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RACGP
Royal Australian College
of General Practitioners

2025.2 RGA SSSA Examination Report

November 2025

2025.2 Rural Generalist Anaesthesia (RGA) SSSA

Examination Report

The RGA-SSSA exam was conducted online via Zoom on November 29 and 30, 2025. Candidates participated from various locations, while examiners were present on-site in Melbourne. The examiners were selected from a panel of fellows representing all three colleges: ANZCA, RACGP, and ACRRM.

The exam consisted of eight viva sessions, each including 2 minutes for reading and 13 minutes for questioning. Additionally, three minutes were allocated for transitioning candidates between Zoom rooms. The exam scenarios were designed to align with the RGA curriculum and covered topics such as RGA Roles in Practice, Clinical Fundamentals, and Specialised Study Units.

Candidates were assessed on various clinical scenarios, focusing on their clinical management strategies, responses to evolving situations, resource allocation, quality and safety measures, and the application of their knowledge in rural or remote contexts.

The RGA-SSSA aims to evaluate clinical judgment in anaesthetic practice, recognising that multiple safe and appropriate approaches exist for patient care across different clinical scenarios. The viva scenarios presented various clinical situations to assess candidates' abilities to make sound and safe decisions. Examiners looked for candidates to demonstrate readiness for independent practice.

Candidates were encouraged to respond to questions by describing their typical actions in specific situations. Strong responses should be tailored to the individual patient context, providing patient-specific answers rather than relying solely on memorised responses.

Effective communication is essential during the viva. Candidates should articulate clear, organised responses to demonstrate their expertise and ability to address complex issues. Utilising an appropriate framework can help structure answers and ensure that key safety aspects are covered. However, it is vital to avoid irrelevant frameworks that could waste time and detract from addressing core issues.

Completing the entire viva is not mandatory to pass; however, maintaining a steady pace is crucial to adequately cover all topics. High-performing candidates manage their pace effectively while providing concise answers grounded in solid clinical principles. They demonstrate the ability to organise their thoughts and make informed decisions, reflecting consultant-level thinking.

In summary, successful performance in the viva requires a combination of effective communication, efficient time management, organised and concise responses, and sound decision-making based on clinical knowledge. By focusing on these key aspects, candidates can showcase their expertise and competence in handling various clinical scenarios.

Pass Mark

A total of 48 candidates took the exam. The overall pass rate for the 2025.2 SSSA viva examination was 79%.

The RGA Examination Committee use a set of criteria to determine the pass mark for this exam. Each viva is scored out of 24, with a score of 12 being considered to be the minimum accepted standard. In order to pass overall, candidates must:

- Achieve a pass mark of 50% (96 marks) overall, and
- Achieve a pass mark of 50% (12 marks) in 6 of 8 vivas, and
- Not score below 9 marks for any viva if 2 vivas are not passed, and
- Not score below 6 marks for any viva, and
- Must be deemed to have demonstrated “safety for independent practice” by a minimum of 13 of 16 examiners.

These criteria may be used as a guide for future exams, but the final decision may depend on the difficulty of the individual questions, examiner feedback and special circumstances as appropriate.

Technical issues

A small number of technical issues arose during the exam when candidates were being connected to the examiner's virtual room. Some were related to the candidate's internet connection and audio quality. Most issues were quickly resolved, and additional time was granted.

Two incidents are as follows:

1. Due to an audio issue with one candidate during a viva on Saturday, their viva was rescheduled to Sunday morning, prior to the planned exam. After the candidate completed the viva, they were held in a zoom room until the exam commenced for remaining candidates.
2. During the final station of the Sunday exam, the usual 2-minute reading bell was not activated. This issue was resolved by extending the viva by 60 seconds.

It is recommended that candidates choose a location with reliable internet access, properly connected audio/headphones, and fully charged devices. Candidates should ensure that all computers and devices are plugged in or charged and should be familiar enough with their equipment to troubleshoot quickly (for instance, in case of accidental muting or Bluetooth disconnection). The most common problem appears to be

Bluetooth disconnection, which is best avoided using a hard-wired audio device. Attending the exam from non-standard or non-compliant venues (for example, an operating theatre) not only causes audio issues for the examiners but also presents a distracting background.

Vivas

Each viva was conducted by a primary examiner who assessed the candidates via Zoom. A second examiner observed the candidates alongside the examiner and provided a second independent assessment.

At the end of the exam day, the court of examiners held a meeting to review the examination process. The court has identified several common issues among candidates that may have affected their performance in these vivas:

- 1- Providing a rote-learned answer to an evolving clinical scenario without applying it to the context of the patient in question.
- 2- The use of vague statements like “multimodal analgesia” without providing any specific medications or doses.
- 3- Repeating the question, not answering the question or providing irrelevant information, which reduces the time available to finish the viva.
- 4- Having a limited understanding of the resources available in Scenarioville or the logistics of requesting further investigations.

