JCCA

Curriculum for General Practitioner Anaesthesia

5TH EDITION – 2018

The Joint Consultative Committee on Anaesthesia (JCCA) is a tripartite committee of the Australian and New Zealand College of Anaesthetists (ANZCA), The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM)

RACGP
Royal Australian College *of* General Practitioners

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

JCCA

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Introduction

The Joint Consultative Committee on Anaesthesia (JCCA) is a tripartite committee with representatives from the Australian and New Zealand College of Anaesthetists (ANZCA), The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The JCCA is in part based on the following principles:

- There are large areas of Australia where there will always be a requirement for general practitioners (GPs) to be administering anaesthesia (mainly small rural towns and provincial cities).
- GPs providing anaesthesia services must have appropriate training and must be providing safe anaesthesia. However, there are some situations where general practitioners providing anaesthesia services may and should work in cooperation with specialist anaesthetists.
- GPs providing anaesthesia services must maintain their anaesthesia skills and knowledge through a commitment to anaesthesia and participation in ongoing anaesthesia continuing professional development.

The JCCA supervises and examines GP registrars from the RACGP and ACRRM who are completing a 12 month Advanced Rural Skills Training (ARST) post or Advanced Specialised Training (AST) post in anaesthesia. This training aims to broaden the skills and capacity beyond the standard scope of general practice training to meet the community needs of the diverse Australian geography and population distribution.

The JCCA has a CPD program previously known as the Maintenance of Professional Standards (MOPS) program. It enables general practitioners providing anaesthesia services in rural general practice to maintain their skills and knowledge in anaesthesia. While this program is voluntary, many hospitals insist on participation as a requirement for ongoing credentialing. The JCCA recommends that all general practitioners providing anaesthesia services complete CPD to the Standard defined in this program.

The JCCA Curriculum for General Practitioner Anaesthesia Fifth Edition 2017 replaces the JCCA Curriculum Statement in Anaesthesia (CSA) for Advanced Rural Skills Training (ARST) post or Advanced Specialised Training (AST) Fourth Edition 2010.

The JCCA Curriculum for General Practitioner Anaesthesia Fifth Edition 2017 is issued under the crests of the three Colleges reflecting the input, membership and authority of the JCCA. This curriculum is the academic basis for training of general practitioners who wish to provide anaesthesia services. A doctor undertaking this training is hereinafter referred to as a JCCA registrar.

As from 1 January 2018 the JCCA's statement of completion of training has a currency of three years, dependent on successful completion of the JCCA CPD Standard.

Scope of Practice

The Scope of Practice for general practitioners providing anaesthesia service will always be dependent upon the knowledge, skills and capabilities of the individual practitioner and subject to local infrastructure and jurisdictional credentialing.

In the context of rural and remote medicine, general practitioners providing anaesthesia service are called upon to provide a range of services to meet the individual needs of their communities.

As a general guideline (as described in the table below) a rural general practitioner providing anaesthesia services should only be considering patients who are in the ASA 1 and ASA 2 categories. In some situations, following appropriate assessment, patients in the ASA 3 category may be considered.

Patients in the ASA 4, ASA 5 and ASA 6 categories should only be considered by a specialist anaesthetist.

The purpose of the grading system is simply to assess the degree of a patient's 'physical status' prior to selecting the anaesthetic or prior to performing surgery. Describing patients' preoperative physical status is used for recordkeeping, for communicating between colleagues, and to create a uniform system for statistical analysis.

ASA Physical Status (PS) Classification System:

ASA CATEGORY	PREOPERATIVE HEALTH STATUS	COMMENTS, EXAMPLES
ASA 1	Normal healthy patient	No organic, physiologic, or psychiatric disturbance; excludes the very young and very old; healthy with good exercise tolerance
ASA 2	Patients with mild systemic disease	No functional limitations; has a well-controlled disease of one body system; controlled hypertension or diabetes without systemic effects, cigarette smoking without chronic obstructive pulmonary disease (COPD); mild obesity, pregnancy
ASA 3	Patients with severe systemic disease	Some functional limitation; has a controlled disease of more than one body system or one major system; no immediate danger of death; controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, chronic renal failure; bronchospastic disease with intermittent symptoms
ASA 4	Patients with severe systemic disease that is a constant threat to life	Has at least one severe disease that is poorly controlled or at end stage; possible risk of death; unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure
ASA 5	Moribund patients who are not expected to survive without the operation	Not expected to survive > 24 hours without surgery; imminent risk of death; multiorgan failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulopathy
ASA 6	A declared brain-dead patient whose organs are being removed for donor purposes	

Training posts, supervision and duration

Information in this section should be read in conjunction with the JCCA Training Regulations document.

