe medicine use and recovery after discharge. For clinicians, it supports a consistent approach to post-discharge pain management and helps reinforce the same messages across the healthcare team.

Development of the Pain Medicine Discharge Plan

The Pain Medicine Discharge Plan was developed to address recognised gaps in post-discharge pain care and to improve communication between hospitals, patients and primary care providers.

The plan also includes advice on opioid reduction, safe storage and disposal of unused opioids, constipation management, non-pharmacological pain management strategies, and what patients should do if their pain is not adequately controlled.

Consumer feedback played an important role in ensuring the resource used clear language, addressed common concerns and remained useful after patients returned home. The plan was kindly shared with the ASA who has adapted it, translated it and made it freely available for wider dissemination.

The plan is currently available in several translated versions, with consumer and Aboriginal health input also contributing to a version designed for Aboriginal and Torres Strait Islander peoples. We at the ASA are keen to explore translating it into other languages.

The resource also reflects a broader shift in acute pain medicine. Rather than focusing solely on pain intensity and pain scores, clinicians are increasingly using functional recovery to guide pain management decisions. The goal is not simply to reduce pain, but to help patients move, breathe and participate in recovery.

This evolution has coincided with the changing understanding of chronic post-surgical pain. Rather than viewing severe acute pain as a direct pathway to chronic pain, clinicians increasingly recognise that some patients are vulnerable to both because of shared risk factors such as chronic opioid use, psychological factors and a history of trauma.

Bridging anaesthesia, pain medicine and postoperative recovery

Associate Professor Jenny Stevens is an associate professor at the University of NSW and the University of Notre Dame Sydney, and a visiting medical officer in anaesthesia and pain medicine at St Vincent's Hospital Sydney. She maintains

an active clinical anaesthesia practice, predominantly in private. Working across both public and private practice, she has seen firsthand the challenges of translating evidence into consistent postoperative pain management.

Associate Professor Stevens was a founding member of the Opioid Stewardship Working Party and this had a pivotal role in developing the Pain Medicine Discharge Plan. She regards acute pain medicine as sitting at the intersection of anaesthesia, pain medicine and postoperative recovery. She shares with us her tips for using the Pain Medicine Discharge Plan.



EP #122

From Theatre to Tribunal -
Dr Gaby Bolton on Fair Pay
for Junior Doctors



Find more episodes here:
www.asa.org.au/asa-public-podcasts



Dr Gaby Bolton

ASA Trainee Member |
Australian Medical Association (AMAV) Junior Doctor of the Year (2025)

Using the Pain Medicine Discharge Plan in practice

Associate Professor Stevens says the plan is designed to be practical and straightforward, giving patients written instructions they can take home and helping GPs understand the intended medication strategy after discharge.

Step 1: Introduce the plan before discharge. Introduce the form before the patient leaves hospital so they understand what each medicine is for, when to take it and when it should be reduced or stopped.

Step 2: Explain the traffic light format. The plan groups medicines in a simple visual structure, with regular analgesics such as paracetamol and celecoxib marked in green, and higher-risk medicines such as atypical opioids and oxycodone placed in higher-risk sections.

Step 3: Prescribe only one opioid. Associate Professor Stevens emphasises that the form should make clear that patients should not be discharged with multiple opioid types. If an opioid is required, the plan should specify one opioid and provide structured advice about how and when it should be reduced.

Step 4: Avoid modified-release opioids. One of Associate Professor Stevens' key tips is to use the free text section to communicate directly with the GP. She often writes: "Please do not prescribe modified-release opioids."

Step 5: Include safety advice. The plan should also cover what to do if pain is not controlled, how to manage opioid-related constipation with laxatives, and how to return unused opioids safely.

Step 6: Encourage patients to keep a copy. Associate Professor Stevens encourages patients to photograph both sides of the form before leaving hospital so they still have the instructions if the paper copy is misplaced.

Step 7: Use translated versions. The Pain Medicine Discharge Plan is available in Arabic, Aboriginal, Chinese, English and Vietnamese. Consumer and Aboriginal health input also shaped the version for Aboriginal and Torres Strait Islander peoples.

Step 8: Refer patients to watch the video guide. For patients who prefer to watch a plain language explanation of how to use the discharge plan, there is a video on the ASA's YouTube channel, as well as on the ASA website.

Step 9: Reinforce the same message across the care team. In public hospitals, pharmacists and nurses can use the same form for patient education, helping ensure the patient receives consistent advice from the wider team.



Patients can also access a video guide on how to use the plan on the ASA's YouTube channel

<https://youtu.be/fQACG8pZsL0?si=K7nSw4zQXkUWe-To>

Further listening and resources

The Pain Medicine Discharge Plan and related opioid stewardship resources are available through the ASA website.

<https://asa.org.au/publications/pain-medicine-discharge-plan>

Associate Professor Stevens also discusses chronic post-surgical pain prevention, co-authoring the 6th edition of McIntyre's Acute Pain Management book, and winning the Anaesthesia and Intensive Care Best Paper Prize with Associate Professor Suzi Nou in the Australian Anaesthesia podcast.

Listen to the full interview on the Australian Anaesthesia podcast available on our website:

<https://asa.org.au/asa-public-podcasts/australian-anaesthesia>



or please scan the QR code.



Final Exams

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

Website

Virtual Bronchoscopy Suite

https://pie.med.utoronto.ca/VB/VB_content/simulation.html 

"Useful to help visualise what you'd be expecting to see with DLT insertion!"

LITFL Top 150 ECGS

<https://litfl.com/top-100/ecg/> 

"Online ECG practice, do one a day or 10 at a time with your study group!"

Alf.Prop.Sux

<https://alfpropsux.wordpress.com/> 

"A blog of SAQ ideal answers by the authors of Propofol Dreams"

Ketamine Nightmares for the Fex

<https://ketaminenightmares.com/fex/> 

"Collection of notes and topic summaries. Great professional document and landmark trial sections"

SNACC: Society for Neuroscience in Anaesthesiology and Critical Care

<https://www.snacc.org/wp-content/uploads/2019/05/SNACC-Cognitive-Aids-for-Neuroanesthetic-Emergencies.pdf> 

"Cognitive aids for neurosurgical emergencies"

A Guide for the ANZCA Fellowship Exam

<https://anaesthesiaguide.org/exams/> 

"Awesome suggested study guide by Dr Ryan Juniper (WA), including time to spend on each curriculum theme over 12 months of preparation. Heaps of other resources such as a comprehensive list of current guidelines and important studies and trials"

SOBA UK

<https://www.sobauk.co.uk/guidelines-1> 

"Single page summaries for management of the obese patient (also an app!)"

Orphan Anaesthesia

<https://www.orphananaesthesia.eu/> 

"Anaesthesia considerations for rare and uncommon diseases"

ASRA "How I do it"

<https://asra.com/guidelines-articles/how-i-do-it> 

"Another valuable regional resource"

RNSH Part 2 Tutorials

<https://rnsanaesthesia.org/video-category/part-2/> 

"Collection of Final Exam tutorials from Royal North Shore Hospital"

ICU One Pager

<https://onepagericu.com/> 

"Great one page summary of ICU topics for visual learners"

This guide has been curated by the ASA Trainee Members Group



Contact the TMG: trainees@asa.org.au

Courses

ASA Final Exam Support Sessions



"Live interactive SAQ and viva sessions facilitated by past examiners, prize winners and successful candidates. Great opportunity to benchmark yourself to others around the country!"

ANZCA Long and Short Courses



"State-based long (~weekly) and short (1-2 week) refresher courses. Perfect for a tax deductible get-away! Hot Tip: sign up for the Vic Short Course and get immediate access to recorded content - a great study tool!"

Anaesthesia Collective Viva Bootcamp



"Sign up to the interactive and live set date courses, or for the online pre-recorded version. Dr Megan Shaw's (Cecil Gray Prize Winner 2023.2) Medical Viva Lecture provides an incredible structure for the vivas!"

EMAC: Effective Management of Anaesthetic Crises



"A compulsory requirement for training, but try and do it close to the exam (especially pre-viva) to get the most out of the crisis management practise!"

Textbooks and Essential Reading

Oxford Handbook of Anaesthesia by Rachel Freedman et al (eds)

"Available as a digital app - great for day-to-day use"

Examination Anaesthesia by Christopher Thomas et al

"Study guide with lots of investigations for medical viva practice"

A Guide to Pediatric Anesthesia (2nd Edition) by Craig Sims et al

"Paediatric essentials written by Anaesthetists at Perth Childrens Hospital"

Clinical Examination by Talley & O'Connor

"Core examination skills"

160 ECG Cases by John Hampton

"Great little book of ECG practise"

Acute Pain Management: Scientific Evidence by Stephan Schug et al (eds)

"The ANZCA essential pain guide - gold mine for MCQs!"

BJA Education Articles

"Another source of topics! They make the articles into podcast episodes too"

ANZCA Blue Books

"Examiners have been authors, and topics often taken from here for SAQs and vivas!"

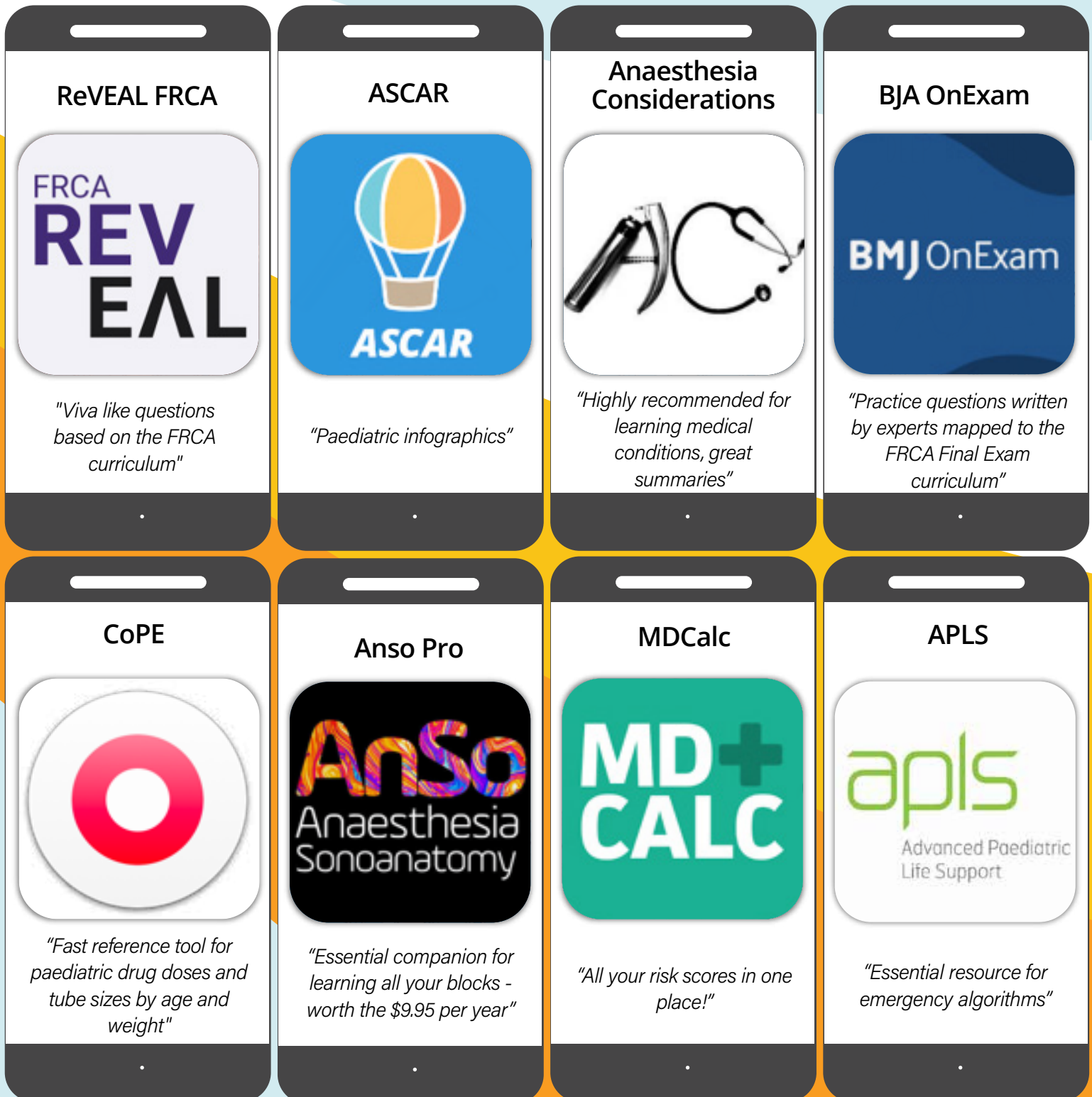


Australian Society of
Anaesthetists[®]

Final Exams

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

Applications



Podcasts

Deep Breaths



"Join Dr Kate Steele & Dr Kate McCrossin (Qld) in this candid and highly relevant Part 2 Exam podcast. Our particular favourites include all you need for your stats study - "One in ten" with Dr Shannon Morrison (S6), the complex airway series "How do I breathe" with Dr Nadia Vargas (S5), and every episode with Dr Ivan RupChuk, Canadian Ice Hockey coach come Cardiac Anaesthetist"

ABCs of Anaesthesia



"Dr Lahiru Amaratunge's (Vic) anaesthesia podcast has something for trainees of all levels. Particularly useful for the final exam is the real practice vivas with current candidates recorded to time, you can also watch the episodes on YouTube!"

BJA Education



"Great way to digest BJA education articles as you're commuting to work"

Block It Like It's Hot



"Clinical pearls and how-to-block-it!"

SNACC Podcast



"Podcast of the Journal of Neurosurgical Anesthesiology - interesting episodes about neuroanaesthesia and crisis management"

Tasty Morsels of Critical Care



"Really succinct and manageable 5-10 minute episodes focusing on ICU topics"



Australian Society of
Anaesthetists



DR KAYLEE JORDAN
EDUCATION COMMITTEE
CHAIR

EDUCATION COMMITTEE

SEPTEMBER EDUCATION UPDATE: LEARNING AND WELLBEING

Welcome to the September Education Committee update for Australian Anaesthetist, featuring key online and in-person learning opportunities. This month features member favourites, new additions and a calendar to help you plan ahead.

The ASA Education Website has recently been revamped. Here you will find a range of online educational content that will accrue your CPD hours, including recordings of previous ASA events that you may have missed or wish to revisit. Please visit the page at <https://asa.org.au/asaeducation>.

National M&M events

Following strong interest in our recent online M&M sessions in collaboration with WebAIRS, the next of these will be held online on Monday, 9th November. Once again, Dr Yasmin Endlich, Medical Director of WebAIRS, will present cases for discussion. If you wish for a case to be considered for future anonymous discussion, add "For discussion at national M&M" to your WebAIRS submission.

History of Anaesthesia seminar

On Sunday, 13th September, join us online or at ASA Head Office in Naremburn, Sydney, for the half-day *History of Anaesthesia: where have we come from?* seminar, including a curator-led tour of the Harry Daly Museum for in-person attendees.

