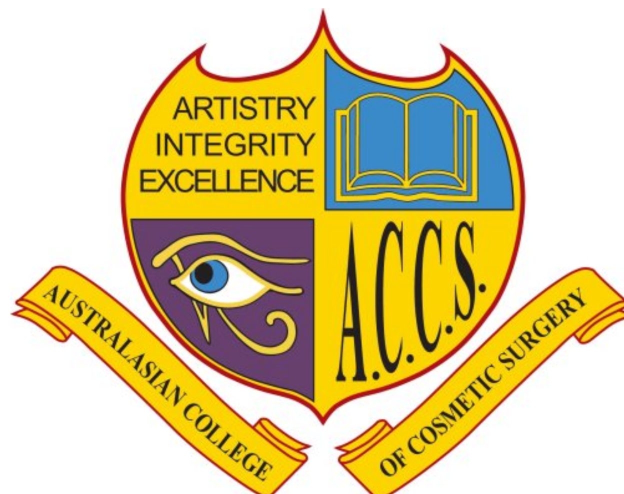
Australasian College of Cosmetic Surgery

Cosmetic Medical Practice

TRAINING PROGRAM HANDBOOK FOR

COSMETIC SURGERY

FACCS



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1. Introduction

1.1 Role of the Australasian College of Cosmetic Surgery

The Australasian College of Cosmetic Surgery (ACCS) was established in 1999 to deliver support and training to doctors wishing to specialize in cosmetic medicine or surgery. The College has a training program for Cosmetic Surgery FACCS and also has a medical faculty which trains doctors in Cosmetic Medicine FFMACCS.

Previously, doctors wishing to specialize in the field of cosmetic medicine and surgery had no option but to acquire privately organized training on an apprenticeship basis. This training was not subject to any quality controls and varied greatly in quality.

From the need to fill this void in quality education, training and support, the ACCS has evolved as a multi-disciplinary body consisting of general surgeons, plastic surgeons, dermatologists, ear nose and throat surgeons, ophthalmologists and other doctors who specialize in cosmetic medicine and surgery. The ACCS was formed as the successor to the Australian Association of Cosmetic Surgery, which was previously formed in 1992.

The College believes that patients will be best served with cosmetic surgery and medicine being officially recognized as a new specialty. This will help to remove the confusion about the training and skills of different types of doctors offering cosmetic services. The ACCS is dedicated to excellence in training, with the overarching aim of the College being summarized by the statement:

"Raising Standards…Protecting Patients"

The Cosmetic Surgery training program has been developed with a wealth of experience to ensure that the program produces cosmetic physicians who are skilled, competent and safe in all manner of practice.

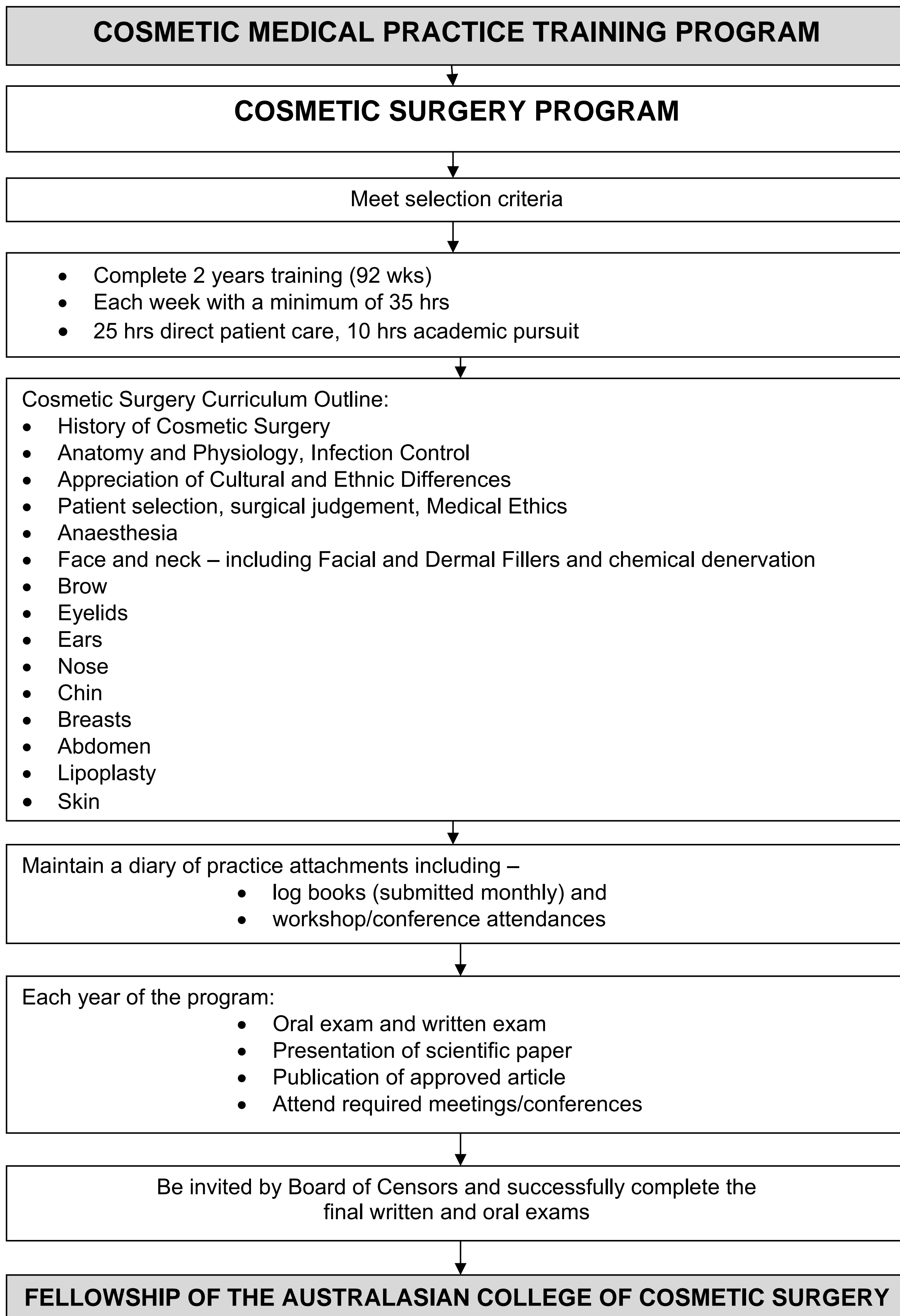
1.2 Contact Information for ACCS:

All Correspondence To:
PO Box 36, Parramatta, NSW 2124

Registered Office:
Level 2, 96 Phillip Street, Parramatta, NSW 2150

T 1800 804 781
F 02 9687 1799
E admin@accs.org.au
www.cosmeticsurgery.org.au
A.B.N. 890 863 834 31

1.3 Overview of the Cosmetic Surgery Training Program



2 Cosmetic Surgery Program

2.1 Cosmetic Surgery Program Objectives

- To produce doctors of sufficient high standard, to be knowledgeable and competent in Cosmetic Surgery and its associated procedures.
- To produce skilled, competent and safe practising cosmetic surgeons.
- To raise standards and benchmark a quality program for cosmetic medical practice and cosmetic surgical practice.
- To help develop, enhance and foster quality skills in the fields of cosmetic surgery.
- To refine an awareness of the particular requirements of cosmetic surgery.
- To improve knowledge and understanding, in order to counsel potential patients in various cosmetic options
- To impart a proper understanding of procedures and realistic expectations of outcomes.
- To encourage, promote and support continuing education in the field of cosmetic medical practice.
- To recognize the differing requirements of those pursuing cosmetic surgical practice and those pursuing cosmetic medical practice.

2.2 Pre-requisites and Candidate Selection

The candidate is to have attained FRACS or an equivalent surgical qualification (as determined by the College), have at least five years post graduate experience including three years of accredited surgical training and be a fully registered practising medical practitioner. The candidate may also be a Dermatologist with surgical experience, an Opthalmologist, ENT or Facio-Maxillary surgeon. Special consideration may apply in some circumstances.

2.3 Cosmetic Surgery Program Duration

The Registrar training program of the College is of TWO YEARS duration but some variation for prior experience may be granted. A MINIMUM of one year would be required and is dependent on review of previous experience and the candidate's log book.

Each year shall be of 46 weeks duration and involve a minimum of 35 hours of which 25 hours shall be patient contact and 10 hours academic pursuit.

Trainees accepted into the program are expected to undertake and complete all aspects of the set surgical training program.

2.4 Cosmetic Surgery Program Requirements

Outline of Requirements:

1. Observation and participation with recognised Cosmetic Surgeons as determined by the College over a period of two years.
2. Each year shall be of 46 weeks duration and involve a minimum of 35 hours of which 25 hours shall be patient contact and 10 hours academic pursuit (92 weeks in total over 2 years). In some circumstances the College may grant extra time to complete the required 92 weeks.
3. Summary of cases assisted at and performed to be supplied to the College in the format specified on a monthly basis. This summary will form the basis of the candidates log book of experience and should include full clinical information for all cases where the candidate has been the primary surgeon.
4. Maintenance of a diary of practice attachments and workshop/conference attendances.
5. Registrars must carry indemnity particular to their scope of practice.
6. Monthly Journal Club participation organised by the registrar group.
7. Bi-monthly meetings of candidates and College sensors or nominees. These meetings will focus of specific topics and practice and preparation for examinations.
8. Attendance at College Accredited Workshops as may be determined.
9. Subscription to appropriate journals. At present the College publication is the American Journal of Cosmetic Surgery. Subscription to the Journal of Aesthetic Plastic Surgery is also required as well as the following recommended journals:
   - Dermatologic Surgery
   - Clinics in Dermatology
   - Journal of Cosmetic Dermatology
   - Lasers in Surgery and Medicine
   - Journal of Cosmetic Surgery and Medicine
10. Purchase of suitable texts on cosmetic surgery as recommended by the College.
    Core Books (2009):
    - **General Text Book:** *Grabb and Smith's Plastic Surgery* 6th Edition, Editors: Sherrell Aston, Robert Beasley, Charles Thorne, Lippincott Williams and Wilkins 2006
    - **Comprehensive Aesthetic Surgery Textbooks:** *Aesthetic Plastic Surgery 2nd Edition* (2 volumes), Rees and LaTrenta , Saunders 1994; *The Art of Aesthetic Surgery* – Principles and Techniques (3 volumes), Foad Nahai, QMP 2005

    Suggested books on procedure specific areas:
    - **Liposuction:** *Refinements in Facial and Body Contouring*, Luiz S. Toledo, Lippincott – Raven 1999;
      Tumescent Technique – Tumescent Anaesthesia & Microcanula Liposuction, Jeffrey A. Klein, Mosby 2000
    - **Breast Surgery:** *Breast Augmentation : Principles and Practice*, Melvin A. Shiffman, Springer 2009;
      Surgery of the Breast – Principles and Art (2 volumes), Spear, Willey, Robb, Hammond and Nahabedian, Lippincott, Williams and Willkins 2005.
    - **Abdominoplasty:** *Atlas of Abdominoplasty* (Techniques in Aesthetic Plastic Surgery), Joseph Hunstad, Saunders 2008

- **Rhinoplasty:** *Aesthetic Rhinoplasty* (2 Volumes), Sheen & Sheen, QMP 1998
- **Facial Plastic Surgery:** *Facial Plastic and* Recon*structive Surgery . 2nd Edition,* Papael, Frodel, Holt, Larrabee and Nachlas, Thieme 2009

11. Successful completion of yearly written and oral exam for each year of the course.
12. Successful completion of final written and oral exams.
13. Presentation of a scientific paper at the College annual conference and submission of an article and evidence of acceptance by a peer reviewed publication acceptable to the College. This requirement exists for *each year* of the training course.
14. Payment of **non refundable** training fee of $30,000 + GST or other amount as amended from time to time.