The JCCA have designed the curriculum to be taught primarily in regional hospital posts which are accredited for ANZCA training. These are likely to be hospitals with a focus on secondary rather than tertiary referral, and with suitable facilities and staffing in anaesthesia. It is assumed that teaching staff will be selected from specialist anaesthesia staff and rural general practitioner anaesthetists associated with the training hospital. The JCCA views as essential that registrars are exposed to the teaching of at least two specialist anaesthetists during the training term.

Training posts

Training posts are available in all states and territories of Australia. Hospitals that are accredited for training by ANZCA can be automatically accredited for JCCA training following agreement by the Director of Anaesthesia that the training will be general practice oriented. Smaller regional hospitals have been accredited for training by the JCCA. Hospitals accredited for a provisional Fellowship year by ANZCA may be suitable for JCCA accreditation on a case by case basis.

Hospitals wishing for suitable posts to be accredited for JCCA training must apply via the JCCA Secretariat and a decision will be made by the committee to accredit or make an accreditation visit to the hospital.

Clinical simulation has become an important component of medical training. It is highly recommended that the JCCA registrars are given the opportunity to include simulation experiences while completing the JCCA curriculum requirements.

Supervision

Each JCCA post should have two nominated supervisors, one of whom is a specialist anaesthetist, usually the Head of Department or Training Supervisor, and the other a non-specialist or general practitioner providing an anaesthesia service nominated by the hospital. It is also strongly recommended that all JCCA registrars have a mentor relationship with a general practitioner providing anaesthesia services who is not directly involved with their supervision and training. This GP's role is to provide the JCCA registrar with a professional mentor with whom they can freely discuss matters.

Duration

The curriculum is designed for a 12 month full-time continuous training post in anaesthesia (including appropriate leave) to acquire the skills necessary for competent independent anaesthesia practice. This training period must not include more than three months of intensive care. During the training period, the JCCA registrar is expected to take on the roles and responsibilities of an anaesthesia registrar under the direction of the head of unit or anaesthetic supervisor.

Overseas training post

The JCCA will consider overseas training posts and qualifications. However, these are reviewed on a case by case basis by the committee. A JCCA registrar wishing to undertake training overseas must first contact the JCCA Secretariat for further details. The JCCA registrar will also be required to submit a detailed application covering all aspects of the training post.

Prerequisites and assumed prior experience

The JCCA does not require applicants for anaesthesia training to be enrolled with any particular specialist medical college training program.

Prerequisite

The JCCA registrar must satisfy the following criteria:

1. JCCA training may be undertaken following Core Clinical/Hospital Training or after some or all of Primary Rural and Remote/General Practice training has been completed.

   When JCCA training is undertaken following 12 months or more training in a rural general practice it provides the registrar with experience of the context of where and how the anaesthesia services will be provided.

   When JCCA training is undertaken following core hospital training it provides the registrar with an opportunity to contribute to an anaesthetics roster in a rural hospital while training in a rural general practice.

   Irrespective of the timing of JCCA training a prospective training plan is important to ensure once anaesthetic training is complete, that there are opportunities to continue to develop and maintain these skills. The JCCA has a **Return to work/upskilling policy** which applies to GPs who have not practised GP anaesthesia for two or more years.

2. Have successful completion of one of the following courses within the last four years:
   - Anaesthetic Crisis Resource Management (ACRM)
   - Emergency Life Support Course (ELS)
   - Rural Emergency Skills Training (REST)
   - Clinical Emergency Management Program (CEMP) Advanced
   - Emergency Management of Anaesthetics Crises Course (EMAC).

Other courses may be considered by the JCCA. For clarification JCCA registrars should contact the JCCA Secretariat prior to undertaking the course.