Counting down to the Combined Scientific Congress

The ASA/NZSA Combined Scientific Meeting will be held in the Hunter Valley from 8–11th October. Please refer to the event page for information about the conference, accommodation, the Hunter Valley Region and how to get there.

Wellbeing support for members

The next event in our Wellness Series is Peer Support Facilitator Training, in collaboration with Hand-n-Hand, on Tuesday, 10th September. Visit the ASA Wellbeing Page at <https://asa.org.au/wellbeing-of-anaesthetists> for member

resources and events. Our partnership with Drs4Drs continues, offering you free, confidential support.

Communications events

Our PPAC Communications Series also continues, facilitated by Dr Andrea Wojnicki, a renowned executive communication coach. The next of these, Communications in Meetings, will be held online on Tuesday, 15th September.

ASA/AMA CPD Home

ASA/AMA CPD Home is now complimentary with ASA membership. Please visit <https://asa.org.au/asaeducation/cpd-made-simple> to learn more about signing up.

Suggestions/Feedback

Email ideas and feedback to events@asa.org.au.

■ Dr Kaylee Jordan

Education Committee Chair



**Register now for
ASA Events**

MEMBERS

SEPTEMBER

10

Thursday
6.30–8.30pm
AEST

Wellness Series

Peer Support Facilitator Training

This interactive workshop run by Hand-n-Hand is sponsored by the ASA for members & is opened also for colleagues interested in Peer Support Facilitator Training.

These sessions are run by expert mental health practitioners & are highly interactive with a focus on scenario-based practice. They also come with a digital booklet of takeaway information.



13

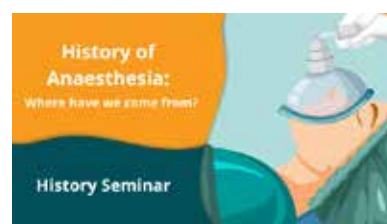
Sunday
9.00am–12.30pm
AEST

History of Anaesthesia: where have we come from?

Hybrid - ASA Sydney Head Office and Online

Join us for a fascinating journey through the development of anaesthesia in Australia & the world. From its early, experimental stages to today's sophisticated techniques, explore the groundbreaking discoveries and pioneering individuals who have revolutionized patient care.

Our speakers will delve into the history of anaesthesia, discussing key milestones, challenges, and the enduring impact of this everyday medical marvel.



15

Tuesday
8.00–9.15pm
AEST

Communication Workshop

Communication in Meetings

Learn the dos and don'ts of in person and online meetings, including strategies to help you speak up with confidence, monitor who's getting airtime, and ensure you're adding value to both the meeting and your own professional development.



OCTOBER

29

Thursday
7.00–8.30pm
AEDT

Practice Wise – Business Series

Billing Conundrums Unlocked. Third in the Series

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



NOVEMBER

09

Monday
7.30–9.00pm
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.



13

Friday
9.00am–5.00pm
AEDT

PMEd Connect

Practice Managers Conference 2026, Rydges, Melbourne

The conference is a full day of educational lectures targeted at Practice Managers in the anaesthetic industry. It is an interactive day that covers professional and continuing medical education issues.



23

Monday
6.30 – 8.00pm
AEDT

ASBD - Acute Severe Behavioural Disturbance Workshop

Emergency Response Activity – Workshop 1

This essential workshop will equip you with the critical skills required to satisfy all the learning objectives & requirements for CPD. Through realistic simulations & scenario-based learning, participants will gain the knowledge & confidence to act swiftly, lead decisively & prioritise safety.



23

Monday
8.10–9.40pm
AEDT

ASBD - Acute Severe Behavioural Disturbance Workshop

Emergency Response Activity – Workshop 2

Designed to support your CPD requirements, this practical workshop will provide the essential skills and knowledge needed to achieve your learning objectives. Using realistic simulations and scenario-based learning, participants will develop the confidence to act quickly, make informed decisions, and maintain a strong focus on safety when it matters most.



NOVEMBER

28

Saturday
10.00am–12.00pm
AEDT

Block by Block: Mastering the Essentials

Webinar 1 – Asia Pacific Session

Is a webinar series bringing together leading experts from Asia Pacific for a high-impact, practice-focused program. Spanning cutting-edge evidence and real-world clinical insights, these online sessions tackle everything from fascial plane block mechanisms and trauma pathways to catheter techniques and perioperative optimisation.

Designed for anaesthetists who want more than theory, this is a uniquely practical forum to elevate regional anaesthesia practice – “block by block”.



30

Monday
7.00–8.30pm
AEDT

Block by Block: Mastering the Essentials

Webinar 2 – Australasian Session

Is a webinar series bringing together leading experts from Australasia for a high-impact, practice-focused program. Spanning cutting-edge evidence and real-world clinical insights, these online sessions tackle everything from fascial plane block mechanisms and trauma pathways to catheter techniques and perioperative optimisation.

Designed for anaesthetists who want more than theory, this is a uniquely practical forum to elevate regional anaesthesia practice – “block by block”.



DECEMBER

02

Wednesday
7.00–8.30pm
AEDT

Block by Block: Mastering the Essentials

Webinar 3 – How I do it: clinical focus session

Is a webinar series bringing together leading experts from Australia for a high-impact, practice-focused program. Spanning cutting-edge evidence and real-world clinical insights, these online sessions tackle everything from fascial plane block mechanisms and trauma pathways to catheter techniques and perioperative optimisation.

Designed for anaesthetists who want more than theory, this is a uniquely practical forum to elevate regional anaesthesia practice – “block by block”.



TRAINEES

SEPTEMBER

01

Tuesday
7.30–9.00pm
AEST

Exam Support Session

Final vivas

This online session will provide candidates with the opportunity to experience realistic viva practice in a supportive environment. Facilitated by experienced fellows, the sessions focus on examination technique, communication skills, and managing the pressures of the viva format. Attend one or more sessions to build confidence, identify areas for improvement, and enhance your exam preparation.



07

Monday
7.30 –9.00pm
AEST

Exam Support Session

SIMG vivas

Designed specifically for Specialist International Medical Graduates preparing for their ANZCA viva examinations, these interactive online sessions provide an opportunity to practise viva technique, receive expert feedback, and build confidence in a supportive learning environment. Join experienced fellows and fellow candidates as you prepare for this important stage of the pathway to specialist recognition.



14

Monday
7.30 –9.00pm
AEST

Exam Support Session

Primary vivas

This online session will give trainees the opportunity to practise structured responses, refine examination technique, and gain valuable feedback from experienced examiners and recent successful candidates. Whether you're sitting the exam for the first time or looking to strengthen your approach, these sessions offer practical support in the lead-up to the exams.



21

Monday
7.30 –9.30pm
AEST

ASA VIC Part 3 Series

Online, via Zoom

Open to participants Australia-wide, Session 2 of ASA Victoria's virtual Part 3 series brings together trainees, SIMGs and new specialists for an evening of practical learning, discussion and professional development. Delivered by experienced fellows, the session focuses on the real-world skills and knowledge that support a successful transition to consultant practice, all from the convenience of an online format.



NOVEMBER

07

Saturday
1.00 – 5.00pm
AEDT

ASA TAS Part 3 Course

ANZCA office, Hobart

ASA Tasmania's face-to-face Part 3 Course offers advanced trainees, SIMGs and new specialists the opportunity to gain practical insights into the transition to consultant practice. Featuring experienced presenters and interactive discussion, the course focuses on the professional skills and real-world knowledge needed beyond clinical training, while providing valuable opportunities to network with colleagues from across the region.



14

Saturday
9.00am – 4.00pm
ACST

ASA SA/NT Part 3 Course

ANZCA office, Adelaide

Join colleagues from South Australia and the Northern Territory for a full day of learning, discussion and professional development at the ASA SA/NT Part 3 Course. Designed for advanced trainees, SIMGs and newly qualified specialists, the course focuses on the practical realities of consultant practice, with insights from experienced fellows and guest presenters. With in-person attendance available in South Australia and virtual access for Northern Territory participants, the course offers a flexible and engaging way to prepare for the next stage of your career.



20

Friday
9.00am – 4.00pm
AWST

ASA WA Part 3 Course

University Club WA, Crawley

Join colleagues in Perth for a full day of practical learning and professional development at the ASA Western Australia Part 3 Course. Designed for advanced trainees, SIMGs and newly qualified specialists, the course explores the real-world challenges and opportunities that come with the transition to consultant practice. Drawing on the experience of established anaesthetists and industry experts, participants will gain valuable insights, practical advice and the opportunity to connect with peers and mentors in a collaborative face-to-face environment.



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

Keeping up with your SPECIALIST HIGH-LEVEL CPD REQUIREMENTS



High-level requirements (HLRs) are specific CPD activities relating to relevant specialties for medical practitioners registered as specialists.

As an Anaesthetist, to meet the requirements of the Standard*, you are required to complete and record CPD activities with supporting evidence to meet the high-level requirements (HLRs) approved by the Medical Board of Australia for your registered scope of practice.

Which specialists are required to complete high-level requirements?

The Medical Board of Australia has approved the below HLR activities by specialty in 2026. Completion of these activities is mandatory under the Standard*.

Below is a summary of the CPD HLRs by specialty, including anaesthesia.

Specialty	HLR	Domain of Learning
Anaesthesia	A specialist anaesthetist must complete at least one: - emergency response activity per year - of the following activities per year to directly evaluate and reflect on their own clinical practice: - structured patient survey - peer review - multi-source feedback - clinical audit.	- Educational Activity - Reviewing Performance and/or - Measuring Outcomes Activity
Emergency Medicine	A specialist emergency medicine physician (including all fields of specialty practice) must: - complete three core procedural skills per year: 1x core airway procedural skill 1x core breathing procedural skill 1x core circulation procedural skill - complete one activity per year to reflect on and develop leadership skills that will contribute to - workplace improvement - system-wide improvement and/or - effective interdisciplinary teamwork	- Educational Activity - any category
General Practice	A specialist general practitioner must complete a CPR (cardiopulmonary resuscitation) course every three years.	- Educational Activity
Intensive Care Medicine	A specialist intensive care physician must complete an airway management of critically ill patients' activity ONCE every three years that is of a minimum three hours duration and involves an in-person practical workshop, preparatory and post activity components that specifically consider: - airways assessment - approaches to difficult airway and airway emergencies - teamwork and leadership in an airway crisis - familiarity with equipment - CICO algorithms (can't intubate, can't oxygenate) - management of tracheostomy emergencies - simulation activities that should include performing intubation on appropriate mannequins to expose participants to difficult airway scenarios and include team-based responses.	- Educational Activity

Specialty	HLR	Domain of Learning
Obstetrics and Gynaecology	A specialist obstetrician and gynaecologist must complete an in-person Basic Life Support (BLS) program every two years. While coursework can be completed online, the assessment must be completed in-person.	- Educational Activity
Pain Medicine	A specialist pain medicine physician must complete at least one: - emergency response activity per year - of the following activities per year to directly evaluate and reflect on their own clinical practice: - structured patient survey - peer review - multi-source feedback - clinical audit.	- Educational Activity - Reviewing Performance and/or - Measuring Outcomes Activity
Psychiatry	A specialist psychiatrist must complete a minimum of 10 hours of formal peer review per year.	- Reviewing Performance
Radiology	A specialist radiologist must complete anaphylaxis training as part of basic or advanced life support training once every three years.	- Educational Activity
Sport and Exercise Medicine	A specialist sport and exercise physician must complete: - WADA/Sport Integrity Australia anti-doping education every three years; and - ANY ONE of the following courses in every three-year period: - management of Sports Trauma course (MOST) - basic cardiac life support course (BCLS) - advanced cardiac life support course (ACLS) - AFL Emergency Care Course - immediate care in rugby course (Level 2/3 course).	- Educational Activity
Surgery (except OMS)	A specialist surgeon (including all fields of specialty practice except OMS) must participate in the Australia and New Zealand Audit of Surgical Mortality (ANZASM) by completing all surgical case forms sent by ANZASM. If by 31 December of the CPD year you have not received a form, you will need to make a declaration on your AMA CPD Home Tracker to comply with the HLR.	- Reviewing performance and/or - Measuring Outcomes Activity

* Medical Board of Australia's (MBA) Registration Standard: Continuing professional development (the Standard)



If you are an AMA CPD Home Subscriber and have added your specialty(ies) to your account, self-recording your HLRs on your CPD Tracker is easy. Contact AMA CPD Home if you need assistance recording your HLRs.



FREE

~~\$220~~
per calendar year

Home Subscriber

**You do the CPD.
You do the paperwork.**



\$594

~~\$880~~
per calendar year

**Home Subscriber
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**You do the CPD.
We do the paperwork.**





DR REGINALD EDWARD
CONSULTANT
ANAESTHETIST
VMO, AUSTIN HEALTH

FEATURE ARTICLE

INTRATHECAL PRILOCAINE 2%: MATCHING SPINAL DURATION TO SHORT-DURATION SURGERY

For ambulatory surgery, a subarachnoid (spinal) anaesthetic can be technically successful yet operationally mismatched. The procedure ends, but residual motor and autonomic block continues and delays mobilisation and discharge.

Hyperbaric intrathecal prilocaine 2% offers an intermediate-duration alternative to bupivacaine. Its shorter motor and sensory block profile relative to conventional bupivacaine regimens is well established. Its clinical and operational value is less certain - that depends on whether earlier neurological recovery produces earlier mobilisation, earlier discharge readiness and, ultimately, earlier safe departure from hospital.

Those are related outcomes, but they are not interchangeable.

The mismatch we have normalised

A 52-year-old patient presents for elective knee arthroscopy. The expected operating time is 40 minutes. The department routinely uses hyperbaric bupivacaine 7.5 to 10 mg because it is familiar, reliable and already stocked. The operation finishes on time, but recovery from the anaesthetic takes longer than the surgery. This is

not a complication. It is the foreseeable consequence of selecting a drug whose duration substantially exceeds the surgical requirement.

The harder question is not whether prilocaine is shorter acting. It is whether the reduction in block duration is clinically meaningful, sufficiently reliable and capable of changing the patient's actual journey through hospital.

Prilotekal is a hyperbaric prilocaine hydrochloride 2% solution (containing 20 mg/ mL). It was entered on the Australian Register of Therapeutic Goods in March 2023 for spinal anaesthesia in adults undergoing short-duration surgery. The usual adult dose is 40 to 60 mg, with a maximum dose of 80 mg.^{1,2}

What duration matching means

The objective of an ambulatory spinal is straightforward: 1) reliable surgical anaesthesia for the anticipated procedure, 2) an adequate margin for predictable variation in surgical duration, and 3) timely recovery of motor, sensory and autonomic function.

Dose reduction can shorten the duration of bupivacaine, particularly when it is

The aim of an ambulatory spinal is simple: reliable surgical anaesthesia for the expected duration of the procedure, followed by timely recovery of motor, sensory and autonomic function.

combined with an intrathecal opioid. It does not, however, consistently reproduce the recovery profile of a genuinely shorter-acting local anaesthetic. Lower doses may also trade prolonged recovery for inadequate block, tourniquet pain or greater dependence on intrathecal opioids and sedation.

