ANZCA
FPM

September 4, 2023

Medical Sciences Council
e mail: Dr Susan Calvert, the Council @medsci.co.nz

Dear Dr Calvert

Submission on the review of the scope of practice for Anaesthetic Technology Practitioners

The Australian and New Zealand College of Anaesthetists (ANZCA) is committed to setting the highest standards of clinical practice in the fields of anaesthesia, pain, and perioperative medicine. As one of the largest medical colleges in Australasia, ANZCA is responsible for the postgraduate training programs of anaesthetists, in addition to promoting best practice and ongoing continuous improvement that contributes to a high-quality health system.

Thank you for the opportunity to participate in this thorough and open process for a prospective change to the registration, name, scope, and practice settings for Anaesthetic Technicians (ATs), with whom our medical speciality works closely, and whose roles we greatly value.

The New Zealand Committee of the college would like to provide our collated feedback on the review of the name and the scope of practice of anaesthetic technology practitioners.

1. Proposal to change title from Anaesthetic Technician to Perioperative Practitioner

Firstly, the name. While this may appear a relatively unimportant issue, within the health workforce (as elsewhere), there is huge symbolism embedded in titles that have historically existed. We have issues both with the term “Perioperative” and “Practitioner”. Perioperative Medicine is a very specific description describing all aspects of a patient journey from contemplation of surgery through to optimal outcome (discharge home). It is not merely a broad description of working in settings “providing airway support and stabilising haemodynamically unstable patients.” ANZCA itself has an accredited Diploma of Perioperative Medicine – a specialist extension of practice for vocationally trained Anaesthetists, fellows of ANZCA. It appears that the Medical Sciences Council (the Council) are working on a different definition of “Perioperative” which encompasses “door to door” from entry to exit from the wider operating theatre environment. Use of this term will potentially create the misunderstanding that this scope could now encompass pre-assessment, investigation, risk assessment and optimisation, and complex shared decision making pre-operatively, along with post-operative management and rehabilitation – roles for which these graduates are not prepared. The argument for using ‘perioperative’ to encompass Emergency Departments (ED), Intensive Care Units (ICU) and Interventional Radiology (IR) is also inappropriate - as many patients in those services are neither pre, nor post-surgery.

Secondly, the tile of Practitioner (as opposed to the more generic use of the term Health Practitioner, which refers to someone regulated under the HPCA Act), has the potential to convey to the public that a Practitioner may be a medical doctor (as per General Practitioner)

or a Nurse Practitioner (NP) equivalent. As a NP is a registered nurse (RN), masters educated, and who has completed a prescribed suite of additional study lasting some 4-5 years post-registration, this is clearly not equivalent. In our view, the title chosen for a specific degree qualification should not determine a regulated vocational title.

On canvassing our specialist anaesthetist members, names with technician or assistant more properly describe their "fit" in the team and would reduce role confusion. Continuing the use of the title Anaesthetic Technician would have the virtue of not creating a two-tier workforce or diminishing the perceived value of existing ATs. Another suggestion is Anaesthetic Healthcare Practitioner (the name used in Queensland by diploma educated, regulated AT equivalent practitioners), which may make role comparisons easier for job seekers from overseas.

We would ***not*** wish to see any reduction in the deployment of skilled nurses either in theatre or post-operative settings, and do not consider the new graduates to have interchangeable training or experience compared to RNs.

2. Proposal to broaden scope to work in all areas of perioperative environment.

The ANZCA national committee consider that the current scope does ***not*** limit the ability to work in the modern health care environment. ATs can and do already work in expanded scopes including vascular access if they are appropriately trained and supervised with ongoing credentialing. ANZCA agree that ATs can be trained to insert arterial lines (which is done preoperatively by anaesthesia assistants in Canada and works well) though they do not insert central lines. Clarity is required about the use of ultrasound for vascular access (IVs, PICCs, and Arterial lines). ATs already provide expert assistance in ED and IR. The suggestion that the new scope include preoperative assessment is not appropriate at present, given the current level of training and experience. The term "advanced patient monitoring" should also be better defined as this already exists in areas such as paediatric, cardiac, and neurosurgical anaesthesia. The suggestion that the new scope could substitute for a nurse in patient transfer support will need qualification depending on the unique situation of each patient, transfer length and type, medication administration, and specific risk.

There is a tension in that workforce pressures mean we need ATs first and foremost to work alongside anaesthetists, to maintain the current high standard of delivery of anaesthetic services in New Zealand. We support the potential for ATs to increase the variety of their work, and to benefit from more fulfilling career progression options. However, this should be as an extension to their core scope of practice and be separately detailed with addition qualifications and credentialing. This would also support more flexibility in our health workforce whilst prioritising safety and respect of roles.

