

10. APPENDICES

Appendix A: Governance

i. Code of conduct

SASA member code of conduct for anaesthesia professionals

Health Professions Council guidelines

SASA expects its members to adhere to all Health Professions Council of South Africa (HPCSA) rules and regulations regarding good professional and ethical practice. This document is to be read in conjunction with the HPCSA guidelines pertaining to good practice, ethical rules, etc. (<http://www.hpcsa.co.za/conduct/ethics>). This incorporates the Generic Ethical Rules, Good Practice Guidelines, Patients' Rights Charter, and other relevant guidelines.

Oath of care

Anaesthesia professionals are bound by the shared spirit and principles underlying the various oaths subscribed to by newly qualified healthcare professionals (i.e., revised Hippocratic Oath, and others). This social contract holds healthcare providers to a strict code of professional and personal conduct, forming the pillars of the SASA Code of Conduct for Anaesthesia professionals.

The practice of anaesthesia has its own, inherently unique demands and challenges regarding the nature of patient interaction, standards of care, quality of service delivery, safety requirements, and inter-collegial relationships. This Code of Conduct outlines the commitment every SASA member makes to ethical practice.

Basic components of ethical practice

An anaesthesia professional has ethical responsibilities to:

- Patients
- Colleagues and community
- Him-/herself
- Healthcare fraternity
- Workplace

Responsibilities to patients

- Always place the patient's interests foremost.
- Be truthful to patients.
- Appreciate and respect the patient's supreme rights in medical decision-making, appropriate to the patient's developmental capacity and medical circumstances. Medical knowledge and skills should never be used to coerce or restrain patients with adequate decision-making capacity.
- Appreciate that patients are extremely vulnerable in the perioperative period. Take care of the patient's physical and psychological wellbeing. The patient's right to dignity, privacy, and comfort is paramount. Patients should always be treated with respect, regardless of their state of consciousness.

- Honour confidentiality regarding medical and personal information.
- Honour and respect religious and cultural beliefs and be sensitive in this regard in the provision of treatment.
- Provide appropriate postanaesthesia care, as and when applicable.
- Provide emergency care for all patients, irrespective of the patient's financial status.

Responsibilities to colleagues and community

- Promote respectful and cooperative relationships with colleagues and healthcare workers to the benefit of patients.
- Consult with colleagues as and when appropriate.
- Cooperate and participate with colleagues to improve the quality and efficiency of anaesthesia care, and medical care in general.
- Advise and assist impaired/suspected impaired colleagues within the boundaries of your own abilities, to the benefit of patients.
- Immediately and adequately address any dangerous/negligent practices that potentially endanger patients and/or healthcare personnel. This includes reporting a colleague to the relevant authority, sooner rather than later.
- Participate in keeping potentially dangerous substances secure from illicit use.

Responsibilities to yourself

- Maintain competence and skill as is necessary in your practice.
- Take responsibility for your own mental and physical wellness.
- Seek timeously assistance, evaluation, and care when in doubt about your own health and wellness.
- Seek timeous assistance and support when in doubt about your own clinical competence, be this in general, case or skill(s) specific.
- Modify or cease practice when incapacitated in any way that has the potential to be detrimental to patients.
- Take responsibility for your personal financial protection and wellbeing, preventing financial needs from interfering with clinical decision-making.

Responsibilities to the healthcare fraternity

- Refrain from seeking or accepting potentially compromising donations, gifts, or sponsorships from any source.
- Avoid placing yourself in a position of perversity, potential position of perversity, or potentially perceived perversity.
- Declare all donations, gifts, or sponsorships where the potential exists for undue influencing, or perceived influencing. This is specifically expected from faculty at events, conferences, and congresses. Any interest, whether perceived as a direct influence on the topic or not, should be declared at the start of a presentation.
- Adhere to ethical and consistent billing practices, refraining from overreaching and overservicing practices. Additionally,

appreciate your responsibility as an anaesthesia professional in seeking cost-saving treatment mechanisms.

- Appropriately inform patients regarding cost and your billing practices, where possible, in order for the patient to make an informed financial decision.
- Refrain from participating in exploitative financial relationships.