In an Australian randomised trial of 50 patients undergoing ambulatory knee arthroscopy, intrathecal prilocaine 20 mg with fentanyl 20 microg was compared with plain bupivacaine 7.5 mg with fentanyl 20 microg. At two hours, motor block had resolved completely in 86 per cent of the prilocaine group compared with 27 per cent of the bupivacaine group. Median sensory regression to L4 was 97 versus 280 minutes, and significant hypotension occurred in 32 per



cent versus 73 per cent.³ These results demonstrate substantially faster recovery with the prilocaine regimen. They should not be interpreted as a direct evaluation of the usual 40 to 60 mg Prilotekal regimen. The trial used only 20 mg of prilocaine and included fentanyl in both groups. It supports the principle that a prilocaine-based spinal can recover faster than low-dose bupivacaine, but it does not establish that every contemporary hyperbaric prilocaine regimen will reproduce the same magnitude of benefit.

Nor is the shortest block automatically the best block. A short spinal becomes a poor anaesthetic if the operation outlasts it, if tourniquet pain requires escalating sedation, or if supplementation or conversion to general anaesthesia becomes necessary. Duration-matching requires a safety margin. The objective is not simply to achieve the earliest Bromage score of zero.

Dose, formulation and reliability

In a dose-finding study of ambulatory knee arthroscopy, the estimated ED₅₀ of hyperbaric prilocaine was 28.9 mg and the ED₉₀ was 38.5 mg. Forty mg produced

successful surgical anaesthesia in 46 of 50 patients, or 92 per cent.⁴

That result is clinically useful, but it should not be treated as a stable universal success rate. With only 50 patients, the exact 95% confidence interval around 46 successes is approximately 81% to 98%. The underlying risk of inadequacy could therefore be materially greater than the observed 8 per cent. 'Success' also requires definition. A technically successful spinal is not necessarily an operationally satisfactory anaesthetic. Audit should distinguish failure to establish an adequate sensory level, inadequate block requiring systemic analgesia, tourniquet pain, sedation beyond the intended plan, conversion to general anaesthesia, and abandonment or delay of surgery.

An 8 per cent supplementation or inadequacy rate may be acceptable in a pathway with immediate rescue capability. It may be unacceptable in an environment where conversion is difficult, delayed, or clinically consequential.

Formulation matters. Camponovo and colleagues compared hyperbaric prilocaine 40 mg, hyperbaric prilocaine 60 mg, and plain prilocaine 60 mg. Hyperbaric preparations produced faster

motor recovery and earlier voiding. Twelve of 60 patients receiving plain prilocaine failed to achieve a T10 sensory level, compared with none receiving hyperbaric prilocaine 60 mg.⁵

'Prilocaine' is therefore insufficiently precise for prescribing, protocol development, comparison or audit. Dose, concentration, baricity, intrathecal adjuvants, injection level, and patient positioning should all be specified.

How much faster is recovery?

Across comparative trials, prilocaine generally produces faster sensory and motor regression than conventional bupivacaine regimens. In day-case perianal surgery, hyperbaric prilocaine 30 mg with fentanyl 20 microg reduced mean time to home-readiness from approximately 207 to 155 minutes compared with hyperbaric bupivacaine 7.5 mg with fentanyl.⁶ However, 'home-readiness' is not the same as actual departure, and mean differences conceal substantial individual variation. A 2025 Bayesian network meta-analysis included 44 randomised trials and 3,299 patients undergoing ambulatory non-

A mean duration of 90 minutes does not mean that an individual patient will recover at 90 minutes. Nor does a surgeon's average operating time adequately define suitability. Selection should be based on the distribution of procedure duration, including the frequency and consequences of outliers.

arthroplasty surgery. Shorter-acting agents generally performed better than high-dose bupivacaine for motor and sensory recovery. Prilocaine ranked favourably for several functional recovery outcomes.⁷ The comparison with optimised low-dose bupivacaine is less decisive. The network's estimated time to discharge readiness was 294 minutes for prilocaine and 297 minutes for low-dose bupivacaine, a difference of approximately three minutes. Both estimates were supported by low-certainty evidence and had overlapping credible intervals. The synthesis therefore does not establish a clinically important discharge-readiness advantage for prilocaine over carefully selected low-dose bupivacaine regimens.

The defensible interpretation is narrower: prilocaine generally shortens motor and sensory block relative to conventional bupivacaine regimens. Whether it produces a meaningful discharge advantage over optimised low-dose bupivacaine remains uncertain. Chloroprocaine ranked highest for several recovery outcomes and produced faster recovery than prilocaine in direct comparison.^{7,8} At the time of writing, intrathecal chloroprocaine is not commercially available in Australia. It is therefore relevant as a pharmacological benchmark, but not as an immediately implementable Australian formulary alternative.

Prilocaine should consequently be understood as an intermediate-duration spinal anaesthetic that fills a practical Australian formulary gap, not as an ultra-short-acting equivalent to chloroprocaine.

The problem of unpredictability

Mean recovery times can create false precision. In a prospective observational study of 384 patients receiving hyperbaric intrathecal prilocaine, Lacroix and colleagues found substantial inter-individual variation in motor-block duration. The investigators defined the end of motor block as regression to Bromage 1, meaning that the patient was just able to move the knees. This was not complete motor recovery to Bromage 0.⁹ In a subgroup of 65 patients who received 60 mg at L4 to L5 and remained supine, the mean time to Bromage 1 was 90 minutes, with a standard deviation of 30 minutes. The observed range was 40 to 199 minutes. Patient height was statistically associated with duration, but the model explained only 11.6 per cent of the variability.

This study should therefore not be interpreted as showing that complete motor recovery after 60 mg reliably occurs at approximately 90 minutes. It shows almost the opposite: even under relatively standardised conditions, time to partial motor regression varied widely and was poorly predicted by the measured patient and procedural variables.

A surgeon's average operating time is therefore inadequate for patient selection. The relevant quantity is the distribution of procedural duration, including: positioning and preparation time, median skin-to-skin time, the 80th or 90th percentile duration, tourniquet time, the frequency of unexpected extension, and the consequences of block regression before completion.

An operation that usually takes 60 minutes but periodically takes two hours is not an obvious prilocaine case merely because its mean duration appears acceptable. There is also no validated universal 90-minute cutoff. Suitability depends on the dose used, required block height, procedure-duration distribution, rescue capability, and the clinical consequences of an overrun.

Block regression is not discharge

The evidence base is dominated by three different classes of outcome. Pharmacological recovery - sensory regression, motor-block regression, and Bromage score, 2) functional recovery - unaided ambulation, spontaneous voiding, and fulfilment of discharge criteria, 3) operational recovery - actual departure from hospital, unplanned admission, prolonged recovery-unit occupancy, and cancellation or disruption of subsequent cases.

These outcomes should not be collapsed into one another. The 2025 network meta-analysis acknowledged that included trials frequently used 'discharge readiness' and 'time to discharge' interchangeably, even though readiness and actual departure may differ substantially in clinical practice. A prospective randomised trial comparing hyperbaric prilocaine 60 mg with plain ropivacaine 12 mg illustrates the problem. Complete motor recovery occurred approximately 60 minutes earlier with prilocaine, but median time to discharge criteria differed by only five minutes and was not statistically significant.¹³

That is not evidence that faster motor recovery lacks value. It is evidence that motor recovery may cease to be the binding constraint once other discharge processes dominate.

Actual departure may be delayed by postoperative pain, nausea or vomiting, urinary retention, surgeon review, pharmacy processes, incomplete documentation, transport arrangements, mobility assessment, or absence of a responsible adult.

A drug that saves 60 minutes of motor block produces little operational value if the patient subsequently waits 90 minutes for medications or transport. Bromage zero is a pharmacological endpoint. Actual departure is a systems endpoint. Hospitals introducing prilocaine should therefore measure time to adequate motor recovery, time to independent mobilization, voiding when clinically required, pain scores and opioid consumption, postoperative nausea and vomiting, discharge readiness, actual departure time, supplementation and conversion, unplanned admission, and, patient-reported recovery.

Without these data, an institution may demonstrate pharmacological success while achieving no meaningful improvement in patient flow.

Analgesia after block regression

Earlier sensory regression may expose postoperative pain sooner unless multimodal analgesia has been established before the spinal resolves. This is not an argument against prilocaine. It is an argument against relying on residual spinal anaesthesia to conceal an inadequate postoperative analgesic pathway. A shorter spinal should be accompanied by procedure-specific analgesia planned in advance, including appropriate combinations of non-steroidal anti-inflammatory medication when suitable, local infiltration analgesia, targeted peripheral nerve blocks, limited rescue opioids, and clear post-discharge instructions.

The relevant outcome is not simply earlier return of sensation. It is earlier functional recovery without an increase in pain, opioid exposure, nausea, delayed mobilisation or unplanned admission.

Patient selection and consent

Selection should not be reduced to procedure name. Relevant variables include the surgeon's median and upper-range operating times, anticipated tourniquet duration, required sensory level, probability of procedural extension, chosen prilocaine dose, patient height and mobility, bladder dysfunction, comorbidity, postoperative analgesic requirements, rescue capability, and the consequences of early block regression.

The same operation may be suitable in one unit and unsuitable in another because surgical-duration variance, rescue capability and recovery processes differ. Consent should communicate the trade-off accurately.

Prilocaine may permit earlier return of movement and earlier mobilisation. It may provide less residual sensory blockade after surgery and may require supplementation or conversion if the procedure is prolonged. It does not guarantee early discharge.

Calling it the 'faster spinal' is therefore incomplete and potentially misleading. The intended benefit is a better match between the anaesthetic and the operation.

Urinary retention

Shorter motor recovery does not eliminate postoperative urinary retention. Kreutziger and colleagues studied 86 patients receiving hyperbaric prilocaine 60 mg for ambulatory lower-limb surgery. Twenty patients, or 23%, required catheterisation. The incidence was 38 per cent in women and 12 per cent in men.¹⁰ That figure should not be interpreted as the intrinsic urinary-retention rate of all hyperbaric prilocaine regimens. The study used a single 60 mg dose, liberal intravenous

fluid administration, and a defined bladder-management protocol.

Bladder outcomes are influenced by local-anaesthetic dose, sacral block duration, intravenous fluid volume, procedure type, age and sex, pre-existing bladder dysfunction, opioid administration, and the threshold used for catheterisation.

A rational pathway should avoid unnecessary fluid loading, define when bladder scanning is required, and identify which patients genuinely need to void before discharge. A rigid universal voiding requirement can itself create avoidable delay.

Neurological and haematological safety

Intrathecal lidocaine historically offered rapid recovery but became strongly associated with transient neurological symptoms. A Cochrane network meta-analysis found substantially fewer transient neurological symptoms with prilocaine than with lidocaine, with an estimated relative risk of 0.18.¹¹ This is reassuring, although estimates for uncommon neurological outcomes remain limited by sample size. A retrospective series of 3,291 day-surgery patients receiving prilocaine reported low rates of anaesthesia-related complications and unplanned admission, with one event compatible with transient neurological symptoms.¹² Retrospective surveillance can identify common operational problems, but it cannot exclude rare neurological injury, particularly when post-discharge follow-up is incomplete.

Prilocaine is metabolised to o-toluidine, which can produce methaemoglobinaemia. Clinically significant methaemoglobinaemia has not emerged as a prominent signal in published spinal-anaesthesia series using standard doses, but the evidence is insufficient to declare the risk absent.

Australian product information contraindicates use in congenital or acquired methaemoglobinaemia and severe anaemia and advises caution with concurrent oxidising medicines.¹

There is no evidence supporting routine methaemoglobin measurement after an uncomplicated standard intrathecal dose in a low-risk patient. Risk assessment remains necessary, particularly in patients with known methaemoglobinaemia, severe anaemia, limited cardiopulmonary reserve, unexplained baseline cyanosis, or concurrent exposure to oxidising medicines.

A rational Australian position

Hyperbaric intrathecal prilocaine 2% should not replace bupivacaine universally. It should be available as a duration-matched option for selected, predictable procedures in which earlier neurological recovery has genuine clinical or operational value. Potential candidates include knee arthroscopy, selected perianal procedures, selected urological procedures, inguinal hernia repair, and other operations with a sufficiently predictable duration and an acceptable rescue plan.

Unsuitable or higher-risk situations include procedures with a broad or unpredictable duration distribution, operations whose upper-range duration approaches the anticipated block window, cases in which prolonged postoperative sensory blockade is advantageous, patients in whom supplementation or conversion would be hazardous, and environments without immediate rescue sedation or general anaesthesia.

Introduction should be treated as a governed formulary change rather than a simple drug substitution. Minimum requirements include confirmation that the stocked formulation is approved for intrathecal administration, clear physical separation from non-neuraxial local anaesthetic products, prescribing and documentation in milligrams rather than millilitres alone, procedure and patient-selection criteria, staff education, a block-failure and conversion algorithm, a postoperative analgesic plan, bladder-management guidance, structured adverse-event reporting, and prospective measurement of actual operational outcomes.

The test is not whether prilocaine produces a shorter Bromage duration. The test is whether it shortens safe recovery and actual stay without increasing inadequate anaesthesia, supplementation, conversion to general anaesthesia, postoperative pain, opioid consumption, urinary retention, unplanned admission, or patient dissatisfaction.

If those outcomes are not measured, the institution does not know whether adopting prilocaine improved care.

Conclusion

Hyperbaric intrathecal prilocaine 2% addresses a genuine duration mismatch in ambulatory anaesthesia. In selected short and predictable procedures, it generally produces faster motor and sensory regression than conventional bupivacaine regimens while providing satisfactory surgical conditions. Australian registration therefore fills a useful formulary gap. The evidence does not establish universal superiority or guaranteed earlier discharge. Success estimates are procedure-specific. Recovery remains variable. Many trials measure neurological regression or discharge readiness rather than actual departure. Evidence of a clinically important discharge advantage over carefully optimised low-dose bupivacaine is particularly uncertain. Prilocaine should therefore be introduced as a governed, duration-matched option rather than as a default replacement for bupivacaine. Its value depends on the interaction between surgical-duration distributions, patient selection, rescue capability, postoperative analgesia, bladder management and the removal of non-anaesthetic discharge delays.

The drug can shorten the block. Only the system can reliably shorten the patient's stay.