Examiners also provided the following advice for future candidates:

- 1- Candidates are encouraged to carefully read the stem and opening question, and answer the question that is asked.
- 2- For paediatric scenarios, reading time is a good opportunity to calculate drug doses, equipment sizes and fluid boluses etc. Describing paediatric drug dosing in mg/kg or mcg/kg or actual doses is more exact than using mls.
- 3- Candidates are encouraged to ask examiners to repeat any questions or information if they are unclear about what was asked or stated.
- 4- Candidates are encouraged to highlight how a clinical scenario would cause them to alter their standard practice, rather than describe their standard practice in unnecessary detail.
- 5- When asked to provide a plan, candidates are encouraged to describe what they would actually do, rather than provide an exhaustive list of possible options, particularly if those options are clearly inappropriate to the scenario.
- 6- Candidates are advised to avoid the use of non-standard mnemonics or abbreviations, eg SPEEDBOMB, that the examiner may not be familiar with.

The following stems and key topics were covered during the 24 vivas. This information is provided to help candidates prepare for their exams and to provide an example of the level of knowledge required to pass the viva examination successfully.

2025. RGA SSSA Vivas

Viva 1 – Airway Management

There is a 7-year-old male patient in ED who has suffered a Colles fracture of his wrist when he fell from some playground equipment about an hour ago. He had a muffin in one hand, which is why he fell. The paediatric orthopaedic surgeon at your referral centre has recommended that a semi-urgent closed reduction is required due to marked angulation and neurovascular compromise. The ED doctor has called you to provide anaesthesia.

He is a polite and compliant boy. He has no known allergies and has mild asthma using salbutamol MDI via puffer and spacer prn. He had an adenotonsillectomy aged 5 for snoring with no anaesthetic or surgical complications.

For the last 2 days, he has had a mild URTI.

He weighs 42kg.

Outline your history and examination of this patient.

Key Topics Assessed:

- Pre-operative assessment, airway management plan
- Difficult ventilation, absence of capnography post-induction
- Management of severe bronchospasm
- Considerations for extubation

Feedback from examiners:

This question was generally well answered. Many candidates failed to recognise that the child was significantly overweight for his age, or to consider the implications of this. Better candidates considered the elevated risk of respiratory complications due to his asthma and a recent URTI, and considered the possibility of other injuries. Candidates are advised to be familiar with a range of techniques for safely managing unfasted patients in the ED. Better candidates were able to consider multiple possible causes of severe bronchospasm and rapidly institute appropriate treatment, including volatile agents and adrenaline.

Viva 2 – General Anaesthesia and Sedation

You are in the theatre doing an endoscopy list at Scenarioville. The surgeon has stated that he would like to add a 72-year-old female to the end of your list today.

She was admitted a week ago with a partial bowel obstruction for conservative management for a right-sided colon cancer (CT confirmed).

She has undergone bowel preparation this morning as best tolerated.

She has a background of Type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary Disease.

Her medications are metformin and spiriva inhaler.

What additional information would you like to obtain prior to proceeding with her case?

Key Topics Assessed:

- Pre-operative assessment
- Impact of malignancy on perioperative care
- Considerations for proceeding with case
- Anaesthetic plan
- Postoperative delirium

Feedback from examiners:

This question was generally well answered, however a surprising number of candidates were slow to consider the impact of a bowel obstruction and bowel prep on fluid status and haemodynamics. Better candidates were able to appreciate the anaesthetic, as well as the psychosocial aspects of a cancer diagnosis in an elderly patient. Most candidates recognised the high aspiration risk, but some failed to provide airway protection, and instead sedated the patient. Some outstanding candidates also considered the logistics of a high-risk patient being added to the end of a list and potentially after hours. A surprising number of candidates failed to recognise hypoxia as a potential cause of post-operative agitation, particularly in a patient with COPD who may have aspirated during the case.

Viva 3 – Obstetric Anaesthesia

A 28-year-old primigravida has an epidural placed for labour analgesia. Her epidural has been secured at 11cm at skin following loss of resistance at 6cm.

You are called an hour later to review the patient with patchy breakthrough pain to the right lower area of her abdomen with contractions.

Discuss your approach to trouble-shoot this block.

Key Topics Assessed:

- Trouble-shooting an inadequate epidural during labour
- Emergency management of foetal distress
- Implications of a general anaesthetic for emergency caesarean section
- Anaesthetic management of GA for emergency caesarean section
- Considerations for blood transfusion

Feedback from examiners:

This question covered topics that are core material for RGAs, and better candidates were able to demonstrate their experience in managing it well. Common mistakes included failure to recognise the epidural top-up as a cause of foetal distress, or consider the foetus when planning a general anaesthetic for a caesarean section. Otherwise, the risks of a GA caesarean section were well answered. Tachycardia in the mother was frequently assumed to be the result of blood loss without considering other causes, and a PPH management plan implemented without addressing the original question of the maternal tachycardia.

