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RACGP
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2026.1 RGA SSSA Examination Report

July 2026

2026.1 Rural Generalist Anaesthesia (RGA) SSSA Examination Report

The RGA-SSSA exam was conducted online via Zoom on 27th June, 2026. 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 4 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 to patient care exist 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, concise responses, and sound decision-making grounded in clinical knowledge. By focusing on these key aspects, candidates can showcase their expertise and competence in handling a range of clinical scenarios.

Pass Mark

A total of 20 candidates took the exam. The overall pass rate for the 2026.1 SSSA viva examination was 75%.

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 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, often related to the candidate's internet connection and audio quality. Most issues were quickly resolved, and additional time was granted in one case.

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.

The Court of Examiners continues to note several common, recurring 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 highlight how a clinical scenario would cause them to alter their standard practice, rather than describe their standard practice in unnecessary detail.
- 4- 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.
- 5- 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 16 vivas. This information is provided to help candidates prepare for their exams and to illustrate the level of knowledge required to pass the viva examination successfully.

2026.1 RGA SSSA Vivas

Viva 1

You are called by your ED colleagues to assist in the management of a 45-year-old male who has fallen from the roof of a single-story building.

His vital signs are:

- HR 120 bpm
- BP 150/90 mmHg
- RR 24 bpm
- SpO₂ 95% on non-rebreather mask at 15 L/min
- GCS is 7

There is blood to the right side of his head and face. He also appears to have a deformed right upper leg.

You decide that securing his airway is necessary.

Describe how you will prepare for securing his airway.

Key Topics Assessed:

- Trauma resource management
- RSI with cervical spine protection
- Secondary brain injury prevention
- Arterial line placement
- Preparation for retrieval

Feedback from examiners:

Generally well answered, with most candidates managing cervical spine protection appropriately. Good understanding of importance of managing intracranial pressure, however most candidates targeted systolic blood pressure rather than mean pressure.

Better candidates demonstrated understanding of ventilation and osmotic therapy in secondary brain injury prevention, as well as discussing seizure prophylaxis and ongoing sedation and paralysis. Most discussed basic preparation for retrieval, however better candidates demonstrated experience in doing so, including discussion with the next of kin and further investigations prior to transfer.

Viva 2

A 60-year-old male is seeing you for a pre-anaesthetic consult prior to his elective hydrocoele repair in one week's time.

His relevant medical history is as follows

1. Obesity (BMI 30)
2. Hypertension
3. Asthma
4. Hypercholesterolemia
5. Reflux esophagitis (GORD)
6. OSA on CPAP

His medications include:

1. Symbicort 200/6 (budesonide/formoterol) 2 puffs bd
2. Wegovy (semaglutide) 2.4mg weekly. Wegovy started 12 months ago.
3. Lercanidipine 10mg daily
4. Atorvastatin 40mg daily
5. Salbutamol prn
6. Pantoprazole 40mg daily

He has no known allergies.

He reports waking after a colonoscopy 12 months ago with a sore throat, sore jaw and a small nosebleed.

What do you think might have happened during his procedure under sedation 12 months ago?

Key Topics Assessed:

- Airway risk assessment
- Optimisation for surgery
- Infective exacerbation of asthma
- Spinal block for surgery
- Discharge considerations after spinal anaesthesia

Feedback from examiners:

This was a straightforward question which most candidates answered very well. Better candidates managed the infective asthma flare-up beyond bronchodilators and cancelled the case, with consideration for long-term therapy modification. Candidates are reminded to be up to date with guidelines around GLP-1 use and to be cautious with the use of sedation to augment a spinal anaesthetic in these patients due to their increased aspiration risk.

Viva 3

The general surgeon would like to book a 14-year-old boy (45 kg) with cerebral palsy on your list in 2 weeks' time for surgery to remove ingrown toenails bilaterally.

He has had many operations at the tertiary paediatric centre, but none in Scenarioville. His mother is keen to have surgery done locally.

In what ways can cerebral palsy impact on perioperative care?