2.5 Education Requirements – Diary of Practice and Procedure Log

Apart from the 25 hours per week of patient contact time, a candidate needs to complete 10 hours per week academic pursuit relevant to the curriculum.

The Registrar must keep a diary of practice (Appendix 6) and a summary/log of all procedures assisted at and performed (Appendix 7), as these need to be sent to the College in the format specified on a monthly basis. The Preceptor will need to sign off on the diary of practice and the procedure log, at least at the end of each term.

A monthly Journal Club participation is to be organised by the registrar group as well as bi-monthly meetings of candidates and College sensors or nominees. (focus of specific topics and practice and preparation for examinations).

2.6 Scientific Papers

Each year of the course a candidate must present a scientific paper at the College annual conference or an academic meeting acceptable to the College, the presentation needs to be approximately 10-15 minutes in duration. The Candidate must also submit an article to a peer reviewed publication acceptable to the College. The article must be accepted for publication.

The scientific paper submitted must meet the following criteria:

- The Registrar must be the primary author of the paper;
- The paper presented must be either original research or a review/case report/case series of a major topic **with a full literature review**;
- The paper must be of relevance to the course ie. relating to cosmetic surgery;
- The paper must be submitted to a peer reviewed publication acceptable to the College and evidence of acceptance must be supplied;
- The candidate must also present the paper at the annual conference or acceptable academic meeting.

2.7 Examinations

The content, format and type of examinations may be altered from time to time. Candidates will receive appropriate notice of any changes. Candidates will attend examinations by invitation of the Board of Censors. Such invitations may or may not be issued, determined by the satisfactory conduct, progress and application shown by the candidate as assessed by the Board of Censors.

Yearly oral and written examinations are held at various times each year. Candidates may only sit examinations when invited to attend.

Final examinations are conducted in two parts – the written clinical examination is held at a time determined by ACCS, and the Viva and practical examination is held approximately four weeks later.

2.8 Attendance at Workshops and Annual Conference

All Registrars are expected to attend the Annual Conference which is held each year around April/May in various locations around Australia. It is a requirement that Registrars prepare a paper for presentation at the Annual Conference or at an academic meeting for each year of the training program.

Attendance at workshops and conferences should be validated by a copy of the attendance certificate or an invoice of the registration fee and these copies should be attached to the diary of practice where relevant.

The registration fee of the Annual Conference and specified workshops are waived for Registrars for the duration of their training period.

2.9 Assessment by Preceptor

During a term with a preceptor, the Registrar will be evaluated to help identify areas of strengths and weaknesses, so that specific training can be planned to attain the high standard of clinical and practical experience needed to fulfill criteria for awarding fellowship into the College.

2.10 Further Training

If at the completion of the training program a candidate is considered to require further training, an extension of six months may be granted to achieve the required experience and competence. If at the completion of this first extension period the candidate is still considered to require further training, then a further six months may be granted but the candidate will be required to resit the final examinations. If, in the opinion of the College sensors, the candidate does not meet the required standards of experience and/or competence at that time, then no further consideration will be afforded and the candidate's registrar status will be withdrawn and Fellowship will not be available to the candidate.

2.11 Appeal

An appeal against decisions of the Board of Censors may be lodged in writing to:
The Administrator ACCS, PO Box 36, Parramatta, NSW 2124. Any appeal will be heard by a committee selected by the Council and determinations will be FINAL. No further discourse will be entered into.

2.12 Outline and Acceptance Form

Candidates for training positions are required to send a signed and dated "Outline and Acceptance Form for Cosmetic Surgery Program" (Appendix 8) to the College, as written acknowledgement of the training requirements and an acceptance of the conditions. The two signed and dated pages are to be sent to the College Administration Office:
Australasian College of Cosmetic Surgery, PO Box 36, Parramatta NSW 2124

3 Cosmetic Surgery Program Curriculum

3.1 History of Cosmetic Surgery

- Historical perspective, evolution of modern concepts, definitions, beauty and self image, and bibliography.

3.2 Anatomy and Physiology , Infection Control

- Detailed knowledge and understanding of the embryology, growth and development (including factors interfering with normal development), anatomy and physiology of the regions and organs involved in aesthetic surgery.
- Detailed knowledge and understanding of Infection Control principles and appropriate antibiotic management.

3.3 Appreciation of Cultural and Ethnic Differences

- Knowledge of "normal" aesthetic cultural differences and appearances in various racial groups including Caucasian, Asian, Melanesian, Polynesian, Micronesian. Methods of clinical examination and analytical investigation.

3.4 Patient Selection, Surgical Judgement , Medical Ethics

- General indications, contraindications both physical and emotional. Informed consent, medico-legal (including doctor and patient rights). Imaging and photography — communication, planning and records.
- Understanding of psychological and psychiatric issues and in particular assessment of Body Dysmorphic Syndrome.
- Ability to assess patient expectations and identify unrealistic goals.
- Decision to treat

a) Adequate information
b) Informed consent
c) Dissatisfied patient
d) Responsibility to Medical Indemnity Insurer
e) Documentation

- Assessment for other existing medical conditions

3.5 Anaesthesia

- Advantages and disadvantages and complications of general anaesthesia.
- Local anaesthesia with and without sedation.
- Pharmacology of local anaesthetics, anxiolytic and hypnotic medications. used in conjunction with local anaesthesia.
- Indications and complications of vasoconstrictors.
- Prevention and management of surgical and post-operative bleeding.
- Methods of monitoring cardio-respiratory function during surgery.
- Anaesthesia and ambulatory surgery.
- Understanding of appropriate legislation and regulation in the jurisdiction in which you work.
- Cardio-Pulmonary Resuscitation
- Management of surgical complications and emergencies

3.6 Face and Neck

- Abnormalities, surgical anatomy, pathophysiology.
- Face Lifting procedures— subcutaneous, SMAS flaps. Surgical incisions and their indications. Platysma manipulation.
- Minimally Invasive Surgical Techniques and applications and patient selection
- liposuction and fat augmentation
- Dermal fillers.
- Chemical Denervation - Botulinum toxin injections.
- Permanent Allografts.
- Skin Rejuvenation
  - dermabrasion,
  - chemical peels,
  - laser resurfacing,
  - non ablative rejuvenation
  - laser and light based therapies.
- Malar augmentation autogenous v allograft, types of materials, implant selection.
- Ancillary procedures — buccal fat resection, lip lifts, submandibular gland resection, muscle modulators – Botulinum toxin.
- Complications — avoidance and treatment.
- Secondary and revision procedures.
- Effects of ageing and sun damage — prevention agents. Chemical peels, dermabrasion, laserbrasion, collagen/hyaluronic acid injection, sclerotherapy, laser therapy – vascular, hair removal. Cosmetic camouflage agents.

3.7 Brow

- Indications and techniques of browlift (open and endoscopic).
- Incisions — their indications and complications.
- Associated muscle and neural procedures.
- Complications — avoidance and treatment.

3.8 Eyelids

- Abnormalities and their causes (familial, racial, ageing, and disease).
- Surgical anatomy and physiology (including lacrimal mechanism).
- Surgical procedures —
- Upper and lower eyelid, including conjunctival incisions, their indications and complications.
- Skin, muscle, fat and orbital septal manipulation and excision — indications and complications.
- Canthoplasty, canthopexy — indications, technical options and complications.
- Fat and collagen/hyaluronic acid augmentation, chemical peeling and dermabrasion.
- Re-surfacing and other non ablative procedures procedures.
- Light based therapies.
- Management of ectropion, entropion, ptosis and eyelid shape.
- Complications — their avoidance and treatment.

3.9 Ears

- Embryology, anatomy, congenital and aesthetic deformities.
- Associated syndromes and conditions.
- Traumatic deformities.
- Aesthetic otoplasty techniques — indications, techniques, complications.
- Reconstructive procedures — complications, their avoidance and treatment.

3.10 Nose

- Deformities — aesthetic, traumatic, disease, congenital, tumour and prior surgery.
- Airway physiology, function and pharmacology.
- Deformities — aesthetic, traumatic, disease, tumours, congenital and iatrogenic (prior surgery).
- Associated conditions (eg: allergic or vasomotor rhinitis, epistaxis, polyps, airway obstruction with septal deviation etc).
- Rhinoplasty — open, closed, vault, tip, indication and complications.
- Septoplasty, turbinate and paranasal sinus surgery.
- Augmentation using autogenous tissue (eg: cartilage, bone, fascia or dermis) or synthetic materials, eg. Alloderm or fat grafts.
- Complications — their avoidance and treatment

3.11 Chin

- Deformities and associated problems — causes, assessment and treatment.
- Augmentation genioplasty.
- Mentoplasty, augmentation and reduction genioplasty using autogenous and alloplastic materials (eg: hydroxyapatite).
- Complications — their avoidance and treatment.

