

**Canadian Anesthesiologists' Society
Council Meeting
June 27-28, 1995
Ottawa, Ontario**

**FINAL REPORT
FROM THE
TASK FORCE ON
ANESTHESIA ASSISTANTS**

Executive Summary

The Canadian Anesthesiologists' Society (CAS) Task Force on anesthesia Assistants, formed in June of 1993, has dedicated time and effort to examining the role of assistants in the provision of anesthesia services and care in Canada. As the national representative body for anesthesia, the CAS Council made a great effort to ensure that the Task Force could be viewed as a forum for informed discussion rather than an expansion of empire by the CAS. What was accomplished was an organized and accessible process for debate which has turned out to be beneficial to associated providers.

There is a great deal of concern amongst residents and staff physicians who deliver anesthesia services that the model being developed could be the precursor for the American model of nurse Anesthesiologists. It was not the intent of this Task Force, nor the intent of the members of the Task Force, to formulate a curriculum or a role that would pre-empt the essential role of physician Anesthesiologist services in Canada. Anesthesia Assistants are not meant to be alternatives to Anesthesiologists nor to reduce in any way the requirement for physician human resources in the provision of anesthesia services. The Task Force wishes to put to rest the concept that it is moving towards the development in Canada of anesthesia nurses or that the Task Force had any intent to move towards such a goal.

The Task Force deliberated extensively on the appropriate term for the newly developed anesthesia allied health provider. The common term in use is "anesthesia assistant" but this did not clearly reflect the new role. After considerable discussion the Task Force agreed by consensus to settle on "anesthesia therapist". When one looks at Webster's Encyclopedia of English Language, Canadian Edition, one finds that therapeutics is the branch of medical practice concerned with curing or treating disease, injuries, etc. A therapist is one skilled in a particular therapy. A therapy is the treating of a physical or mental illness by therapeutic means.

The term therapist is one that has considerable currency in the provision of health services and is being used by respiratory therapists, occupational therapists and physiotherapists, etc. Therefore, the Task Force feels that "therapist" more appropriately represents the nature of the allied health provider than "anesthesia assistant". The Task Force recommends that the new term for an allied health provider working in a department of anesthesia should be an anesthesia therapist.

The final report of the Task Force on Anesthesia Assistants was accepted by CAS Council in June 1995. The following motion was passed: It was duly moved and seconded that Council accept the report of the Task Force on Anesthesia Assistants, however, that Council not support the use of the term "therapist" and that the term be substituted with "assistant".

Motion #14, Council Meeting, June 27-28, 1995

Conclusions

The Task Force has determined that there is a place for assistants in the delivery of anesthetic services. Because of the expanding nature of anesthesia services inside and outside the operating room, it is now recognized that Anesthesiologists require assistance similar to that required by surgeons in an operating room.

The objective of the Task Force was to establish appropriate terms of reference for anesthesia assistants and to provide workable recommendations for the standardization of provision of care and the education of anesthesia assistants.

The Task Force concluded that the Anesthesiologist would retain responsibility for patient care and that the Anesthesiologist and anesthesia assistant would work as a team to provide the best care.

To provide education for anesthesia assistants it was recommended that existing programs be built upon and a unique challenge exam be established to determine levels of skill.

The Task Force suggests that membership for anesthesia assistants be determined within existing CAS categories such that they have affiliation with CAS and are privileged to attend CAS meetings and conferences as Anesthesia Associates, for example.

Preamble

In 1993 the Council of the CAS recognized there were various allied health providers who were assisting Anesthesiologists in the delivery of anesthesia services across Canada. Council also recognized that these allied health providers lacked consistent training and consistency of skills and knowledge to offer to anesthesia.

A need was identified to develop a training curriculum for anesthesia assistants. An examination process to give a successful candidate a recognized designation would also be required, and these issues discussed by the Task Force. Graduates and certificants could then form a society based on their goals in the health care system. That society could establish a formal relationship and become associated with the Canadian Anesthesiologists' Society.

