INDIAN SOCIETY OF ANAESTHESIOLOGISTS (ISA)

POSITION STATEMENT FOR ANAESTHESIOLOGIST'S IN PRIVATE PRACTICE IN INDIA

A PRIVATE PRACTITIONER'S FORUM (PPF) INITIATIVE

PREFACE

The Private Practitioners Forum (PPF) of the Indian Society of Anaesthesiologists (ISA) has proposed this position statement to promote safe anaesthesia practices throughout India. This is a continuation of our attempt to standardise and regularise anaesthesia practices in the country.

The main vision of having position statements includes the following:

1. Guidance: These provide clear guidance on best practices, standards, and recommendations for practising anaesthesiologists, ensuring consistency and excellence in patient care.
2. Policy development: Position statements inform and shape healthcare policy, influencing decision-making and resource allocation, especially in smaller cities.
3. Education and training: These serve as a foundation for development programs, ensuring that all anaesthesiologists receive accurate and up-to-date information.
4. Advocacy: Position statements support advocacy efforts, enabling ISA to effectively communicate its stance on critical issues.
5. Credibility and authority: We demonstrate our expertise and thought leadership by issuing evidence-based position statements.
6. Member support: These help members understand the association's stance on key issues, supporting their practice and decision-making.
7. Interprofessional collaboration: Position statements facilitate collaboration amongst our members, promoting a unified approach to patient care.
8. Patient safety: Position statements improve patient safety and outcomes by promoting evidence-based practices, adequate monitoring, and emergency preparedness during anaesthesia care.
9. Research and innovation: These identify areas for further research and innovation, driving progress in healthcare.
10. Accountability: Position statements hold medical associations accountable for promoting evidence-based practices and high standards in healthcare.
11. Medication safety: Help promote safe anaesthesia practices, including medication error prevention and rational drug use.
12. Continuing education: Encourage ongoing education, training, and skill development for anaesthesia practitioners.
13. Interdisciplinary collaboration: Fostering collaboration with other healthcare professionals to ensure comprehensive patient care.
14. Equipment and infrastructure: Ensuring access to essential anaesthesia equipment and suitable healthcare infrastructure to promote safe anaesthesia care.

15. Patient autonomy: To help respect patient autonomy, informed consent, and dignity in anaesthesia care.
16. Rural and underserved areas: Ensuring access to quality anaesthesia services in rural and underserved areas through outreach programs and resource allocation.
17. Environmental sustainability: Promoting eco-friendly practices in anaesthesia, such as reducing waste and using environmentally sustainable gases, inhalational agents, drugs and equipment.
18. Mental health and well-being: Supporting mental health and well-being among anaesthesia practitioners to prevent burnout and ensure quality care.
19. We strongly propose justifiable remuneration for our professional efforts to improve the work culture and standard patient care in perioperative practice.

By issuing a well-drafted position statement, ISA can influence healthcare practices, policies, and outcomes, benefiting patients and the broader healthcare community. This position statement can guide anaesthesia practitioners in India, aligning with global standards and addressing local healthcare needs.

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Eternal Vigilance

Message from the President, ISA, National

I am delighted that the Indian Society of Anaesthesiologists has come out with a position statement for anaesthesiologists in private practice in India. This initiative of the Private Practitioners' Forum of the ISA is a much-needed document to standardise and improve working conditions in anaesthesia practice, increase patient safety and improve perioperative care in our country. The position statement covers four major sections:

1. Minimum mandatory standards in the operation room
2. Functioning of city branches
3. Ethical conduct of Anaesthesiologists
4. Remuneration of Anaesthesiologist: the RVG system

Each of these sections is important. Anaesthesiologists can quote this document to ensure that nursing homes and hospitals conform to these norms and make sure that essential equipment and medications are made available by the hospital management. Several sample forms and checklists are enclosed to improve documentation and reduce medicolegal risks. The ISA city branches are the core of the ISA, and a united and strong city branch can greatly improve working conditions and remuneration of anaesthesiologists in the area. This position statement contains valuable tips on how city branches can become more effective and cohesive professionally and socially and increase the image and profile of anaesthesiologists. The Relative Value Guide system exemplifies how we can rationally and scientifically determine respectable and deserving renumeration for our services. Of course, this position statement is not a binding document: it provides guidance, but practice can be modified in the case of individual patients and based on local conditions.

This position has been in the making for several months. The initial draft was modified after input from the ISA Governing Council members, sent for external review, and modified again based on all these comments. It has been a priority for the ISA and a labour of love for the PPF and the authors. I congratulate the ISA PPF leadership for spearheading this initiative. I am sure this will ensure that we give optimal perioperative care to our patients and work with unity, safety and dignity.

Long live ISA! Jai Hind!

Dr. J.V. Divatia,

President, ISA National

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Message from the President-Elect, ISA, National

Dear Dr Pankaj Gupta,

Greetings from Dr J Balavenkatasubramanian, Secretary WFSA.

I would like to convey my heartiest wishes to you and your team for spearheading the initiative to create certain pertinent guidelines to enhance perioperative safety for all our surgical patients.

This initiative would be very useful for hundreds of Anaesthesiologists practising across our subcontinent and in similar countries with similar challenges.

I am sure this is a big step forward in decreasing perioperative critical incidents.

I truly appreciate the entire team involved in bringing out this repository for Private Practitioners.

Sincere thanks

With warm regards

Dr J Balavenkatasubramanian
President-Elect ISA National
Secretary, WFSA

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Message from the Vice President, ISA, National

Greetings,

ISA has come out with a position statement regarding private practitioners promoting safe anaesthesia practice, which includes various clauses.