3. Registration for those who do not hold the B Health Science (Perioperative Practice)

We commend the Medical Sciences Council for clearly outlining the processes by which current ATs (and RNs) can transition to new scopes and named roles. There are, however, some inconsistencies to be addressed. One is the requirement for RNs to have additional time in practice and to sit an exam (compared to the new graduates, who will neither have to sit an exam, nor do they have equivalent hours training in clinical placement). It is already in an RN scope to act as an assistant to the anaesthetist where appropriately trained. Why

would they need dual registration? Given the likely small numbers involved, will the exam continue to be offered, and for how long? Our members would support the retention of / or introduction of a workforce pre-entrance exam for all, including one with a substantial practical component. This may alleviate some of the current concerns about a relatively ill-prepared new workforce. It would also provide ongoing opportunity for assessment of appropriate qualifications, and ongoing accreditation of education providers.

The reference to "ensuring those with the diploma are still eligible for registration ***for the short term***" is concerning. Is there a time frame in which diploma graduates will be required to expand their practice through "appropriate education" - and if so, what is it? Any move that signals to diploma qualified ATs that their continued employment is not guaranteed risks destabilising this vital, highly experienced group.

In addition, there appear to be no clearly published standards whereby educational organisations may be accredited to provide appropriate qualification(s) for registration as a Perioperative Practitioner. Any provider must be assessed as suitable for delivering the qualification and regularly re-accredited to ensure ongoing maintenance of high quality and appropriate education. Robust monitoring should occur more frequently with a new qualification or new education provider, and the outcome of any accreditation assessment should be made publicly available. Accreditation standards would also provide a framework for assessment of health practitioners from overseas or from another craft group in a fair and transparent manner.

4. Requirement for all newly registered practitioners to undergo a period of supervision:

The requirement for supervision (beyond normal orientation and induction) is a direct consequence of the degree not meeting ANZCA's standards for the assistant to the anaesthetist (PS08). Either the Council should mandate the appropriate level of clinical experience during training, or it must ensure that it is provided subsequently. Given the Council 's role in protecting the public, those who can't work independently should have provisional registration until a comprehensively designed supervision and competency assessment allows full registration. Stronger wording about this process and sign off should replace the need for "three months supervision". The Council's verbal assurances that this is a minimum, contingent on agreement of competence between the Council, the supervisor and the trainee are welcome. However, this puts considerable onus on the workplace to ensure safety, where the need to produce independent practitioners for their rosters may produce a conflict of interest. With a brand-new qualification, the MSC needs to clearly prescribe the assessment/supervision of provisionally registered graduates, to ensure this new qualification is safely monitored. Experienced ATs currently provide orientation and mentoring for new ATs. It may however be more difficult for them to provide this for a workforce who have been educated differently, as current AT supervisors will not be fully familiar with what the new workforce have or have not been trained to do.

5. Anything requiring further clarification:

The college is encouraged by the care with which the Council is carrying out this consultation, as the risk of unintended and adverse consequences is high. There is for example the potential for the exacerbation of tension between anaesthesia technicians and nurses. This needs strong leadership to set expectations and endorse collaboration between the professional groups – nurses should be able to train and supervise technicians in expanded roles, and technicians should be able to train and supervise nurses working in

the anaesthesia assistant role. This reciprocal expectation could be more clearly stated. In many hospitals this is not happening, although it would be a natural solution to the workforce crisis.

One further concern related to this consultation: the removal of Certificate and Diploma qualifications for a national anaesthetic technical workforce due to the closure of these courses risks creating new and unnecessary hurdles for routes into the workforce. When combined with considerable additional costs (university fees, accommodation away from home, increased length of training, loss of the ability to earn-while-learning on-the-job), this also has the potential to be a disincentive for students from disadvantaged backgrounds, and for Māori and Pacific students outside Auckland in particular. This runs counter to the imperative to increase the diversity of the health workforce. ANZCA advocates for the exploration of the resumption of these qualifications (perhaps by another provider – which would also produce opportunities for closer-to-home training) and for the retention of these qualifications in our regulated workforce. We also ask that the Council retain the option of a registration route for ATs for any future New Zealand based Diploma or Certificate graduates, should new courses be developed, or existing ones resurrected.

The New Zealand health care workforce is under undeniable pressure and is in competition with overseas jurisdictions for clinicians of all types. As such, we urge that responses from leaders in the field to your consultation are taken on board, and that the issues identified are appropriately and fully addressed before proceeding further. We look forward to continuing to work with the Council on this important change.

Nāku noa, nā

Dr Graham Roper, FANZCA
Chair, New Zealand National Committee
Australian and New Zealand College of Anaesthetists

(For more information, please contact Léonie Walker, Senior Policy Advisor lwalker@anzca.org.nz)