■ Dr Reginald Edward

Consultant Anaesthetist
VMO Austin Health

References

1. B Braun Australia Pty Ltd. Prilotekal: Australian product information. Sydney: B Braun Australia Pty Ltd; 2026.
2. Therapeutic Goods Administration. PRILOTEKAL prilocaine hydrochloride 100 mg/5 mL solution for injection ampoule: ARTG ID 376271. Canberra: Australian Government Department of Health, Disability and Ageing; 2023.
3. Black AS, Newcombe GN, Plummer JL, McLeod DH, Martin DK. Spinal anaesthesia for ambulatory arthroscopic surgery of the knee: a comparison of low-dose prilocaine and fentanyl with bupivacaine and fentanyl. *Br J Anaesth*. 2011;106(2):183-188.
4. Guntz E, Latrech B, Tsiberidis C, Gouwy J, Kapessidou Y. ED50 and ED90 of intrathecal hyperbaric 2% prilocaine in ambulatory knee arthroscopy. *Can J Anaesth*. 2014;61(9):801-807.
5. Camponovo C, Fanelli A, Ghisi D, Cristina D, Fanelli G. A prospective, double-blinded, randomized clinical trial comparing the efficacy of 40 mg and 60 mg hyperbaric 2% prilocaine versus 60 mg plain 2% prilocaine for intrathecal anaesthesia in ambulatory surgery. *Anesth Analg*. 2010;111(2):568-572.
6. Kaban OG, Yazicioglu D, Akkaya T, Sayin MM, Seker D, Gumus H. Spinal anaesthesia with hyperbaric prilocaine in day-case perianal surgery: randomised controlled trial. *Scientific World Journal*. 2014;2014:608372.
7. Singh NP, Siddiqui NT, Makkar JK, Guffey R, Singh PM. Optimal local anesthetic for spinal anaesthesia in patients undergoing ambulatory non-arthroplasty surgery: a systematic review and Bayesian network meta-analysis of randomized controlled trials. *Can J Anaesth*. 2025;72(4):550-566.
8. Wesselink E, Janssen-van den Hurk G, van der Vegt R, et al. Chloroprocaine versus prilocaine for spinal anaesthesia in ambulatory knee arthroscopy: a double-blind randomized trial. *Reg Anesth Pain Med*. 2019;44(10):944-949.
9. Lacroix SP, Malaise PR, Degey SV, Deflandre EP. Predictability of the duration of motor blockade induced by unique injection of intrathecal prilocaine: an observational study. *J Physiol Pharmacol*. 2019;70(3):419-424.
10. Kreutziger J, Frankenberger B, Luger TJ, Richard S, Zbinden S. Urinary retention after spinal anaesthesia with hyperbaric prilocaine 2% in an ambulatory setting. *Br J Anaesth*. 2010;104(5):582-586.
11. Forget P, Borovac JA, Thackeray EM, Pace NL. Transient neurological symptoms following spinal anaesthesia with lidocaine versus other local anaesthetics in adult surgical patients: a network meta-analysis. *Cochrane Database Syst Rev*. 2019;12(12):CD003006.
12. Ambrosoli AL, Di Carlo S, Crespi A, et al. Safety and effectiveness of prilocaine for spinal anaesthesia in day surgery setting: a retrospective study on a sample of 3291 patients. *J Anesth Analg Crit Care*. 2023;3(1):40.
13. Aguirre J, Borgeat A, Bühler P, Mrdjen J, Hardmeier B, Bonvini JM. Intrathecal hyperbaric 2% prilocaine versus 0.4% plain ropivacaine for same-day arthroscopic knee surgery: a prospective randomized double-blind controlled study. *Can J Anaesth*. 2015;62(10):1055-1062.

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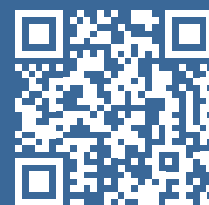
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DR NAMRATA SINGH
PUBLIC PRACTICE
ADVISORY COMMITTEE
CHAIR

PUBLIC PRACTICE ADVISORY COMMITTEE

WNSW ROTATIONAL SCHEME – DUBBO FROM A CONSULTANT'S AND A REGISTRAR'S EYES.



DR JOHN FARIS
ROTATIONAL SUPERVISOR
OF TRAINING
WNSW ROTATIONAL SCHEME
DUBBO BASE HOSPITAL

JOHN FARIS IS A CONSULTANT ANAESTHETIST AT DUBBO BASE HOSPITAL. HE FIRST CAME TO DUBBO IN 2015. HE BECAME A SOT, WHICH HELPED HIM GAIN INSIGHT INTO THE PROBLEMS OF RECRUITING IN REGIONAL AREAS. AFTER 3 YEARS' WORK, HE HELPED MANAGE THE FORMATION OF THE WESTERN NSW LOCAL HEALTH DISTRICT ROTATIONAL SCHEME AND BECAME THE REGIONAL SUPERVISOR OF TRAINING FOR THE SCHEME.

JOHN STARTED HIS MEDICAL CAREER IN AVIATION MEDICINE AND FOLLOWED THIS SPECIALTY FOR 20 YEARS IN THE ROYAL NEW ZEALAND AIR FORCE, WHERE HE ALSO JOINED THE 176 PILOTS' COURSE AND GAINED HIS AIR FORCE WINGS.

From a consultant's eyes - Rotational Supervisor of Training, WNSW Rotational Scheme, Dubbo Base Hospital

Having spent over 12 years in Dubbo, I can reflect on the journey we've undertaken. Base hospitals across regional Australia face numerous challenges, with staffing – encompassing medical, nursing, and allied health – being one of the most significant.

Dubbo Base Hospital, like many, has grappled with attracting and retaining specialists, particularly anaesthetists. Four years ago, we embarked on a mission to make a difference. As one of three base hospitals in the WNSW Local Health District (LHD), we recognised our potential to create change alongside Orange Base Hospital, which faces similar hurdles.

Although Dubbo Base Hospital had long been accredited for ANZCA training, reliance on rotations from major metropolitan hospitals meant we were not fully utilising our potential. Most trainees were Basic Trainees Year 1 and 2, and we also engaged independent trainees at various levels.

We envisioned a bold strategy to foster and sustain our own specialists, beginning with registrar training. It became clear that while both hospitals had independent trainees, the most capable sought out scheme jobs, making it vital to create a scheme that would attract exceptional registrars.

The notion that training in rural areas can lead to practice in those areas resonates deeply. While many specialists who train in the bush may ultimately gravitate to metropolitan centres, it is evident that exposure to rural practice is essential for those willing to serve in regional settings. The work is not only fulfilling but also requires practitioners to be adept across various specialties, undertaking complex surgeries without specialty backup. The challenges are profound, as our patients often face systemic health issues, including obesity, cardiovascular disease, diabetes, and substance abuse.

Our practice volume analysis showed ample justification for 104 weeks of ANZCA accreditation. By collaborating, Dubbo and Orange Hospitals could cover nearly all surgical specialties, except a few. Dubbo Hospital manages six theatres, with over 10,000 cases annually, including approximately 1,300 births.

Both hospitals face significant paediatric demands, collectively treating around 100 children under two years old each year.

With a shared vision, Dubbo and Orange Hospitals were granted an increase in accredited training time to 104 weeks in late 2023 and early 2024.

Support from the Chief Executive of the WNSW LHD paved the way for a revolutionary rotational scheme

between our two hospitals. After fruitful discussions with Royal Prince Alfred Hospital and Prince of Wales Hospital funding was secured for a year in Sydney, culminating in service-level agreements between the LHDs. This rotation plan allows registrars to experience each hospital and Sydney, fostering regional training and positioning WNSW as an attractive destination for medical education, inspiring future generations.

A fundamental criterion for participation in the scheme is a strong affiliation with and experience in regional areas, particularly within the WNSW LHD. The establishment of this new rotational scheme marks an inspiring milestone in our commitment to advancing regional medical training and enhancing healthcare in WNSW.



DR LAUREN GAM
ANAESTHETICS REGISTRAR
CENTRAL COAST LHD

LAUREN IS AN ANAESTHETIC TRAINEE BASED ON THE CENTRAL COAST. SHE RECENTLY COMPLETED HER INTRODUCTORY TRAINING DURING A SIX-MONTH REGIONAL ROTATION IN DUBBO. SHE IS REALLY EXCITED FOR HER CAREER IN ANAESTHESIA AND HAS A PARTICULAR INTEREST IN MEDICAL EDUCATION AND SIMULATION.

From a registrar's eyes - WNSW Rotational Scheme, Dubbo Base Hospital.

I moved to Dubbo for six months as a rotation from my home hospital, which was certainly a leap outside my comfort zone. I was pleasantly surprised by Dubbo itself, which turned out to have a lot of charm. It has lots of great cafes and restaurants, and it was so nice being able to live just five minutes away from work.

Clinically, I was exposed to a high volume and broad range of anaesthetic practice. There was a lot of bread-and-butter obstetrics, general surgery and orthopaedics, plus a range of subspecialty work including ENT, thyroid, breast, paediatrics, ophthalmology and more. There were many complex and comorbid patients, often ASA 3 and 4, presenting for both elective and emergency surgery.

I learnt about the flexibility and creative problem-solving required in regional anaesthetic practice, particularly when caring for patients who had travelled many hours and who may have had limited access to or engagement with healthcare services. Working with a diverse team of visiting medical officers and locums exposed me to a wide range of experience and different approaches to anaesthetic practice.

The regular nurses, doctors, and other hospital staff were very used to welcoming rotating doctors and helped us to find our feet. A particular highlight was the camaraderie amongst the other registrars. We could share the experience of living and working away from home, which created a great sense of community.

Overall, while working in a regional setting was challenging at times, working in Dubbo was a hugely valuable experience. I learnt a lot about anaesthetic practice and adaptability, as well as gaining a greater understanding of the demands and rewards of working regionally.



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

SCIENCE PRIZES, AWARDS AND RESEARCH COMMITTEE

The SPARC has great pleasure in congratulating the recipients of this year's pre-National Scientific Congress research awards. These awards recognise outstanding clinician-researchers whose work advances our specialty and ultimately improves the care we provide to patients across Australia and New Zealand.

Each year, the Society's research awards provide vital support to clinicians at different stages of their research careers. Beyond the financial support they offer, these awards represent confidence in the recipients' ideas and acknowledge the considerable effort required to develop competitive research proposals. On behalf of SPARC and the ASA, I would like to sincerely congratulate this year's award recipients.

Jackson Rees Research Grant

Congratulations to **Dr Earlene Silvapulle**, recipient of the Jackson Rees Research Grant of the value of \$27,500.

Dr Silvapulle's SPECTRE (Secondary Prevention Therapy for Postoperative Myocardial Injury after Noncardiac

Surgery) trial with lifestyle interventions, risk factor modification and cardiovascular pharmacotherapy is novel and builds on her important work in the postoperative myocardial injury space. We congratulate her on this well-deserved achievement and wish her every success as the project progresses.

The Jackson Rees prize has a proud history of supporting emerging investigators and innovative research within our specialty. It honours the legacy of Jackson Rees, whose contributions continue to inspire generations of anaesthetists committed to improving patient care through research and scholarship.

ASA Annual Research Grant and Scholarship

Congratulations to **Dr Michelle Chong**, recipient of the ASA Annual Research Grant and Scholarship of the value of \$75,000.

Dr Chong's successful application is for a PhD on regional anaesthesia in shoulder surgery, including the SAXIPec Trial (Suprascapular, Axillary, and Lateral Pectoral Nerve Blocks Versus Superior



DR EARLENE SILVAPULLE

I am a Staff Specialist Anaesthetist at the Royal Melbourne Hospital. My biggest clinical and research interests are perioperative risk prediction, preoperative cardiovascular evaluation (prior to noncardiac surgery), transfusion medicine and trauma. My PhD program of research is examining cardiac risk stratification and myocardial injury after noncardiac surgery. In the long-term, I hope to improve survival, clinical outcomes and quality of life for patients experiencing postoperative cardiac events.

Outside of work, I love spending time outdoors, anything fitness-related and playing with my two gorgeous boys.

Trunk Block for Shoulder Arthroscopy). This randomised study and its subsequent works set out to evaluate phrenic nerve function, pain intensity and patient-reported outcomes. We look forward to following the progress of this important project and seeing its contribution to advancing evidence-based anaesthesia.

The Annual Research Grant and Scholarship is one of the Society's flagship research initiatives, supporting higher degree by research students, such as PhD candidates. Competition for this award is consistently strong, reflecting the depth and quality of research being undertaken by ASA members.

Selecting award recipients is never easy. Each year SPARC receives applications covering an impressive breadth of clinical and translational research, educational innovation and patient safety initiatives. The quality of submissions reflects the remarkable research culture that exists within our profession.

To every applicant, I would like to offer my sincere thanks. Preparing a competitive grant application requires significant time, thoughtful planning and commitment. Even when an application is ultimately unsuccessful, the process of refining research questions, developing methodology and engaging collaborators strengthens future research and often leads to even stronger applications in subsequent years.

I would also like to acknowledge the members of SPARC and our independent reviewers, whose expertise and generosity ensure that applications are evaluated rigorously, fairly and transparently. Their commitment is essential to maintaining the high standards of the Society's research funding program, and abstract shortlisting for the CSC 2026. This year our reviewers were: Dr Peter Harrigan, Dr Paul Maclure, Dr Lisa Deecke, Dr Frances Page and Dr David Elliott.

Looking ahead to the Combined Scientific Congress (CSC)

These awards also provide an excellent opportunity to look ahead to the upcoming Combined Scientific Congress in the Hunter Valley 8-11 October 2026.

The Combined Scientific Congress remains one of the highlights of the ASA calendar, bringing together anaesthetists from across Australia and New Zealand to share new knowledge, discuss emerging evidence and strengthen the professional connections that underpin our specialty.

Research will once again feature prominently throughout the scientific program, showcasing the breadth of innovation occurring across anaesthesia in Australia and New Zealand. It is always inspiring to see established researchers present alongside trainees and early-career investigators, demonstrating the exciting future of anaesthesia research.

Congratulations once again to our award recipients, and I hope to see many of you at the CSC Hunter Valley.

■ Associate Professor Indy Lin

Science Prizes, Awards and Research Committee Chair



DR. MICHELLE CHONG

Dr. Michelle Chong is a staff anaesthetist at St Vincent's Hospital Melbourne and a PhD candidate with the Department of Critical Care at the University of Melbourne. Shoulder surgery is associated with significant perioperative pain and regional anaesthesia plays a pivotal role in improving patient comfort and recovery. While current techniques provide excellent analgesia, their benefits can be overshadowed by complications such as diaphragmatic paresis, rebound pain, and dense motor blockade that may delay functional recovery.

Michelle's PhD investigates targeted, tailorable peripheral nerve block strategies for shoulder pain.

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.



webAIRS

Jessica Sprialis, Phillip Quinn,
Yasmin Endlich and the ANZTADC
Case Report Writing Group

THE CARDIAC THEATRE AS A MEDICATION ERROR AMPLIFIER

Case 1.

A patient undergoing valve surgery developed profound vasodilatory shock and malignant ventricular arrhythmias after receiving a large, concentrated bolus of dopamine instead of the intended drug milrinone. The dopamine had been drawn up neat into a syringe that was subsequently mislabelled. The patient required immediate high-dose noradrenaline and vasopressin, followed by antiarrhythmics and multiple defibrillation attempts to treat recurrent episodes of ventricular tachycardia and ventricular fibrillation.

The anaesthetist reported this error caused severe harm to the patient and identified multiple contributing factors: simultaneous requests for medications, several staff members working near the drug trolley, high cognitive workload, and suboptimal theatre layout that prevented visual cross-checking.

While events like the above are thankfully very uncommon due to the standard precautions anaesthetists take, the incident highlights how multiple system and human factors can align in a high-risk environment to permit a serious medication error. Medication errors remain among the most frequently reported incidents in anaesthesia and have the potential to cause significant patient harm^{1,2}. Analysis of the first 4,000 reports submitted to webAIRS found medication errors accounted for 11.6% of incidents, with wrong-dose (29.4%) and wrong-drug (28.1%) events the most common categories³. Despite established strategies such as standardised labelling, double-checking processes and improved medication storage, these preventable incidents continue to occur as they arise from complex interactions between human, environmental and system factors.