Viva 4 – Paediatric Anaesthesia

It is Sunday morning, and you are working in the emergency department when a nurse asks you to review a child at triage.

He is a 5-year-old (20kg) boy who has been brought in by his aunty after a fall while skateboarding down his driveway at home.

His left arm has been placed in a sling by the triage nurse, but it is obviously deformed (~30 degrees angulation).

His Aunty has given him some Panadol dissolved in chocolate milk that he took in the waiting room. He is trying to be brave, but is in obvious pain despite this.

What are your immediate priorities in managing this patient?

Key Topics Assessed:

- Immediate management of child with forearm fracture
- Considerations for procedural sedation

- Discussion regarding consent
- Anaesthetic plan for manipulation / reduction of fracture
- Aspiration and difficult airway management
- Mandatory reporting

Feedback from examiners:

Candidates are reminded that working in rural communities often means working in ED, and managing patients as soon as they arrive at the hospital. Common aspects of immediate ED management were overlooked, such as assessing for other injuries, before jumping to an anaesthetic assessment specifically. Although the question mentions consideration of procedural sedation, candidates were expected to recognise the aspiration risk in a clearly unfasted child, and choose a safer alternative path. Candidates are again advised to use reading time to calculate drug doses, ETT sizes etc for paediatric patients, and consider how paediatric management differs from that of adults (eg issues around consent, IV access, and risk factors for aspiration).

Viva 5 – Pain Medicine

You are the Anaesthetist on call and have been asked to review a 37-year-old man in the ED.

He has fallen 2 metres off a ladder. There was no loss of consciousness or evidence of a head injury, but the patient complains of severe left-sided chest and shoulder pain and extensive chest wall bruising. He has known opiate use disorder (OUD), and the ED are wanting you to review and provide advice on pain management.

What factors might influence this man's pain?

Key Topics Assessed:

- Acute and chronic pain assessments
- Factors influencing pain response
- Acute pain management in opioid tolerant patient
- Procedural sedation for shoulder relocation
- Requirements for safe recovery after anaesthesia
- Use of PCA, including background infusion of opioid
- Discharge planning for pain management with GP

Feedback from examiners:

Acute pain assessment and management, including multimodal techniques, were generally done well. Better candidates considered the impact of chronic pain, mental health issues, drug and alcohol use, previous healthcare interactions and other psychosocial factors on the acute presentation. Many candidates needed to be prompted to consider shoulder relocation as an analgesic strategy, and often used relatively small drug doses to achieve this, particularly for an opioid tolerant patient. While most candidates considered the potential for opioid overdose with PCA infusions, very few considered the possibility of opioid withdrawal with inadequate replacement. Better candidates used a multidisciplinary approach to discharge planning, including physio, psychology, drug and alcohol services, and advice from chronic pain specialists when discharging a patient on significant opioid doses.

Viva 6- Perioperative Medicine

You are seeing a 72-year-old female prior to a Total Knee Replacement (TKR).

She had a coronary artery stent inserted 10 years ago and has been well since then. She stopped smoking at that time.

She had a permanent pacemaker (PPM) inserted 2 years ago for symptomatic second-degree heart block.

She has had very limited mobility due to knee pain for the past 12 months.

Her blood pressure is 140/90.

Her medications are:

- Aspirin 100 mg daily
- Ramipril 5 mg daily
- Atorvastatin 40 mg daily

How would you assess her ischaemic heart disease?

Key Topics Assessed:

- Assessment of ischaemic heart disease
- Assessment of permanent pacemaker (PPM)
- Preoperative cardiac investigations
- Perioperative management of pacemaker
- Intraoperative and postoperative management of cardiac ischaemia

Feedback from examiners:

This question was answered adequately by most candidates, with very few outstanding answers. Many candidates gave a generic cardiac assessment without focussing on the specifics of this case. Many did not appreciate the functional limitation of knee pain, and the need for dynamic assessment with a stress test or dobutamine stress echo rather than a resting echocardiogram. Better candidates considered the rural and financial implications of this. Many candidates requested investigations such as troponins and BNP's without justification, yet many failed to request a group and hold. Few candidates demonstrated a safe working knowledge of pacemakers, with many giving vague answers or referring to cardiology or action cards. Many candidates failed to consider bone cement implantation syndrome as a cause of haemodynamic instability.

Viva 7- Regional Anaesthesia

You are asked to review a 65-year-old First Nations lady for an emergency left knee washout for suspected septic arthritis. She has a hot, swollen and very painful left knee. Her observations are within normal limits, and she is feeling systemically well, other than a very painful knee.

She has a background history of heavy smoking (50 pack-year history) with moderate COPD, type 2 diabetes mellitus on oral hypoglycaemics, and stage 3 chronic kidney disease.