To act on the above issues, a Task Force was established by the CAS Council, the Operating Room Nurses Association of Canada (ORNAC) and the Canadian Society of Respiratory Therapists (CSRT). The goal of the Task Force was to determine the future role of those who assist in the provision of anesthetic services in Canada. (See Appendix 1 for list of Members.)

It was deemed critical to the success of the Task Force for it to be viewed as a forum for discussion, rather than a "power grab" by the CAS. As the national representative body for anesthesia, the CAS acted to establish an organized process for debate that would be beneficial to all associated providers.

At its first meeting the chair set out principles to guide the deliberations of the Task Force:

- to deal with issues and terms of reference as set out by the CAS;
- that deliberations were not to be driven by Anesthesiologists but by the team of representative experts who comprised the Task Force, working together towards the predetermined goal.

The Task Force met in January, March, April and November of 1994 and January and March of 1995. A preliminary report was presented to the CAS Council in June of 1994 and again in February of 1995.

Thanks and appreciation goes to the Task Force participants from ORNAC, the CSRT and the CAS for their time and for the resources they made available to the Task Force. The Chair is most grateful.

Terms of Reference

The amended terms of reference from the January 8, 1994 meeting, as accepted by the Task Force on Anesthesia Assistants are as follows:

1. The Task Force should comprise of representatives from the CAS and Allied Health Professions (AHP).
2. The Task Force is to prepare a position paper on the professional relationship between Anesthesiologists and their assistants.
3. The Task Force is to perform a task analysis of allied health providers in the field, identify the needs of Anesthesiologists, and develop a national skills profile.
4. The Task Force is to prepare recommendations on job descriptions and educational needs.
5. The Task Force is to develop an organizational structure for a national support organization and its relationship with the CAS.
6. The Task Force is to provide recommendations on future paradigms in patient care provision in anesthesia.

Process

The work of the Task Force proceeded in this manner:

- by means of a literature review pertaining to current curricula and training;
- review of terms of reference for various types of anesthesia assistance across the country;
- review of the roles of anesthesia technologists, assistants and nurse Anesthesiologists in other countries;
- review of letters and proposals from Anesthesiologists and other anesthesia providers across Canada.

To deal with some of the concerns raised at meetings especially whether or not anesthesia assistants might replace physicians or be considered contemporaries of American nurse Anesthesiologists, the Task Force established a position task analysis and a description of the relationship between the Anesthesiologist and the assistant. Job descriptions were obtained from outside sources.

The format for meetings was a continuation of the statement of intent of the Task Force, which was to provide a forum for discussion and debate. No one voice dominated and an effort was made to incorporate each view into discussions.

Canadian Anesthesiologists' Society Membership Survey Responses, March 1994

In March 1994, the Canadian Anesthesiologists' Society surveyed its membership. A question on the need for allied health providers in the provision of anesthesia services was asked, and the response varied according to the level of anesthesia service: 54 % of specialist Anesthesiologist respondents supported the use of allied health providers in the provision of anesthesia services; 28.5 % of family practice Anesthesiologist respondents supported the use of allied health providers in the provision of anesthesia services; and 19.1 % of all respondents supported allied health providers giving services independently.

In a question asking about the link to the CAS with allied health providers, 79.3 % said that this was appropriate. A national regulatory body for allied health providers was supported by 58 %, and to establish anesthesia training for allied health providers was supported by 49.3 % of respondents.

Guidelines to the Practice of Anesthesia

Extracted from the *Guidelines to the Practice of Anesthesia*, as recommended by the Canadian Anesthesiologists' Society, Revised Edition 1995.

Ancillary Help

The Health Care facility must ensure that ancillary personnel are available where appropriate. Anesthesia technicians or other qualified allied health professionals may, with the approval of the governing body of the hospital, render certain ancillary assistance in providing anesthetic, resuscitative, and intensive care services. These personnel must be properly trained, and must have received accreditation by the appropriate authority where applicable. The tasks which they may perform must be clearly defined. An Anesthesiologist must only delegate, or assign to such personnel, tasks for which they have approval or accreditation.