Cardiac surgery may represent a particularly vulnerable setting; utilising powerful pharmaceuticals within a time-critical environment characterised by high cognitive demand and rapidly changing physiology of patients with severe comorbidity.

To explore whether medication errors in cardiac surgery differ from those reported across the broader anaesthetic community, we reviewed webAIRS reports involving open cardiac surgical procedures. Twenty-three incidents met inclusion criteria. Drug substitution errors were the most common event type (13 incidents), followed by overdose errors (7 incidents) and underdose errors (3 incidents). Although the number of reports was small, the pattern differed from the broader webAIRS medication error dataset, where dose errors predominated.

Case 2.

During cardiopulmonary bypass protamine was administered via infusion instead of the intended DDAVP due to a syringe swap error. This was noticed after the protamine syringe had finished infusing, though no pump alarms had occurred. Emergency measures were undertaken by the team to re-heparinise with a new bypass circuit, avoiding any complications for the patient.

The anaesthetist reported that pre-emptively drawing up protamine was the main factor that contributed to the error, noting unfamiliarity with DDAVP may have also played a role.

Drug substitution errors

Drug substitution errors accounted for more than half of all incidents. Anticoagulant reversal agents and sympathomimetics were the most frequently involved drug classes.

Four incidents involved syringe swaps, where the correct medication had been prepared and labelled but the wrong syringe was subsequently selected and administered. The remaining substitution errors originated during medication preparation, with the unintended drug being drawn up and labelled as another agent.

Multiple incidents involved substitutions between protamine and tranexamic acid due to similar ampoule appearance. In another report, one of the two

vials of intended protamine had been inadvertently substituted for a vial of noradrenaline, and the subsequent syringe of mixed drugs was administered. Two cases involved dopamine being administered instead of another intended medication, including the incident described in Case 1.

Inattention was the most frequently reported contributing factor, identified in more than half of substitution incidents. Look-alike medications, mislabelling and failure to check were also common themes.

These incidents were primarily reported as resulting in minor immediate effects, with one causing severe harm. All but two described acute complications requiring urgent recovery measures. Three required additional neurological post-operative monitoring. One patient returned to theatre due to post-operative graft site bleeding.

Case 3.

During a high-risk patient for open cardiac surgery, significant hyperkalaemia was noted upon separation from cardiopulmonary bypass. Intravenous insulin was planned as part of the treatment regimen; however, due to a factor error in drawing up the insulin, the patient received 100 units rather than the intended 10 units.

The anaesthetist reported contributing factors including inexperience, unfamiliarity with the insulin preparation, and the time pressure of drug administration.

Dose errors

Seven overdose and three underdose incidents were identified. Insulin was the most frequently implicated drug class in overdose events, accounting for three cases. Two involved ten-fold dosing errors during treatment of severe hyperkalaemia. Opioids were implicated in two further overdose events, both associated with pump programming errors and failure to check settings.

One infant received more than fourteen times the intended morphine dose over almost two hours, while another patient received a large dose of remifentanyl due to the persisting syringe program swap, well known to all clinical anaesthetists.

Underdose events were less common but carried significant risks. In two cases, the omission of intended medications risked intraoperative awareness during bypass for valve replacements; in one case, the error was not recognised until the rewarming stage. While potential signs of awareness were present in both cases, thankfully neither patient had any recollection post-operatively.

Failure to check was the most frequently reported contributing factor in dose errors. Inexperience and unfamiliarity with medications or equipment were also commonly identified.

All but one dose error resulted in complications needing immediate intervention, with one anaesthetist declaring an emergency and three patients requiring additional post-operative monitoring.

How do cardiac incidents differ?

Compared with the broader webAIRS medication error analysis, cardiac surgery demonstrated a different profile of both medications involved and contributing factors. A comparison of drug error classes and factors between cardiac and all surgical specialities is shown in table 1.

The most frequently implicated drug classes in dose errors for the aggregated surgical specialties were opioids, sympathomimetics and local anaesthetics. In contrast, insulin accounted for the largest proportion of dose errors in cardiac surgery. Similarly, while non-depolarising neuromuscular blocking agents featured prominently in substitution errors across the wider dataset, anticoagulants and anticoagulant reversal agents predominated this error type in cardiac surgery.

The most frequently reported contributing factors also differed. Failure to check and unfamiliarity with drugs or equipment were more frequent contributors to dose errors in cardiac cases than inexperience, which was the most common factor reported in the broader dataset. For drug

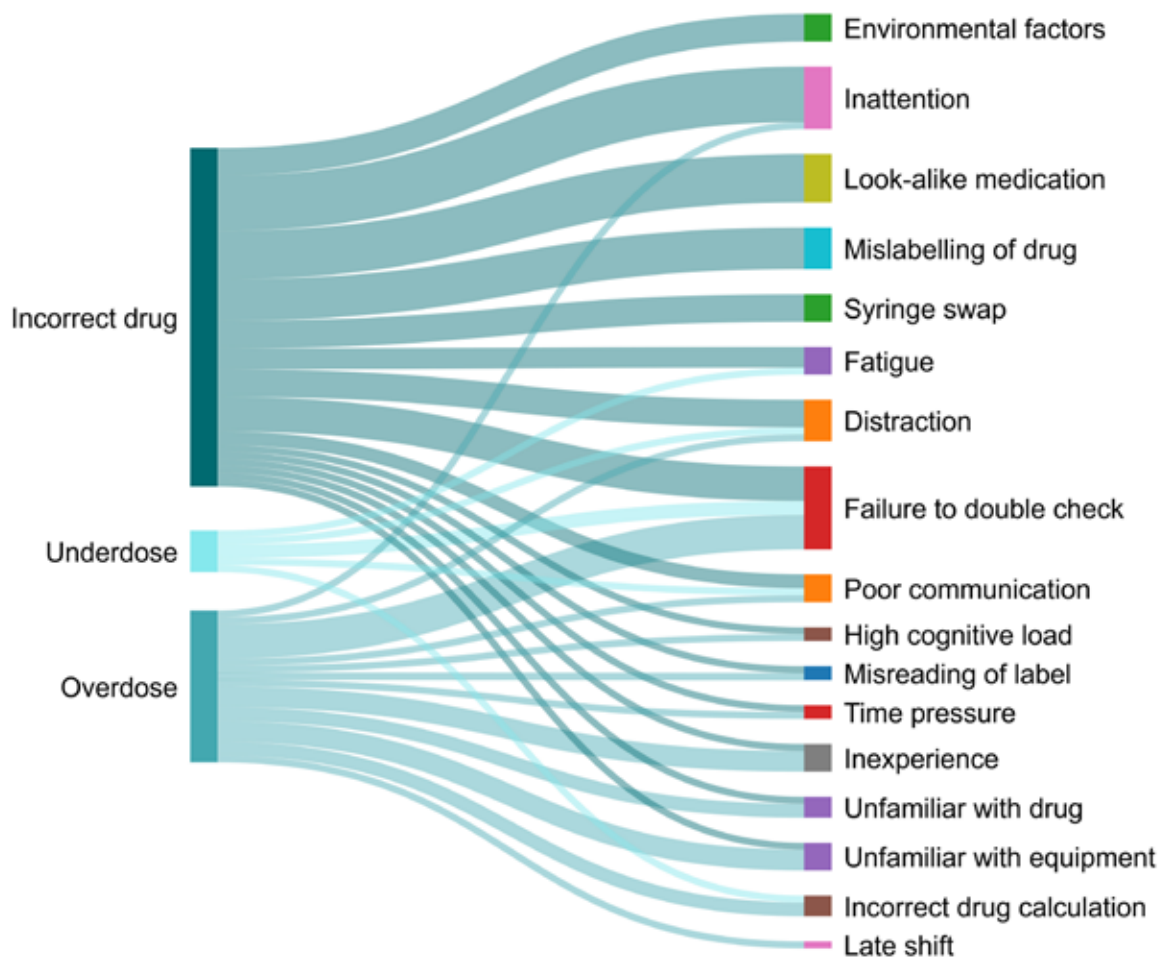


Figure 1. Sankey diagram showing the relationship between error type (left) and contributing factors reported (right). NB: The thickness of each band is proportionate to the quantity of incident reports in which each factor was recorded.

	All Surgical Specialties	Cardiac
Dose errors most common drug class	Opioid Sympathomimetic Local anaesthetic	Insulin Opioid Antibiotic
Factors	Inexperience Poor communication Inattention	Failure to check Unfamiliarity (drug or equipment) Inexperience
Drug substitution errors drug class	ND-NMBA Sympathomimetic Opioid	Anticoagulant reversal Sympathomimetic Anticoagulant
Factors	Look-alike medication Storage issue Time pressure	Inattention Look-alike medication Mislabelling of drug

substitution errors across all surgical specialties, look-alike medications and storage issues were the most frequently reported factors; however, inattention was the recurrent factor in cardiac drug substitution incidents. A Sankey diagram for visualisation of the patterns of contributing factors for drug errors is provided in figure 1.

Lessons for practice

Although based on a relatively small number of reports, the divergence in patterns from those observed across the broader anaesthetic specialty reflects the unique pharmacological and operational demands of the cardiac theatre. Drugs that are uncommon sources of medication incidents in general anaesthetic practice were overrepresented in errors within this subspecialty; including insulin, dopamine, heparin and protamine.

Each incident involved multiple contributing factors, with reports

identifying between two and six contributing elements. Human factors were most prevalent, particularly failures to check, inattention and unfamiliarity.

However, environmental and system issues—including look-alike medications, workspace design and interruptions during drug preparation—were frequently present alongside individual actions. The persistence of medication errors in anaesthetic practice represents vulnerabilities within existing safety systems. The differing characteristics of these cardiac anaesthesia errors suggest further review of a larger sample and dissection of the broader data may provide insight into reducing error in specialised, high-risk environments. The challenge for cardiac anaesthesia is incorporating and designing systems and processes that remain resilient despite the high cognitive load, time pressure and complexity that characterise the modern cardiac surgical environment.

■ Jessica Sprialis, Phillip Quinn, Yasmin Endlich and the ANZTADC Case Report Writing Group

References

1. Kelly FE, Frerk C, Bailey CR, et al. Human factors in anaesthesia: a narrative review. *Anaesthesia*. 2023;78(4):479-490. doi:10.1111/ANAE.15920
2. Geneva: World Health Organization. Medication Safety in High-risk Situations. 2019. Accessed July 3, 2026. <https://iris.who.int/server/api/core/bitstreams/020cac11-563b-42d1-b12d-ac4604369797/content>
3. Kim JY, Moore MR, Culwick MD, Hannam JA, Webster CS, Merry AF. Analysis of medication errors during anaesthesia in the first 4000 incidents reported to webAIRS. *Anaesth Intensive Care*. 2022;50(3):204-219. doi:10.1177/0310057X211027578



**DR MICHAEL
LUMSDEN-STEEL**
CHAIR, ECONOMICS
ADVISORY COMMITTEE

ECONOMICS ADVISORY COMMITTEE

MBS ANAESTHESIA RELATIVE VALUE GUIDE REVIEW

You have a voice – have you used it?

Members should be aware by now of the review of the Medicare Benefits Schedule (MBS) Anaesthesia Relative Value Guide (RVG) that the ASA is undertaking with the Australian Government Department of Health and Aged Care (the Department).

The ASA is the custodian of the RVG. It was introduced into the MBS following many years of lobbying by the ASA, with the support of Australian Medical Association. When the anaesthesia RVG was introduced into the MBS on 1 November 2001 the RVG unit value was \$17.15. In July 2026, the unit value was indexed to \$23.70.

The MBS Anaesthesia RVG is set out in the MBS under Category 3, Group T10: Relative Value Guide for Anaesthesia. It comprises Subgroups 1 to 26 and covers MBS items 20100 to 25205. Importantly, Medicare benefits are only payable for anaesthesia performed in association with an eligible service.

Medicare benefits for anaesthesia services are generally payable only where the service is provided by a registered medical specialist to an eligible patient. While anaesthesia RVG items are not

restricted exclusively to specialist anaesthetists, the provision and claiming of anaesthesia services must comply with the requirements of the *Health Insurance Act 1973*, including Part II, section 16, and relevant MBS notes². Practitioners must comply with MBS Note TN.10.5, *Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)* and ensure that the anaesthesia is performed in association with an eligible service. Anaesthetists should also be familiar with MBS Notes TN.10.01 to TN.10.30, which provide further guidance on the requirements applying to anaesthesia RVG items.

The current review also includes the anaesthesia consultation and attendance item numbers located at Category 3, Group T6: Anaesthetics (17610 to 17630, 17680, 17690 and specialist attendance item numbers by anaesthetists 17640 to 17655). The RVG review does not include Category 3, Group T7: Regional Or Field Nerve Blocks – these are the procedural item numbers performed as pain medicine/pain management (i.e. MBS items 18213 to 18298).

Anaesthesia fees are calculated by using the MBS RVG to determine the total number of units for the service, then multiplying those units by the doctor's chosen unit value. The ASA RVG complements the MBS RVG by including additional items that are not otherwise listed in the MBS RVG, noting that ASA-only items do not attract Medicare rebates.

The ASA works closely with the Australian Medical Association to maintain the integrity and relevance of the anaesthesia RVG. This is particularly important because remuneration for anaesthesia services provided to patients covered by workers compensation or motor accident schemes is often specified by reference to the AMA RVG, rather than the MBS RVG.

In short, the ASA undertakes significant work on behalf of all anaesthetists by maintaining, reviewing and advocating for the RVG, regardless of how frequently individual anaesthetists use it.

It is important to highlight that anaesthetists working exclusively in public hospitals also benefit from the RVG. The RVG may be used in public hospital settings for billing under rights of private practice (ROPP), or to calculate

The ASA works closely with the Australian Medical Association to maintain the integrity and relevance of the anaesthesia RVG. This is particularly important because remuneration for anaesthesia services provided to patients covered by workers compensation or motor accident schemes is often specified by reference to the AMA RVG, rather than the MBS RVG.

allowances derived from ROPP earnings. This is because the anaesthesia RVG helps determine fees for anaesthesia services provided to private patients, as well as patients covered by motor vehicle accident schemes, workers compensation or overseas travel insurance schemes. This remuneration can represent a significant component of staff specialist anaesthetist's overall remuneration package, often in the range of 25 to 35 per cent of base salary.

The RVG also has an indirect influence on public sector remuneration. During industrial negotiations, and in jurisdictions experiencing challenges attracting and retaining anaesthetists in the public hospital system, public hospital remuneration packages are often considered in the context of private practice earnings. In addition, many Victorian public hospitals remunerate specialists for after-hours emergency work and weekend work using a fee-for-service model based on the ASA RVG.

Public work outsourced to private, commonly referred to as 'Public in Private' or 'PIP', is generally remunerated on a fee-for-service basis. Some hospitals have attempted to make bundled payments for such work, which is the ASA's preferred method for determining fee for work – at an appropriate unit value.

The ASA is seeking to ensure that all members have the opportunity to provide feedback on the anaesthesia RVG. Feedback should cover both MBS anaesthesia items and ASA RVG items.

