ANZCA
FPM

September 16, 2020

Dr Roger Boyd
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By email: nswh-ssocpu@health.nsw.gov.au.

Dear Dr Boyd,

## Consultation on Draft Model Scope of Clinical Practice for Anaesthesia

The Australian and New Zealand College of Anaesthetists, including the Faculty of Pain Medicine ('ANZCA'/'the college') is committed to the highest standards of clinical practice in the fields of anaesthesia, perioperative medicine and pain medicine. As one of the largest medical colleges in Australia, ANZCA is responsible for the postgraduate training programs of anaesthetists and specialist pain medicine physicians, in addition to promoting best practice and ongoing continuous improvement that contributes to a high quality health system.

Thank you for your invitation to provide feedback on the New South Wales Health draft model Scope of Clinical Practice (SoCP) for Anaesthesia.

The draft model SoCP was reviewed by a number of groups across the college with specific interest and/or expertise in the relevant issues, including the Safety and Quality Committee, the Professional Affairs Executive Committee, relevant Special Interest Groups, and the New South Wales Regional Committee.

The following feedback is provided for the consideration of the working group in finalising the model SoCP.

***1. Core: Is the Core SoCP a reasonable description of the type of work that can reasonably be expected to be undertaken by all practitioners in the specialty? If not, what do you suggest?***

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| **Paediatrics** | The ANZCA curriculum expected outcome for paediatric skills is that on completion of the training program fellows are able to manage children down to the age of two. This is further amplified in ANZCA professional document, *PS29 Guideline for the provision of anaesthesia care to children*, where item (6.1) states that the ANZCA training program expects graduates to have the knowledge and skills required to independently provide anaesthesia and sedation for children over 2 years of age without significant co-morbidities, undergoing surgery of moderate complexity.<br><br>(Refer also to items 8 and 9 under 'specific'.) |
| **Pain medicine** | In most circumstances pain medicine should be limited to **acute pain associated with surgery and trauma**. The expert management of complex cancer pain and chronic pain is within the core SoCP of Specialist Pain Medicine Physicians (SPMPs) (see the model SoCP for Pain Medicine.) If it is necessary |

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| | to include complex, chronic and procedural pain management in the anaesthesia SoCP, these should be listed as requiring **specific** credentialling with reference to existing NSW Health SoCP documents. |
| **Echocardiography** | Goal-directed transthoracic echocardiogram (TTE) should be included in the core SoCP.<br><br>(Refer also to items 1 and 2 under 'specific'.) |
| **Intensive care** | The reference to intensive care seems at odds with the preface which states *"A specialist Anaesthetist appointed primarily to work in Intensive Care should be considered for application of the Intensive Care Medicine model SoCP*." If an anaesthetist is planning to work in an Intensive Care Unit, then the ICM SoCP should apply. If required to apply skills within the ICU environment in an emergency or unplanned situation, this would be covered under specialist anaesthetist *'Emergency practice'* (page 7). Therefore, consideration should be given to omitting this in order to avoid confusion. |
| **Advanced life support** | Providing advanced life support for all ages, including neonates and children, should also fall within an anaesthetist's core SoCP. |
| **Quality and safety in patient care** | *'Quality and safety in patient care'* is a core dimension of every health professional's scope of practice. If considered a noteworthy part of a specialist anaesthetist's SoCP, is this because anaesthetists have a special role in Q&S within hospital practice? If so, could be better articulated? For example, with reference to emergency response systems, equipment, gas supplies, etc. |
| **Statement regarding urgent care** | The contingency statement starting *'Occasionally urgent care…'* is also covered by the *'Emergency practice'* section (page 7). Given that this pertains to exceptional, rather than core practice, any missing nuances about paediatric practice could be moved into the '*Emergency practice'* section. If it must remain in this section, perhaps it could be shortened and reference made to the longer explanation under *'Emergency practice'*. Ideally, exceptional practice should not be discussed in the core section – it should be either in the specific or emergency sections. |
| **Wording** | The first paragraph lists attributes rather than a scope of clinical practice *per se*.<br><br>For example, the first sentence could be reframed as follows:<br>*"Core Scope of Clinical Practice for ~~a~~ Specialist Anaesthetist<u>s</u> includes ~~knowledge and skills in~~ <u>the planning and management of general</u> anaesthesia<u>,</u> ~~and~~ sedation, regional anaesthesia/analgesia, airway management…",* and so forth. |

***2. Specific: Does the Specific SoCP appropriately reflect procedures or practices which require specific credentialing for safe and effective performance, but which are within the practice of the relevant specialty? If not, what do you suggest?***