Primary Responsibility of Anesthesiologist

The Anesthesiologist's primary responsibility is to the patient receiving care. The Anesthesiologist must remain with the patient at all times throughout the conduct of all general, major regional and monitored intravenous anesthetics. The Anesthesiologist should leave only when the patient has been transferred to the care of the post anesthesia recovery room or ICU personnel. Under exceptional circumstances, for example to provide life-saving emergency care to another patient, an Anesthesiologist may elect to delegate routine care of the patient to a competent person whose only responsibility is to monitor that patient during the Anesthesiologist's absence. In this situation the Anesthesiologist must inform the surgeon.

The practice of simultaneous administration of general, spinal, or epidural anesthesia by one Anesthesiologist for concurrent operative procedures on more than one patient is unacceptable. However, in an obstetrical unit it is acceptable to supervise more than one patient receiving regional analgesia for labour. Due care must be taken to ensure that each patient is adequately observed by a suitably trained person following an established protocol. When an Anesthesiologist is providing anesthetic care for an obstetrical delivery, a second individual, appropriately trained, should be available to provide neonatal resuscitation.

Extracted from the *Guide to the practice of anesthesia* published by the Corporation professionnelle des médecins du Québec, March 1992.

The simultaneous administration of anesthesia other than local to two patients by a single physician is to be prohibited, except in an emergency or in the case of a regional analgesia during childbirth.

The development of anesthesia assistants must be done in relationship to the *Guidelines to the Practice of Anesthesia* which are now standards for the provision of anesthesia services in Canada. These Guidelines indicate that it is inappropriate for one Anesthesiologist to manage two anesthetic services simultaneously. This verifies the view of the Task Force that anesthesia assistants are not meant to replace a physician so that a single Anesthesiologist may actually duplicate services to two patients simultaneously.

Outcomes

The Task Force deliberated in an open and collegial manner on these issues:

- the future role of anesthesia assistants in Canada;
- their role in clinical anesthesia service;
- the type of training desirable for anesthesia assistants;
- their academic requirements;
- the relationship of anesthesia assistants to the physician Anesthesiologist;
- the future relationship of the anesthesia assistants= organization with the CAS.

Two dominant issues became evident:

- **that the development of a formalized anesthesia assistants program, with people trained to provide assistance with Anesthesiologists was not meant to be, nor will be, an alternative to those services which are delivered by a physician Anesthesiologist;**
- **that there is a need to develop a formalized program for training of anesthesia assistants across Canada, with a challenging process to determine the national standard of skills, and a process to form a society which can offer training and can accredit.**

Education and training of anesthesia assistants was discussed exhaustively by Task Force members. It was determined that training for anesthesia assistants would not be unique, but would be added to pre-existing programs, since candidates would come from an informed/ educated group. This group will consist of individuals with recognized degrees as well as persons trained within individual departments of anesthesia and acting as anesthesia technologists. For the establishment of anesthesia assistants qualifications, a unique testing process will be developed. This would allow candidates with varying backgrounds to take challenge exams and, if successful, be recognized as an anesthesia assistant.

Accreditation, Credentialling, Acceptable Identity

The Canadian Medical Association plays a role in the accreditation of certain programs including the Canadian Respiratory Therapy program. It was hoped that the development of this new group of anesthesia assistants could be accredited by the CMA processes. However, the CMA, only accredits entry-level-trained allied health providers. People who achieve the level of education envisioned for anesthesia assistants will come from various specialty groups such as nursing or respiratory therapists and they would not be eligible for accreditation by the CMA.

At the suggestion of the CMA and in discussion with others, the Task Force recognized that once a challenge exam process had been developed for new anesthesia assistant registrants, a number of people could be challenged with the exam. They could then unite to form a society of anesthesia assistants. Once the society has been formed, it would be in a position to establish an accreditation process that could be approved by the CAS and thus fall under the umbrella of the CMA. This process is recommended for the new category of allied health professionals to be known as anesthesia assistants.

There is no intention to allow anesthesia assistants in Canada to seek reciprocity with any other group in the field of international anesthesia. Anesthesia assistants will be trained to serve the needs of Canadian anesthesia services.