Key Topics Assessed:

- Preoperative assessment of cerebral palsy and anaesthetic implications
- Decision to proceed or cancel and justification
- Acute pain assessment and management in a non-verbal patient

Feedback from examiners:

Most candidates gave a good outline of the implications of CP for anaesthesia, with better candidates giving more specific detail in their answers. Most candidates understood the limitations of managing complex paediatric patients in a rural setting, but few considered the impact on nursing, allied health and other teams within the system. Few candidates proceeded with surgery without considering the risks involved.

Viva 4

The general surgical team has booked an emergency laparoscopic cholecystectomy. The patient is a 34-year-old female with confirmed acute cholecystitis.

Her past medical history is as follows

1. BMI 32
2. Smoker (15 pack-year history)
3. Heavy THC use
4. Heavy alcohol use (6 standard drinks a day on average)
5. Chronic back pain
6. Depression

Her medications are:

1. OxyContin (Oxycodone Slow release) 20mg twice a day
2. Oxycodone immediate release- takes a 5mg tablet when back pain is 'severe'
3. Temazepam 1-2 tablets at night
4. Citalopram 20mg daily

You are told that she is in a lot of pain.

What potential issues will you anticipate in managing this patient?

Key Topics Assessed:

- Perioperative management of complex pain and polysubstance dependence
- Management of pain crisis at PACU
- Transitioning to oral analgesia and discharge planning

Feedback from examiners:

This was a straightforward question in which most candidates could cover the basics safely. Better candidates were able to demonstrate clinical understanding and experience with more detailed and structured answers, and greater emphasis on risk management.

Common mistakes included vague plans for existing long-term opioid use, transitioning to oral opioids without consideration of usage in the preceding 24 hours, and not calculating opioid equivalents when planning dosing. Better candidates considered long-term opioid management including drug and alcohol services, psychology and chronic pain physician involvement.

Viva 5

You receive a phone call from the emergency department to assist in the management of a 65-year-old woman who has been in a house fire.

She has significant burns to her face, neck, torso and arms.

She is distressed, in pain and working hard to breathe.

The ED doctor has asked you to assist in managing the airway.

How will you assess this patient's airway and breathing?

Key Topics Assessed:

- Assessment of airway, potential airway burns, risk assessment.
- Intubation for transfer
- Burns assessment and management
- Anaesthesia for dressing changes
- Implementing a new procedure (eg methoxyflurane)

Feedback from examiners:

This question was well answered, with most candidates covering the clinical aspects of burns management, airway assessment and intubation well. Better candidates were able to consider the rural aspects of a patient returning to Scenarioville for ongoing care, and the wider implications of that for nursing and theatre staff. They also considered the staff training and resource implications of implementing a new procedure, in this case methoxyflurane.

Viva 6

The obstetrician has requested a category 2 LUSCS in a 40-year-old, G3P2 patient (73kg - BMI 28.5) at 38 weeks gestation.

She is in labour with hypertension (BP 150/90) and proteinuria.

Platelet count is $90 \times 10^9/L$ this morning.

Previous general anaesthetics have been uneventful despite a documented grade 3 direct laryngoscopy.

Outline your assessment of this patient and preparation for anaesthesia

Key Topics Assessed:

- Assessment and management of pre-eclampsia
- Anaesthetic options and justification
- Management of a difficult airway after a failed spinal
- Awareness under GA – patient management and follow-up

Feedback from examiners:

Candidates were expected to assess and manage a patient with presumed pre-eclampsia, and prepare them for a Category 2 LUSCS. Some candidates were heavily reliant on their obstetric colleagues to institute pre-eclampsia management rather than doing so themselves. The decision between spinal and general anaesthesia was challenging, but handled well by most with good justification of their decision.