Her medications are:

- Metformin 1000mg twice a day
- Empagliflozin + Linagliptin 25/5mg daily
- Fluticasone + Vilanterol 100/25microg daily
- Salbutamol 100mcg MDI as needed

She lives in a small, remote community 150km from Scenarioville. She is refusing to give consent for the surgery and states, "I just want to go home to my family". The surgeon is frustrated and requests your review.

What are the anaesthetic considerations in this case?

Key Topics Assessed:

- Preoperative assessment of complex emergency case
- Consent issues
- Anaesthetic options – GA versus neuraxial vs peripheral nerve block
- Post-spinal deterioration

- Post-operative hypotension / sepsis
- Management of delirium / agitation

Feedback from examiners:

This question was generally well answered, with some candidates able to demonstrate their experience with similar cases and provide more detailed answers. Better candidates tailored their answers to the specific case without getting bogged down in generic answers. Consent discussions that were targeted to the patient and her wishes scored better than generic consent discussions. A surprising number of candidates did not consider the direct effect of the spinal itself as a cause for hypotension. Management of sepsis was done variably, with some candidates neglecting to mention simple interventions such as fluids, vasopressors and antibiotics.

Viva 8- Resuscitation, Trauma and Crisis Management

You are just having a break in the theatre tearoom at Scenarioville Hospital when one of the theatre nurses comes in to ask for your assistance in the other operating theatre.

Your colleague is in the theatre anaesthetising a 60kg, 21-year-old female with acute appendicitis.

The patient was febrile and tachycardic pre-operatively but was otherwise previously well – ASA1E.

Your colleague performed a Rapid Sequence Induction with fentanyl, propofol & suxamethonium, and then proceeded to maintain anaesthesia for laparoscopy with sevoflurane.

Your colleague has asked for another pair of hands as they are a bit concerned following abdomen insufflation for pneumoperitoneum.

The following vital signs are visible on the anaesthetic machine monitor:

HR 135 bpm

BP 120/75

ETCO₂ 60mmHg

SaO₂ 97% on FiO₂ 50%

Temp 38.9°C

(a) How do you approach this? then

(b) What are the potential differential diagnoses?

Key Topics Assessed:

- Recognition / management / differential diagnosis of tachycardia and hypercarbia
- Management of suspected malignant hyperthermia
- Considerations for proceeding with surgery
- Documentation and follow-up after suspected MH
- Planning MH-safe anaesthesia

Feedback from examiners:

Most candidates were able to predict that this viva would evolve to an MH scenario, and better candidates were able to use their reading time to plan their answers accordingly. Better candidates were able to also consider and exclude other differentials without focussing on MH alone. Once MH was identified, the management was generally covered well by most candidates. The subsequent management of a first degree relative for elective surgery while the diagnosis was still unconfirmed was variable, with some candidates choosing to not wait for testing results.

Viva 9- Airway Management

You are called in to the emergency department at 2 pm to assist with a patient presenting with respiratory distress.

He is 60 years old, 90kg, with type 2 diabetes on metformin. He is in the resuscitation cubicle with his wife present. He is in distress with audible stridor and a visible swelling in his right neck, with erythematous overlying skin. His sats are 90% on room air.

Outline your immediate management of the patient.

Key Topics Assessed:

- Immediate management of stridor and respiratory distress
- Further assessment
- Airway management plan for expected difficult airway
- Front of neck access technique
- Management of haemodynamic instability

- Complications of femoral CVC insertion

Feedback from examiners:

This scenario clearly outlines a patient with respiratory distress, stridor and neck swelling, however when asked for an airway plan, many candidates gave very generic airway assessments and plans without considering the context of an expected difficult airway or their limited cardiac and respiratory reserve. Better candidates mobilised appropriate resources, including another RGA, a surgeon (not an ENT surgeon), and early notification to retrieval services. They also outlined clear plans B and C and CICO, and considered how being in a rural area would impact on their planning. Management of sepsis and CVC insertion was done well by most.

Viva 10- General Anaesthesia and Sedation

A 30-year-old man is booked for a left knee arthroscopy today with the visiting Orthopaedic surgeon. He was added to the list at short notice, so hasn't been seen in the anaesthetic clinic.

On his health questionnaire, he has ticked 'yes' to both reflux and recent illicit drug use. He takes no regular medications, has no allergies, and is 84kg (BMI 27).

What is your approach to assessing this patient?

Key Topics Assessed:

- Preoperative assessment
- Risk assessment for intraoperative awareness
- Assessment and management of intraoperative tachycardia and hypertension
- Suitability for extubation, use of peripheral nerve stimulator
- Postoperative tachycardia and hypotension
- Criteria for safe discharge

Feedback from examiners:

This question was well answered by most, with few outstanding answers. Most were able to provide an adequate assessment of GORD and illicit drug use, but many struggled to adequately assess the patient's risk of awareness or develop a plan to reduce this risk. Many candidates focused on illicit drug use to explain haemodynamic instability without considering more common cause (eg prolonged tourniquet time).

Some candidates were clearly unfamiliar with atracurium or the use of a peripheral nerve stimulator.

