Memorandum of Understanding
GP Anaesthetists, Consultant Anaesthetists and Rural Hospitals Perioperative services

Introduction
Rural hospitals may have a workforce consisting of GP anaesthetists, consultant anaesthetists, GP registrars and registrars in training to provide both elective and emergency anaesthetic and resuscitation services.

It is essential that there is a co-ordinated and well planned approach to the allocation of anaesthetic lists (including recognition and allocation of resources for pre- and post-operative care) and on-call responsibilities for each individual hospital dependent on the skill mix, location and clinical services provided at each health unit.

Workforce Planning
There will be times when there are workforce issues which may require extra support by consultant and locum anaesthetists to support the GP workforce which currently provides the majority of the anaesthetics and on call resuscitation services in most rural South Australia hospitals.

It is essential that there be close co-operation between the resident GP anaesthetists and the visiting consultant anaesthetists in the allocation of theatre lists to ensure that a high standard of anaesthetics are delivered to rural patients, as well as ensuring enough clinical cases and maintenance of skills.

Skill maintenance
There must be adequate opportunities and experience for GP anaesthetists to maintain and extend their airway maintenance and emergency crisis response skills.

This is essential for both their elective and emergency anaesthetic service provision as well as the advanced resuscitation they undertake in emergency departments, out of hospital resuscitation and delivery suites in their rural locations.

Allocation of lists
The allocation of the operating lists should ideally take place with discussion between the appropriate hospital administration, the GP anaesthetists and the consultant anaesthetists, and in some cases, the surgeons who are providing operative services as there may be a particular case mix of patients that would be suited to consultant anaesthetists or a GP anaesthetist with advanced skills e.g. Paediatrics and Obstetrics.

There must be a formal planning process (which may vary across individual health units) well in advance, and adequate discussions and planning of lists and patient and surgery suitability amongst the anaesthetists, surgeons and the theatre services manager/admissions staff to ensure that the highest anaesthetic standards are maintained to ensure best patient outcome.
Significant changes to rosters and the allocation of lists and on-call service provision should be formally agreed upon and done in an appropriate time frame with adequate opportunity to discuss the long term implications for anaesthetic services at that particular hospital.

Planning for operative lists must include allocation of responsibilities/resources to manage the pre-anaesthetic review and post-operative care, as specific considerations in addition to the procedure itself.

Coordination of post-operative care and handover of care is an important component in perioperative planning and should involve coordination between visiting anaesthetic and surgical staff as well as resident GP anaesthetists.

**After hours and on-call services**

There should also be formal arrangements agreed upon to provide appropriate on-call anaesthetic services which again may require a mixture of resident GP anaesthetists as well as consultant anaesthetists.

The after hours and obstetric anaesthetic workload must be shared appropriately by the anaesthetists who are doing the elective lists at each individual hospital and a formal roster maintained taking into account individual site specific services, location and the cost of services.

The availability of anaesthetists after hours may depend on a number of different factors including some anaesthetists providing after hours services in other rural locations in the vicinity of the main surgical hospital.

**Up-skilling and Further Education**

It is essential there be adequate educational opportunities for anaesthetists to up-skill and in many cases this can be done in the local hospital, utilising the services of the consultant anaesthetists. However there should be opportunities to develop formal up-skilling relationships with tertiary and regional hospital anaesthetic departments, which many rural GP anaesthetists have utilised in the past.