Responsibilities in the workplace

- Dress appropriately and always maintain yourself in a clean, dignified, and presentable manner.
- Treat your co-workers with respect, including colleagues, nursing staff, cleaners, porters, etc.
- Refrain from using inappropriate and derogatory language and behaviour, in whatever situation.
- Maintain absolute professional conduct in theatre and in the workplace and refrain from doing anything that may make co-workers unhappy or uncomfortable.

This code of conduct represents the principles, values, and norms to be practised and maintained by all anaesthesia professionals as SASA members. The purpose of the code is to provide a clear framework within which SASA members are expected

to conduct themselves. Continuous self and peer assessment against this code of conduct serves the best interest of patient and practitioner, contributing towards a healthy and prosperous anaesthesia community in South Africa.

ii. Scarce skills: anaesthetic services

Specialist anaesthesiologists in SA

South Africa has an overall skills shortage, a problem significantly visible in the healthcare sector. The figure below published in 2015 by Econex on behalf of the Hospital Association of South Africa expresses the number of doctors per 100 000 citizens in various countries in 2013.

On average, South Africa has far fewer doctors per 100 000 population than any other BRICS (Brazil, Russia, India, China and South Africa) country – by 10 when compared to India and less than half of that of Brazil.

Importantly, from a SASA perspective, as a majority specialist representative society, the number of specialists per 100 000 citizens paints a woeful picture. When compared with multiple Organization for Economic Cooperation and Development (OECD) countries and resource-rich countries providing forms of national health insurance, the South African workforce of

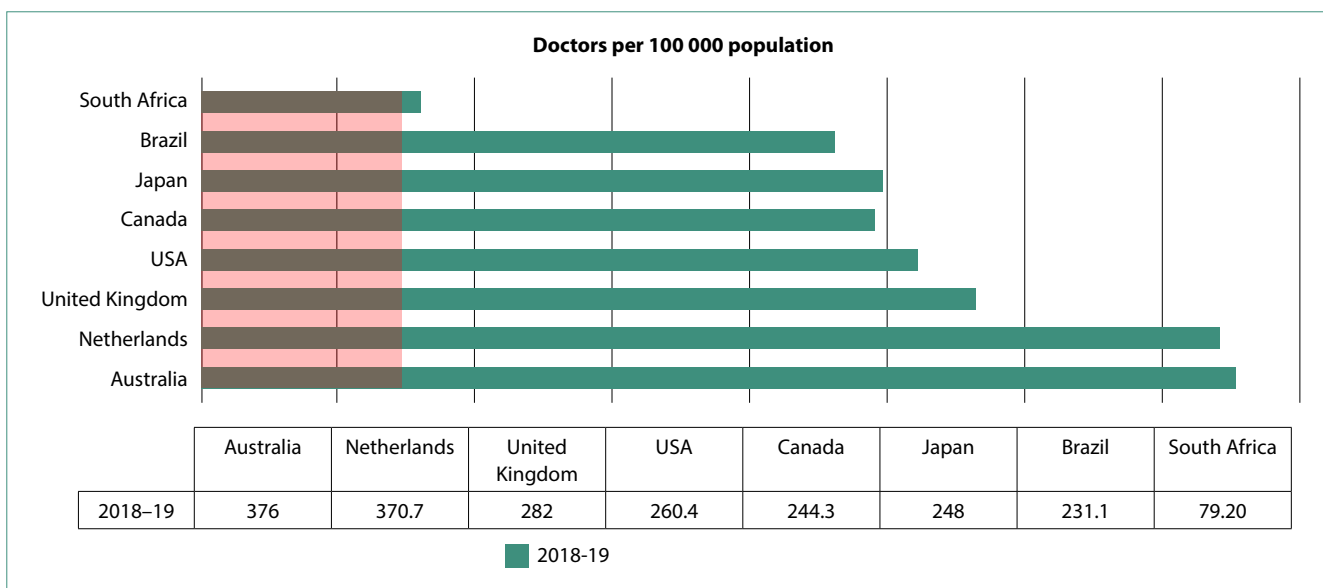


Figure 1: Country comparison – All doctors per 100 000 citizens (2018–19)