All ASA members should have received an email from their State or Territory Chair outlining the RVG review and providing a link to the feedback webform.

The ASA has also contacted the relevant Special Interest Groups to seek targeted feedback and suggestions on areas of the RVG relevant to their specific fields of practice.

Why is this review necessary?

This review is necessary because anaesthesia practice has changed significantly since the RVG was introduced into the MBS in 2001 and the RVG must continue to evolve to remain clinically relevant and fit for purpose. The current RVG consists of 26 subgroups, and the review provides an opportunity to consider whether its structure remains appropriate, including whether similar subgroups could be consolidated and duplicated or overlapping items rationalised.

A critical feature of the RVG is relativity. While the initiation of anaesthesia items (referred to as base items) reflect the relative complexity of different procedures, the purpose of this review is not to uplift base items to compensate for the Government's failure to index the MBS in line with health CPI. Nor is the purpose of the review to address health funds' failure to index known-gap limits adequately.

The ASA is aware that longer cases are disproportionately affected by known-gap limits. The recent ASA *Specialist Fees and Patient Out-of-Pocket Costs Survey* found that anaesthetists are very conscious of patient out-of-pocket costs, due to inadequate MBS indexation and limited or absent indexation of health insurance known-gap limits. These constraints can materially affect the final fee charged. The survey found that 60 per cent of anaesthetists identified procedure duration as the most significant factor influencing fees, followed closely by procedural complexity (55%) and insurer arrangements (54%).

This issue is particularly relevant for longer cases. In the MBS RVG, time units remain in ten-minute intervals beyond four hours, whereas the ASA and AMA RVG both apply five-minute intervals beyond four hours.

As new procedures have evolved in public hospitals and been introduced into the MBS, the implications for the anaesthesia RVG have not always been considered or addressed – transperineal biopsy of the prostate for example, which is replacing transrectal ultrasound (TRUS) guided biopsy of the prostate.

Minimally invasive procedures have also expanded significantly. Percutaneous image-guided interventions, interventional structural cardiac procedures, and interventional neuroradiology procedures are now, where clinically appropriate, alternatives to traditional open procedures.

Pain medicine procedures have similarly evolved, including the placement of spinal cord stimulator leads in the epidural space using a combination of mini-open and percutaneous techniques without being a procedure on the spine or spine cord. These procedures may involve significant anaesthetic complexity without necessarily being captured appropriately as spinal, spinal cord, or orthopaedic procedures.

Orthopaedic procedures have also evolved. For example, unicompartmental knee replacement and revision of a joint replacement can range from a complex staged procedure to changing a single component, e.g. acetabular liner.

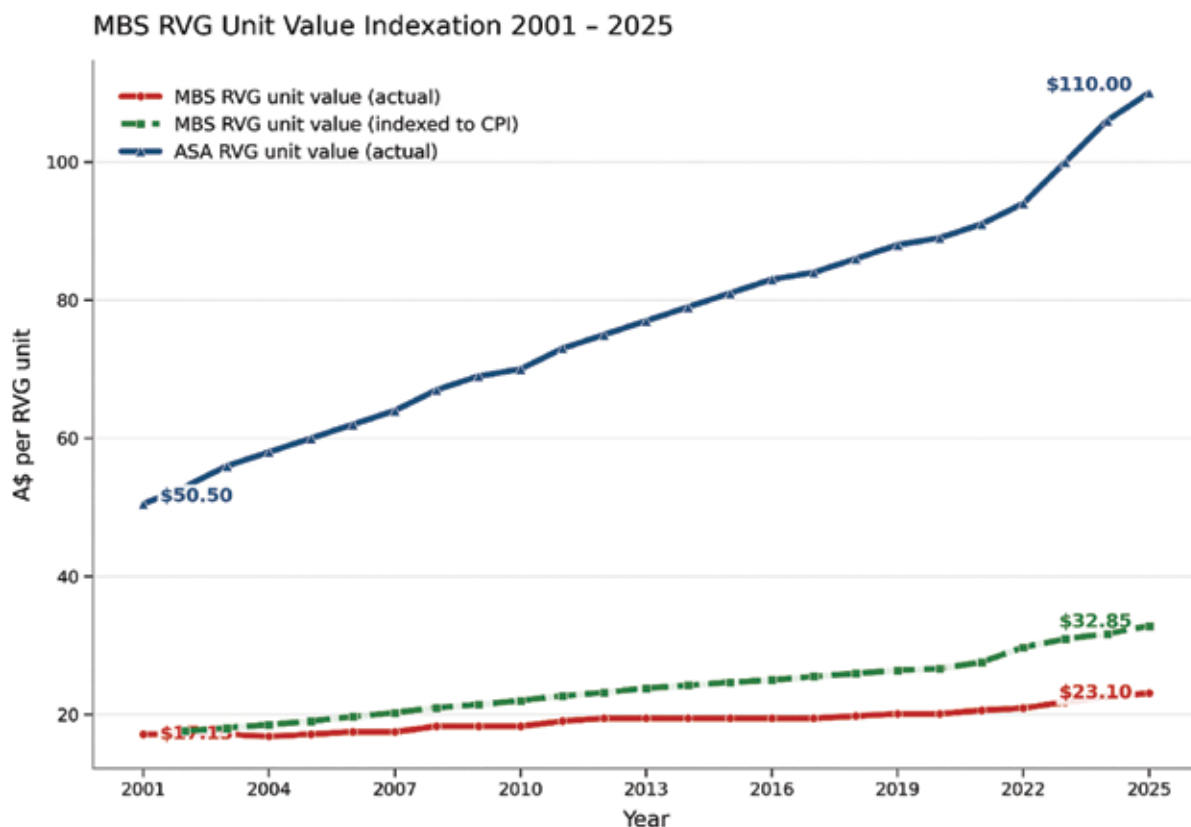
Spinal and major spinal surgery have continued to evolve, and there is a clear level of complexity gradient between a single-level laminectomy, as opposed to a single-level anterior lumbar interbody fusion, posterior lumbar interbody fusion, or transforaminal lumbar interbody fusion.

Medicare compliance remains a significant and evolving issue. Medicare has increasingly been matching initiation of anaesthesia items against associated surgical procedural items and some of this analysis has already been presented to the ASA. For example, data on anaesthesia for spinal surgery has highlighted variation in the initiation of anaesthesia item numbers used for these procedures. This scrutiny is likely to increase. The Federal Government has announced additional investment in Medicare compliance and MBS billing oversight, reinforcing the importance of ensuring that anaesthesia item numbers are clinically appropriate, internally consistent, and clearly aligned with the procedures to which they relate.

If you would like to contribute any feedback or comments to the RVG Review you still have time, but you need to do this quickly.

Notwithstanding this, the ASA and other peak medical bodies will continue to call out the government for failing to increase the patients MBS rebate for anaesthesia.

The graph below shows actual indexation of the MBS RVG unit value from 2001 to 2025 (red line). It also shows indexation of the MBS RVG unit value if it had been indexed to CPI (green line) and actual indexation of the ASA RVG unit value (blue line) over the same time period. Had the MBS RVG unit value of \$17.15 in December 2001 been indexed in line with CPI, it would be \$32.87 by December 2025 – well above the current unit value of \$23.70, illustrating the cumulative impact of sustained under indexation.



Anaesthesia RVG unit value PHI update

Private health insurance funds indexed their RVG unit values on 1 July 2026 as per the table below:

Fund	RVG unit value	Indexation since 1 July 2025
MBS	\$23.70	2.6%
DVA	\$38.30	0%
ASA	\$110	3.8% ¹
CPI		3.8% ²
Know gap		
Medibank Private	\$39.15	2.6%
AHSA3	\$39.48	2.6%
St Lukes	\$40.75	2.5%
HCF	\$39.10	2.6%
Bupa	\$39.25	2.6%
NIB GapSure	\$45.00	4.7%
No gap		
HBF Specialist Anaesthetist^{4,5}	\$44.10	3.9%
HBF Full Cover^{4,6}	\$40.60	10.6%
HCF	\$40.30	2.7%
HBF Provider Choice^{4,7}	\$38.60	14.9%
Bupa	\$40.20	2.7%

1. ASA RVG unit value was indexed on 1 November 2025
2. The CPI Figure is for the 12 months to July 2026
3. Average value – varies from state to state. AHSA RVG unit values for each state are:
 NSW/ACT \$39.60
 VIC \$39.60
 QLD \$39.60
 WA \$38.60
 SA \$39.60
 TAS \$39.60
 NT \$39.60
4. HBF “no gap” schedules apply in WA. For all other states, see the relevant AHSA table.
5. HBF Specialist Anaesthetist Schedule reduces unit values for time units from 16 – 120 (item numbers 23025 - 23085) to \$43.80
6. HBF Full Cover reduces unit values for time units from 16 – 120 (item numbers 23025 - 23085) to \$40.25
7. HBF Provider Choice reduces unit values for time units from 16 – 120 (item numbers 23025 - 23085) to \$38.45

Whilst the majority of health funds apply a consistent unit value across the RVG, it is interesting to note that the HBF WA Specialist Anaesthesia (a no-gap scheme specific and limited as an option for WA anaesthetists only) RVG does not apply the same RVG unit value across their RVG. The HBF WA Specialist anaesthesia rate of \$44.10 is reduced to \$43.80 for Time items for 16 min to 120 minutes (23025 to 23085), Items 25013 and 25014 by \$43.80, Initiation of anaesthesia items 20745 \$41.55 and 20750 \$40.40.

Medical Cost Finder site

The ASA continues to meet with the Department’s Medical Cost Finder team. The ASA notes at the most recent meeting, the Department noted it is still exploring the methodology for how doctors’ fees will be reported. The ASA is continuing to engage with other peak medical bodies.

■ Dr Michael Lumsden-Steel

Chair, Economics Advisory Committee

References

- 1 Australian Government Department of Health, Disability and Ageing. (2026, July 7). MBS Online: July 2026 downloads. Medicare Benefits Schedule. <https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-20260701>
- 2 Australia. (1973). Health Insurance Act 1973 (Cth). Federal Register of Legislation. <https://www.legislation.gov.au/C2004A00101/latest>
- 3 Australian Society of Anaesthetists. (2026). ASA specialist fees and patient out-of-pocket costs summary report. Australian Society of Anaesthetists. <https://asa.org.au/wp-content/uploads/2026/04/ASA-Specialist-Fees-Patient-Out-of-Pocket-Costs-Summary-Report>



DR AMY CHAPMAN
ADVANCED TRAINEE
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CIG SCHOLARSHIP
WINNER

COMMON ISSUES GROUP SCHOLARSHIP RECIPIENT REPORT

CANADIAN ANESTHESIOLOGISTS' SOCIETY ANNUAL CONFERENCE

Ottawa Canada, 5 - 7 June 2026

DR AMY CHAPMAN, MBCHB(PRET) GCERTCLINUS GCERTCRITCARE, IS AN ADVANCED TRAINEE WORKING AT FLINDERS MEDICAL CENTRE IN ADELAIDE. SHE IS WORKING ON EXPANDING HER PORTFOLIO INTO RESEARCH AND EXAM EDUCATION WHILE BALANCING HER WORK AS CO-CHAIR OF THE SA-NT TRAINEE COMMITTEE.

The opportunity to represent Australia and the Australian Society of Anaesthetists as a senior trainee at the Canadian Anesthesiologists' Society Annual Conference was a genuine privilege.

The three-day conference brought together doctors from across Canada. There was also a strong medical student presence, reflecting North America's system of matching into a specialty at the end of four years of medical school. This gave me the opportunity to speak with students about their views on anaesthesia and what they were doing to improve their chances of securing a training position. Unsurprisingly, research, education, and an undefined but substantial amount of keenness were considered essential qualities—something all pre-vocational Australian trainees know a great deal about.

Anaesthetic trainees or "residents" raised topics that would sound familiar in any Australian tearoom. Concerns centred on trainee welfare, access to supervision and complex cases, the

growing use of non-doctor practitioners, and uncertainty about future specialist employment opportunities. By the end of these conversations, I had developed an even greater appreciation for the systems we have in place in Australia, while recognising that we face many of the same challenges.

It was not all corridor conversations. With multiple streams running throughout the conference, there was a strong focus on artificial intelligence and its impact on anaesthesia, regional anaesthesia, communication with patients and healthcare teams, and the influence of new Canadian studies that are helping shape patient care. By the end of the weekend, my phone was filled with photos of practice-changing slides and ideas that I could not wait to share with colleagues back home. My personal highlight was a discussion on patient complaints in obstetric anaesthesia and how different experts approached both the validity of these complaints and strategies for preventing them.

The clear take-home message from the conference was that anaesthetists can only meet the growing challenges facing our profession if we speak with a united voice and have the support of every member. As Australian anaesthetists, we are fortunate to have the ASA representing our interests to government, hospital administrators, and the broader community.

Thank you for the opportunity to attend the conference in Ottawa. I will finish with the important observation that I also managed to cycle 80 km around Gatineau Park on my day off, which I understand is a mandatory requirement for eventual consultant status.

■ Dr Amy Chapman

Advanced Trainee
Flinders Medical Centre, Adelaide
CIG scholarship winner



Day 1 of the CAS conference.



Day 2 of the CAS conference.



Trying to convince a Medical student to move to Australia.



Lunch time discussions on best place to work in the world (and why it's Adelaide)



Cycling along the Ottawa river.



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DR JAMES HOSKING
PROFESSIONAL ISSUES
ADVISORY COMMITTEE
CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

PHARMACIST PRESCRIBING

The ASA recently made a submission to the Pharmacy Board's consultation on pharmacist prescribing¹ arguing, against the extension of Pharmacy prescribing to all Schedule 4 and Schedule 8 medicines.

"The Pharmacy Board of Australia (the Board) is seeking... to endorse the registration of suitably qualified pharmacists under section 94 of the National Law as being able to administer, obtain, possess, prescribe, sell, supply, or use a scheduled medicine or class of medicines. If approved by Ministerial Council, the Board would endorse the registration of pharmacists who have completed an approved program of study or a program of study that the Board considers to be substantially equivalent to an approved program of study, to prescribe scheduled medicines.

Currently pharmacists prescribe Schedule 2 - pharmacy medicines, and Schedule 3 -pharmacy-only medicines which in the Pharmacy Board's own words "[gives] a defined scope and level of regulatory control to protect public health and safety." Pharmacists have in recent years

been authorised to prescribe Schedule 4 – prescription-only medicines to support continued use.

The consultation discusses whether endorsement of pharmacists should include Schedule 4 medicines alone, or whether Schedule 8 medicines should also be included. It is the position of the ASA that both Schedule 4 and Schedule 8 medicines should not be prescribed by pharmacists. This is a patient safety issue as only medical education and training provides the skills required for appropriate diagnosis, treatment, and follow-up. This is not disputing pharmacists' expertise in medicine with their important role in medication safety. The four pharmacist prescribing scenarios in Appendix F of the Board document include apparent otitis media, apparent acute herpes zoster, wound management, and completing a new medication chart in a Residential Aged Care Facility.

There is also the conflict-of-interest issue of selling the medication that you yourself have prescribed. This conflict is acknowledged by the Pharmacy Board to the point of developing guidelines to mitigate it. These guidelines include

recognising conflicts, informing the patient of conflicts, and not allowing commercial interest in a hospital or pharmacy to affect the way in which patients are treated. This conflict appears pervasive and insurmountable.