For JCCA registrars who have not completed an emergency medicine course prior to their training completion date, advice of a secure position in a future course is to be advised. The certificate of satisfactory completion of the course is to be supplied to the JCCA within two weeks of completion.

Assumed prior experience

The JCCA registrar must satisfy the following criteria:

1. Demonstration of relevant knowledge, skills and experience including, or similar to, experience as an RMO in a term in anaesthesia
2. Demonstration of a commitment to rural general practice, including experience of at least one term in rural general practice
3. Development of a knowledge of anatomy, physiology, pharmacology and research appropriate for a resident medical officer in a department of anaesthesia
4. Competence in the following basic skills:
   - history taking, physical examination and clinical assessment skills
   - intravenous cannulation
   - advanced management, including endotracheal intubation
   - cardiopulmonary resuscitation.

Learning outcomes

The learning outcomes for Australian rural practice varies from working in a large regional town or small city with some tertiary support to a single doctor community which may be geographically isolated in extreme conditions.

Some of these objectives are not exclusive to GP anaesthesia practice but are universal to any medical practice.

Communication skills and the patient-doctor relationship

The JCCA registrar will be able to:

- establish and utilise a comprehensive professional referral network
- demonstrate an understanding of the physical and mental states which may influence conduct of anaesthesia
- outline the influence of emotional, psychological and social factors on an individual's response to pain (acute and chronic)
- demonstrate an ability to communicate and cooperate with a range of rural specialist anaesthetists in the provision of safe anaesthetic services
- demonstrate an understanding of the emotional impact of patients undergoing surgery and provide supportive counselling
- demonstrate an ability to communicate effectively with frightened and uncooperative adults and children.

Applied professional knowledge and skills

The JCCA registrar will be able to:

- develop the clinical skills required to competently manage safe anaesthesia practice in a rural GP setting
- demonstrate confidence to make decisions and accept the outcomes of those decisions working within his/her own scope of practice
- utilise a problem solving approach
- demonstrate clinical skills required for appropriate pre-operative assessment and care of patients
- identify features of the pre-operative assessment which will require specialist anaesthesia services and refer appropriately
- use and maintain a range of equipment required for general anaesthesia and monitoring
- induce and maintain unconsciousness and provide intra-operative analgesia
- administer and reverse muscle relaxation safely
- administer local, topical and regional anaesthesia
- describe the principles of common or important operations requiring anaesthesia and their appropriateness in rural GP anaesthesia practice
- provide post-anaesthesia care
- demonstrate knowledge of, and ability to care for, all aspects of a patient's respiratory system, including recognition of problems, use of oxygen, ventilators and artificial airways
- manage acute pain and chronic cancer and non-cancer pain
- effectively manage patients of all ages suffering from cardiac or respiratory arrest

- assess a patient's suitability for transportation
- stabilise, support and organise safe transportation for the critically ill patient
- demonstrate an ability to predict pre-operative, intra-operative and post-operative anaesthesia risks, consulting with a specialist anaesthetist and referring when necessary.

Professional and ethical role

The JCCA registrar will be able to:

- demonstrate an understanding of the particular need and difficulties in maintaining confidentiality in small communities
- critically review relevant literature, analysing and utilising it appropriately in the workplace
- develop skills in balancing the caseload and demands of working in isolation in a rural practice with social and personal responsibilities
- develop an understanding of the principles of small business management appropriate to a rural general practice
- demonstrate an ability to establish professional networks, organisations and utilise available rural resources and referral agencies
- develop a commitment to continuing self-directed learning and professional development sufficient to provide quality anaesthesia care
- demonstrate an attitude of adaptability to changes in anaesthetic practice relevant to safer rural anaesthesia
- develop the appropriate skills for self-care and self-reliance
- demonstrate awareness of current ANZCA standards for anaesthesia practice (College Professional Documents) and act in ways consistent with these standards
- work effectively as part of a multidisciplinary team.