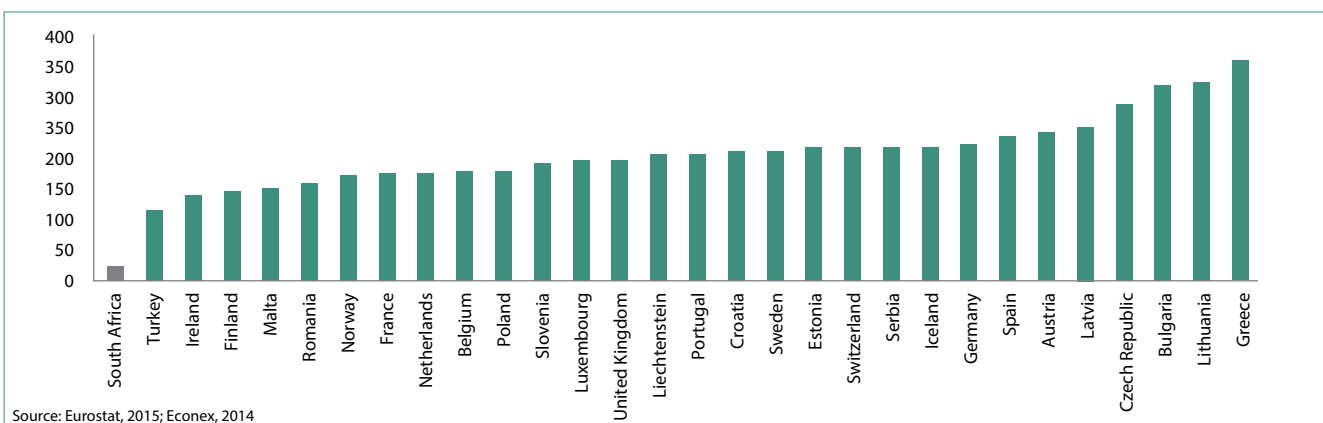


Figure 2: Number of specialists per 100 000 citizens in developed countries and South Africa (2011)

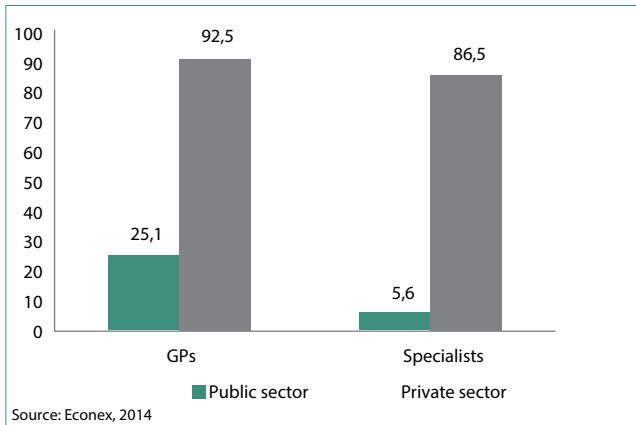


Figure 3: Number of doctors in the public sector per 100 000 citizens, relative to the number of doctors in the private sector per 100 000 beneficiaries (2013)

specialists is one-eighth to one-tenth of countries whose public health systems are considered to function effectively under a national health insurance scheme.

When considering public vs private sectors, there remains a considered opinion that a high-capacity workforce exists in the private sector that may, or is likely to, be able to meaningfully work and cope with the shortfall of service available in the public sector. While various options may exist to address such a shortfall, the figure above indicates that approximately 86.5 specialists per 100 000 citizens currently exist in the privately insured/funded market of 8 800 000 lives. When assessing this number in conjunction with the prior figure, it is clear that at this ratio in the private sector, the number of specialists to population ratio remains less than half of almost all OECD countries' ratios that

provide social national health insurance.

This skills shortage has a significant impact on the number of people receiving surgery, especially in the public sector in South Africa. The comment published in *The Lancet* by Dare, Onajin-Obembe and Makasa, on the perioperative patient outcomes in the African Surgical Outcomes Study: (ASOS): a 7-day prospective observational cohort study by Biccard et al., quantifies this issue for Africa:

"In the study countries, the average provider-to-population density of specialist surgeons, anaesthetists, and obstetricians (another core surgical indicator) was around 30 times lower than the recommended global minimum."