3.12 Breasts

- Development and Surgical anatomy, physiology. Age related changes.
- Deformities — aesthetic, traumatic, disease, congenital, tumour, and iatrorogenic (prior surgery).
- Augmentation mammaplasty — indications and assessment, techniques, implant materials (eg: silicone — its history to current day status and complications), follow-up assessment and management.
- Reduction mammaplasty — indications, techniques and their indications with relevance to breast size, scar position and size, nipple areola preservation, breastfeeding, re-operations and the place of liposuction.
- Mastopexy — indications and techniques.
- Tubular breasts — techniques of correction.
- Asymmetric breast deformities — assessment and treatment.
- Gynaecomastia — investigations, indications and surgical techniques. Role of liposuction.
- Nipple and areola reconstruction.
- Inverted nipples — aetiology and treatment.
- Complications, their avoidance and treatment.

3.13 Abdomen

- Abnormalities — post partum, post surgery, associated with lipodystrophy, obesity and weight loss; divarication of recti causing abnormal contour.
- Surgical anatomy and physiology
- Associated problems such as herniae.
- Surgical procedures — indications and techniques.
- Liposuction and sculpting.
- Abdominoplasty — skin incisions, muscle plication, associated liposuction, umbilicoplasty.
- Complications, their avoidance and treatment

3.14 Lipoplasty

- Deformities of fat maldistribution, their causes and associated medical conditions.
- Understanding of normal aesthetic body shape and methods of assessment.
- Lipoplasty — indications and techniques; deep and superficial, "tumescent" and wet/dry, fluid replacement, types and sizes of cannulae. Indications and complications.
- Fat injection.
- Associated procedures — body contour surgery, thigh and buttock lifts, brachioplasty.
- Complications — their avoidance and treatment.

3.15 Skin

- Surgical anatomy, histology, physiology, pathology, wound healing, pharmacology of dermatological steroid medication.
- Treatment of scars including hypertrophic and keloid.
- Skin cancer management surgical, excision, flaps, grafts.

- Skin cancer management, non surgical, eg. PDT, immunomodulation, chemotherapy.
- Local steroid therapy, pressure therapy, scar revision.
- Common skin care programs — active ingredients (eg: AHA, Tretinoin), hypopigmenting agents (eg: Hydroquinone).
- Acne management and management of acne scarring.
- Common dermatologic conditions eg Rosacea, Lupus,inflammatory dermatoses.
- Lasers and other Light Therapies
- Chemical De-nervation
- Collagen Induction therapies
- Skin manifestation of internal disease

4 Requirements for Granting Fellowship of the Australasian College of Cosmetic Surgery; FACCS

Successful completion of all elements of the program is required before a Registrar can apply to the College for Fellowship. The checklist below outlines all elements that a Registrar needs to complete before an application for Fellowship will be accepted.

Absence from formal training is not acceptable and will result in the Registrar not being awarded Fellowship.

Maintenance of the Fellowship will require adherence to and completion of the College CME and Recertification Program and observance of College Constitution and By-Laws as amended from time to time.

Award of the Fellowship involves the completion of the following checklist:

Checklist of Requirements for Granting Fellowship of Cosmetic Surgery		
1.	□	Submission of diary of practice, logs and attachments to ACCS on monthly basis
2.	□	Successful completion and evaluation by each preceptor of hands-on practice hours
3.	□	Successful submission and acceptance of scientific paper for each year of the program
4.	□	Presentation of scientific paper at annual conference/academic meeting for each year of program
5.	□	Attendance at all required meetings, workshops and conferences
6.	□	Be invited to sit and successfully complete, all written and oral exams for each year of the program
7.	□	Complete payment of all fees owed to ACCS for program

Upon completion of the above criteria, the Registrar is invited to apply to the College for Fellowship (application form – Appendix 5).

Final evaluation of total course elements will be made by the Dean of Training and acceptance by the Censor in Chief of the recommendation of the Dean to accept the candidate for the award of fellowship.

Appendix 1. Code of Conduct – ACCS Registrars

State medical boards have their own Codes of conduct/Guidelines to Good medical Practice. This Code of Conduct does not replace such Codes/Guidelines but highlights specific aspects relevant to cosmetic medical practice and training situations.

Most of the patients you will see are private cosmetic patients. Remember the following points:

- Patients have come for their own reasons, not for your training benefit;
- Quality patient care is always the more important concern above your training needs;
- Every patient must be treated politely and considerately;
- Patients' dignity and privacy must be respected;
- Patients' views must be respected;
- Patients' appearance is very important to them and should neither be denigrated nor made light of;
- Give patients information in ways they can understand;
- Respect patients' right to decide whether or not to have treatment, to decide which appropriate treatment best suits their requirements and who should perform this treatment;
- Respect patients' right to refuse to be involved in teaching episodes;
- Do not allow personal beliefs and prejudices to influence relationships with patients.

During your training:

- Recognise the limits of your own professional and clinical competence and seek help or advice as required;
- Work within your supervision boundaries;
- Do not denigrate other staff members, fellow registrars, supervisors or mentors;
- Respond constructively to assessments and appraisals of your knowledge and clinical performance.

Your supervisors and mentors are allowing you access to their practices and patients with no thought of payment. This privilege should be respected and not abused.

- Arrive punctually at pre-arranged times
- Observe the practice dress code
- Appreciate that appointment schedules should be kept and training often makes this difficult
- Report any perceived gaps in training to your supervisor and/or ACCS administration office so that this may be addressed.

Observance of this Code in addition to relevant medical board Codes, requirements and the ACCS Code of Practice should allow smoother passage through the registrar program.

As participants in the College training program it is not permitted for Registrars to place advertisements or allow advertisements to be placed which contain any incorrect or misleading information. Specifically:

- Registrars must not advertise that they are trainees with the College nor are they permitted to use any post-nominals related to that training;
- Registrars must not advertise procedures which form part of the curriculum in which they are being trained; without express permission of the College which may be granted after certification in particular circumstances;
- Registrars must not claim, or allow the implication of any claim of, specialist qualification from the College or "specialized" skill training, relation to their training during the course of their program.

Registrars must recognize that their position on the College training program is a privilege and is conditional on observance of this 'Code of Conduct' and observance of the overall aims and interests of the College as reflected in the Constitution and By Laws of the College and the ACCS Code of Practice. This privilege may be withdrawn due to breaches of this Code of conduct and may result in Registrars not being allowed to complete their training and/or not being invited to sit the College examinations.

I, …………………………… have read and understood the ACCS Registrar Code of Conduct and agree to observe and be bound by this code.

Signature;

Date;

Appendix 2. ACCS Registrar Training Checklist - Year One

YEAR 1

Name:………………………………………………………………………………………

Term Dates	Preceptor	Evaluation Received		Log & Diary signed by Preceptor	
1.		□ Yes	□ No	□ Yes	□ No
2.		□ Yes	□ No	□ Yes	□ No
3.		□ Yes	□ No	□ Yes	□ No
4.		□ Yes	□ No	□ Yes	□ No

Participation in Journal Club	□ Yes	□ No
Attendance at Registrar Meetings/workshops	□ Yes	□ No

Conference Presentation	
Title:	**Meeting:**
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………

Paper Submitted for Publishing	
Title:	**Journal:**
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………

Appendix 3. ACCS Registrar Training Checklist - YearTwo

YEAR 2

Name:…………………………………………………………………………………………

Term Dates	Preceptor	Evaluation Received		Log & Diary signed by Preceptor	
1.		□ Yes	□ No	□ Yes	□ No
2.		□ Yes	□ No	□ Yes	□ No
3.		□ Yes	□ No	□ Yes	□ No
4.		□ Yes	□ No	□ Yes	□ No

Participation in Journal Club	□ Yes	□ No
Attendance at Registrar Meetings/workshops	□ Yes	□ No

Conference Presentation	
Title:	**Meeting:**
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………

Paper Submitted for Publishing	
Title:	**Journal:**
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………
…………………………………………………	…………………………………………………

Appendix 4. ACCS Registrar Training Checklist - Completion

Name:……………………………………………………………………………………………

ELECTIVE TERM						
Dates	Preceptor	Location	Preceptor Evaluation		Trainee's Diary & Logs	
			□ Yes	□ No	□ Yes	□ No
			□ Yes	□ No	□ Yes	□ No
			□ Yes	□ No	□ Yes	□ No
			□ Yes	□ No	□ Yes	□ No

Examinations				
Year 1.	Viva Voce	□ Pass	□ Intermediate	□ Fail
Year 2.	Written Exam	□ Pass	□ Intermediate	□ Fail
Year 2.	Viva Voce	□ Pass	□ Intermediate	□ Fail

Overall Position			
Training Completed		□ Pass	□ Fail
Training Incomplete	Extension Granted	□ Yes	□ No
Training Incomplete	Extension 2	□ Yes	□ No
Final Determination		□ Pass	□ Fail

Comments:……………………………………………………………………………………

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Appendix 5. ACCS Registrar Application for Fellowship - Completion

Name:………………………………………………………………………………………………

Cosmetic Surgery Application for Fellowship

Checklist of Requirements for Granting Fellowship of Cosmetic Surgery		
1.	□	Submission of diary of practice, logs and attachments to ACCS on monthly basis
2.	□	Successful completion and evaluation by preceptor of hands on practice hours
3.	□	Successful submission and acceptance of scientific paper for each year of the program
4.	□	Presentation of scientific paper at annual conference/academic meeting for each year of program
5.	□	Attendance at all required meetings, workshops and conferences
6.	□	Be invited to sit and successfully complete, all written and oral exams for each year of the program
7.	□	Complete payment of all fees owed to ACCS for program
8.	□	Application signed below to Cosmetic Surgery Faculty for Fellowship

As a Registrar of the Cosmetic Surgery Training Program, I hereby apply for Fellowship of the Faculty of Cosmetic Surgery, after having successfully completed all the above criteria (please send completed and signed form to the ACCS).

Signed:___________________________________

Date:_____________________________________

Comments:………………………………………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Appendix 6.ACCS Registrar Training - Sample Diary of Practice

Registrar Name:……………………………………………………………Signature:…………………………Date:………………

Dates	Theory Covered	Meetings/Workshops/Conferences/ Journal club attendance	25 Contact hours completed		10 Academic Study hours completed	
Week …. …./…./…. …./…./….	……………………………………………………... ……………………………………………………... ……………………………………………………...	……………………………………………………… ……………………………………………………… ………………………………………………………	□ Yes	□ No	□ Yes	□ No
Week …: …./…./…. …./…./….	……………………………………………………... ……………………………………………………... ……………………………………………………...	……………………………………………………… ……………………………………………………… ………………………………………………………	□ Yes	□ No	□ Yes	□ No
Week …. …./…./…. …./…./….	……………………………………………………... ……………………………………………………... ……………………………………………………...	……………………………………………………… ……………………………………………………… ………………………………………………………	□ Yes	□ No	□ Yes	□ No
Week …. …./…./…. …./…./….	……………………………………………………... ……………………………………………………... ……………………………………………………...	……………………………………………………… ……………………………………………………… ………………………………………………………	□ Yes	□ No	□ Yes	□ No

This is a true record of the above Registrar’s diary of practice as witnessed by- Preceptor Signature:…………………………………

Preceptor’s Name: ……………………………………………………Date:………………………………...