Viva 11- Obstetric Anaesthesia

A G1P0, 25-year-old patient at 38 weeks of gestation on the labour ward has a CTG showing a foetal bradycardia that is not recovering.

The obstetrician has called you requesting a Caesarean delivery as soon as possible, saying that she is suspected to have had a placental abruption. Bloods have been sent off, but results are not yet available.

Describe your approach to pre-anaesthetic assessment for this case.

Key Topics Assessed:

- Preoperative assessment and plan for emergency caesarean section
- Management of post-partum haemorrhage
- Considerations for blood transfusion
- Intra-operative and post-operative analgesia for caesarean section
- Use of chemical thrombo-prophylaxis following caesarean section
- Failure to give thromboprophylaxis resulting in DVT

Feedback from examiners:

This question was very well answered by most candidates. Better candidates had a well thought out approach to a GA caesarean section, including timing of opioids after cord clamping, and sensible transfusion triggers while being cognisant of the blood resources available in a rural setting.

Viva 12- Paediatric Anaesthesia

You are meeting a 7-year-old (25kg) male for the first time on the morning of a booked adeno-tonsillectomy.

His past history includes:

- 2 episodes of tonsillitis in the last 12 months that resolved with oral antibiotics.
- Seasonal asthma for which he takes inhaled corticosteroids (flixotide 125mcg bd) and prn salbutamol, which he only usually requires when unwell or sometimes with sports.
- He had a dry cough and runny nose 4 weeks ago, but has recovered well.

He has no known medication allergies.

He is fasted but had a sip of apple juice at 6 am this morning.

He is the last patient on your list and is a little tired, hungry and grumpy.

How would you assess this patient in preparation for his surgery today?

Key Topics Assessed:

- Preoperative assessment
- Considerations for decision to proceed with surgery
- Detailed anaesthetic plan for adenotonsillectomy
- Desaturation following inhalational induction
- Assessment and management of post-tonsillectomy bleed

Feedback from examiners:

The initial assessment and consideration of proceeding with surgery was done well by most, although only a few overtly recognised the increased risk of respiratory complications with asthma and a recent URTI. Most candidates gave good justification for their decisions around anaesthetic management of the initial surgery. Better candidates considered the impact of travel, family and the future availability of an ENT surgeon on the decision to proceed. A large number of candidates did not recognise the potential for concealed (swallowed) blood loss post-tonsillectomy, or the importance of resuscitation prior to returning to theatre. Some did not appreciate the potential for a difficult airway or consider having additional assistance (eg another RGA). Candidates are again encouraged to use reading time to calculate paediatric drug doses and equipment sizes. A good working knowledge of these is essential without needing to refer to handbooks etc.

Viva 13- Pain Medicine

You are called to the Emergency Department to review a 75-year-old female who has presented with abdominal pain. She has been seen by the surgeons and diagnosed with a likely small bowel obstruction, which will be conservatively managed at this stage. She has a naso-gastric tube in situ on free drainage and is nil by mouth. The surgeon has asked for your assistance to help manage her pain.

Her medical history is significant for treated hypertension and knee osteoarthritis.

Medications – Perindopril 5mg, Celecoxib 100mg bd prn and Panadol osteo 2 tablets prn.

She weighs 75kg and her BMI is 28.

Discuss your initial approach to pain assessment in this patient.

Key Topics Assessed:

- Acute pain assessment
- Analgesia options
- Intra-operative and post-operative analgesia plan
- Transitioning from parenteral to oral opioids
- Discharge planning for oral opioids

Feedback from examiners:

This question was generally well answered, with better candidates recognising the high risk of complications including acute kidney injury, and targeting their answers to this specific patient. Candidates who gave an extensive list of medications that *could* be used, rather than what they *would* use, did not demonstrate their knowledge. Increasing the dose of COX-2 inhibitors in an elderly, hypovolaemic patient is not recommended, and there is no role for long-acting opioids in acute pain management. Candidates are reminded that PCA use may be appropriate in a rural setting, but managing that PCA will be up to the RGA, not an Acute Pain Service. Increased post-operative monitoring in a special care setting should be considered for higher risk patients. Safe discharge plans included a multi-disciplinary approach, clear communication with patient, family and GP, and an appropriate quantity of discharge medications to avoid rebounding back to hospital.

Viva 14- Perioperative Medicine

A 68-year-old male is booked for a laparoscopic inguinal hernia repair. He has smoked 25 cigarettes per day for the past 40 years. He becomes breathless walking more than 200 metres, and can walk up one flight of stairs without stopping. He weighs 58 kg and his BMI is 21.

His medications are:

- Tiotropium inhaler
- Combined inhaled steroid and long-acting bronchodilator

How would you assess his Chronic Obstructive Pulmonary Disease (COPD)?