Although the main aim of Biccard and colleagues' study was to quantify surgical outcomes, the most alarming finding was how few people received surgery. Surgical volume (the number of operations per 100 000 population) is an indicator of met need for surgical care. The ASOS findings suggested that this is unacceptably low in Africa. Among the 25 countries that contributed data, only a median of 212 operations (IQR 65–578) were done per 100 000 catchment population. These numbers are 20 times lower than the crucial surgical volume required to meet a country's essential surgical needs each year (defined as 5 000 operations per 100 000 people).

Bibliography

- Biccard BM, Madiba TE, Kluyts H-L, et al. Perioperative patient outcomes in the African Surgical Outcomes Study: a 7-day prospective observational cohort study. *Lancet*. 2018;391(10130):1589-98. [https://doi.org/10.1016/S0140-6736\(18\)30001-1](https://doi.org/10.1016/S0140-6736(18)30001-1).
- Econex, 2014
- Eurostat, 2015; Econex, 2014
- World Health Organisation, 2014

iii. Safety incident reporting and learning

This document is only available as part of the online publication of the SASA Practice Guidelines 2022 Revision on www.sasaweb.com.

iv. Core standards

This document is only available as part of the online publication of the SASA Practice Guidelines 2022 Revision on www.sasaweb.com.

v. Peer review document

This document is only available as part of the online publication of the SASA Practice Guidelines 2022 Revision on www.sasaweb.com

Appendix B: Standard for equipment/facilities guides

IUSS Health Facilities Guides

This is available at: <https://www.sasaweb.com>

Appendix C: Sedation

These guidelines are available at:

- [SASA Guidelines](#) for the safe use of procedural sedation and analgesia for diagnostic and therapeutic procedures in adults: 2020–2025
 - [SASA paediatric guidelines](#) for the safe use of procedural sedation and analgesia for diagnostic and therapeutic procedures in children: 2021–2026)
-

Appendix D: Facilities agreements

This is available at:

[SASA Facilities Group Agreement](#)

[SASA Clinical Service Provider Facilities Group Agreement](#)

Appendix E: Day-case surgery

This is available at: <https://www.sasaweb.com>

Appendix F: Position statements

i. Ketamine clinics

2022 review by Sekai Ndemera

Ketamine administration for severe depression as either a stand-alone therapy or in combination with electroconvulsive therapy (ECT) has been widely accepted in South Africa and worldwide as an evidence-based treatment modality.

Anaesthesiologists are increasingly being asked to assist with delivering ketamine as *therapy* in these specific situations.

Typically, the psychiatrist treating the patient will prescribe and monitor the effects of ketamine on the patient's general mood and condition, using the anaesthesiologist to administer the ketamine therapy after organising a suitable facility for the therapy to take place.

Initially, this was a hospital-based treatment provided only in standard operating theatres. Over time there has been a proliferation of satellite and "stand-alone" clinics offering ketamine infusions.

SASA has addressed this development with patient safety as a primary concern.

Ketamine is classified as an anaesthetic drug, and as a result, its use requires qualified sedationists.

The use of ketamine in this manner falls under the practice of procedural sedation and anaesthesia.

The SASA Sedation Guidelines published in April 2020 clearly address the conditions necessary for the use of anaesthetic drugs during procedural sedation. The Society believes the same should be extrapolated to the use of ketamine infusions.

General anaesthesia induction agents (propofol, ketamine, etomidate, dexmedetomidine) and short-acting opioids (fentanyl, alfentanil, sufentanil, remifentanil) should only be used by those formally trained in anaesthesia or intensive care medicine, or by experienced sedation practitioners with experience in anaesthesia who are trained in specific advanced sedation techniques. Sedation practitioners using these drugs must have at least a qualification in advanced life support.

Any practitioner involved in these ketamine infusions must ensure that the facilities in which they practice comply with SASA Sedation Guidelines, SASA Practice Guidelines and SASA Private Practice Guidelines.