The scenario then developed to a failed spinal anaesthetic, conversion to a GA, and an inability to intubate. This was an uncomfortable and challenging scenario, but most were able to appropriately apply a model such as the Vortex model, and maintain oxygenation successfully. Some candidates tried to anticipate where the viva was heading without considering the information presented to them, and based their decisions on those unfounded assumptions, in some cases leading to an unjustified surgical airway. Despite being a challenging scenario, better candidates were able to synthesise the issues, make appropriate decisions and justify them clearly.

Viva 7

You are in the pre-op clinic and see a 75-year-old man booked for inguinal hernia repair in a week. His wife died last year, and his daughter is coming to stay from the city to care for him post-procedure.

He weighs 80kg, he has hypertension and Atrial Fibrillation. He is on Telmisartan and Apixaban.

On examination, he has a new murmur.

Please outline your pre-operative assessment of this patient.

Key Topics Assessed:

- Preoperative assessment and investigations
- Anaesthetic options, Spinal anaesthesia in AS
- Principles of management of AS for GA

Feedback from examiners:

This viva explored a relatively common comorbidity, aortic stenosis, and the implications that it has for anaesthesia. Most candidates outlined a thorough preoperative assessment and appropriate requests for further investigations. Many struggled to interpret the echocardiography findings though, with some being reliant on cardiology input for guidance. Many candidates were correctly cautious of spinal anaesthesia and outlined the importance of vasopressor support, but many did not appear to understand why, and some proceeded with a spinal despite their hesitation. It is important to understand the pathophysiology of AS and how a spinal anaesthetic impacts on this. Patients with AS have a relatively fixed cardiac output, and are dependent on adequate preload, adequate diastolic filling time, adequate afterload to maintain coronary perfusion, and may have LV hypertrophy and microvascular ischaemia despite normal coronary flow. A spinal anaesthetic and sympathetic blockade results in a rapid, non-titratable drop in SVR, while reducing compensatory mechanisms like tachycardia and vasoconstriction, leading to profound hypotension and potential for widespread ischaemia and cardiovascular collapse. There is of course a spectrum of severity, and mild-moderate AS can be safely managed perioperatively with a sound understanding of the pathophysiology behind it.

Viva 8

A 7-year-old female patient is presenting for the extraction of multiple decayed teeth. She weighs 20 kg, and her only significant past medical history is asthma.

Please describe the focused history you would take about her asthma.

Key Topics Assessed:

- Anaesthetic assessment and plan, nasal intubation
- Intraoperative bronchospasm
- Local anaesthetic overdose

Feedback from examiners:

This viva covered key paediatric topics and most were covered well. Assessment of asthma and management of intraoperative bronchospasm were well answered. Better candidates were more specific with details rather than giving vague, “scattergun” answers. Candidates are expected to know safe doses of commonly used drugs, including induction drugs, and be able to apply principles of safe drug dosing to different clinical situations.

Viva 9

It is 10am on a Friday and you receive a phone call from the Birthing Suite requesting an epidural.

The patient is a 35-year-old woman who is G1P0 at 40 weeks and has presented for an induction of labour.

She has a BMI of 32, and she has previously had spine surgery.

Describe your assessment and preparation of the patient for an epidural, including discussion of risk.

Key Topics Assessed:

- Assessment, preparation, risk discussion for labour epidural
- Recognition and management of inadvertent dural puncture
- GA Caesarean management
- Competing clinical priorities & Neonatal Resuscitation

Feedback from examiners:

Candidates were able to describe their assessment, preparation and discussion prior to epidural insertion with little difficulty. They were similarly able to describe a safe plan for a GA LUSCS. Better candidates were able to discuss the risks and benefits of leaving an intrathecal catheter rather than re-siting the epidural in the setting of an inadvertent dural puncture, but most were able to describe a safe management plan. The greatest spectrum of answers came in the discussion of competing clinical priorities of managing a mother under a general anaesthetic and a neonate in need of resuscitation, and in the practicalities of neonatal resuscitation itself. Candidates are reminded that RGAs are frequently called on to assist midwives and obstetric staff in neonatal resuscitation, and paediatricians are rarely, if ever, present. It is a core topic for RGAs to be familiar with.