Development of Curriculum for Anesthesia Assistants

The Task Force spent considerable time looking at the various areas where anesthesia services are provided, starting from the pre-anesthetic role to the administration of anesthesia services, quality issues, and administrative issues. What is outlined in the report is a series of skills and knowledge sets that the Task Force thinks would be appropriate for anesthesia assistants. Individuals who will attain the degree of an anesthesia assistant will likely have come from a pre-existing program where they have already developed skills and knowledge sets.

Task Force members felt that it was inappropriate for them to actually develop a curriculum for the training of anesthesia assistants. It is recommended that the Association of Canadian University Departments of Anesthesia, in conjunction with the CAS, ORNAC and the CSRT and other appropriate stakeholders should formally develop a curriculum based on existing programs within ORNAC and the CSRT. This was considered an appropriate approach.

The Task Force feels that the development and provision of a program for anesthesia assistants is best established at the college level. Once programs are established at the college level, it might be appropriate to have similar curriculums developed at the university level, if that is considered desirable and feasible at that point.

At least three groups need to be involved in the development of the curriculum process, and the approval of the process. These would be ACUDA, the CSRT and ORNAC in collaboration with the CAS.

The Task Force feels that provincial colleges would agree on curriculum skills and knowledge requirements and that these should then be vetted and approved by the CAS, and thus promoted by the CAS.

Targeted Competencies

The Task Force concluded that anesthesia assistants are not meant to function independently or to offer the services of nurse Anesthesiologists as they exist in other countries.

As discussed at the November 1994 meeting of the Task Force, the anesthesia assistant would work in conjunction with and under the direction of the Anesthesiologist. Following is a description of targeted competencies. **NB: These roles apply to any site requiring anesthesia services, and should not be a limitation on future or present roles.**

1. Pre-Anesthetic Role

- a) To administer a pre-established protocol of patient evaluation, counselling and management, eg. limited history/physical, data interpretation, triage (PRN), initiating communication of care plan, etc.
- b) Pre-anesthetic preparation: to assemble and prepare needed resources, eg. generic checklist, special needs, general maintenance, etc.

2. Anesthetic Period

Under anesthesia direction and collaboration. Attend to patient's comfort and anesthesia needs, eg. comfort, positioning and support, physiological monitoring, pharmaceutical therapy, airway management, crisis management, etc.

3. Post-Anesthetic Period

Early: under anesthesia direction and collaboration. Attend to patient's comfort and anesthesia needs, eg. transfer, set-up and therapies, (ie. airway, drug), reporting, etc.
Late: to evaluate patient's comfort, monitoring and ongoing therapy, eg. acute pain management, PCA, epidural, QA evaluation, therapies, etc.

4. Administrative Competence

QA, human resources (evaluation, performance, numbers), budget, supplies, etc. This would also include education, ie. patients, AHP, students, orientation.

An anesthesia assistant should be knowledgeable enough to assist in the safe discharge of anesthesia services, including identification and initial therapy of anesthetic complication. In turn, the Anesthesiologist must remain immediately available to supervise as necessary should complications arise.

CAS Council should seek concurrent approval from the Canadian Nursing Association or ORNAC and the CSRT. A curriculum team should be established. In addition, there should be a marketing concept within the CAS and within hospitals to allow recruiting for these new certificants. Target dates for final development of a recognized program for training of anesthesia assistants need to be set.

Role of Anesthesia Assistants

A fully qualified anesthesia assistant who has successfully challenged and passed the exams for qualification will be trained to function in every environment where anesthesia services are offered across Canada. However, the full scope of their skills may not be required in many facilities offering anesthesia services.

The role of the anesthesia assistant within any given anesthesia service will be dependent on the nature of services that the hospital/facility provides, and the need of the individual service for anesthesia assistants to complete the provision of anesthesia services. That is, the decision to hire anesthesia assistants will be dependent upon the hospital or facility in which anesthesia services are provided and the physician-Anesthesiologists who are providing those services. The development of the anesthesia assistant group as allied health providers does not mean that they participate in every area where anesthesia services are offered.