Organisational and legal dimensions

The JCCA registrar will be able to:

- outline legal responsibilities regarding notification of disease, birth, death and autopsy, and related documents
- demonstrate his/her responsibility in relation to obtaining informed consent
- demonstrate an understanding of the social/domestic pre-requisites for day only surgery

Areas of anaesthesia practice

The following table covers a broad range of areas of anaesthesia practice in which the JCCA registrar should become involved. The list of topics is neither complete nor comprehensive, some parts will be exhaustively covered, and others will merely be touched upon.

While, under normal circumstances, it is expected that a JCCA registrar would gain experience in all of the listed areas, this curriculum is designed to be flexible to accommodate a different depth and extent of coverage. The determination of coverage should take place through a negotiated agreement between the registrar and the designated training post supervisors. The supervisors would usually be involved in the anaesthesia teaching program at the hospital.

The negotiation process should take into account:

- the selection of a broad and representative set of common conditions likely to be encountered in the context of most rural general anaesthesia practice
- the potential geographical location of the registrar and the perceived needs arising from that location (where this is known), and
- the background and experience of the registrar.

The outcome of the negotiation process should be a written statement setting out proposed coverage of content for the year of study, which should be signed by the parties concerned. The content should be subject to periodic review. At the very least, reviews should take place three monthly. Reviews should take into account factors such as the workloads and clinical exposure of the units to which the registrar is attached, the changing interests of the registrar, and the strengths and limitations of the registrar's work in anaesthesia procedures.

6.1 PRE-OPERATIVE AND GENERAL MEDICAL CARE	
Physical and mental states which influence conduct of pre operative anaesthesia	» history taking, physical examination and relevant investigations » identification of suitable day surgery patients » patients unsuitable for GP anaesthesia
Previous and family history	
Relevance of previous medical, surgical and anaesthetic events	» significant features in the previous history, eg. failed intubation, anaphylaxis » family and genetic disorders » oesophageal reflux
Clinical examination and investigation	
Significant symptoms and signs requiring further investigation	» relevant history, eg. chest pain suggestive of ischaemic heart disease » physical signs, eg. prediction of difficult intubation » recent food and fluid ingestions » laboratory and radiological investigations » conditions requiring post-operative intensive care, eg. respiratory failure
Post-operative pain relief methods	
Disease and drug therapy	» the effect and treatment of surgical diseases on body systems
The primary (surgical) conditions	» effect of surgical illnesses and injuries on anaesthesia, operative and post-operative management » aetiology, natural history and effect of surgical illness relevant to rural anaesthesia practice » the effects of anaesthesia on the patient's condition and incidence of post-operative complications » urgency of surgery, preparation of patient, and suitability for transportation » preparation of patient for surgery with emphasis on resuscitation
Intercurrent disease	» local and general effects of relevant medical diseases » its relevance to case selection for rural GP anaesthesia, principles of management » principles of management » effect of anaesthesia and surgery on intercurrent disease » effect on anaesthesia » consultation with specialist anaesthetist in pre-operative preparations
Drug therapy	» physiological response to anaesthesia » principles of drug interactions » interactions between anaesthesia drugs, and drugs used in the treatment of disease » modification of existing drug therapy for anaesthesia and surgery » discussion of drug therapy modification, eg. stopping anticoagulation with the treating surgeon

6.1 PRE-OPERATIVE AND GENERAL MEDICAL CARE

Assessing risk of anaesthesia and surgery	» risks of anaesthesia and surgery relevant to the rural location » urgency of the surgery in relation to the risk of anaesthesia, eg. a higher anaesthesia risk may be accepted if surgery is life saving » prediction of pre-operative, intra-operative and post-operative anaesthesia risks, consulting and referring to a specialist anaesthetist if necessary
Pre-operative medication	» the emotional impact of patients undergoing surgery and provide supportive counselling » informed consent » pharmacology principles » administration objectives
Day care surgery and anaesthesia	» principles of selection of patients for day care surgery and anaesthesia » surgical procedures suitable for day care surgery » evaluating patients suitable for day care surgery » social/domestic pre-requisites for day care surgery

6.2 CORE COMPETENCIES

Assessment and management of	» Management of difficult airway, including CICO » Adult cardiac/ respiratory arrest » Anaphylaxis » Massive transfusion/ haemorrhage » Malignant hyperthermia » Laryngospasm