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| **Item 1.** ***Echocardiography (diagnostic)*** | For clarity, and to align with ANZCA professional document *PS46 Guideline on training and practice of perioperative cardiac ultrasound in adults*, consideration should be given to changing *'Echocardiography (diagnostic)'* to *'Echocardiography - Comprehensive Studies'*. |
| **Item 2.** ***Echocardiography (goal-directed)*** | Point-of-care ultrasound and **goal-directed transthoracic echocardiography (TTE)** should be included in the **core SoCP**.<br><br>This is a rapidly evolving area with many well-validated training courses beyond those referred to in PS46, which is currently due for review. These skills are used by many anaesthetists on a daily basis to direct patient care.<br><br>**Diagnostic/comprehensive echocardiography** is suited to **specific SoCP** as it entails a higher level of training. |
| **Item 8.** ***Anaesthesia for young children (without significant co-morbidities, undergoing surgery of moderate complexity)***<br><br>Patient age limitations:<br>Age 1 to 2 years | The college has been advised by a member of the SoCP working group that this item is intended to reflect a negotiated 12-24 month age range for elective low risk work for some, but not all, anaesthetists. This item should be retained, but explained more comprehensively in the document.<br><br>In the event of any doubt, credentialling committees should defer to the ANZCA Curriculum and PS29. |
| **Item 9.** ***Paediatric Anaesthesia (medically complex children or children undergoing major surgery, including Neonatal and Infant surgery, complex airway surgery, major Plastic Surgery, Neurosurgery)***<br><br>Patient age limitations:<br>Up to 16 years | Recognising that an age range exists between jurisdictions, PS29 does not specify an upper limit, but defines paediatric patient as "neonate, infant, child and adolescent"<br><br>Feedback received from the college's New South Wales Regional Committee suggests that the majority of anaesthetists would maintain core skills in anaesthetising children over the age of 12 years without volume of practice and as such this age limit would be appropriate to maintain in "core SoCP". Item 9 therefore should refer to "Up to 12 years". |
| **Other items** | Adult cardiac anaesthesia, paediatric cardiac anaesthesia, extracorporeal perfusion, hyperbaric medicine and liver transplant anaesthesia are appropriately "Specific SoCP". |

***3. Useability: Do you expect the Core and Specific descriptions to be useful in a medical appointments and credentialing process? If not, what do you suggest?***

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| **General feedback** | As a structured, formalised tool the model SoCP could assist departments and individual practitioners to appropriately define SoCP, and it appears to provide a sensible and feasible framework. |
| **Clinical duties** | The 'clinical duties' described on page 3 of the document do not seem to be tailored for anaesthesia practice; some are not applicable (for example, "*Admitting"* "*Outpatients" and "Procedural"* duties). |
| **Definitions and terminology** | Definitions of the following terms would provide greater clarity for users of the document:<br>• **'crisis management'**.<br>• **'moderate complexity'**<br>• **'scope of clinical practice'** and **'credentialling'**<br>These terms are often used synonymously, leading to misunderstanding. ANZCA definitions are set out in *PS02 Statement on credentialling and defining the scope of clinical practice in anaesthesia*:<br>*…*<br>*2.2 Credentialling is the formal process used to verify the qualifications, experience and professional standing of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.*<br>*…*<br>*2.4 Defining the Scope of Clinical Practice is delineating the extent of an individual practitioner's clinical practice within a particular organisation, based on their credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support such clinical practice. This is not to be confused with the term "scopes of practice" used by the Medical Council of New Zealand to differentiate between general, vocational and special purpose scopes under the HPCAA (2003) NZ legislation* |

***4. Potential Implications: Are there any foreseeable adverse implications which may arise from the description of the Core and Specific section of each model SoCP, for example, for workforce or operational matters? If so, please outline your concerns.***

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| **Composition of credentialling committees** | Further explanation could be given regarding the necessary expertise required on credentialling committees.<br><br>In order to avoid sub-optimal decision-making, appreciation of subtle nuances requires the involvement of clinicians with relevant expertise from the same discipline. PS02 should serve as a guide for membership of credentialling committees to ensure that relevant expertise is present, and *PS50 Guideline on return to anaesthesia practice for anaesthetists*, for reference to recency of practice. |

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| **Clarification on use** | So that credentialling committees can contextualise and interpret information, supporting better decision-making and applicability, clarification should be provided on how the SoCP document is intended to be used. |
| **SoCP at different sites** | In order for clinicians to continue to provide services within their SoCP at multiple sites, any limitations imposed due to limited service capabilities of any healthcare facility should not adversely affect the SoCP at any other site. |

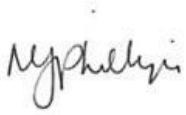
Thank you again for the opportunity to provide feedback on this significant document.

In closing, we would ask that appropriate citations are used if direct quotes from ANZCA professional document PS29 are retained in the final version of the document.

Should you have any questions, please do not hesitate to contact the policy unit at policy@anzca.edu.au in the first instance.

Yours sincerely,

Dr Vanessa Beavis
**President**



Dr Nicole Phillips
**NSW Regional Committee Chair**