Key Topics Assessed:

- Pre-operative assessment of COPD
- Assessment of frailty
- Advice regarding smoking cessation
- Assessment and management of acute infective exacerbation
- Pre-operative optimisation
- Post-operative agitation assessment and management

Feedback from examiners:

This question integrates the roles of RGAs in both hospital and community settings, managing acute and chronic health conditions, and incorporates aspects of preventative medicine. Most candidates answered it well, with some common pitfalls including a poor understanding of pulmonary function tests in COPD, limited knowledge of the benefits of smoking cessation (both short and long-term), and the role of pulmonary physiotherapy in optimising pulmonary function pre-operatively. Candidates should be familiar with methods of assessing frailty, and have tools to improve functional capacity with nutrition, physio, cognitive therapy etc. Candidates should have been able to prioritise hypoxia and hypercarbia as potential causes of post-operative agitation in this patient, while still considering other non-respiratory causes.

Viva 15- Regional Anaesthesia

You are called to the labour ward to prepare a 30-year-old G1P1 for emergency theatre. She sustained a fourth-degree tear during vaginal delivery, requiring surgical repair.

She has no significant past medical history. Antenatal history is unremarkable. She takes no regular medications and has no allergies.

She has an epidural catheter in-situ which was inserted approximately 4 hours ago by one of your RGA colleagues. However, the patient states that the epidural did not do much to cover her pain during her labour, even though she was given the maximum prescribed doses.

She prefers not to have a general anaesthetic and is unfasted. All her vitals are stable.

How will you assess the adequacy of the epidural block?

Key Topics Assessed:

- Assessment of epidural block
- Risks of converting to spinal anaesthesia

- Preoperative optimisation
- Neuraxial block in setting of scoliosis
- Management of high spinal block, cardiac arrest

Feedback from examiners:

This question was adequately answered by most, with few outstanding answers. Many candidates did not consider the potential for significant blood loss with a fourth degree tear. Several candidates misunderstood this case as being a caesarean section and answered accordingly. Candidates are reminded to read the stem carefully during reading time. Many struggled to adequately assess an inadequate epidural, including failing to examine the patient or inspect the catheter. Of concern were the number of candidates who failed to recognise that a heart rate of 15 with an unrecordable BP and absent oximeter trace represents a cardiac arrest, or progress through ALS protocols in managing this scenario.

Viva 16- Resuscitation, Trauma and Crisis Management

It is 0200 hours and you are the Rural Generalist Anaesthetist on call. You are asked to attend the Emergency Department by the night shift ED doctor.

An ambulance pre arrival phone call has been received that a stolen car has crashed into a power pole at high speed with 3 unrestrained occupants inside.

There are 3 ambulances on the way with three casualties as follows:

- 17-year-old male (driver) with severe head injury, GCS 6, unresponsive
- 16-year-old female (front passenger) with suspected left-sided pneumothorax and pelvic injury, a pelvic binder has been placed, GCS 15.
- 16-year-old female (rear passenger), right ankle fracture / dislocation, GCS 14, screaming in pain.

The ED doctor asks for your help preparing for arrival of these patients. What personnel and resource allocation do you discuss with them?

Key Topics Assessed:

- Resource allocation for multiple trauma patients
- Emergency intubation for patient with head injury
- Prevention of secondary neurological injury
- Vascular access in patient with shock
- Causes and management of shock

Feedback from examiners:

This question gave candidates an opportunity to demonstrate clinical leadership, resource allocation and an understanding of rural emergency crisis management. Candidates who have experience in these areas are likely to have performed better than those who have spent little time in ED. Most handled the clinical aspects well, including safely navigating a trauma RSI and neurological injury prevention, but better candidates also considered the workflow in ED, moving non-urgent patients out, and called a code brown or trauma call. Common omissions included not giving TXA or using manual inline neck stabilisation for cervical spine protection. Understanding the different types and causes of shock is essential to effectively targeting management to the underlying cause.

Viva 17- Airway Management

Your GP Obstetric colleague asks you to review a 34-year-old woman for D&C after an incomplete miscarriage at 9 weeks of gestation. She is an otherwise healthy, non-smoker and drinks alcohol socially. She has had one previous general anaesthetic for a laparoscopic cholecystectomy 2 years ago, after which she reports she had a chipped upper incisor.

Weight 88kg (BMI 30), no regular medications, NKDA

HR 95/min, BP 110/80

Last ate 10 hours ago, 200ml apple juice 3 hours ago.

Describe your anaesthetic assessment of this patient.

Key Topics Assessed:

- Pre-operative assessment
- Anaesthetic plan
- Management of soiled airway
- Trouble shooting absence of capnography post intubation
- Management of persistent hypoxia
- Preparation for extubation
- Considerations for discharge following critical event

Feedback from examiners:

This question was generally answered well with some very high scores. Assessment and planning was well answered, with some candidates needing prompting to check previous anaesthetic charts. Management of aspiration and absence of capnography post intubation was best answered with a systematic approach and a wider list of differentials to consider. Better answers also considered the clinical context of a patient being head down in lithotomy position during a crisis. Extubation was generally well handled, but with a surprising number of candidates keen to perform investigations and transfer the patient despite normal vital signs.

