



Position statement on staffing of accredited departments of anaesthesia

Background Paper

1. Purpose of review

This professional document was reviewed in 2013 as part of the usual five year review cycle. There had been changes in terminology and the employment environment and, as a consequence, the document required updating to meet contemporary expectations.

2. Background

This document applies to *accredited* departments of anaesthesia. These departments provide the majority of training within the ANZCA training program. They should be adequately staffed to provide this training, particularly in regard to providing adequate supervision of trainees. The department must provide a safe high quality clinical service and be able to effectively manage the service. Consequently, though the document primarily addresses anaesthesia staff, it encompasses other staff members within the department.

3. Statement of and explanations for significant changes

3.1 Clinical support time

This new term has been introduced (item 1.2.2) and uses a definition similar to one that features in the Australian Medical Association (AMA) position statement *Clinical Support Time for Public Hospital Doctors*.¹ This term replaces “other professional duties” and the earlier “non-clinical duties”. The new term is an appropriate one which, with AMA support, could lead to standardisation of terminology across the medical colleges. In addition, it better captures the sense of the relationship of such duties to the clinical work as also indicated in the term “paraclinical activity”.² It needs to remain clear that clinical support time is distinct to hospital administrative activities, such as rostering and financial management.

A list of some of the major duties performed during such time has been included to extend the definition sentence and to explicitly specify the link between time and duties. The intention here is to indicate how crucial such duties are for efficient functioning of departments.

Four notable changes have been made, namely:

- 3.1.1 Blocks: clinical support time that occurs as blocks of time (excluding leave entitlements such as study leave, professional development leave and similar) should be counted when assessing a department’s amount of such time (item 2.1.5.5).
- 3.1.2 Logbook: There is a recommendation for a logbook (item 2.1.5.4) to record appropriate activities. This aligns with the College’s expectations for the productive use of such time,

provides a mechanism for routine supervision and checking of the use and provides evidence for administrators and college Training Accreditation Committee visitors.

- 3.1.3 Averaging: the work demands on a department may vary on a week to week (or longer) basis. For example in a particular week there may be more staff permitted to take leave or attend a conference, but in a subsequent week there may be far fewer staff on leave. Similarly the requirements for clinical support time will vary. The previous percentage rules were very frequently applied inflexibly as being fixed weekly allocations. The efficiency of a department can be increased by local adaptation to varying demands. Averaging of clinical support time is explicitly allowed (item 2.1.5.6), so mention of an amount (for example, “two sessions per week”) in PS42(A) may be interpreted as an average rather than an invariable weekly specification for time allocation. Additionally some staff could receive more clinical support time if used productively, and staff less prepared to be involved in training could receive less. The averaging would be across the whole group, not the individual. The director should be permitted the discretion to make arrangements in this regard that benefit the training situation.
- 3.1.4 Secretarial support: if a department lacks sufficient secretarial support then anaesthetists have to undertake administrative tasks themselves, increasing requirements for clinical support time (see item 2.1.5.7).

3.2 Clinical time

Supervision and instruction of trainees during practical training is the cornerstone of the College's training model. A statement has been added (item 2.1.5.1) to explicitly indicate that a specialist must have sufficient rostered clinical time.

A trainee can contribute to the clinical service of the department to a limited degree after an initial period of level 1 supervision. The extent of such service will be dictated by the educational needs of the trainee, the experience of the trainee, the mix of surgical specialties, subspecialty training requirements and the roster pattern, and may therefore vary significantly between institutions. The required supervision levels are specified in more detail in the relevant ANZCA training and accreditation handbook.

The guideline values for workload calculations have been increased to up to three sessions per week for advanced trainees (assuming they are actually being supervised beyond level 1) and six sessions per week for provisional fellows. These values should be varied to reflect the reality in appropriate circumstances (for example, zero sessions per week for a provisional Fellow in a new sub-speciality with level 1 supervision).

3.3 Balance: clinical and non-clinical duties

Specifying an appropriate balance between clinical time and clinical support time that can apply to all accredited departments is challenging given the significant variation in size, location, employment contracts, department structure, trainee numbers and status and the particular strengths and weaknesses of different departments. Local administration (director and senior department leaders) is best placed to manage this. Nevertheless a guide is helpful. In particular, staff in College supervisory roles need a minimum amount of time available for required college duties, and at times (for example, when interviewing a new group of trainees) may require more than the specified minimum (see items 2.1.5.2 and 2.1.5.3).