Ultimately it is the medicines and poisons legislation in each of the states of Australia that would determine what medicines pharmacists could prescribe.

The Pharmacy Board also places great faith in the real-time prescription monitoring systems for prescribing Schedule 8 medicines. It states "Mandatory use of real-time prescription monitoring systems that inform practitioner decisions about prescribing and supply and mitigates against unsafe prescribing of monitored medicines." While these systems provide information on previous use and prevent issues of multiple prescriptions, they provide no information on what Schedule 8 medicines are appropriate for, the current patient presentation, or the impact of the patient's comorbidities. Interestingly the Joint Pharmacy Organisations' (JPO)² own submission to the Board excludes botulinum toxin and cannabis.

Extensive amounts of the evidence used to argue for pharmacist prescribing involve collaborative models. However, the JPO continues to argue for independent prescribing of Schedule 4 and Schedule 8 medicines. This is despite the exclusion of narcotics in most of the overseas models.

The medical insurer Avant has raised its own concerns with Pharmacy prescribing³. "An analysis of Avant claims found medication-related issues were involved in around one in six matters resulting in regulatory action or claim for patient compensation, making prescribing one of the leading contributors to serious medico-legal matters." Again, opioid prescribing was notable for prominence in regulatory action or claims for compensation. Another example highlighted by Avant was the change in scheduling of codeine medication in 2018 due to public health risks. This would be the opposite of returning control of supply to pharmacists by allowing independent prescription of Schedule 8 medicines⁴.

The Australian Medical Association has also argued that the proposal should not proceed and also emphasises collaboration⁵. They assert that there is:

- Insufficient evidence of need or cost-benefit
- Inadequate training in comparison to clinicians or nurses for autonomous prescribing
- Safety risks of misdiagnosis, inappropriate prescribing, missed drug interactions, inadequate follow-up, fragmented care, delayed diagnosis of serious illness.
- Specific areas of concern with antibiotics, antidepressants, oral contraceptives, opioids and other Schedule 8 medicines.
- Concerns with Schedule 8 prescribing of dependence and addiction risks, diversion, and misuse.
- Conflict of interest with loss of separation between prescribing and dispensing, with financial incentives to prescribe what they sell.
- Fragmentation of care especially with GP's, a particular concern in chronic disease or multiple comorbidities.

- Infeasibility of evidence from overseas as models involve. Tightly defined scopes, integration with multidisciplinary teams or GP practices.

The ASA will continue to argue against the expansion of autonomous pharmacy prescribing for Schedule 4 and Schedule 8 medicines.

ASA Statement on Private Hospital Ownership

As per the ASA Update sent to all members via email on 2 July, the ASA recently responded to media and stakeholder enquiries concerning anonymous correspondence about our Position Statement on Private Hospital Ownership. This was published on the ASA website in late May⁶. All ASA position statements can be accessed on the ASA website⁷.

The ASA response reflected the policy positions adopted following all usual processes and was also informed by independent research, including our recent *Specialist Fees and Informed Financial Consent Survey Report*⁸.

PIAC is always open to feedback and suggestions regarding ASA Position Statements or any ASA publications. Members with specific interest and expertise are always welcome to be involved in our reviewing process.

ASA SIMG Pathways Resource Document

We recently published a resource for Specialist International Medical Graduates (SIMGs) which is available on the ASA website. This document outlines the current pathways available for overseas-trained anaesthetists to gain specialist registration in Australia, including recent reforms aimed at addressing workforce shortages.

It also provides information on the Area of Need Pathway (for SIMGs willing to work in shortage areas) and the Short-Term

Training Pathway available to SIMGs in training who would like to undertake up to 24 months of specialist or advanced training in Australia. You can read or download a copy of this resource on the ASA website⁹.

New 'Sip Til Send' guidance

The Australian Commission on Safety and Quality in Healthcare have produced a new Sip till Send Guidance available on its website¹⁰. The guidance has been informed by a literature review and environmental scan, and developed with expert clinical oversight and stakeholder input. It is accompanied by implementation resources to support local adoption by health service organisations.

Increased minimum recommended dantrolene stocks

ANZCA has recently revised the amount of dantrolene that is required to be stocked at each anaesthetising facility. For more information ANZCA published a News and safety alert in late April on this topic¹¹.

Please also refer to ANZCA Position Statement PS55 Minimum safe facilities¹², Appendix 2: Malignant Hyperthermia and its accompanying Background paper (PS55BP).

ASA submission to the ACCC regarding Honeysuckle Health Ltd and nib health funds limited

In late July the ASA has made a submission to the ACCC opposing the proposed re-authorisation of Honeysuckle Health and nib's collective contracting arrangements.

The ASA is concerned that these arrangements could increase insurer market power, reduce competition, limit patient choice, and place further pressure on anaesthetists and other medical specialists. The submission also highlights risks for regional and rural communities, where reduced provider choice and ongoing private service closures may worsen access to timely care.

The ASA argues that the claimed public benefits have not been demonstrated and that the ACCC should undertake a fresh assessment based on current market conditions and the actual outcomes of the previous authorisation period.

To read the ASA submission, or for more information about Honeysuckle Health Ltd and nib health funds limited application visit the ASA website¹³.

■ Dr James Hosking

Professional Issues Advisory
Committee Chair

References

1. Pharmacy Board of Australia. (2026, April 20). Consultation opens on proposed national standard for pharmacy prescribing. Australian Health Practitioner Regulation Agency. <https://www.pharmacyboard.gov.au/News/2026-04-20-Consultation-opens.aspx>
2. Pharmacy Guild of Australia, Advanced Pharmacy Australia, & Pharmaceutical Society of Australia. (2025, October). Joint Pharmacy Organisations' paper for endorsed pharmacist prescribers [Submission]. Pharmacy Guild of Australia. https://www.guild.org.au/_data/assets/pdf_file/0035/168947/Endorsed-Pharmacist-Prescribers-Submission.pdf
3. Avant Mutual. (2026, June 18). Prescribing expansion should alarm GPs. Avant. <https://avant.org.au/resources/prescribing-expansion-should-alarm-gps>
4. Avant Mutual. (2026, June 15). *Avant submission to the public consultation on the proposed endorsement for scheduled medicines for pharmacists* [Submission to the Pharmacy Board of Australia]. Avant. <https://assets.avant.org.au/cdf6134c-01d7-0292-26f5-2f5cf1db96f8/162fd55a-605e-44ec-979d-5a6af844635b/Avant%20submission%20to%20the%20public%20consultation%20on%20the%20proposed%20endorsement%20for%20scheduled%20medicines%20for%20pharmacists.pdf>
5. Australian Medical Association. (2026, June 29). *Submission on Pharmacy Board consultation on endorsement for scheduled medicines for pharmacists*. Australian Medical Association. <https://www.ama.com.au/articles/submission-pharmacy-board-consultation-endorsement-scheduled-medicines-pharmacists>
6. See https://asa.org.au/wp-content/uploads/_pda/2026/05/ASA__PS27_Statement-on-Private-Hospital-Ownership.pdf
7. See <https://asa.org.au/representation/position-statements>
8. See <https://asa.org.au/publications/asa-specialist-fees-patient-out-of-pocket-costs-summary-report>
9. See <https://asa.org.au/publications/pathways-for-sims-to-obtain-specialist-registration-in-anaesthesia-in-australia>
10. See <https://www.safetyandquality.gov.au/clinical-topics/medicines-safety-and-quality/iv-fluids-therapy-management>
11. See <https://www.anzca.edu.au/news-and-safety-alerts/ps55-mh-update-increased-minimum-recommended-dantrolene-stocks>
12. Australian and New Zealand College of Anaesthetists. (2021). PS55 position statement on minimum facilities for safe administration of anaesthesia in operating suites and other anaesthetising locations (Appendix 2 update, 2026). Australian and New Zealand College of Anaesthetists. [https://www.anzca.edu.au/getContentAsset/9b0c33f8-6a0f-4f76-9e90-a751dc181f12/80feb437-d24d-46b8-a858-4a2a28b9b970/PS55-Minimum-safe-facilities-2021-\(Apdx-2-2026\).pdf?language=en](https://www.anzca.edu.au/getContentAsset/9b0c33f8-6a0f-4f76-9e90-a751dc181f12/80feb437-d24d-46b8-a858-4a2a28b9b970/PS55-Minimum-safe-facilities-2021-(Apdx-2-2026).pdf?language=en)
13. See <https://asa.org.au/news-and-media/submissions/asa-submission-to-the-accc-regarding-honeysuckle-health-ltd-and-nib-health-funds-limited>



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HISTORY OF ANAESTHESIA, LIBRARY, MUSEUM AND ARCHIVES COMMITTEE

PAIN MEDICINE IN THE HARRY DALY MUSEUM

The history of pain medicine is thousands of years longer than that of modern anaesthesia, yet anaesthetists have played a major part in the development of pain medicine in the last 180 years. Here are some of the analgesic-related items to be found in the ASA Harry Daly Museum Collection.

Placebos and traditional remedies

The study of the placebo response began in the 1940s and 1950s with Lasagna, Beecher and others comparing pain relief from subcutaneous injections of placebo and morphine – something that might not be considered ethical today.

The Harry Daly Museum at the ASA has examples of placebo from various eras that were available in Australia such as Dr Sheldon's Magnetic Liniment. The Sheldon Drug Company was based in Sydney and established in 1904 by American chemist Samuel Sheffer. From 1908 to 1929 the company manufactured Rexona products developed by Alice Sheffer, wife of the founder, until these were taken over by Lever Brothers (later Unilever).



Placebos.

There is no evidence and no reason to believe Dr Sheldon's Liniment had any magnetic properties at all. Magnetism, thought to have beneficial effects for centuries, was of great public interest at the time and it is likely the name, as with those of other similarly branded "electro" or "magnetic" liniments and ointments, was nothing more than pseudoscientific



Bupivacaine

quackery. Another theory is that some of these "magnetic" therapies contained traces of magnesium which may also have contributed to the name but, again, there is little evidence in support of this.

Sloan's Family Liniment, which may have been more than just a placebo, was originally developed by harness maker and self-taught veterinarian Andrew



Local anaesthetics.

TEETH EXTRACTED WITHOUT PAIN.

MR. NORRIE is prepared to perform operations on the Teeth, through the agency of Æthereal inhalation; a pure æther will always be prepared for the purpose, and the fees will be proportionately low, so that every person may avail themselves of this extraordinary agent.

Pitt-street, near Bathurst-street

Australian Medical Journal, July 1847.



Cyprane Inhaler



Emotril

There is no evidence and no reason to believe Dr Sheldon's Liniment had any magnetic properties at all. Magnetism, thought to have beneficial effects for centuries, was of great public interest at the time and it is likely the name, as with those of other similarly branded "electro" or "magnetic" liniments and ointments, was nothing more than pseudoscientific quackery.

Sloan, around the time of the American Civil War, as a liniment for lame horses, possibly using a formula obtained from Native Americans. It was subsequently marketed widely and successfully by his sons, Earl and Foreman Sloan, later being adapted and sold as 'good for man and beast' after being modified to contain capsaicin. Earl Sloan, taking on the title 'Dr' from his father's veterinary business, incorporated a family company which was sold in 1913 to Warner and Co, later Warner-Lambert, and eventually bought by Pfizer. Sloan's Liniment remains available today, with active ingredients varying slightly by location of manufacture but including capsaicin,

methyl salicylate, pine oil, turpentine oil, eucalyptus oil, and camphor.

Many of these preparations had unknown formulations that were closely guarded by the manufacturing company and never put on the bottle – a very different practice to standard medications today.

Local anaesthetics

Local anaesthesia techniques have been a mainstay of anaesthesia and modern pain medicine. A variety of local anaesthetic preparations have been used clinically since 1884 when Koller (via Sigmund Freud) realised topical cocaine induced corneal insensibility. The



Emotril

will we see a return to earlier techniques of analgesia in labour such as the Cyprane Inhaler?

This trichlorethylene inhaler, first introduced in the 1940s in England, was a handheld air drawover vaporiser for analgesia in obstetrics, dentistry, and very minor procedures. There was a variable dial to adjust the concentration, the aim being to provide analgesia but not a high enough concentration to induce anaesthesia. Also, it was held by the patient, supposedly another safety feature. In the 1970s some Cyprane inhalers were modified to use methoxyflurane for obstetric analgesia. Methoxyflurane, though not used in general anaesthesia anymore, is known to many through the 'green whistle' analgesic devices used in many ambulance services. Similar air vaporiser inhalers using methoxyflurane were used in some Australian obstetric units until the early 1990s as an alternative to nitrous oxide/oxygen demand flow devices which we may eventually see replaced.

Another means of administering trichlorethylene during labour and found in the Harry Daly Museum is the Emotril Trichloroethylene Analgesia Apparatus. Designed in 1949 by Hans Epstein and manufactured by the Medical and Industrial Equipment Ltd, the "Emotril" name is from Epstein, Macintosh, Oxford Trilene inhaler.

■ Associate Professor John A Loadsman

Anaesthetist, Royal Prince Alfred Hospital, and University of Sydney

■ Associate Professor Michael Cooper AM

HALMA Committee Chair

References

1. Cousins M, Carr DB. *History of Anaesthesia VIII*. ASA, 2016, 139-148.
2. Lasagna L et al. *Am J Medicine* 1954; 16 (6): 770-779.
3. Albright GA. *Anesthesiology* 1979; 51 (4): 285-7. Kamel et al. *J Hist Dent* 2021; 69 (3): 191-199.

same year, Halsted and Hall in New York used cocaine in peripheral nerve blocks performed on themselves – initially the supraorbital nerve and then dental nerve blocks. Both became addicted to cocaine – but that is another story.

The ASA Harry Daly Museum collection has some early preparations of drugs, some of which we have not used for nearly a century including Stovaine (amylocaine) in beautiful and delicate handmade bulb ampoules for spinal anaesthesia. It was synthesised at the Pasteur Institute in Paris in 1903 by Ernst Fourneau whose name is French for stove – hence the trade name. It was the first synthesised local anaesthetic and was much less addictive and toxic than cocaine.

An example of a more recent item is the 20ml ampoule of bupivacaine 0.75% sourced from the US in 1990 by one of the authors. Bupivacaine was synthesised in 1956 and introduced into the market in 1965. However, it was until around 1980 that the cardiac toxicity of bupivacaine compared with lignocaine was finally appreciated with prolonged resuscitation being required from overdose or intravascular injection. In 1983 the United States Food and Drug Administration recommended discontinuation of bupivacaine 0.75%

for obstetric epidural anaesthesia. At this time, Dr George Albright from Stanford University presented 49 cases of bupivacaine-induced cardiac arrest, with 16 of the 21 ensuing deaths being of obstetric patients who received the drug epidurally. Other countries like Canada and the United Kingdom soon followed the US. Note that our ampoule says for epidural and retrobulbar anaesthesia but not for obstetric or spinal anaesthesia.