Appendix 7. ACCS Registrar Training - Sample Procedure Log

Registrar's Name:………………………………………………………………………Signature:……………………………………..

Patient's Initials	Date of Procedure	Procedure	Complications	Location	Observed	Assisted	Primary Physician/ Surgeon

This is a true record of the above Registrar's procedure log as witnessed by- Preceptor Name:………………………………………….

Preceptor's Signature: ……………………………………………Date:………………………………

Appendix 8. Outline and Acceptance Form for Cosmetic Surgery Program

The Registrar training program of the College is normally conducted over a course of TWO YEARS duration. Circumstances may determine that a longer time period may be required to complete all elements.

Outline of Requirements:

1. Observation and participation with recognised Cosmetic Surgeons as determined by the College over a period of two years.
2. Each year shall be of 46 weeks duration and involve a minimum of 35 hours of which 25 hours shall be patient contact and 10 hours academic pursuit (92 weeks in total over 2 years).
3. Summary of cases assisted at and performed to be supplied to the College in the format specified on a monthly basis. This summary will form the basis of the candidates log book of experience and should include full clinical information for all cases where the candidate has been the primary surgeon.
4. Maintenance of a diary of practice attachments and workshop/conference attendances.
5. Registrars must carry indemnity particular to their scope of practice.
6. Monthly Journal Club participation organised by the registrar group.
7. Bi-monthly meetings of candidates and College sensors or nominees. These meetings will focus of specific topics and practice and preparation for examinations.
8. Attendance at College Accredited Workshops as may be determined.
9. Subscription to appropriate journals. At present the College publication is the American Journal of Cosmetic Surgery. Subscription to the Journal of Aesthetic Plastic Surgery is also required as well as the following recommended journals:
10. Dermatologic Surgery;
11. Clinics in Dermatology;
12. Journal of Cosmetic Dermatology;
13. Lasers in Surgery and Medicine;
14. Journal of Cosmetic Surgery and Medicine.
15. Purchase of suitable texts on cosmetic surgery as recommended by the College.
    - **Core Books (2009):**
      General Text Book: *Grabb and Smith's Plastic Surgery* 6th Edition, Editors: Sherrell Aston, Robert Beasley, Charles Thorne, Lippincott Williams and Wilkins 2006
      Comprehensive Aesthetic Surgery Textbooks: *Aesthetic Plastic Surgery 2nd Edition* (2 volumes), Rees and LaTrenta , Saunders 1994; *The Art of Aesthetic Surgery* – Principles and Techniques (3 volumes), Foad Nahai, QMP 2005
    - **Suggested books on procedure specific areas:**
      Liposuction: *Refinements in Facial and Body Contouring*, Luiz S. Toledo, Lippincott – Raven 1999;
      Tumescent Technique – Tumescent Anaesthesia & Microcanula Liposuction, Jeffrey A. Klein, Mosby 2000

Name:………………………………………Signature:…………………….Date:…………….

DRAFT

Breast Surgery: *Breast Augmentation : Principles and Practice*, Melvin A. Shiffman, Springer 2009;
Surgery of the Breast – Principles and Art (2 volumes), Spear, Willey, Robb, Hammond and Nahabedian, Lippincott, Williams and Willkins 2005.
Abdominoplasty: *Atlas of Abdominoplasty* (Techniques in Aesthetic Plastic Surgery), Joseph Hunstad, Saunders 2008
Rhinoplasty: *Aesthetic Rhinoplasty* (2 Volumes), Sheen & Sheen, QMP 1998
Facial Plastic Surgery: *Facial Plastic and* Recon*structive Surgery . 2nd Edition,* Papael, Frodel, Holt, Larrabee and Nachlas, Thieme 2009

16. Successful completion of yearly written and oral exam for each year of the course.
17. Successful completion of final written and oral exams.
18. Presentation of a scientific paper at the College annual conference and submission of an article and evidence of acceptance by a peer reviewed publication acceptable to the College. This requirement exists for *each year* of the training course.
19. Payment of **non refundable** training fee of $30,000 + GST or other amount as amended from time to time.

The content, format and type of examinations may be altered from time to time. Candidates will receive appropriate notice of any changes. Candidates will attend examinations by invitation of the Board of Censors. Such invitations may or may not be issued, determined by the satisfactory conduct, progress and application shown by the candidate as assessed by the Board of Censors.

If at the completion of the training program a candidate is considered to require further training, an extension of six months may be granted to achieve the required experience and competence.

If at the completion of this first extension period the candidate is still considered to require further training, then a further six months may be granted but the candidate will be required to resit the final examinations.

If at this time, in the opinion of the College sensors, the candidate does not meet the required standards of experience and/or competence then no further consideration will be afforded and the candidate's registrar status will be withdrawn and Fellowship will not be available to the candidate.

An appeal against decisions of the Board of Censors may be lodged in writing to:
The Administrator ACCS, PO Box 36, Parramatta, NSW 2124. Any appeal will be heard by a committee selected by the Council and determinations will be FINAL. No further discourse will be entered into.

Name:……………………………………Signature:…………………….Date:……………

To accept the conditions of the ACCS Cosmetic Surgery Registrar Training Program, please sign and date this acceptance form (on both pages) and send the two signed pages back to the College Administration Office: Keep a copy for your records.
Australasian College of Cosmetic Surgery, PO Box 36, Parramatta NSW 2124

Appendix 9. ACCS Consumer/Patient Code of Practice

A. Introduction

Membership of the Australasian College of Cosmetic Surgery (ACCS) provides patients with an assurance that ACCS Members meet the highest standards.
The aim of this Code is to protect the public by making these standards transparent and ensuring that they are met. The Code also establishes transparent complaints and external adjudication processes.

The ACCS is currently the only body in Australia which trains, examines and annually recertifies cosmetic surgeons and physicians.

The ACCS promotes and endorses truthful, ethical and informative advertising, and the provision of appropriate information to patients and potential patients. It also requires a face to face consultation with the Member offering a procedure before any procedure is undertaken. These processes are designed to ensure patients are provided with comprehensive advice allowing them to make fully informed decisions before consenting to undergo a cosmetic procedure.

The ACCS favours national regulation of cosmetic medicine and surgery with recognition by the Australian Medical Council (AMC) of a separate specialty of Cosmetic Medical Practice. Currently there is no such mechanism and the AMC has not assessed the bona fides of the cosmetic training of **any** qualification including those of plastic and reconstructive and other surgeons qualified by the Royal Australasian College of Surgeons.

An application to the AMC by the College for such recognition has been accepted by the AMC for full assessment. The formal recognition of this separate specialty will not automatically recognise any qualification or training body. It will however provide a framework whereby all practitioners of cosmetic procedures will be able to have their training and qualifications properly assessed and accredited by the AMC. In the absence of a national approach the ACCS Code is the sole set of formal standards specifically developed to protect cosmetic surgery and cosmetic medical patients.

Whilst all medical practitioners must adhere to relevant laws and guidelines, which vary from state to state, the Code highlights those responsibilities and sets additional and higher standards for Members of the ACCS.

To assist in compliance with laws and guidelines, the ACCS will provide Members with a guide of their overall responsibilities to consumers and to each other.

B. Interpretation

“**Advertising**” applies to all promotional material and is to be interpreted broadly. It includes websites and all electronic media. It also includes any advertising carried out on behalf of a Member and conduct by a Member’s employees or agents or representatives. Those representatives include any third parties acting on behalf of members.

“Cosmetic Medical Practice” is defined by the College as operations, procedures and treatments that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient’s appearance or self-esteem.[1] It includes non-surgical cosmetic medical procedures and cosmetic surgical procedures.

“FACCS” means a Fellow of the Australasian College of Cosmetic Surgery.

“FFMACCS” means a Fellow of the Faculty of Medicine of the Australasian College of Cosmetic Surgery.

C. Code Administration Committee

There will be a Code Administration Committee, comprised of at least 3 members. There is to be an independent Chair, being someone with experience of developing codes. Another member is to be a consumer representative nominated by an organisation such as the Australian Consumers Association. Further there is to be at least one member representing the College.

The Committee will review the Code tri-annually and report to the College on its review. It is able to make recommendations to the ACCS about the Code and its administration.

In its review the Committee shall consult with relevant regulatory bodies.

In its review the Committee will have access to matters considered by the Complaints Panel and the Appeals Committee.

The College will adopt the recommendations of the Committee unless it gives written reasons why a recommendation is not accepted.

The review and the ACCS response will be placed on the ACCS Website and will be submitted to the ACCC.

The ACCS must collect and keep data that will assist the Code Administration Committee in its reviews.

The Code

1. General Considerations

Australasian College of Cosmetic Surgery Members have a duty to the public and to each other. That duty is not a duty to legal minima, but one that seeks to constantly improve standards and consumer welfare.

Members must:

1 Adapted from definition adopted by the UK Department of Health. *Expert group on the regulation of cosmetic surgery: report to the Chief Medical Officer*, January 2005, p. 3. And see e.g. *Provision of cosmetic surgery in England: Report to the Chief Medical Officer Sir Liam Donaldson*, 2004.

1.1 practice with integrity and honour, in the best interests of their patients, with the patient's safety and quality of care being paramount;
1.2 conduct their professional affairs in accordance with all applicable laws, relevant professional guidelines and ethics, and in a manner that upholds the good reputation of the medical profession;
1.3 strive for the advancement of the speciality of cosmetic medical practice through research and development, ensure the maintenance of the highest standards through continued medical education and training, keep themselves up to date on legislative and ethical requirements relevant to being a medical practitioner and specialising in cosmetic procedures and
1.4 adhere to the College Constitution, By Laws and Codes.
In addition ACCS members must comply with the following guidelines:

2. Advertising and promotion

2.1 Advertising must not contain false, misleading or deceptive statements, or create misleading impressions about the doctor or clinic or the services offered. It should provide balanced information on the procedures or products advertised and should not suggest these are risk free. Critical omissions can also be misleading.