The original document was based on a five-day week of 10 working sessions, and recommended seven clinical work sessions and three non-clinical work sessions. Subsequently as employment contracts changed so that more full-time staff worked four-day weeks of eight sessions, the old specification had no relevance. PS42(A) was then changed to be 70 per cent

clinical time and 30 per cent for other professional duties. This has also with time become problematic as the percent split did not divide eight sessions evenly, while seemingly requiring the allocation of time on a strictly weekly basis. In addition there were other factors that impacted on the split. For example, in some departments to create a four-day working week, there was a trade-off of non-clinical sessions. This suited the employees and employers and in many places did not adversely affect training.

In summary some minima are highly appropriate and remain but local department administration is required to tailor arrangements.

3.4 Supervisory roles

Naming of roles: The approach adopted accommodates the ANZCA training program in Australia, New Zealand and the affiliated training regions.

3.5 Director and deputy director

The particular change is the removal of the minimum clinical duty specification. The amount of clinical time of the director (and deputy) is variable and relates to the size of the department, the number of staff and the complexity of the administrative arrangements within the hospital. In a small department with only one or two trainees, the director may have a primarily clinical workload. In a large department, the director may have a small clinical role and instead be primarily engaged in administration. This would be the case when a director is concurrently engaged in a broader executive role (for example, divisional executive director). To require a 40 per cent clinical role may impair the person's ability to take on more senior responsibilities.

3.6 Staff calculations

The number of staff employed is a decision for hospital management, but remains an important consideration for the College. A department that is understaffed for the workload can result in a poor training environment. This is the significant interest of the College and it should also be in the interest of the hospital to correct such a situation. It is not in the interests of the College to intervene in industrial or contract matters directly.

It is possible to give a reasonable estimate of required staff numbers based on actual workload, and a consideration of the employment arrangements of staff, if sufficient information is available.

4. Summary

Significant changes introduced as a consequence of the 2013 review included:

- 4.1 Change to "clinical support time" as the preferred term for the various activities that are not direct clinical patient care.
- 4.2 Blocks of such time (excluding leave that is part of an award) are to be counted in assessments of the amount.
- 4.3 A logbook is recommended to improve the effectiveness of monitoring the appropriate use of the time. This logbook should be available for inspection by department administration and Training Accreditation Committee visitors
- 4.4 Averaging of clinical support time over a period of more than a week is explicitly allowed to permit more flexibility and an increased correlation with periods of either increased clinical

demand (for example, many other staff off on leave) or of more intense need for clinical support duties (for example, introductory trainee interviews at the start of a placement).

- 4.5 The core role of clinical time for supervision and training is more explicit.
- 4.6 The specification of the maximum of clinical time and minimum of clinical support time for specialists is calculated as sessions rather than percents. Percent contribution remains for assessing the output of the department as a whole.
- 4.7 The required clinical loading on the director and deputy director has been removed to allow flexibility, depending on the local situation.
- 4.8 The specification of a series of guiding points (rather than a formula) continues to be the approach taken in the staffing calculations section.
- 4.9 The guideline about the baseline workload contribution of advanced trainees and provisional Fellows has been increased but may be varied to suit actual local circumstances.

The revised version of PS42(A) was promulgated in 2013 for a pilot phase, during which further feedback was sought with a view to producing a definitive version. No significant amendments to the document were considered necessary at the close of the pilot phase in 2014.

References

1. Australian Medical Association. Clinical support time for public hospital doctors. Barton: AMA, 2009. From: <https://ama.com.au/policy/positionstatements> Accessed 27 March 2013.
2. Baker A.B. Counting the other non-clinical professional activities. In: Australian and New Zealand College of Anaesthetists. Australasian Anaesthesia. Melbourne: ANZCA, 2001.

Process of document review

The core group responsible for development of this professional document was:

Dr Mark Reeves, FANZCA, Councillor (Chair)

Dr Vanessa Beavis, FANZCA, Councillor

Dr Kerry Brandis, FANZCA, Councillor

Dr Peter Roessler, FANZCA, Director of Professional Affairs (Professional Documents)

The following were also consulted:

ANZCA national/regional committees

New Zealand National Committee

Faculty of Pain Medicine Board

ANZCA Trainee Committee

Heads of departments of anaesthesia in Australia and New Zealand

Anaesthetists in Management Special Interest Group

Medical Education Special Interest Group

Ms Michaela Lodewyckx, Project Officer - Specialist Training Program

As noted above, no significant amendments to the document were considered necessary at the close of the pilot phase in 2014.

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the college's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated:	2013
Reviewed:	2014
Date of current document:	September 2014
Republished	December 2016

© Copyright 2020 – Australian and New Zealand College of Anaesthetists. All rights reserved.

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from ANZCA. Requests and inquiries concerning reproduction and rights should be addressed to the Chief Executive Officer, Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne, Victoria 3004, Australia. Email: ceo@anzca.edu.au

ANZCA website: www.anzca.edu.au