6.3 SPECIAL CONSIDERATIONS

» managing obese patients » managing elderly patients » managing paediatric patients » cognitive impaired patients » previous cardiac stents » diabetic patients » obstructive sleep apnoea	

6.4 GENERAL ANAESTHESIA	
Equipment for general anaesthesia and monitoring	» range, function, clinical use and hazards of equipment » safety issues in the use and maintenance of equipment » choosing, assembling and using equipment, eg. systematic check of anaesthetic machine » balancing benefits of using particular items, eg. endotracheal tubes, against potential complications » requirements of, and skills for, equipment maintenance (as technical backup is often lacking in a rural hospital) » use of pulse oximetry, capnography, volatile agent monitoring, ECG monitor and non-invasive BP monitors » use and hazards of diathermy
Narcosis and analgesia	» induction of unconsciousness and sensory blockade » theory of mechanisms involved in narcosis, anaesthesia and sensory blockage » pharmacology of drugs used to modify consciousness, opioid drugs, sedatives, neuroleptics agents and tranquillisers as well as those used to provide sensory and reflex blockage » choice and administration of suitable drugs to induce and maintain unconsciousness and provide intra operative analgesia » factors involved in choice of agents for induction and maintenance of anaesthesia » patients' emotional response to induction » venepuncture, airway maintenance and tracheal intubation, including cricoid pressure and rapid sequence induction, and indications for the relevant techniques » failed intubation drill, particularly for obstetric anaesthesia » use of 'difficult airway' equipment, eg. bougies, alternative laryngoscopes or any other suitable equipment for unexpected difficult intubations
Muscle relaxation	» the mechanisms of muscle tone » the pharmacology of muscle relaxants » safe provision and reversal of muscle relaxation » physiology of muscle relaxation » indications and complications » provision of satisfactory relaxation » inappropriate response and plan of management » understanding of the principles, and use of a nerve stimulator

6.5 LOCAL AND CONDUCTION ANAESTHESIA	
Physiology, anatomy and pharmacology	» physiology and anatomy relevant to local, topical and conduction anaesthesia » pharmacology of local anaesthetic drugs » indications for different drugs » management of overdose or abnormal response
The practice of local, topical and regional anaesthesia	» techniques, effects and complications and their management » techniques of subarachnoid anaesthesia and commonly used nerve blocks, eg. axillary and ischaemic arm blocks » physiological responses to subarachnoid and epidural blockade » monitoring techniques for use in local and conduction anaesthesia » management of immediate and delayed complications » use of sedative and neuroleptic drugs in conjunction with local and conduction anaesthesia » implications of general anaesthesia in conjunction with local and conduction anaesthesia
JCCA policy on epidural skills	The JCCA believes that it is difficult to conduct obstetric anaesthesia practice without epidural skills. It is desirable that JCCA registrars acquire these skills during their training, but the committee recognises that this is not always possible. Registrars will be specifically asked about epidural skills and experience in their formal assessment.

6.6 CARE RELATED TO SURGERY AND ANAESTHESIA	
Interpersonal management	» effective communication with adults and children » emotional reactions of patients to hospitalisation, surgery and anaesthesia » effect of emotional state on response to anaesthesia and surgery » communication with frightened or uncooperative adults, children and their carers » effect of illness and separation on patients' relatives and carers
Specialist anaesthetists	» communication, support and cooperation with, and support from, rural specialist anaesthetists
Rural GP anaesthetists	» establishment of cooperative GP anaesthetic networks » maintenance of quality anaesthetic services before commercialism
Staff and patient safety	» hazards of the operating theatre » hazards of infection, (eg. HIV, hepatitis B, C, or other blood borne infections) » physical injury, electric shock, radiation, surgical and anaesthetic equipment and environmental pollution » hazards of cross infection, patient posture, and immobility » plans to avoid hazards

6.7 SPECIFIC APPLICATIONS OF CARE DURING SURGERY AND ANAESTHESIA

» Principles of common or important operations requiring anaesthesia » Whether the effect on the patient and conduct of anaesthesia is appropriate for rural GP anaesthesia » Particular problems, associated with specific procedures and methods to overcome them » Administration of appropriate IV fluids during operations	