2.2 Members must not mislead consumers about the need for any procedure.

2.3 Superlatives should not be used in any advertising unless they can be readily proven to be correct and as such are not misleading. For example, to claim that a particular breast implant has the “least” risk of a specific complication would be acceptable if true and supported by the peer reviewed literature. Such information is of value to consumers. To claim a practitioner is the “best” in any way is not permissible as it is a value judgement, not readily proven, which could mislead consumers.

2.4 Members must be able to substantiate any claims made in their advertising at the time the claims are made.

2.5 Comparative advertising should be used with caution. It can be valuable in conveying information to consumers but it must be correct and readily proven. For example, to claim a type of treatment is safer than another type of treatment is acceptable if true and supported by the peer reviewed literature. Again such information is of benefit to consumers.
2.6 Photographs may be used to display the results of treatment and or complications. ‘Before and after’ photographs should be presented with similar pose, presentation, lighting and exposure. Any uncomplicated results shown should be typical and be likely to be reproduced in a similar patient. Photographs must not be altered in any way other than to protect a patient’s identity. ‘Before and after’ photographs must be of the advertising doctor or clinic’s own patients and contain accurate and informative captions.

2.7 Testimonials should not be used in advertisements.

2.8 Medical or surgical procedures should not be offered as inducements or prizes in competitions or contests, or as a way of generating business.

2.9 Offers of gifts or other inducements shall not be used in order to attract potential clients.

2.10 Discounts for early payment should not be used as an inducement to commit to a procedure.

2.11 No Member will offer finance facilities as part of the services provided, except a credit card facility. In no circumstances should a Member accept any commission from a credit provider.

2.12 The College notes that in Victoria advertisements of a surgical (invasive) procedure shall include in a prominent place and in a visible fashion the following statement:

"*Any surgical or invasive procedure carries risks. Before proceeding, you should seek a second medical opinion*".
Whilst this is not mandatory in other States and Territories, Members advertising in other States and Territories are encouraged to use such a statement.

College and Certification logo and post nominals

2.13 The College logo or relevant Certification logo may only be used by doctors who are currently accredited Fellows, or Fellows of the Faculty of Medicine of the College. Additionally, the Certification logo can only be used if the doctor is currently compliant with the College CME programme, as evidenced by the CME certificate.

2.14 If any doctor who holds an FACCS or FFMACCS wishes to perform any invasive surgical procedure for which he or she is not accredited by the College, then that doctor shall not be entitled to use their College
post nominals, nor mention the College in any way which might be seen or heard by a patient considering undertaking such a procedure.

3. Guidelines for informed consent - applicable to all procedures

3.1 Informed consent is a process, not simply the signing of a consent form**.** Members should give information about the risks of any intervention, especially those that are likely to influence the patient's decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare.

3.2 All Members must make available to patients, before any procedure is agreed to, a College produced information brochure about cosmetic procedures. This must include information about what College qualifications mean and also outline the College's complaints process. The brochure must inform patients how to obtain a full copy of this Code of Conduct. To the extent possible the same information is to be on the College's website and on Members' websites, either directly or via a link to the College's website. The brochure will contain information about other

routes for patients to make a complaint; for example Medical Boards and statutory health care complaint bodies. The brochure will also advise patients that a second opinion is advisable before making any decision to have a procedure.

3.3 All Members must, before any procedure is agreed to, provide the patient with full disclosure of the fees and charges, and likely total cost of the procedure. Patients should be made aware that further costs could be incurred in the event of complications occurring.

3.4 Members must, before any procedure is agreed to, provide patients with information about:

- how and where the procedure is performed;
- who will be assisting in the procedure;
- possible complications and side-effects, their frequency and severity;
- any anticipated post operative scarring;
- whether the patient be required to go to a hospital;
- whether the patient will need to take time off work;
- the post-operative course and expected recovery time;
- possible alternative treatments where appropriate including the option of no treatment at all;
- the expected realistic outcome.

3.5 No procedure should take place unless the Member has consulted with the patient beforehand and has fully explained to the patient the procedure and any associated risks. Patients should be encouraged to ask questions at this consultation.

3.6 If a Member offers an invasive procedure to a patient which that Member has performed less than 100 times previously, then the Member must disclose to the patient, at the initial consultation, how many times the Member has performed the procedure before.

Guidelines for informed consent for more invasive procedures with a significant risk of an adverse long term outcome

3.7 The guidelines described in this section are in addition to the rules concerning Members' conduct described above. These guidelines refer to invasive procedures which have a significant risk of an adverse long term outcome. They are not relevant to temporary fillers or botulinum toxin treatment for example, to which all statutory requirements and the additional requirements for ACCS members as detailed above apply. They would apply, for example, to laser resurfacing, chemical peels with the potential to affect the dermis and to permanent fillers.

3.8 The patient must have at least one consultation, with the Member performing the procedure before the day of surgery.

3.9 For geographical reasons it is sometimes impractical for patients to meet the doctor face to face for their initial consultation. In these circumstances it is acceptable for the patient to send photographs to the doctor and then for the

doctor to have a telephone or video consultation with the patient. This can be considered to be the initial consultation with the doctor performing the procedure. If the patient elects to proceed, the doctor must see the patient face to face before the procedure, preferably at least one day before. It is accepted that there may be instances where, for logistical reasons, this face-to-face meeting can only occur on the day of surgery, but this should not be considered the norm. If the face-to-face meeting, being the exception, does not occur at least a day before the procedure, the reason for this must be properly documented.

3.10 It must be clearly stated to the patient that, if either the doctor or the patient decides at that meeting not go ahead for any reason, then a full refund of any monies paid will be provided. If a cancellation fee from the anaesthetist and/or the hospital might be incurred, the patient must be advised of this prior to paying any monies.

3.11 If there is a consultation with someone other than the Member performing the procedure, this is not an acceptable substitute for the process described in 3.8, 3.9 and 3.10 above, which must still occur.

3.12 If the doctor is inexperienced in the specific procedure contemplated, either because the doctor is new to the procedure or because the procedure itself is new, this should be disclosed to the patient at the first consultation, as per the 100 case rule indicated above.

3.13 At the end of the initial consultation the patient should be provided with a procedure-specific consent form to consider at home.

3.14 The patient should be told, and it should be stated on the consent form, to contact the doctor, by telephone or at another consultation, if they have any questions or need clarification of the consent form.

3.15 If there is doubt about which procedure would be most appropriate for a patient, or if the patient is unsure about having the procedure, the desirability of a second opinion should be emphasised, reinforcing the advice in this respect contained in the information brochure.

3.16 Generally there should be a ‘cooling off’ period of at least five days between the initial consultation with the doctor performing the procedure and the procedure itself. It is accepted that there may be circumstances where, for practical reasons, this period may need to be shorter but it should never be less than one night. If the ‘cooling off’ period is less than 5 days the reasons for this must be properly documented and acknowledged by both the Member’s and patient’s signature.

4. Post-Operative Care

4.1 Each Member must:

- provide full and adequate post-operative care for their patients, including provision for emergency after-hours care. The post-operative surveillance should be appropriate for the magnitude of the surgery performed and to allow for early detection of and intervention in adverse outcomes; and

- provide adequate and appropriate on-going care, either by his or her own assessment and treatment, or by appropriate referral.

5. Complaints Processes

5.1 Preamble

The Rules dealing with the Complaints regime and disciplinary process adopt the concepts of natural justice. In this context ***natural justice***, also known as procedural fairness, has three main principles:

1. The Member complained of is provided with:

- a fair hearing;
- all information within a reasonable timeframe required to answer the allegations made against him/her; and
- an opportunity to respond to all allegations or decisions affecting him/her and;
- their response is genuinely considered.

2. The decision maker is impartial; and

3. The Complainant must be kept properly informed at all times.

Complaints

5.2 All complaints must be in writing.

5.3 If a complaint is made to the College in writing that a Member has allegedly breached any part of the Code of Practice, the complaint will be handled in accordance with the procedures set out in the Code.

5.4 Upon the receipt of a written complaint the College will refer the complaint to the Chairman of the Complaints Panel.

5.5 On receipt of a written complaint, the College shall advise the Complainant and the Member involved in writing within 7 days that the matter has been referred to the Chairman of the Complaints Panel

5.6 The Chairman of the Complaints Panel shall not refer the matter to the Panel if:

(a) the Complainant does not agree, in writing, that their identity can be revealed to the Member complained of, unless that their identity is not necessary for the Panel to investigate the matter;

(b) the information provided by the Complainant does not allege nor disclose a breach of the Code;

(c) it is more appropriate that the complaint be dealt with by a Court or an external complaints, disciplinary, conciliation, or arbitration body or procedure;

(d) the Complainant is seeking compensation or reimbursement only and is not alleging that a Member has been in breach;

(e) the act or omission giving rise to the complaint occurred before the date of commencement of the relevant ACCS Rules;

(f) the subject matter of the particular complaint was comprised in a same complaint by the same person (or any one or more of them) previously considered by the Complaints Panel and finalised;

(g) the complaint is against a non ACCS Member;

(h) the matter is being handled by a medical insurer; or

(I) the Chair of the Panel is of the view that the matter is frivolous or vexatious.

5.7 If, in the view of the Chair of the Panel, the breach is of minor nature and can be dealt with by advice to the Member the complaint will not be referred to the Panel. The Chair will inform the Complainant in writing of this decision and advise the Complainant that if he or she is not satisfied with this outcome the Complainant can insist the complaint be referred to the Complaints Panel and this then must occur.

5.8 Any complaints resolved under the process described in 5.7 above are to be included by the Chairman of the Complaints Panel in the annual report described in Section 8 below.

Complaints Panel

5.9 The College Council will appoint a Complaints Panel. The role of the Panel is to consider complaints against an ACCS member alleging breaches of the ACCS Code.

5.10 The Panel shall have a minimum of three members at least one of whom shall have legal qualifications and at least two of whom shall not be a Member of the ACCS. The Chair of the Panel will be independent of the ACCS and shall have legal qualifications. At least one of the members shall be an ACCS Member.

5.11 No Member who is in any way concerned with the matter in question, or who is connected in any business entity, firm, corporation, or department with the Member accused or the party who originated the complaint, shall be a member of the Panel.