Viva 18- General Anaesthesia and Sedation

You are on call for anaesthetics when the GP Obstetrician calls you urgently about a 24-year-old patient who requires an emergency laparoscopy for a ruptured ectopic pregnancy. She was found collapsed at home an hour ago by her partner.

She is usually well, with no significant medical history, and no regular medications. She is a non-smoker. She has never had a general anaesthetic. She weighs 60 kg.

On arrival, her heart rate is 120 bpm, respiratory rate is 30, Blood pressure is 90/45, and temperature is 36.5 °C.

She is pale, cool peripherally, and drowsy. She is unable to answer any further questions.

Outline your initial assessment of this patient.

Key Topics Assessed:

- Initial assessment of shocked patient
- Definition, classification and quantification of shock
- Management of shock
- Induction plan for laparoscopy
- Hazards of port insertion and insufflation
- Risk assessment and prevention of PONV
- Assessment and management of dystonic reaction

Feedback from examiners:

Most candidates were able to recognise the severity and acuity of this presentation, and provide a safe resuscitation and induction plan in the context of significant haemodynamic compromise. However, many candidates were unable to give a succinct description of shock or its causes. Better candidates considered the rural context and

discussed availability of blood products and other resource limitations. A surprising number of candidates were unable to describe the impact of pneumoperitoneum on respiratory dynamics, hypercapnoea or the risk of damage to internal structures. Dystonic reactions are uncommon, but have a specific treatment which candidates should be aware of. Discussion, disclosure and documentation were frequently overlooked.

Viva 19- Obstetric Anaesthesia

A 28-year-old, G3P2, at term gestation is in established labour. She reports a normal pregnancy, and your colleague inserted an epidural 12 hours ago after multiple attempts.

The catheter was secured at 12cm at the skin (loss of resistance achieved at 7cm) and was working well. The midwife calls at 11 pm, informing you that the epidural is now inadequate.

Discuss your approach to trouble-shoot this issue.

Key Topics Assessed:

- Trouble-shooting inadequate epidural block in labour
- Anaesthetic options for emergency caesarean section
- Preparation for spinal block, drug choices
- Management of vomiting post-spinal
- Anaesthesia for post-partum surgery

Feedback from examiners:

This viva covered core material and candidates with significant obstetric experience were able to progress quickly through the questions. Epidural trouble shooting was done well, although bolus doses tended to be on the conservative side. Consideration of neuraxial vs GA for caesarean section was done well, however few candidates considered the increased risk of bleeding with GA, or post-dural puncture headache with multiple repeated neuraxial attempts. Many candidates did not appreciate the potential haemodynamic effects of persistent bleeding post-operatively or attempt to resuscitate the patient prior to induction for EUA. Candidates were expected to recognise that the increased aspiration risk of pregnancy continues into the post-partum period, and an RSI was expected if choosing a GA.

Viva 20- Paediatric Anaesthesia

You are the on-call RGA for Scenarioville on a Saturday afternoon when you receive a call from the Emergency Department asking for assistance with a 7-year-old girl who has been involved in a quad bike accident.

She is due to arrive in 15 minutes.

Please outline how you will prepare for this patient's arrival.

Key Topics Assessed:

- Preparation for arrival of paediatric trauma patient
- Ketamine versus fentanyl for immediate analgesia
- Considerations for anaesthesia for supracondylar fracture
- Anaesthetic plan
- Post-operative agitation
- Communication with parent regarding agitation

Feedback from examiners:

This question was well answered by most candidates. Better answers showed a clear understanding of the rural context and resource limitations when managing trauma in rural areas. Better candidates showed a familiarity with paediatric drug dosing, equipment sizes and managing a distressed child (and their parents). They also considered the possibility of other injuries and provided a more holistic management plan than those who focussed on airway concerns. While some candidates mentioned peripheral nerve blocks or gas inductions in an unfasted trauma patient, most were quick to retract these answers. Candidates are reminded to discuss what they would actually do in a given clinical scenario, rather than mentioning all possible options, even if they are later deemed to be inappropriate.

Viva 21- Pain Medicine

You are called to the emergency department to assist with pain management for a patient who has been brought in by ambulance after an unwitnessed fall at a nursing home. The patient is a 73-year-old First Nations man with an obvious leg deformity and severe hip pain. He is distressed and crying out in his first language. A copy of his medication chart lists: ramipril 2.5mg, bisoprolol 2.5mg, rivaroxaban 15mg, rosuvastatin 20mg, olanzapine 2.5mg prn. An allergy to morphine is listed.

Outline your approach to assessing this man's pain.