There are many providers who are aiding and abetting the delivery of anesthesia services across Canada who may not desire to seek qualification as an anesthesia assistant. This is not inappropriate. Such decisions should be determined by the department of anesthesia in the hospital/facility where these services are being offered. The development of anesthesia assistants is not meant to set a standard that must be replicated in every anesthesia program or service across Canada.

It is not the intent of the Task Force to insist that people presently assisting in anesthesia departments across Canada become anesthesia assistants. Rather, the Task Force is endeavouring to offer a standard for anesthesia assistants that will allow these people to use their skills and knowledge in any area where anesthesia services are provided. If a present assistant wishes to use the term "anesthesia assistant" then that individual must assure him / herself of appropriate knowledge and skills in order to pass the challenge exams. The individual must accept the need to be examined through the challenge exam, and if successful in this challenge, the individual will have the right to be called an anesthesia assistant and to become a member of that group of allied health providers.

Those allied health providers who are presently working in anesthesia departments need an opportunity to achieve success in the challenge exam. It is felt that their role within departments should not be altered until adequate time has been provided for them to prepare and meet the challenge. It is felt that a window of three to five years should be made available so that these people may achieve accreditation and become a certificant in anesthesia assistance if they so desire.

Two types of candidates may wish to proceed and achieve the certificate as an anesthesia assistant: 1) a new candidate, without prior work experience within a department of anesthesia; 2) anesthesia assistants who are offered an opportunity to gain skills over the three to five year window.

Many people presently providing assistance to anesthesia services may choose not to achieve the standard for anesthesia assistants. This is no reflection on what they are presently doing, nor a suggestion that they should cease their role as assistants within the departments of anesthesia.

It should be noted that people who achieve the certification of anesthesia assistants will also have a professional role relating to their primary academic background (ie. nurse, respiratory therapist, other group). When they are working within an anesthesia service, these people have a

commitment to the anesthetic service for the type of care that they provide. They also have to continue to maintain the professional standard from their originating profession. These people will be working as part of a team in the provision of anesthesia services, and teams are composed of people working together for the betterment of a particular service and its quality. The anesthesia assistants should not lose their professional relationship with their profession of origin, but should still function within the team under the direction of the chief of anesthesia services.

The addition of an assistant to anesthesia services allows the right people to be doing the right job within the service. It should improve the speed of service and efficiency of services, and in effect, reduce overall costs to hospitals by reducing individual case times, allowing opportunity to increase the volume of cases and improving the safety and quality of services provided.

Funding for Anesthesia Assistants

It is the strong belief of the Task Force that the funding for anesthesia assistants is the obligation of the facility or hospital where anesthesia services are being provided. Furthermore, the Task Force believes that improved efficiency and improved quality for patient care will in itself be cost effective because of the skills and knowledge that the anesthesia assistants will bring to any anesthesia service. That will warrant the hiring of anesthesia assistants to assist in the delivery of services.

Operating rooms are a very costly environment within any hospital, and the most expensive cost centre in a hospital. Any changes which can improve the flow of services and the quality of services within this environment are advantageous not only to the patient served but to the hospital responsible for funding those services. The Task Force believes that utilization will improve in operating environments where anesthesia assistants are available to assist in the delivery of anesthesia services.

It is recognized that increased operative procedures will increase costs in total, but will drive down individual costs per case. Funding by costs per case is foreseeable in the future.

Terminology

The Task Force deliberated extensively on the appropriate term for the newly developed anesthesia allied health provider. The common term in use is "anesthesia assistant" but this did not clearly reflect the new role. After considerable discussion the Task Force agreed by consensus to settle on "anesthesia therapist". When one looks at Webster's Encyclopedia of English Language, Canadian Edition, one finds that therapeutics is the branch of medical practice concerned with curing or treating disease, injuries, etc. A therapist is one skilled in a particular therapy. A therapy is the treating of a physical or mental illness by therapeutic means.

The term therapist is one that has considerable currency in the provision of health services and is being used by respiratory therapists, occupational therapists and physiotherapists, etc. Therefore, the Task Force feels that "therapist" more appropriately represents the nature of the allied health provider than "anesthesia assistant". The Task Force recommends that the new term for an allied health provider working in a department of anesthesia should be "anesthesia therapist".