The monitoring, equipment needed, safety requirements and staff needed for these therapy sessions are dealt with in the SASA sedation guidelines and are typically the same as those needed for routine ECT.

Proper history taking, examination and consent should be standard practice. Appropriate monitoring should be utilised. The dose quoted in the literature ranges from 0.10–0.75 mg/kg, administered over about 40 minutes. Repeat sessions are common and guided by the psychiatrist.

A responsible adult must accompany the patient home, and only once the patient meets the required discharge criteria. Sedation must not be administered if an escort is not available. Carers must be advised to seek immediate help in case of complications.

Contact details of a physician, hospital, and ambulance service in case of any procedure- or sedation-related adverse events in the first 24 hours after sedation must be included in the information package on discharge.

Patient safety, avoidance of adverse events and the appropriate response should they occur underline the recommendations around the use of ketamine infusions for depression.

Essential

1. Adherence to SASA sedation guidelines in terms of monitoring and equipment
2. One patient at a time per sedationist
3. Sedationists must at least have a qualification in advanced life support

Bibliography

- Andrade C. Ketamine for depression, 4: In what dose, at what rate, by what route, for how long, and at what frequency? *J Clin Psychiatry*. 2017;78(7):e852-7. <https://doi.org/10.4088/jcp.17f11738>.
- Clinical algorithm for ketamine administration for depression University of Texas Health Science Centre at San Antonio, Texas. Undated.
- Cohen SP, Bhatia A, Buvanendran A, et al. Consensus guidelines on the use of intravenous ketamine infusions for chronic pain from the American Society of Regional Anesthesia and Pain Medicine, the American Academy of Pain Medicine, and the American Society of Anesthesiologists. *Reg Anesth Pain Med*. 2018;43(5):521-46. <https://doi.org/10.1097/aap.0000000000000808>.
- Gao M, Rejaei D, Liu H. Ketamine use in current clinical practice. *Acta Pharmacol Sin*. 2016;37(7):865-72. <https://doi.org/10.1038/aps.2016.5>.
- Gómez-Revuelta M, Fernández-Rodríguez M, Boada-Antón L, Vázquez-Bourgon J. Apnea during slow sub-anaesthetic infusion of intravenous ketamine for treatment-resistant depression. *Ther Adv Psychopharmacol*. 2020;10:2045125320981498. <https://doi.org/10.1177/2045125320981498>.
- Kirota K, Lambert DG. Ketamine and depression. *Br J Anaesth*. 2018;121(6):1198-202. <https://doi.org/10.1016/j.bja.2018.08.020>.
- Kurdi MS, Theerth KA, Deva RS. Ketamine: current applications in anaesthesia, pain and critical care. *Anesth Essays Res*. 2014;8(3):283-90. <https://doi.org/10.4103/0259-1162.143110>.
- McIntyre RS, Rosenblat JD, Nemeroff CB, et al. Synthesizing the evidence for ketamine and esketamine in treatment-resistant depression: an international expert opinion on the available evidence and implementation. *Am J Psychiatry*. 2021;178(5):383-99. <https://doi.org/10.1176/appi.ajp.2020.20081251>.
- Roelofse J, Jansen van Rensburg M. SASA Guidelines for the safe use of procedural sedation and analgesia for diagnostic and therapeutic procedures in adults: 2020–2025. *South Afr J Anaesth Analg*. 2020;26(2 Suppl 1):S1-75.
- Strayer RJ, Nelson LS. Adverse events associated with ketamine for procedural sedation in adults. *Am J Emerg Med*. 2008;26(9):985-1028. <https://doi.org/10.1016/j.ajem.2007.12.005>.

- ii. **Ampoule sharing**
 - iii. **Power outage**
 - iv. **Use of sugammadex**
 - v. **Haemodynamic printouts**
-

Appendix G: Infection control

This guideline is available at: <https://www.sasaweb.com>

Appendix H: Consent policy/Green formy

These are available at:

[Green form](#)

[Consent blurb](#)

Appendix I: WHO checklist

This checklist is available at: <https://www.who.int>

Appendix J: ICU

These guidelines are available at: <https://www.sasaweb.com>