5.12 Panel processes must be conducted in private.

5.13 The Member complained of may be legally represented before the Panel, provided that:

(a) the Panel is advised not less than 5 days prior to the date set down for any hearing of the intention of the particular party to have legal representation, and the name and contact details of each such legal representative, and

(b) the Panel may, if it is satisfied that legal representation has served or may continue to serve to delay the hearing of the matter, terminate the right of the party to have legal representation in which event the legal representative or representatives must depart the hearing and take no further part in it and the hearing must proceed in the absence of that legal representation.

5.14 No party may be compelled to appear at a hearing of the Panel, but any party to a hearing may provide written submissions and evidence to the Chair of the Panel at least 3 days before the hearing.

5.15 The Panel may make such procedural arrangements as it thinks fit, including directions for the provision of written submissions and evidence.

5.16 The Panel may conduct hearings as it considers fit, having regard to the necessity that adequate consideration be given to matters before it. However the Panel shall hold a hearing if the Member complained of asks that there be a hearing.

5.17 The laws and rules of evidence do not apply to proceedings before the Panel.

5.18 The Panel may obtain legal advice and have legal advisers in attendance at a hearing.

5.19 The Panel may conduct hearings or other meetings of the Panel in person or by other means, provided that all members of the Panel are able to hear and speak to each other.

5.20 All determinations and decisions of the Panel are to be made by a majority of the members of the Panel.

5.21 The Member complained of in any matter shall be informed, at least 14 days prior to any hearing, of:

(a) the name of the Panel Chair and members of the Panel;

(b) the exact nature of the complaint and the disciplinary charge that the Member will be required to address;

(c) the time, date and place for the hearing;

(d) the right of the Member concerned to be heard in regard to the allegations;

(e) whether or not the person instigating the complaint may be called to give evidence and/or provide a written submission in statutory declaration form;

(f) whether or not other witnesses may be called to give evidence and/or provide a written submission in statutory declaration form;

(g)what material the Member should bring to the hearing.

5.22 The Complainant shall, at least 7 days prior to any hearing, be informed of the time, date and place of the hearing and whether or not they will be required to give evidence at the hearing.

Admission of Evidence

5.23 No documents will be admitted into evidence that have not been made available to the Member complained of within a reasonable time prior to the hearing. This timeframe will be at the discretion of the Chair of the Panel. If any party wishes to introduce additional documentary evidence, the Chair may, if necessary, adjourn the hearing to allow the other party sufficient time to consider the evidence.

Hearing Procedure

5.24 The procedures for the hearing shall be at the discretion of the Chair of the Panel.

5.25 A transcript of a hearing is to be kept and a copy given to the Member complained of and the person who instigated the complaint, if that person was asked by the Panel to be involved in the hearing. A fee may be charged by the College for the transcript.

Panel's Decision

5.26 The Chair of the Panel shall furnish in writing to the ACCS Council, the Panel's decision, the reasons for the decision and details of any sanction to be imposed.

Sanctions

5.27 Where the Panel determines that a Member has not been involved in a breach, the Panel shall make a determination to dismiss the matter.

5.28 Where the Panel determines that a Member has been involved in a breach, the Panel shall make a determination of breach against the Member complained of, and may impose one or more of the following sanctions:

(a) reprimand the Member;

(b) admonish the Member publicly;

(c) counsel the Member;

(d) suspend the Member from membership of the ACCS, for such period and on such terms or conditions as the Panel thinks fit;

(e) where the Member is already the subject of an order for suspension, continue that suspension for such period and on such terms or conditions as the Panel thinks fit;

(f) require the Member to take such steps as the Panel may determine to correct the effects of any breach found to have been engaged in;

(g) require a payment to the ACCS to be used as the Panel recommends, such penalty to be no more than $10,000.00 for the first instance and no more than $20,000.00 for any subsequent breach;

(h) require the Member to undertake such education or compliance program as the Panel thinks fit, provided that the purpose of such program is to reduce the likelihood of future breaches by the Member;

(i) expel the Member from membership of the College;

(j) adjourn the proceeding subject to compliance with such conditions as to sanctions as the Panel may otherwise impose in accordance with the ACCS Rules;
(l) order the Member to reimburse a patient; or
(m) impose any other Order that the Panel thinks fit.

5.29 Where the Panel considers the matter to involve a serious risk to public safety and patient welfare it must refer the matter to the relevant regulatory authorities in the relevant State or Territory.

5.30 Where the Panel is of the view that a Member has unreasonably failed or refused to co operate with the Panel then that non-cooperation can be held to be a breach of the Code and the Panel can impose an appropriate sanction until such time as the Member cooperates.

5.31 The Panel can award reasonable costs at its discretion against an ACCS Member involved in the matter before it.

5.32 The Panel shall have a pre-sentence process, to relay likely sanctions to the Member complained of, and give that Member an opportunity to state any objections to likely sanctions.

5.33 When determining any sanction, the Panel may take into consideration any penalty imposed on the Member as a result of external legal proceedings brought against that Member in relation to the same matter.

5.34 A suspended Member must comply with the ACCS CME requirements and provide a return for each year as normally required.

5.35 If a suspended Member breaches the conditions of suspension, then the penalty shall be expulsion from Membership.

5.36 The Panel shall have the power to stay any sanction pending an appeal. The member involved in an appeal must apply to the Panel for a stay and provide reasons for a stay or partial stay.

Notification of Decision

5.37 The Member complained of and the party who instigated the complaint shall be informed in writing of the Panel's decision, the reasons for the decision, and any rights of appeal against the decision.

5.38 The Panel will issue a written determination within 30 days of its decision.

5.39 The Member concerned shall be provided with a copy of the Panel's written determination.

Appeals Committee

5.40 The Appeals Committee, shall be a three-member appeal body, including the Chair, appointed from time to time by ACCS Council. The Chair, who must possess legal qualifications, shall be appointed by Council. The Committee is not to be a standing Committee, but established when there is an appeal.

5.41The Chair will recommend the other two members to the Council. The Council will accept the recommendations unless any appointments raise issues of conflict of interest. One member recommended by the Chair shall be an ACCS member with relevant experience in the matter before the Committee.

Appeal Process

5.42 The Member complained of may, within 21 days of being notified of the Panel's decision, appeal against that decision by notice in writing to the Chair of the Appeals Committee.

5.43The College can also appeal a Panel decision and must do so within 21 days of the decision.

5.44 The Chair of the Appeals Committee shall notify the Chair of the Complaints Panel when an appeal has been lodged and shall request copies of the relevant correspondence and records of proceedings held by that Panel. This documentation may include:
(a) the original complaint;
(b) the charge formulated from this complaint;
(c) all correspondence and written evidence in relation to the matter and;
(d) the record of the Panel's hearing, if any.
.
5.45 This material will be provided to the Appellant.

5.46 The Chair of the Committee will also advise the original Complainant of an appeal being lodged.

5.47 The Appellant is to notify in writing the basis of the appeal including all documentation within 21 days of lodging the appeal. If the Appellant considers more time is necessary to prepare the appeal, the Appellant may submit a request in writing to the Chair of the Appeals Committee for an extension of time.

5.48 Parties to the appeal, other than the Appellant, shall provide written responses to the Appellant's submission within timeframes determined by the Chair of the Appeals Committee.

5.49 If the Appellant does not comply with the timeframe determined by the Appeals Committee Chair and an approval for extension of time has not been granted by the Chair of the Appeals Committee, the appeal shall be deemed to be abandoned and the parties informed accordingly in writing.

5.50 Where the Chair of the Appeals Committee is of the view that the material submitted by the Appellant does not support a valid appeal, the Chair can dismiss the appeal and inform the parties in writing,

Withdrawal of Appeal

5.51 An Appellant may withdraw an appeal by giving notice in writing to the Chair of the Appeals Committee.

5.52 A withdrawal must be received no later than seven days before the day scheduled for any hearing. After this time the Appellant will be responsible for any costs incurred by the Appeals Committee.

Conduct of Appeal Hearing

5.53 The procedure and conduct of the appeal hearing will be at the discretion of the Chair of the Appeals Committee, including the involvement of the original Complainant.

5.54 The Appeals Committee will not, except where the Committee requests additional material, accept any additional material once the hearing has commenced.

5.55 Appellants may be represented by legal counsel or other person on terms and conditions set by the Appeals Committee.

Consequences of Appeal

5.56 The Appeals Committee may uphold the appeal, dismiss the appeal or may vary the sanction imposed by the Panel.

5.57 The Appeals Committee must give written reasons for its decision.

5.58 The ACCS Council must be informed of the Appeals Committee's decision.

Action by Council

5.59 The ACCS Council cannot overrule or vary the decision of the Appeals Committee.

Costs Awarded by the Appeals Committee

5.60 Reasonable costs of the appeal may be awarded by the Appeals Committee, either in favour of the Appellants or against the Appellants;

Notification to Parties

5.61 The Chair of the Committee shall advise the parties of the Appeals Committee's decision in writing. The original Complainant is also to be advised of the outcome of any appeal.

Quorums

5.62 A decision of the Appeals Committee shall not be invalidated in consequence of a vacancy in its membership or the absence of any member provided that the decision is made by at least two Members, including the Chair of that Committee.

Keeping Complainants informed

5.63 The College may keep a person instigating a complaint informed of progress in handling the complaint, provided always that the College must not provide any information to a Complainant in relation to the progress of the complaint where:

(a) to do so may expose the College or the Complaints Panel or Appeals Committee to liability for civil damages;

(b) to do so would or could prejudice, impede or in any other manner adversely affect the investigation of the complaint or;

(c) to do so would deny procedural fairness to the Member, the subject of the complaint.

6. Publication of decisions

6.1 The College must maintain a Register of all determinations made by the Complaints Panel and the Appeals Committee and make the Register available for inspection by Members and relevant regulatory authorities. otherwise make available

6.2 The College may, publish to Members, any other persons or the public generally the content of, or an extract from, or précis of, any determinations by the Complaints Panel and the Appeals Committee and the register maintained by the College.

6.3 The College shall publish regular information about the outcome of disciplinary matters including an annual overview of the operation of the Colleges disciplinary regime.

6.4 Where a Member has been suspended or expelled the College shall advise relevant State and Territory Medical Boards.

7. Indemnities

7.1 The College will indemnify each member of the Panel and Appeal Committee against any claim, action or proceeding brought against that person by any other person arising out of or in connection with, a proceeding before the Panel or Committee, or any order, determination or decision made by the Panel or

Committee, and this indemnity will extend to the conduct of the defence of any proceedings and the payment of any costs thereof.