6.8 EXAMPLES OF SPECIFIC APPLICATION OF CARE DURING SURGERY AND ANAESTHESIA

Neurosurgery	» recognising that elective neurosurgery is inappropriate but emergency cases may arise » control of intracranial pressure » signs of raised pressure » anaesthesia techniques which minimise untoward changes
Thoracic surgery	» recognising that elective cases are inappropriate but emergency cases may arise » changes which follow open surgical pneumothorax » plan for control of secretions and air leak

6.8 EXAMPLES OF SPECIFIC APPLICATION OF CARE DURING SURGERY AND ANAESTHESIA

Paediatric surgery and JCCA policy on paediatric anaesthesia	» principles of paediatric anaesthesia » modification of apparatus and technique
	The JCCA believes that competency in paediatric anaesthetics is essential for the practice of anaesthesia in rural and remote areas. As such, it is strongly desirable that all registrars undertake adequate training in paediatric anaesthesia and it is recognised that most registrars will achieve the minimum caseload for endorsement to the age of five years. The JCCA recommends that registrars undertake a period of training in a paediatric anaesthesia unit if there is inadequate exposure at their primary training location. The two levels for clinical scope for endorsement in the area of paediatric anaesthetics are: [1] 1. Endorsement to the age of five years. i. The registrar must have: undertaken a minimum of 30 cases below the age of 10 years prior to the examination. In the event that this minimum number has not been reached, the registrar will not be approved to sit for the exam until further experience has been obtained. 2. Endorsement for an age limit of 3–5 years. The registrar must have: i. undertaken a further 20 cases in this age bracket (minimum of 50 paediatric cases) ii. a satisfactory training supervisors' report, indicating competency in paediatric anaesthesia iii. approval of the JCCA to undertake anaesthetics for this age bracket. In making a determination, the JCCA must have knowledge of planned practice post completion of training, ongoing plan for maintenance of competency in paediatric anaesthesia and an outline of an ongoing plan to maintain CPD in paediatric anaesthesia. Ongoing competency in paediatric anaesthesia requires ongoing volume of practice. This will be reviewed each CPD triennium. Failure to provide evidence of volume of practice will result in reclassification of paediatric endorsement. Please note that this policy applies only to registrars who commence their training following this Curriculum for general practitioners providing anaesthesia services, 5th edition, 2018. Paediatric anaesthesia training, initial credentialing and ongoing credentialing are local jurisdictional matters with varying requirements and minimum age restrictions, which are not governed by the Terms of Reference of the JCCA. 1. If the registrar is finding it difficult to obtain adequate exposure to paediatric anaesthetics, they should seek advice and assistance from their training college.
Obstetric anaesthesia and analgesia	» important physical and emotional changes in pregnant women, relevant to anaesthesia » analgesic and anaesthetic factors which influence fetal wellbeing » analgesic techniques in obstetrics » neonatal resuscitation
Other procedures	» similar considerations, as above, to patients undergoing other procedures including, abdominal surgery, dentistry or oral surgery, ENT surgery, genito-urinary surgery, gynaecology, plastic surgery, orthopaedic surgery and ophthalmic surgery

6.9 POST-ANAESTHESIA CARE	
Natural history of post-anaesthesia recovery	» emotional impact of recovery phase » causes of post-operative discomfort (including pain) » criteria for discharge from recovery room
Clinical assessment	» aetiology, symptoms, signs, effects and management of post-anaesthesia complications » disturbances of physiology especially airway, respiration and circulation » complications identified in the recovery room » management of unconscious patients, especially maintaining an unobstructed airway

6.10 RESPIRATORY CARE (INCLUDING PRE-, INTRA-, POST-ANAESTHESIA AND INTENSIVE CARE)	
Respiratory system	» control and function of the respiratory system » symptoms and signs of respiratory failure » basic respiratory physiology » common respiratory problems and their management » interpretation of radiography and lung function testing » mechanisms of changes in blood gases and capnographs
Oxygen therapy	» pathophysiology of hypoxaemia » indications for oxygen therapy » hazards in respiratory failure and prematurity » oximetry » indications for hyperbaric oxygen therapy
General care	» clearing respiratory secretions » physiotherapy » suction and humidification
Ventilators	» the principles and practice of respiratory support and ventilation » principles of, and indications for, mechanical ventilation » safety features » methods of monitoring » choosing and using ventilators in patients with varying degrees of resistance and compliance » use of ventilators in theatre, intensive care and during or awaiting transport
The artificial airway	» indications, management and complications for artificial airways » advantages and disadvantages of each type » insertion of pharyngeal airways, laryngeal masks, oral and nasal tracheal tubes and tracheostomy » management of immediate and delayed complications of an artificial airway, eg. laryngeal spasm