Viva 10

A 5-year-old boy (25kg) with Level 2 Autism Spectrum Disorder (ASD) is listed as the second patient on your elective ENT list for tonsillectomy today.

He was reviewed alongside his mother two weeks ago at the pre-anaesthetic clinic and deemed clinically unremarkable, and consent was obtained for general anaesthesia.

How will you assess the patient and prepare for this child's anaesthetic?

Key Topics Assessed:

- Preoperative assessment and preparation for paediatric ENT surgery
- Inhalational induction in a child
- Laryngospasm management
- Emergence delirium management
- Post-operative analgesia

Feedback from examiners:

This viva covered core topics in paediatric anaesthesia that most RGAs will experience in their practice and should be very familiar with managing. It was surprising that so many had difficulty describing the recognition and management of laryngospasm. Some candidates confused this with a CICO scenario and incorrectly applied a Vortex approach, without addressing the underlying issue or instituting simple treatments eg CPAP, propofol, suxamethonium and intubation. In some cases, this resulted in a surgical airway scenario. Emergence delirium was also poorly managed, with many candidates unable to describe any non-pharmacological management or consider any differential diagnoses. Candidates and their supervisors are encouraged to maximise exposure to as much paediatric anaesthesia as possible, particularly surgery that involves a shared airway. In the absence of a suitable clinical workload, there are some excellent courses available to practice managing common paediatric emergencies.

Viva 11

It is 6pm on Saturday evening.

You receive a call from the ED doctor on shift asking you to come in to the hospital to provide assistance, as they have been notified by the ambulance service to expect three patients.

The initial information is that there has been a shed collapse and some of the patients have burn injuries.

They are coming from a property about 40 km from Scenarioville and are expected to arrive in 20 minutes.

Please describe your preparation of environment, personnel & equipment as you await more information and await the arrival of these 3 patients.

Key Topics Assessed:

- Disaster / multi-casualty trauma planning and preparation
- Paediatric burns trauma primary and secondary survey
- Management of paediatric burns
- Trauma intubation including cervical spine management

Feedback from examiners:

Despite being a complex scenario, it was very well answered across the board. Answers tended to be well structured and thorough, and key clinical issues were identified and managed well.

Viva 12

It is 7pm and the surgeon requests your attendance for an open repair of an inguinal hernia which is incarcerated and possibly strangulated.

The patient is a 56-year-old male (120kg – BMI 39) who presented 3 hours ago with groin pain.

He reports type 2 diabetes that he is on metformin and empagliflozin for.

Please describe your assessment of this patient.

Key Topics Assessed:

- Pre-op assessment & anaesthesia plan for emergency abdominal surgery
- Approach to post-induction hypotension
- Anaphylaxis Management & Follow Up

Feedback from examiners:

Most candidates described a thorough preoperative assessment and correctly identified that this patient had an elevated aspiration risk and potential difficult airway, but then proceeded to choose a spinal anaesthetic and deep sedation, which did nothing to reduce the risk of either complication. An incarcerated, and possibly strangulated hernia is a very different scenario than an elective hernia repair, and few candidates clearly identified the risk of bowel obstruction or modified their usual technique to account for this. Post-induction hypotension was managed well, as was anaphylaxis once declared. Better candidates were able to synthesise the information succinctly, assess and manage concurrently, and be decisive in their responses.

Viva 13

A 40-year-old female is booked for a hysterectomy.

The surgeon is concerned about her asthma and has asked you to assess her suitability to be done at Scenarioville Hospital.

This patient is new to your rural area. She is 60kg and has a BMI of 21.

She smokes 25 cigarettes per day, having done so for the past 20 years, and also vapes.

Outline your preoperative assessment with a focus on the patient's history of asthma.