7.2 The indemnity does not extend to actions brought by the College against any person.

8. Annual Report

8.1 The Complaints Panel and Appeals Committee shall submit an Annual Report to the ACCS.

8.2 Those Annual Reports will also be submitted to the ACCC.

8.3 Those Reports will be provided to the Code Administration Committee.

9. Assistance to the Complaints Panel and Committees

9.1 The College will provide appropriate resources to the Complaints Panel and Appeals and Code Administration Committees in order for them to undertake their tasks.

10. Compliance Audits

10.1 The College will engage an independent person to undertake periodic audit checks in relation to compliance with the Code, in particular, issues relating to informed consent, information provided to potential customers and claims made about procedures and need for procedures.

10.2 Such audit checks will include random checks on Members.

10.3 Apparent breaches of the Code so discovered are to be referred to the Complaints Panel as if they were complaints.

10.4 The results of such audits are to be provided to the Code Administration Committee.

11. Enforcement

11.1 The College Council will enforce any Orders of either the Panel or the Appeals Committee.

11.2 Where a Member fails or refuses to comply with an Order of the Panel or the Appeals Committee, the Council will either suspend or expel the Member, as the Council deems appropriate.

ACCS MARCH 2009

Appendix 10. ANZCA Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures

Australian and New Zealand College of Anaesthetists Professional Document - PS9 (2008)
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For an up-to-date version, go to: http://www.anzca.edu.au/resources/professional-documents

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852
GASTROENTEROLOGICAL SOCIETY OF AUSTRALIA
ABN 44 001 171 115
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS
ABN 29 004 167 766

Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical or Surgical Procedures

This document is intended to apply wherever procedural sedation and/or analgesia for diagnostic and interventional medical and surgical procedures are administered, especially where sedation and/or analgesia may lead to general anaesthesia. The Australian and New Zealand College of Anaesthetists recognises that practitioners with diverse qualifications and training are administering a variety of medications to patients to allow such procedures to be performed. This document addresses pertinent issues for all practitioners involved in such activities.

1. DEFINITIONS

1.1 **Procedural sedation and/or analgesia** implies that the patient is in a state of drug-induced permissiveness of uncomfortable or painful diagnostic or interventional medical or surgical procedures. Lack of memory of distressing events and/or analgesia are desired outcomes, but lack of response to painful stimulation is not assured.

1.1.1 **Conscious Sedation** is defined as a drug-induced depression of consciousness during which patients are able to respond purposefully to verbal commands or light tactile stimulation. No interventions are usually required to maintain a patent airway, spontaneous ventilation or cardiovascular function. Conscious sedation may be achieved by a wide variety of techniques including propofol and may accompany local anaesthesia. All conscious sedation techniques should provide a margin of safety that is wide enough to render loss of consciousness unlikely.

1.1.2 **Deep levels of sedation**, where consciousness is lost and patients only respond to painful stimulation, are associated with loss of the ability to maintain a patent airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. Deep levels of sedation may have similar risks to general anaesthesia, and may require an equivalent level of care.

1.1.3 **Analgesia** is reduction or elimination of pain perception, usually induced by drugs which act locally (by interfering with nerve conduction) or generally (by depressing pain perception in the central nervous system).

1.2 **General Anaesthesia** is a drug-induced state characterised by absence of response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes. General anaesthesia is sometimes indicated during diagnostic or interventional medical or surgical procedures and requires the exclusive attention of an anaesthetist (see College Professional Document T1 – Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations).

2. AIMS AND RISKS OF PROCEDURAL SEDATION AND/OR ANALGESIA

The aims of procedural sedation and/or analgesia are to ensure patient safety and comfort, and to facilitate completion of the planned procedure. In order to achieve these aims, a range of sedation options may be required during any one procedure, with a continuum from no medication, through conscious sedation and deep sedation, to general anaesthesia. While no sedation or conscious sedation with small doses of drugs such as benzodiazepines and opioids are options for some patients and proceduralists, many patients and proceduralists want deep levels of sedation or general anaesthesia to be an option during each procedure.

Practitioners authorised or credentialled to administer procedural sedation and/or analgesia should be aware that the transition from complete consciousness through the various depths of sedation to general anaesthesia is a continuum and not a set of discrete, well-defined stages. The margin of safety of drugs used to achieve sedation and/or analgesia varies widely between patients and loss of consciousness with its attendant risk of loss of protective reflexes may occur rapidly and unexpectedly. Therefore practitioners who administer sedative or analgesic drugs that alter the conscious state of a patient must be prepared to manage the following potential risks:

2.1 Depression of protective airway reflexes and loss of airway patency.

2.2 Depression of respiration.

2.3 Depression of the cardiovascular system.

2.4 Drug interactions or adverse reactions, including anaphylaxis.

2.5 Individual variations in response to the drugs used, particularly in children, the elderly, and those with pre-existing medical disease.

2.6 The possibility of deeper sedation or anaesthesia being used to compensate for inadequate analgesia or local anaesthesia.

2.7 Risks inherent in the wide variety of procedures performed under procedural sedation and/or analgesia.

2.8 Unexpected extreme sensitivity to the drugs used for procedural sedation and/or analgesia which may result in unintentional loss of consciousness, respiratory or cardiovascular depression.

Over-sedation, airway obstruction, respiratory or cardiovascular complications may occur at any time. Therefore, to ensure high standards of quality safe patient care, the following guidelines are recommended.

3. PATIENT PREPARATION

3.1 The patient should be provided with written information which includes the nature and risks of the procedure, preparation instructions (including the importance of fasting), and what to expect during the immediate and longer term recovery period, including after discharge.

3.2 Informed consent for sedation and/or analgesia and for the procedure should be obtained (see College Professional Document PS26 – *Guidelines on Consent for Anaesthesia or Sedation*).

4. PATIENT ASSESSMENT

4.1 All patients should be assessed before procedural sedation and/or analgesia. Assessment should include:

4.1.1 Details of the current problem, co-existing and past medical and surgical history, history of previous sedation and anaesthesia, current medications (including non-prescribed medications), allergies, fasting status, the presence of false, damaged or loose teeth, or other evidence of potential airway problems.

4.1.2 Examination, including that relevant to the current problem, of the airway, respiratory and cardiovascular status, and other systems as indicated by the history.

4.1.3 Results of relevant investigations.

4.2 This assessment should identify those patients at increased risk of cardiovascular, respiratory or airway compromise during procedural sedation and/or analgesia, as in such cases, an anaesthetist should be present to care for the patient. These patients include the elderly, those with severely limiting heart, cerebrovascular, lung, liver or renal disease, morbid obesity, significant obstructive sleep apnoea, or known or suspected difficult endotracheal intubation, acute gastrointestinal bleeding with cardiovascular compromise or shock, severe anaemia, the potential for aspiration of stomach contents (which may necessitate endotracheal intubation), previous adverse events due to sedation, analgesia or anaesthesia, and patients in ASA Grades P 4-5 (see Appendix I). See also College Professional Document PS7 – *Recommendations on the Pre-Anaesthesia Consultation*.

5. STAFFING

5.1 There must be a minimum of three appropriately trained staff present: the proceduralist, the practitioner administering sedation and monitoring the patient, and at least one additional staff member to provide assistance to the proceduralist and/or the practitioner providing sedation as required.

5.2 The assistant to the practitioner administering sedation/anaesthesia must be exclusively available to the practitioner at induction of and emergence from sedation/anaesthesia, and during the procedure as required. If general anaesthesia is intended, and especially in emergency situations where endotracheal intubation is planned, a fourth person to specifically assist the practitioner throughout the procedure is required. (See College Professional Document PS8 *Guidelines on the Assistant to the Anaesthetist*)

5.3 The practitioner administering procedural sedation and analgesia requires sufficient training to be able to:

5.3.1 Understand the actions of the drugs being administered, and be able to modify the technique appropriately in patients of different ages, or in the case of concurrent drug therapy or disease processes.

5.3.2 Monitor the patient's level of consciousness and cardiorespiratory status.

5.3.3 Detect and manage appropriately any complications arising from sedation.

5.4 A medical practitioner who is skilled in airway management and cardiopulmonary resuscitation must be present whenever procedural sedation and/or analgesia are administered.

5.5 Techniques intended to produce deep sedation or general anaesthesia must not be used unless an anaesthetist is present (see College Professional Documents PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*, PS2 *Statement on Credentialling in Anaesthesia*, PS8 *Guidelines on the Assistant to the Anaesthetist*, PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*, TE3 *Policy on Supervision of Clinical Experience for Trainees in Anaesthesia,* T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations).*

5.6 In situations other than those when an anaesthetist must be present (noted in 4.2 and 5.5), administration of sedation and/or analgesia and monitoring of the patient should be performed by an appropriately trained medical practitioner other than the proceduralist.

5.7 If an appropriately trained medical practitioner is not present solely to administer sedation and/or analgesia and monitor the patient, there must be an assistant to the proceduralist present during the procedure, who is appropriately trained in observation and monitoring of sedated patients, and in resuscitation, and whose sole duty is to monitor the level of consciousness and cardiorespiratory status of the patient. This person may, if appropriately trained, administer sedative and/or analgesic drugs under the direct supervision of the proceduralist, who must have advanced life support skills and training (see 5.4). If loss of consciousness, airway obstruction or cardiorespiratory insufficiency occur at any time, all staff must devote their entire attention to monitoring and treating the patient until recovery, or until such time as another medical practitioner becomes available to take responsibility for the patient's care.

6. FACILITIES AND EQUIPMENT

The procedure must be performed in a location which is adequate in size, and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

6.1 Adequate room to perform resuscitation should this prove necessary.

6.2 Appropriate lighting.

6.3 An operating table, trolley or chair which can be tilted head down readily.

6.4 An adequate suction source, catheters and handpiece.

6.5 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

6.6 A means of inflating the lungs with oxygen (e.g. a self-inflating bag) together with a range of equipment for advanced airway management (e.g. masks, oropharyngeal airways, laryngeal mask airways, laryngoscopes, endotracheal tubes).

6.7 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment and fluids (See Appendix II).

6.8 Drugs for reversal of benzodiazepines and opioids.

6.9 A pulse oximeter.

6.10 A sphygmomanometer, or other device for measuring blood pressure.

6.11 Ready access to an ECG and a defibrillator.

6.12 A means of summoning emergency assistance.

6.13 Within the facility there should be access to devices for measuring expired carbon dioxide.

(See College Professional Documents T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*, PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*.)