Inhaled analgesics

Nitrous oxide was first demonstrated in Australia around 1845 by JS Norrie, a dentist in Sydney, giving a demonstration of the laughing gas. This was soon picked up and advertised by other dentists. They were quick to pivot to the use of ether two years later in the Australian colony and advertise its availability, and with no particular expertise.

However, the use of nitrous oxide in general anaesthesia and as an analgesic has, after 150 years, been challenged. Current considerations of the environmental effects of nitrous oxide, especially more recently with leaking from hospital pipeline supplies commonly identified, has cast a shadow over its long-term use. There is still a need in obstetric and dental practice, but



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DR ERIC XU
ANAESTHETICS
REGISTRAR
GOSFORD HOSPITAL

COMMON ISSUES GROUP SCHOLARSHIP RECIPIENT REPORT

ASSOCIATION OF ANAESTHETISTS RESIDENT DOCTORS' CONFERENCE 2026

Newcastle upon Tyne, United Kingdom, 17-18 June 2026

I would like to sincerely thank the Australian Society of Anaesthetists (ASA) and the Trainee Members Group for awarding me the CIG Scholarship to attend the Association of Anaesthetists Resident Doctors' Conference in Newcastle, United Kingdom.

The conference brought together trainees from across the United Kingdom and internationally, and provided a valuable opportunity to learn from colleagues working in different healthcare systems. As an ASA scholarship recipient, I was grateful for the opportunity to represent Australian trainees, share experiences from our training programme, and gain new perspectives that I can bring back to colleagues at home.

One of the strongest themes throughout the conference was leadership, workplace culture, and the future of healthcare. A session on resilient leadership explored the concept that resilience is not simply an innate trait, but something that can be developed through reflection on past challenges and adversity, using those experiences as a foundation for growth. Our keynote speaker discussed how understanding and learning from previous setbacks can help individuals build resilience, while also highlighting the importance of supportive workplace cultures in enabling people to thrive.



Tyne Bridge.

Another particularly impactful session focused on sexual safety in healthcare and empowering individuals to speak up when concerns arise. The speakers highlighted the importance of creating workplaces that are safe, respectful, and inclusive, while providing practical strategies for supporting colleagues and fostering positive workplace culture. The session reinforced that creating psychologically safe training environments is a responsibility shared by everyone within the profession.

The conference also featured multiple engaging discussions on artificial intelligence in medicine, including its impact on research, clinical workflow, and the future of AI in anaesthesia. Rather than focusing solely on technological advances, the speakers emphasised the importance of ensuring that AI is developed to address genuine clinical needs, with clinicians remaining actively involved in guiding its implementation. A key message that resonated with me was that while technology will continue

One of the strongest themes throughout the conference was leadership, workplace culture, and the future of healthcare. A session on resilient leadership explored the concept that resilience is not simply an innate trait, but something that can be developed through reflection on past challenges and adversity, using those experiences as a foundation for growth.

to transform healthcare, the human aspects of medicine (communication, empathy, trust, and clinical judgement) will remain irreplaceable.

Among the clinical sessions, I particularly enjoyed presentations on perioperative allergy, medical hypnosis, and prehospital emergency medicine. Although the topics were diverse, a common theme was the importance of communication, preparation, and patient-centred care. The session on medical hypnosis was especially memorable and highlighted how language and communication can significantly influence a patient's experience of healthcare. It served as a reminder that some of the most powerful tools we have as clinicians are not pharmacological, but interpersonal.

A personal highlight of the conference was the opportunity to present my audit examining rural emergency laparotomy outcomes at Coffs Harbour Health Campus. Undertaken during my rural secondment, the project compares local outcomes against NELA and ANZELA standards and seeks to identify opportunities for quality improvement in regional surgical care. Preparing and presenting the project was a rewarding experience, and I particularly enjoyed hearing about the many impressive research and quality improvement initiatives being undertaken by trainees and departments across the UK.



Newcastle castle.

Beyond the formal programme, one of the most rewarding aspects of the conference was meeting trainees from different parts of the world and discussing our respective training experiences. While there are clear differences between the UK and Australian training systems, it was reassuring to see that many of the challenges surrounding examinations, workforce pressures, wellbeing, and career progression are shared internationally. At the same time, these conversations reminded me how fortunate I am to be training in Australia, with access to excellent educational opportunities, supportive supervisors, and a well-structured training programme.

Outside the conference, I also enjoyed exploring Newcastle upon Tyne and experiencing a little of the city's history and culture. Walking along the River Tyne and following the route of its seven bridges provided a unique perspective on the city's industrial heritage. Of course, no visit to Newcastle would have been complete without trying a traditional pie and mash accompanied by a local Newcastle Brown Ale; an enjoyable way to unwind after a full day of scientific sessions and to experience a small part of the local culture alongside fellow delegates.



Resident Doctors' Conference 2026 main stage.

Representing the ASA and Australian trainees overseas was a privilege. The experience provided an opportunity not only to learn from colleagues abroad, but also to share perspectives on Australian anaesthetic training, regional healthcare, trainee advocacy, and quality improvement initiatives. These conversations reinforced the value of international collaboration and highlighted the important role organisations such as the ASA play in supporting trainees and fostering professional connections across healthcare systems.

I am grateful to the ASA and the Trainee Members Group for making this opportunity possible, and allowing me to represent the ASA as an ambassador. I returned with new ideas, renewed enthusiasm for trainee advocacy, education, and research, and valuable insights that I look forward to sharing with colleagues. I hope this scholarship continues to encourage future trainees to engage with our international colleagues, fostering the exchange of ideas and bringing valuable insights back to Australian anaesthetic practice.

■ Dr Eric Xu

Anaesthetics Registrar
Gosford Hospital



Dr Eric Xu audit presentation rural emergency laparotomy outcomes.



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STATE COMMITTEES

AROUND AUSTRALIA

Australian Capital Territory

Dr Valerie Quah

Chair of the Australian Capital Territory Committee of Management

The ACT trainees have had a busy few months with a well-attended and well-regarded ACT "Part 3" course convened by Dr Dharan Sukumar.

We also celebrated a successful result at the recent Primary and Fellowship exams and the ASA was delighted to sponsor a social evening organised by Shubh and Rachael, our ACT trainee representatives.

Upcoming ACT ACE meetings for the calendar include Scan and Ski (July) and the Art of Anaesthesia (October).



TMG representatives Rachel and Shubh with ACT trainee member Arthur.

New South Wales

Dr Katherine Jeffrey

Chair of the New South Wales Committee of Management

Changes at a committee level occurred after four years from Dr Simon Martel standing down and myself stepping up into NSW Committee Chair. Simon has been a strong advocate for the profession and leaves the committee in a strong place. Dr Chris Stone has also become the Deputy Chair. Dr Chris Stone is an anaesthetist on the North Coast, who will give the committee strong regional representation.

With the transition of Northern Beaches Hospital from private to public control, concerns have been raised by surgeons and anaesthetists for the plan of a high-volume surgical unit at Northern Beaches Hospital to assist in list reduction waiting time. In liaison with NSW Australian Medical Association AMA, ASA NSW will be advocating for appropriate surgical services at Northern Beaches Hospital that will assist the population in the area.

NSW anaesthetists and other doctors are currently awaiting the outcome of arbitration for the Staff Specialist Award and the Visiting Medical Officer VMO determination. Australian Salaried

Medical Officers Federation of NSW ASMOF and the AMA NSW organised testimonies from anaesthetists including Dr Simon Martel, Immediate Past Chair, NSW Committee to advocate for appropriate pay levels to match the increasing demands on staff in a stretched medical system. Outcomes for this arbitration will be later in the year or possibly in early 2027.

With the sitting of the 2026 Primary Exam, one in over 250 candidates in NSW and multiple ASA members were involved in examination preparation for candidates. Zoom and face-to-face viva nights were run which has allowed access to all trainees, no matter where in the state, to have access to examination practice. Again, the support of our members to help the next generation of anaesthetists as stunning to see, especially when many have busy clinical and non-clinical lives.

"Part 3" planning is underway to help transition fellows into consultancy with a tentative date in November. With our trainees' representatives Dr Ben Maudlin and Dr Brendan Troy, we hope to provide an informative day with tips and tactics to have a smooth transition for our fellows into consultancy.

Save the date for CSC 2026 at the Hunter Valley from the 8 to 11 October 2026, is getting closer to one of the great wine areas in Australia. Registrations are still open to attend, and the program is gaining a lot of interest with great speakers and family friendly activities. Transport options are easy from Sydney and Newcastle.

And finally, we pause to remember Sam Neill, whose warmth, wit and wonderfully human Instagram posts brought many of us a welcome smile during the darker days of COVID. Vale Sam Neill. Tēnā rawa atu koe.

Victoria

Dr Grace Gunasegaram

Chair of the Victoria Committee of Management

Committee of Management update

The ASA Victoria Committee is looking forward to an active and impactful second half of 2026. I would like to sincerely thank all Committee members, Heads of Departments and ASA support staff for their continued commitment, hard work and invaluable contribution.

2026 Winter Anaesthetic meeting

The ASA Victoria Education Committee delivered a dynamic and well-attended 2026 Winter Anaesthetic Meeting at the Sofitel Hotel from 8 to 9 August, welcoming 250 attendees across two days of education, discussion and practical learning. We were delighted to welcome ASA President Dr Vida Viliunas OAM and ANZCA President Dr Tanya Selak, and thank them for their attendance and support. The program featured a strong Saturday lecture series, including a Morbidity and Mortality session, followed by 28 hands-on workshops on Sunday designed to support members in meeting their CPD requirements. The strong demand for Morbidity and Mortality sessions and emergency response workshops, both of which attracted waiting lists, highlighted clear member interest in these areas. In response, the Committee is exploring opportunities to offer additional sessions in the future.



The Co Conveners Dr Genne Veerbek, Dr Grace Gunasegaram, Dr Michelle Horne with the ASA President Dr Vida Viliunas OAM and the VRC Chair Dr Luck De Silva.



Drs Genna Verbeek and Michelle Horne opening the Victorian Winter meeting. An excellent education program matched by the opportunity to catch up with colleagues.



The panel discussion.

2026 ASA VIC members Annual Meeting

We had a great attendance to the meeting held on the 24th of May at the Kooyoung Tennis centre. Our invited speakers Dr Vida Villiunas OAM (ASA President) shared an ASA update and Dr Hugo Stevenson delivered an engaging talk on AI in medicine/Anaesthesia.

ASA Part Three course

The annual ASA Part Three course is underway, offering a valuable two-part program on Monday 27 July and Monday 21 September. Open to local participants and specialist international medical

graduates, the course provides practical insights and guidance across key areas including, public work, private practice, billing essentials, career advice and planning, CPD and more.

Registrations are now open – secure your place today.

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

Winter hasn't slowed down the ASA and ACE activities in Perth.

Recently, the ASA WA Committee ran a patient survey on Anaesthetic Fee Awareness with over 1000 survey results sent in. As you can imagine, the results have been pretty eye-opening, and we will be sharing the insights from this analysis with WA members in the very near future. We'd like to thank all the groups who assisted in distributing this survey and the ASA Policy team for collating and providing analysis support.

The WA ASA Committee warmly welcomes Dr Daniel Anderson to the committee.

Discovery & Dialogue – ASA WA networking night

Coming up on Friday 25 September, the ASA WA Committee is excited to present 'Discovery & Dialogue', a collegial networking and CPD event to be held at Tucci's in Applecross. The evening will showcase our local emerging researchers through the presentation of the Nerida Dilworth Prize, and feature our 2026 Bunny Wilson Oration to be presented by Dr Grant Turner. Registrations will open soon (complimentary for all ASA members) and we hope to see you there!

WA Country Conference 2026 – Pullman Bunker Bay, November 13-15

Registration has opened for the 2026 ACE WA Country Conference to be held at the Pullman Bunker Bay – while accommodation is now fully subscribed at the Pullman, plenty of Emergency Response and other hands-on workshop places are still available.

Register at <https://www.anzca.edu.au/events-and-courses/2026-wa-ace-country-conference>.

WA ACE activities

Morbidity & Mortality Meeting – 23 April

Held on the 23 April at the WA ANZCA Office, and facilitated by Dr Bridget Hogan (ACE Committee) and Dr Archana Shrivathsa (ACE Committee, ASA WA Chair).

This workshop attracted 85 delegates for an engaging evening of collaborative learning, reflection and discussion. Thanks to all who submitted cases for discussion!



WA ACE Lecture Series Morbidity & Mortality workshop.

POCUS Gastric Ultrasound Workshop – 14 May

Held on the 14 May at the ANZCA Office, and facilitated by Dr Yayoi Ohashi (Fiona Stanley Fremantle Hospitals Group) and Dr Charlie Ho (ACE Committee), this workshop was fully subscribed at 24 delegates.

The workshop provided the delegates with a valuable opportunity to practice and further develop their gastric ultrasound skills through hands-on scanning and case-based learning. Participants were able to update their knowledge on emerging guidelines surrounding



Dr Yayoi Ohashi facilitating the Gastric POCUS ACE Workshop



Facilitators and attendees at the Gastric POCUS ACE Workshop.

GLP-1 medications and their implications for anaesthetic risk, while also refining techniques for gastric volume assessment and aspiration risk evaluation.

Thank you to our coordinators and facilitators for generously volunteering their time, knowledge, and expertise to support the workshop and contribute to its outstanding success:

Dr Charlie Ho, Dr Yayoi Ohashi, Dr Lisana Rodrigues, Dr Nadim Kozman, Dr Bjoern Paganetti, Dr Matthew Haggett, Dr Kiran Venkatesulu, and Mr Simon Ferrero from the Perth Radiological Clinic.

Upcoming ACE events

(registrations now open)

- 22 September - Major Haemorrhage
- 12 October – Morbidity & Mortality

South Australia / Northern Territory

Dr Nicole Diakomichalis

Chair of the South Australia / Northern Territory Committee of Management

The SA/NT committee have had a very productive year supporting our members both in Private and Public practice.

In the Northern Territory, our representative Dr James Corcoran along with our Policy Manager Bernard Rupasinghe and CEO Matthew Fisher met with the Chief Medical Officer to discuss issues such as workforce and the Enterprise Bargaining Agreement. Negotiations continue with regards to the sale of Darwin Private Hospital. We will await further information about this in the coming months.

Dr Tristan Adams continues to attend the elective surgical reform committee meetings with thanks. We have been invited to take part in discussions regarding Public in Private work and look forward to some positive outcomes from these discussions.

As Chair of the SA/NT ASA Committee, I will be undertaking a series of visits to public hospitals across Adelaide to highlight the support provided by the ASA.

These visits will offer a valuable opportunity to connect directly with members, gain insight into the issues they are facing, and better understand the priorities that matter most to them. I am looking forward to these conversations and to strengthening engagement with members across the region.

Dr Ellie Cheah, Dr Mila Sterbova and our new trainee representative, Dr Bernie Lagana are busy organising our Part Three course which will be held on November 21st. We look forward to this event every year as it gives us the opportunity to talk to those transitioning to consultancy about ASA membership. We once again thank Dr Mila Sterbova for all of 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.

We are looking forward to the ASA CSC in the Hunter Valley in October. It is going to be a brilliant meeting and on a personal note I look forward to catching up with fellow members in a beautiful region in New South Wales.

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



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

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