6.11 THE MANAGEMENT OF PAIN	
Physiological and anatomical basis of pain	
Effective pain management in modifying surgical stress response	
Inter-patient variability in analgesic requirement	
Opioid and non-opioid agents which modify pain conduction	
Patient controlled infusion devices	
Supplementation of post-operative analgesia with regional techniques, eg. epidural analgesia, nerve block, if available	
Management of chronic non cancer pain	» influence of emotional, psychological and social factors on an individual's pain response » visual analogue scores for quantifying pain » effect of psychosocial issues » management of chronic pain using non-opioid medication » pain clinic services
Management of chronic cancer pain	» anatomical and pathological mechanisms » psychological effects » therapeutic needs » assessment for pain clinic referral » common methods of treating pain, drugs used, mode of administration, eg. subcutaneous infusion » empathy and communication skills with patients and family

6.12 RESUSCITATION AND EMERGENCY CARE	
Cardiopulmonary resuscitation	» management of cardiac or respiratory arrest in patients of all ages » causes, symptoms and signs of impending cardiac or respiratory arrest » airway management » expired air ventilation » external cardiac compression on patients and models » drugs used in acute clinical situations » defibrillator
Transport of critically ill patients	» the problems and dangers of transport of critically ill patients » criteria for stabilisation and support of critically ill patients at local hospital before transport or retrieval is arranged » principles underlying safe transport of critically ill patients » communication and cooperation with retrieval teams

Assessment

Assessment principles

This curriculum uses a combination of formative and summative assessment. The purpose of assessment, particularly the former kind, is supervisory as well as judgmental. It should provide an indication of progress in the program and guidelines for registrars in directing their own learning as well as an outline of overall development over the training period.

The assessment should be conducted by the designated specialist and non-specialist anaesthetist supervisors, who should be appointed at the beginning of the registrars' programs and continue their involvement with the registrars under supervision for the duration of the training period. There is provision for external moderation of components of the assessment, if circumstances require. This applies to the case commentaries and research project.

Logbook

All JCCA registrars will be required to maintain a logbook throughout their training. This logbook will be needed to be reviewed by the supervisor at regular times throughout the training term.

Formative assessment

Regular discussions should take place between the registrar and supervisors using the diaries/logbooks containing notes of the registrar's work. The contents of the diaries/logbooks should be checked against the lists of topics derived from the negotiation of content. These discussions should ideally take place on a weekly basis and brief annotations could be made in the registrar's diaries by the supervisors.

The style and format of the diary/logbook should largely be decided by each registrar. Where staff other than designated supervisors are responsible for supervision, there should be at least fortnightly discussion using the diary as a basis for the interchange, although annotations may not be necessary.

Summative assessment

Summative assessment should be conducted at the end of the training period. This summative assessment includes two components, being

1. the supervisors' training report, including specific mention of skills in epidural and paediatric anaesthesia, and completion or otherwise of an emergency medicine course; and
2. an examination.

Satisfactory and unsatisfactory grading only should be used for each of these components. Space is provided for comments by the examiners in the examination report proforma.

A satisfactory training report must be presented to the examiners when the registrar presents for formal assessment, as below.

Components of formal assessment

This should include two elements:

A. 60 minute examination with emphasis on risk assessment and management of anaesthesia complications and problems. The examination must cover the seven specified areas of anaesthesia practice, listed in the examination report. The registrar should exhibit judgment skills appropriate to rural GP anaesthesia. The assessment panel should consist of a specialist anaesthetist and a rural GP anaesthetist.

   A supervisor is acceptable as one examiner. If a rural GP anaesthetist is not available, two specialists are acceptable. The examiners' report is forwarded to the JCCA after the assessment by the examiners.

