
POSITION STATEMENT

“Alternate Providers” of Anaesthesia Care: Anaesthesia – A Medical Act

Preamble

This Position Statement is premised on the fact that anaesthesia is a medical act.

Background

The Australian Society of Anaesthetists (ASA) was established in 1934 and has some 2,500 specialist, general practitioner and trainee members. It represents 80% of the medical practitioners (both specialist and general practitioner) who are identified as regular providers of anaesthesia in the public and private sectors.

In those countries with a “British medical heritage” such as the United Kingdom, Australia, New Zealand, Canada, South Africa and the Republic of Ireland, the *medical specialty of anaesthesia* has developed as a *specialty practised by medical practitioners* who have undergone conventional university-based medical teaching and training and early postgraduate experience in general medicine. By contrast, and in marked contradistinction, a very different arrangement has evolved in the United States over the last 90 years, where alternative providers administer anaesthesia under the supervision of medical doctors because there were not, until recently, adequate numbers of anaesthesia providers.

In Australia, anaesthesia is administered to 3.2 million patients (or 16% of the entire population) annually with a safety record not exceeded elsewhere in the world. Most of these anaesthetics are provided by the approximate 2,000 specialist qualified anaesthetists. Some 5% are provided by general practitioners, many of whom have undertaken the joint training programme of the Australian and Zealand College of Anaesthetists (ANZCA) and the Royal Australian College of General Practitioners (RACGP), who practise with appropriate credentialling. Thus all patients who are anaesthetised in Australia have the exclusive and

dedicated care of medically qualified anaesthetists. Anaesthesia in Australia is a medical act.

Australia has been analysing the safety of its anaesthesia rigorously for 45 years. No other country has data analysis that is comparable. Since 1960, the numbers of deaths associated with anaesthesia halved every 10 years over three decades, from 1:5,000, to 1:10,250, to 1:20,000. The most recent triennial report into anaesthesia-related mortality established a mortality of 1:79,500. The mortality definitely attributable to anaesthesia is one death per 220,000 anaesthetics¹. It is similar to the risk of flying. Anaesthesia is in an area of medicine where crises can develop suddenly, at any time, which if not resolved in minutes can result in permanent brain damage or death.

Unlike the United States, where there has been a tradition of alternative anaesthesia providers, surgeons and other proceduralists in Australia do not have the necessary skills in resuscitation and anaesthesia required to assist in an anaesthetic emergency. As such, if an anaesthesia related complication occurs in Australia without a medically qualified anaesthetist present there may be no one capable of rectifying it – leading to significant increased risk of morbidity and mortality.

Recent developments

Over recent years, there have been changes primarily in medical practice and secondly in workforce projections that have provided opportunities for politicians, bureaucrats and some nursing groups to re-open debate on the feasibility of using alternate providers of anaesthesia care in Australia and New Zealand. The motivation and the suggested models for such care have varied depending on the particular proponent.

The following is a list of some of the current issues that are impacting the debate, many of which overlap with each other:

- Perceived shortages of anaesthetists despite the substantial fulfilment of the recommendations of the two Australian Medical Workforce Advisory Committee (AMWAC) reports.
- Reported shortages of anaesthetists in some rural areas and in some (including major) metropolitan hospitals.
- A current overall shortage of medical practitioners.
- Greater demand for anaesthesia services especially for new “out-of-theatre” procedures.
- A perception that “alternative practitioners” may be cheaper.
- Attention to recommended “safe working hours”.
- “Lifestyle issues” such as part-time work by both female and male practitioners.
- An asserted extension of “scope of practice” into non traditional areas by some segments of the nursing profession.

The ASA’S perspective

The ASA believes that ANZCA is the appropriate provider of training in anaesthesia in Australia, and that the standard of anaesthesia facilitated by its structured training program is at least as good as anywhere else in the world.

The ASA notes current ANZCA initiatives, including the following:

- ANZCA has recently had its educational, examination and professional development program approved by the Australian Medical Council (AMC).
- A significant enhancement of the ANZCA training program from 2004.
- An increase in the throughput of anaesthesia trainees, with no restriction on the numbers of trainees.
- The provision of what is seen as a fair and transparent process for the assessment of anaesthetists from other countries via the Overseas Trained Specialist/Area of Need program, including the provision of support to, and training of, those who need it.
- The training of general practitioner anaesthetists via the Joint Consultative Committee – Anaesthesia (JCCA) to aid the provision of appropriate anaesthesia in rural areas.

The ASA believes that anaesthesia is a “medical act” that is practised most competently by medical practitioners, with a fundamental part of anaesthesia training being the basic knowledge of medicine attained at medical school and in the first two or more postgraduate years of general hospital experience.

The ASA acknowledges and encourages the current perioperative roles of nurses and technicians in providing much-valued support in anaesthesia, intensive care medicine and pain medicine, and notes the significant national shortage of clinical nurses. The ASA believes that the introduction of “alternate providers” with shorter and likely poorer training programs must compromise the recognised high standard that has been achieved over a significant period of time by a large number of committed anaesthetists.

Current ASA initiatives include the following:

- Annual surveys of the specialty to identify areas of workforce shortage, and other demographic features. (The Society’s latest surveys confirm the findings of AMWAC reports that there is an adequate number of anaesthetists in Australia.)
- The support of general practitioner anaesthetists through the ASA General Practitioner Anaesthetists Group (GPAG), with close liaison with the Rural Doctors Association of Australia (RDAA).
- The development of initiatives to facilitate anaesthesia delivery in rural areas that have intractable structural reasons for workforce shortage.
- Advocacy in some rural areas and in some (including major) metropolitan hospitals, where terms of employment offered are inadequate to facilitate recruitment and retention of anaesthetists.
- The financial and other support of Quality Assurance activities including Advanced Incident Management System.
- Support for a nationally uniform and legally protected perioperative mortality reporting system.
- Economic modelling of savings to the Australian economy achieved through the existing model of anaesthesia provision.

Conclusion

The ASA believes that doctors, nurses and other professional staff each bring unique skills to the patient's bedside.

The ASA believes that patients benefit most when they receive the best care that medicine has to offer, combined with the best care that nursing and other professionals have to offer. In the ideal scenario, efforts are blended, not divided.

The ASA does not believe there are significant shortages of anaesthetists and notes the recommendations of two AMWAC reports. It does acknowledge that there are distribution problems in some areas. Efforts are required to attract and retain anaesthetists to those areas where there is a shortage.

The ASA is aware that interested groups will continue to make efforts to participate in the provision of anaesthesia services as “alternate service providers”. They are underpinned by the unilateral declaration of expanded “scopes of practice”. These efforts are fuelled by promises of cost-saving and the elimination of areas of workforce shortage.

It would seem to the ASA that such outcomes are unlikely and that the possibility of decreased standards of care would be very real.

Reference

1. Mackay P. (Ed.) Safety of Anaesthesia in Australia A review of anaesthesia-related mortality 1994 – 1996, ANZCA.

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