Key Topics Assessed:

- Acute pain assessment with language barrier
- Acute pain management
- Management of acute deterioration in radiology department
- Management of inadvertent opioid overdose
- Follow up after iatrogenic injury
- Risk assessment for fractured NOF surgery
- Use of transdermal opioid patches in acute pain management

Feedback from examiners:

This question was well answered by most candidates. Acute pain assessment and management was generally done safely, with appropriate prescribing for the scenario. A few candidates delved into the intricacies of a fascia iliaca block, which was not asked for. Some candidates had a limited understanding of transdermal opioids. In general, candidates showed a good understanding of the complexity of managing highly comorbid patients despite their geographical limitations.

Viva 22- Perioperative Medicine

The visiting orthopaedic surgeon has asked you to see a 75-year-old female who has been on the waiting list for a Total Knee Replacement (TKR) for 2 years. The surgeon has some concerns about now proceeding with her surgery.

She has a history of:

- Type 2 Diabetes Mellitus
- Chronic Kidney Disease
- Hypertension
- Rheumatoid Arthritis

Her medications are:

- Metformin
- Gliclazide
- Ramipril
- Methotrexate / Folate

She has recently relocated to supported accommodation as she is no longer able to care for herself at home alone.

What are your initial concerns about proceeding with surgery in this patient?

Key Topics Assessed:

- Assessment of suitability for major surgery in Scenarioville
- Assessment of renal disease
- Assessment of rheumatoid arthritis
- Shared decision making for major elective surgery
- Impact of comorbidities on perioperative care
- Post-operative analgesia plan

Feedback from examiners:

This was a relatively straight forward question covering core topics for RGAs, and was generally answered very well. Pre-operative assessment, particularly when deciding on the risks and benefits of proceeding in a rural setting or not, is an essential part of RGA work. Most candidates were able to manage the clinical aspects well, with better candidates also considering the impact of travel, family support networks, financial impact of having surgery distant from home, etc. When asked for an analgesia plan, listing every possible adjunct does not demonstrate knowledge or context. Prescribing adjuncts like dexmedetomidine, clonidine, gabapentin and ketamine infusions in elderly patients are likely to result in side effects, and should be considered in a step-wise approach rather than as an initial plan.

Viva 23- Regional Anaesthesia

50-year-old female comes to see you at your pre-anaesthetic clinic.

She is booked for an abdominal hysterectomy in 7 days' time. She has no underlying medical conditions. She has confirmed anaphylaxis to morphine and has vomited violently in the postoperative period after being given fentanyl or oxycodone during previous surgeries. As a result, she is now very apprehensive when it comes to opioids.

Her gynaecologist has asked her to speak to you in regard to a spinal block.

What are the advantages and disadvantages of a spinal block in this situation?

Key Topics Assessed:

- Advantages and disadvantages of spinal block
- Perioperative analgesia plan
- Assessment and management of acute pain in PACU
- Assessment of headache post-spinal block
- Management of post-dural puncture headache

Feedback from examiners:

This question was relatively straight forward, with most candidates giving satisfactory answers, but very few excelled. Some candidates either forgot about or ignored the history of opioid sensitivity, and proceeded with an opioid based analgesia plan and did not optimise non-opioid options. When managing an acute pain crisis in PACU, better candidates considered prophylactic anti-emetics and a discussion with the patient before prescribing opioids. Assessment and management of a post dural puncture headache was variable, with some candidates wanting to utilise interventional radiology in their management plans, or failing to maximise simple analgesia, IV hydration and caffeine.

Viva 24- Resuscitation, Trauma and Crisis Management

You are called to assess a 21-year-old male in the Emergency Department in Scenarioville.

It is a Sunday morning, and the general surgeon is hoping to take him to theatre within the next 4 hours to perform a laparoscopic appendicectomy.

The patient is in pain and is vomiting, and he has not been able to tolerate oral intake since Friday evening.

His observations are as follows:

Heart Rate	115 bpm
Blood Pressure	95/50 mmHg
Oxygen Saturation	96% on RA
Respiratory Rate	20 breaths per minute
Temperature	38.4 °C
Weight	80 kg

Outline your assessment of him in the Emergency Department.

Key Topics Assessed:

- Pre-operative assessment of patient for laparoscopic appendicectomy
- Pre-operative optimisation
- Anaesthetic induction plan
- Management of high airway pressure alarm
- Assessment of patient who fails to wake from surgery

- Management of suspected suxamethonium apnoea
- Post-operative counselling and follow-up

Feedback from examiners:

This question was well answered with most candidates scoring well. Better candidates described a package of care for a septic patient, including assessment of acid-base status and appropriate resuscitation. A few candidates were overly cautious with their induction doses and potentially risked awareness during intubation. While it is acknowledged that suxamethonium use has fallen significantly in recent years, it is still in common use outside of theatre (ED and pre-hospital), and RGAs should still have a good working knowledge of its potential hazards, including suxamethonium apnoea. Better candidates were able to recognise the potential for awareness and manage it appropriately, including counselling post-operatively. Few candidates considered documentation, disclosure and discussion at M&M as part of their follow up.