Key Topics Assessed:

- Assessment of asthma & patient optimisation, including smoking cessation
- Anaesthesia plan and intraoperative bronchospasm management
- Approach to extubation and post-operative sedation

Feedback from examiners:

This viva was mostly answered well. Some candidates lacked sufficient detail when discussing the benefits of perioperative smoking cessation or the time frames required for benefit. Optimisation with bronchodilators and steroids was sometimes overlooked, and some candidates delayed surgery for a physician review, which is unlikely to be feasible in rural practice. Management of intraoperative desaturation and extubation were not always approached in a systematic way. Prolonged post-operative sedation was managed well.

Viva 14

You are in the pre-anaesthetic clinic seeing a patient 3 days prior to her scheduled Category 1 open left hemicolectomy.

She is a previously healthy 75-year-old woman who underwent an elective laparoscopic cholecystectomy 5 weeks ago in Scenarioville.

Her postoperative course was complicated by prolonged postoperative nausea and vomiting, then 48 hours of post-operative delirium which eventually settled. She was admitted for a week in total and has since returned to her baseline function.

During the cholecystectomy, the surgeons found an incidental mass on the splenic flexure of the colon. The patient has subsequently undergone imaging and a colonoscopy that confirmed an adenocarcinoma.

Discuss your approach to pre-operative assessment focusing on the patient's risk of recurrent post-operative vomiting and delirium.

Key Topics Assessed:

- Pre-op assessment & anaesthesia planning – delirium & PONV risk
- Management of post-operative agitation / delirium
- Post-op pain management – transition from parenteral to oral analgesia

Feedback from examiners:

Most candidates outlined a clear assessment, PONV risk assessment and analgesia plan, but were less clear when outlining an assessment of cognitive function, frailty or delirium risk. Better candidates were able to stratify delirium risk and identify anaesthetic or analgesic medications that could increase or decrease that risk. Acute post-operative agitation was managed well. Most candidates could identify a regional technique to reduce opioid use, but often deferred to the surgeons when considering NSAIDs. Better candidates outlined oral morphine equivalents (OME) when transitioning to oral opioids post-operatively.

Viva 15

You are the on-call RGA when you are called by the GP Obstetrician to review a patient who has attended the Antenatal Clinic at 1000 hours on a Monday morning.

She is a 20-year-old First Nations (Aboriginal) woman, G1 P0, who has had limited and sporadic antenatal care.

It is estimated she is 35 weeks gestation, but this is not confirmed.

Her blood pressure today is 140/100 mmHg.

She smokes 20 cigarettes a day, reports occasional marijuana use, and drinks alcohol intermittently.

Describe your assessment of this patient.

Key Topics Assessed:

- Anaesthetic assessment of an obstetric patient
- Maternal collapse – seizure
- GA for LUSCS, peripartum haemorrhage
- Preparation for retrieval

Feedback from examiners:

This viva covered core topics in obstetric anaesthesia without any particularly challenging sections. As such, it was well handled by the majority of candidates. Better candidates were able to consider the rural context, particularly in PPH management where resources may be limited.

Viva 16

You are doing an elective endoscopy list in Scenarioville.

The next patient on the list is a 65-year-old man who is booked for a gastroscopy and colonoscopy.

He has a Body Mass Index (BMI) of 35 and a weight of 100kg.

There is a known difficult airway alert for him from a previous intubation at another facility many years ago. He has had surgery at a Major Teaching Hospital since and has no recollection of any issues.

Past Medical History

1. Obesity
2. Hypertension
3. Hypercholesterolaemia
4. Obstructive Sleep Apnoea (OSA)

Medications

- Olmesartan / Hydrochlorothiazide
- Rosuvastatin
- Aspirin
- Semaglutide

What are the features of this case that may make airway management difficult?

Key Topics Assessed:

- Airway assessment
- Intraoperative desaturation and emergency intubation
- Postoperative hypertension management and day surgery discharge

Feedback from examiners:

This was a straightforward viva, and candidates were expected to cover all topics comfortably. Some candidates struggled to describe a structured approach to intraoperative desaturation or progress promptly through their response. Postoperative hypertension was managed well, but some candidates described rare differentials before considering simple explanations or management. Others were very quick to declare an emergency and call for help, when an ability to manage the patient independently was called for.