Recommendations

- 1. Primary responsibility for patients is still held by the Anesthesiologist, and the anesthesia assistant would be directly supervised by the physician.**
- 2. The physician / assistant relationship should be collaborative and a team effort, in the best interests of the needs of the patient.**
- 3. Appropriate curriculum for training of anesthesia assistants should be based upon existing programs. (See Appendix 2 for existing curriculum.)**
- 4. The development and provision of a program for anesthesia assistants is best developed at the college level. Once programs are established the appropriateness of programs at the university level could be determined.**
- 5. Certification should be based on a unique challenge exam, and candidates should be eligible for CAS affiliation if successful.**
- 6. Candidates should be from an educated pool of applicants, not restricted by previous educational experience.**
- 7. A window of three to five years should be made available for those already providing anesthesia assistance who wish to obtain accreditation and achieve certification as an anesthesia assistant.**
- 8. CAS should support affiliation and formation of this new group of professionals and CAS should act as a facilitator.**
- 9. The term “anesthesia therapist” should be used in reference to this allied health provider in the field of anesthesia.**
- 10. A membership category should be selected by the CAS for anesthesia assistants.**
- 11. Non-physician attendance at the CAS Annual Meeting should be encouraged and made accessible.**

**CANADIAN ANESTHESIOLOGISTS' SOCIETY
TASK FORCE ON ANESTHESIA ASSISTANTS**

APPENDIX 1

LIST OF MEMBERS

John Atkinson, MD, FRCPC

Chair

Ottawa, Ontario

Peter Duncan, MD, FRCPC

Kingston, Ontario

Serge Lenis, MD, FRCPC

Montreal, Quebec

Susan Dunnington

CSRT

Toronto, Ontario

Daniel Cashen

CSRT

Dartmouth, Nova Scotia

Jackie Waisman

President, ORNAC

Red Deer, Alberta

Judy Tyndall

ORNAC

Hamilton, Ontario

Thomas McKee

Anesthesia Technician

Kelowna, British Columbia

**CANADIAN ANESTHESIOLOGISTS' SOCIETY
TASK FORCE ON ANESTHESIA ASSISTANTS**

APPENDIX 2

EXISTING CURRICULA

<p>Vanier College Respiratory and Anesthesia Technology Anesthesia 1 1993/94</p>	<p>American Society of Anesthesia Technologists & Technicians Training Guidelines September 1991</p>
<p>Vanier College Respiratory and Anesthesia Technology Anesthesia 2 1991/92</p>	<p>Essentials of an Accredited Educational Program for the Anesthesiologists' Assistant. Adopted June 1987</p>
<p>The Canadian Society of Respiratory Therapists Guidelines for Post Diploma Programs in Anesthesia Technology December 1992</p>	<p>American Academy of Anesthesia Assistants American Medical Association Association for Anesthesiologists' Assistants Education</p>
<p>The Canadian Society of Respiratory Therapists Post Diploma Anesthesia Technology Curriculum November 1991</p>	

OTHER MATERIAL REVIEWED

<p>Basic job description for anesthesia physician assistant. Developed and adopted by the State of Georgia.</p>	<p>Operating Room Nurses Association of Canada Anesthesia Nursing Skills Presented to: The CAS Submitted by: ORNAC Research Committee March 1, 1994</p>
<p>Anesthesia Respiratory Therapist Job Survey 1991/92 The Anesthesia Respiratory Therapy Association of Ontario Respiratory Therapy Society Ontario Journal, June 1992</p>	<p>Delegated Acts - Quebec From the "Compendium of Laws and Regulations" Published by the Corporation professionnelle des médecins du Québec May 1993</p>
<p>Operating Room Nurses Association of Canada (ORNAC) National Survey Report "Expanded Role of the Operating Room Nurse in the Perioperative Practice Setting" ORNAC Research Committee, June 1993</p>	<p>The Canadian Society of Respiratory Therapists Corporate Structure March 1995</p>
<p>Guide to the practice of anesthesia Published by the Corporation professionnelle des médecins du Québec Communications Department March 1992</p>	