7. TECHNIQUE AND MONITORING

7.1 Reliable venous access should be in place for all procedures when procedural sedation and/or analgesia are used.

7.2 As most complications of sedation are cardiorespiratory, doses of sedative and analgesic drugs should be kept to the minimum required for patient comfort, particularly for those patients at increased risk.

7.3 Monitoring of the patient's response to verbal commands must be routine. Loss of patient response to verbal commands indicates that loss of airway reflexes, respiratory and/or cardiovascular depression are likely.

7.4 All patients undergoing procedural sedation and/or analgesia must be monitored continuously with pulse oximetry and this equipment must alarm when appropriate limits are transgressed.

7.5 There must be regular recording of pulse rate, oxygen saturation and blood pressure throughout the procedure in all patients.

7.6 According to the clinical status of the patient, other monitors such as ECG or capnography may be required (see College Professional Document PS18 *Recommendations on Monitoring During Anaesthesia*).

8. OXYGENATION

Hypoxaemia may occur during procedural sedation and/or analgesia without oxygen supplementation. Oxygen administration diminishes hypoxaemia during procedures carried out under sedation /or analgesia, and must be used in all patients. Pulse oximetry enables the degree of tissue oxygenation to be monitored and must be used in all patients during procedural sedation and/or analgesia.

9. MEDICATIONS

A variety of drugs and techniques are available for procedural sedation and/or analgesia. The most common intravenous agents used are benzodiazepines (such as midazolam) for sedation and opioids (such as fentanyl) for analgesia. Even small doses of these drugs may result in loss of consciousness in some patients. Special care is required when local anaesthesia of the larynx and/or pharynx has been administered to facilitate the procedure.

Intravenous anaesthetic agents such as propofol must only be used by a second medical practitioner trained in their use because of the risk of unintentional loss of consciousness. These agents must not be administered by the proceduralist.

10. DOCUMENTATION

The clinical record should include the names of staff performing sedation and/or analgesia, with documentation of the history, examination and investigation findings. A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near the time of administration of the drugs as possible. This record should also note the regular readings from the monitored variables, including those in the recovery phase, and should contain other information as indicated in the College Professional Document PS6 *Recommendations on the Recording of an Episode of Anaesthesia Care***.**

11. RECOVERY AND DISCHARGE

11.1 Recovery should take place under appropriate supervision in a properly equipped and staffed area (see College Professional Document PS4 *Recommendations for the Post-Anaesthesia Recovery Room*).

11.2 Adequate staffing and facilities must be available in the recovery area for managing patients who have become unconscious or who have suffered complications during the procedure.

11.3 Discharge of the patient should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner. The patient should be discharged into the care of a responsible adult to whom written instructions should be given, including advice about eating and drinking, pain relief, and resumption of normal activities, as well as about making legally-binding decisions, driving, or operating machinery.

11.4 A system should be in place to enable safe transfer of the patient to appropriate medical care should the need arise.

12. TRAINING IN PROCEDURAL SEDATION AND/OR ANALGESIA FOR NON-ANAESTHETIST MEDICAL PRACTITIONERS

It is recommended that non-anaesthetist medical practitioners wishing to provide procedural sedation/analgesia should have received a minimum of 3 months full time equivalent supervised training in procedural sedation and/or analgesia and anaesthesia. They should participate in a process of In-Training and Competency Assessment. Training should include completion of a crisis resource management simulation centre course.

It is recognised that there will be non-anaesthetist medical practitioners who have had many years experience in procedural sedation and/or analgesia, but who may not have had a period of formal supervised training as described. Such longstanding clinical experience may be deemed equivalent to a formal period of training as described.

Credentialling, training and clinical support of such medical practitioners should receive close cooperation from nominated anaesthetists in the hospital or centre.

Annual certification in advanced cardiac and life support, and evidence of relevant Continuing Professional Development, are required for credentialling.

13. REFERENCES

The following references provide evidence to support the recommendations made in this document.

AGA Institute (Cohen LB et al.). AGA Institute review of endoscopic sedation. Gastroenterology 2007; 133: 675-701

American College of Radiology (Towbin et al.). ACR practice guideline for adult sedation/analgesia.<www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/iv/adult_sedation.aspx> 2005

American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists (Gross JB et al.). Practice guidelines for sedation and analgesia by non-anesthesiologists. Anesthesiology 2002; 96: 1004-1017

American Society of Anesthesiologists. Statement on granting privileges for administration of moderate sedation to practitioners who are non anaesthesia professionals. <www.asahq.org/publicationsAndServices/standards/40.pdf> 2006

American Society for Gastrointestinal Endoscopy (Chutkan R et al.). Training guideline for use of propofol in gastrointestinal endoscopy. Gastrointestinal Endoscopy 2004; 60: 167-172

American Society for Gastrointestinal Endoscopy (Vargo JJ et al.). Training in patient monitoring and sedation and analgesia. Gastrointestinal Endoscopy 2007; 66: 7-10

Clarke AC, Chiragakis L, Hillman LC, Kaye GL. Sedation for endoscopy: the safe use of propofol by general practitioner sedationists. Medical Journal of Australia 2002; 176: 159-162

Faigel DO, Pike IM, et al. Quality indicators for gastrointestinal endoscopic procedures: an introduction. Gastrointestinal Endoscopy 2006; 63 (4 Suppl.): S3-S9

Qadeer MA, Vargo JJ, Khandwala F, Lopez R, Zuccaro G. Propofol versus traditional sedative agents for gastrointestinal endoscopy: a meta-analysis. Clinical Gastroenterology & Hepatology 2005; 3: 1049-1056

Rex DK Review article: moderate sedation for endoscopy: sedation regimens for non-anaesthesiologists. Alimentary Pharmacology & Therapeutics 2006; 24: 163-171

All College Professional Documents must be complied with, but particular note should be taken of the following:

PS1 *Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia*

PS2 *Statement on Credentialling in Anaesthesia*

PS4 *Recommendations for the Post-Anaesthesia Recovery Room*

PS6 *The Anaesthesia Record. Recommendations on the Recording of an Episode of Anaesthesia Care*

PS7 *Recommendations on the Pre-Anaesthesia Consultation*

PS8 *Guidelines on the Assistant to the Anaesthetist*

PS15 *Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery*

PS16 *Statement on the Standards of Practice of a Specialist Anaesthetist*

PS18 *Recommendations on Monitoring During Anaesthesia*

PS26 *Guidelines on Consent for Anaesthesia or Sedation*

T1 *Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations*

TE3 *Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia*

APPENDIX I

The American Society of Anesthesiologists' classification of physical status:

P 1 A normal healthy patient

P 2 A patient with mild systemic disease

P 3 A patient with severe systemic disease

P 4 A patient with severe systemic disease that is a constant threat to life

P 5 A moribund patient who is not expected to survive without the operation

P 6 A declared brain-dead patient whose organs are being removed for donor purposes

E Patient requires emergency procedure

Excerpted from American Society of Anesthesiologists Manual for Anesthesia Department Organization and Management 2003-04. A copy of the full text can be obtained from ASA, 520 N Northwest Highway, Park Ridge, Illinois 60068-2573

APPENDIX II

Emergency drugs should include at least the following:

adrenaline

atropine

dextrose 50%

lignocaine

naloxone

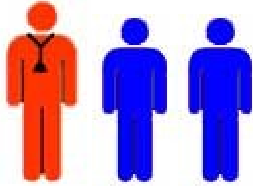
flumazenil

portable emergency O2 supply

APPENDIX III

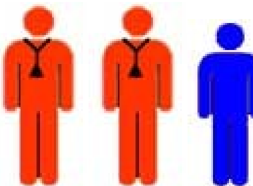
Personnel for Procedural Sedation and Analgesia

Scenario 1: Three practitioners – Sedation by Proceduralist



- Medical practitioner proceduralist with airway and resuscitation skills, and training in sedation
- Practitioner with training in monitoring sedation
- Assistant to assist both
- Conscious sedation in ASA P 1-2 patients
- Propofol, thiopentone and other intravenous anaesthetic agents must not be used

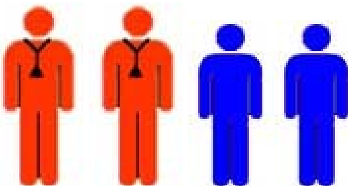
Scenario 2: Three practitioners – Sedation by Medical Practitioner



Proceduralist

- Medical practitioner with airway and resuscitation skills, and training in sedation
- Assistant to assist both
- Conscious sedation in ASA P 1-2 patients
- Propofol, thiopentone and other intravenous anaesthetic agents may only be used by a medical practitioner trained in their use

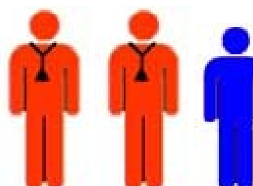
Scenario 3: Four practitioners – Sedation by Medical Practitioner



Proceduralist

- Medical practitioner with airway and resuscitation skills, and training in sedation
- Assistant to assist each*
- Conscious sedation in ASA P 1-3 patients #
- Propofol, thiopentone and other intravenous anaesthetic agents may only be used by a medical practitioner trained in their use

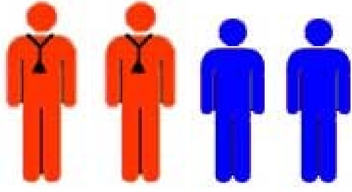
Scenario 4: Three practitioners – Sedation by Anaesthetist



Proceduralist

- Anaesthetist
- Assistant to assist both
- Conscious, deep sedation or general anaesthesia in all patients
- All approved anaesthetic drugs may be used

Scenario 5: Four practitioners – Sedation by Anaesthetist



Proceduralist
- Anaesthetist
- Assistant to assist ***each****
- Conscious sedation, deep sedation or general anaesthesia in all patients
- All approved anaesthetic drugs may be used

**** Recommended if assistance is likely to be required for the majority of the case (e.g. complex or emergency patients)***

#Please refer to Section 4.2

COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:
TE Training and Educational
EX Examinations
PS Professional Standards
T Technical

POLICY *– defined as 'a course of action adopted and pursued by the College'. These are matters coming within the authority and control of the College.*

RECOMMENDATIONS *– defined as 'advisable courses of action'.*

GUIDELINES *– defined as 'a document offering advice'. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.*

STATEMENTS *– defined as 'a communication setting out information'.*

This document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this document in each case.

Professional documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Professional documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that 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.

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Reviewed: 1991, 1996, 2001, 2005
Date of current document: Feb 2008
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