B. Three case commentaries at any stage of the training year. These may be presented to the training supervisor or be blended into the teaching program (eg. Mortality and Morbidity (M and M) meetings).

C. A simple research project may be done instead or as well as B. This can take the form of an audit presented to the anaesthetic community. Any subject relevant to anaesthesia may be chosen.

The case commentaries or research project should be moderated internally by the designated supervisors at an appropriate time, or externally if required. Mention of them can be made in the summative assessment, if indicated. On receipt of satisfactory training and examination reports, the JCCA will consider, at its next meeting, awarding of a statement of completion of training to the registrar.

If the training supervisors feel unable to provide a satisfactory training report for a JCCA registrar, they may recommend a further period of training at the same hospital or another location. (The registrar cannot present for a formal examination without a satisfactory training report). This situation should be notified to the JCCA.

References

- Maintenance of Professional Standards Program (MOPS) for Rural GP Anaesthetists 2014-16
- Curriculum Statement in Anaesthesia for Advanced Rural Skills and Advanced Specialised Training – Fourth Edition 2010
- Maintenance of Professional Standards Program (MOPS) for Rural GP Anaesthetists 2011-13
- Maintenance of Professional Standards Program (MOPS) for Rural GP Anaesthetists 2008-2010
- Maintenance of Professional Standards Program (MOPS) for Rural GP Anaesthetists 2005-2007
- Anaesthetics Advanced Rural Skills Curriculum Statement — Third Edition 2003
- Accreditation Process & Maintenance of Professional Standards of JCCA 2002–2004
- Program for the Maintenance of Professional Standards of Rural GP Anaesthetists (MOPS) 1999–2001
- Anaesthetics Advanced Rural Skills Curriculum Statement — Second Edition April 1998
- Guidelines for the Accreditation/Reaccreditation of Rural GP Anaesthetists – JCCA December 1995
- Advanced Training Curricula in Anaesthetics – Faculty of Rural Medicine, RACGP, 1992

Glossary

ACRRM	Australian College of Rural and Remote Medicine
ALM	active learning module
ANZCA	Australian and New Zealand College of Anaesthetists
Approved department	A department accredited by by the JCCA and/or ANZCA to provide a registrar with supervised experience in clinical practice to attain the defined training objectives as set down in the regulations
ARS	advanced rural skills
ARSP	advanced rural skills post
ARST	Advanced rural skills training
ASA	Australian Society of Anaesthetists
AST	Advanced specialised training
CA	clinical audit
Candidate	A registrar who is presenting for the JCCA examination
CCrISP	care of the critically ill surgical patient
Clinical training	Clinical experience that must be undertaken in approved training to acquire skills appropriate to the registrar's experience.
CPD	continuing professional development
Curriculum	Curriculum for advanced rural skills or advanced specialised training in anaesthesia
ELS	Emergency life support course
EMAC	effective management of anaesthetics crises
EMST/ATLS	emergency management of severe trauma/advanced trauma life support
GP	general practitioner
Hospital employment year	The period of 12 consecutive calendar months coinciding with the commencement and completion dates for annual appointments for (trainee) registrars. While approximating to a normal calendar year, the precise dates of commencement and completion vary in the different areas where JCCA registrars are employed.
JCCA	Joint Consultative Committee on Anaesthesia

General practitioner anaesthetist (GPA)	The term by which the registrar will be known on satisfactory completion of training.
JCCA registrar	a registered medical practitioner undertaking the JCCA's Curriculum training
M and M	Mortality and Morbidity
MOPS	maintenance of professional standards
PDP	professional development program
PHN	Primary Healthcare Network
QI&CPD	quality improvement and continuing professional development
REST	Rural Emergency Skills Training
Rural GPA	rural general practitioner anaesthetist
SCA	supervised clinical attachment
The RACGP	The Royal Australian College of General Practitioners
Training time	Time in approved training, and is inclusive of normal holiday, sickness and parental leave, as well as special leave for study or examination purposes.

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The Joint Consultative Committee on Anaesthesia (JCCA) is a tripartite committee of the Australian and New Zealand College of Anaesthetists (ANZCA), The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM)

RACGP
Royal Australian College *of* General Practitioners

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