The main thing comprises best practices and standards, expert healthcare policies, and updated knowledge about recent trends in anaesthesia. It also provides evidence-based practices and adequate monitoring and prevents medication errors. Finally, it supports the mental health of anaesthesiologists. Private practitioners are the backbone of our ISA and constitute around 60% of our ISA membership. Their upliftment is the need of the hour. Their well-being will definitely promote our ISA to a higher level.

I hope all the suggestions in the position statement will be implemented for the welfare of our ISA.

Long live ISA! Jai Hind!

With regards,

Dr. S.C. GANESHPRABU
VICE - PRESIDENT, ISA, NATIONAL
Professor and Head,
Department of Anaesthesia,
Velammal Medical College and Research Institute,
Madurai, Tamilnadu.

Message by the Honorary Secretary, Indian Society of Anaesthesiologists (ISA) National

My dear colleagues of Indian Society of Anaesthesiologists,

Warm greetings from ISA National Headquarters!

Our esteemed body, the ISA has always been committed to the growth of private practicing anaesthesiologists throughout our nation. The goal of ISA has been to help the practitioners to become well-versed with clinical, social, ethical, legal and financial aspects of practice. Several practitioners are so busy that they cannot dedicate time to travel far to attend conferences and continued medical education programmes to update their knowledge. Nevertheless, the ISA National Clinical Practice Oriented Webinar series (CLI P) and Clinical Reasoning and Problem Solving (CRISP) webinar series are being conducted to bring knowledge at the doorstep of such practitioners.

Furthermore, the practitioners practicing in the periphery often find it difficult to practically follow the clinical guidelines published by international and national bodies mainly due to a lack of available resources, drugs, equipment and manpower in their respective set ups. Many a times, the best possible treatment in the clinical scenario faced by the practitioner must be delivered, both in elective and emergency situations. The clinical dilemmas faced by the practitioner are many. However, having understood this basic need of the practitioners and to provide guidance in the management of clinically difficult scenarios, the ISA Private Practitioner Module is also coming up. This will probably be the first of its kind in the world. The first workshop related to this module has already been held at Jhunjhunu in Rajasthan and the next one is being held in the National conference of the ISA, ISACON Patna 2024. These workshops can bring in a lot of diverse, practically feasible and valuable clinical inputs from practitioners practicing in different areas, especially different zones of our nation. We, as a nation boast of unity in diversity; nonetheless, we as anaesthesiologists practising diversely in diverse environments can also boast of successful anaesthetic practice in a vast diversity.

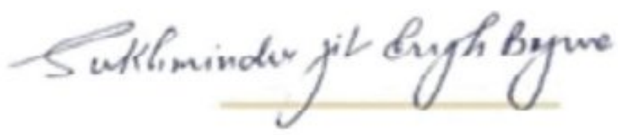
Clinical practice in Anaesthesiology is often compounded with medicolegal litigations and ethical challenges. Many a times our practitioner colleagues are caught unaware or are found to be struggling to obtain guidance and achieve solace from cases of medical negligence, etc. The problem of low and non-uniform remuneration has been on the lips and in the minds of most practitioners. These problems have been discussed zone wise in the ISA National

Private Practitioner Webinar series that was conducted this year and was widely appreciated. There was a long-felt need for the publication of guidelines in this context. Time and again, attempts have been made by the past Presidents of ISA National and our senior Governing Council colleagues to provide guidance on these aspects and the old record of 2016-17 has now been revised with the changing times and the guidelines are being published in this book. The guidelines contain four sections and four annexures. The sections include information on four important aspects viz- minimum mandatory standards in the operating room, the functioning of city branches, ethical conduct of the anaesthesiologist and remuneration of the anaesthesiologist. These guidelines have been reviewed by several knowledgeable practitioners and academicians and are a product of long hours of intellectual toil.

I sincerely appreciate and congratulate the entire Governing Council of ISA National for bringing out this book which will radiate the light of clinical guidance and professional support to the practitioners in our country, now and in the years to come.

Long Live ISA!

Dr. Sukhminder Jit Singh Bajwa



Honorary Secretary, ISA National.

Message by the Treasurer, Indian Society of Anaesthesiologists (ISA) National

Dear Esteemed Members of the Indian Society of Anaesthesiologists,

Safe Anaesthesia practice has always been the main agenda of ISA for all its members. I congratulate the PPF of ISA for laying down this position statement led by Dr Pankaj Gupta, Dr Virendra Sharma, Dr Sunil Sethi, Dr Manisha Katikar all leading practitioners in their cities.

The work done by PPF has been commendable in the last few years, and I wish all our members a happy and safe Anaesthesia practice.

Dr Manoj Kumar,
Treasurer, ISA National

Message by the Editor-in-Chief, Indian Journal of Anaesthesia, Indian Society of Anaesthesiologists (ISA) National

Greetings from the Indian Journal of Anaesthesia (IJA) office!

It is heartening to introduce this important compilation of practice statements framed by the Private Practitioners Forum (PPF) of the Indian Society of Anaesthesiologists (ISA). These practice statements have been framed with the unique needs and challenges of private practitioners in anaesthesiology, where the dynamics and demands of care can often differ significantly from institutional settings.

Anaesthesiologists in private practice serve a critical role in the Indian healthcare system, delivering essential services to diverse patient populations under varying circumstances. However, this also places them in environments where resources, staffing, and infrastructure may not always match the optimal standards found in larger hospitals. The practice statements aim to provide clear, actionable guidelines tailored to private practitioners. These statements consider daily challenges: managing high patient volumes, working in diverse clinical settings, or ensuring access to the latest medications and technologies. They are designed to support in upholding the highest standards of care while addressing the practical realities of private practice.

I would like to acknowledge the efforts of the PPF and the contributors, especially Dr Pankaj Ramkrishna Gupta, National Coordinator, PPF, ISA, who have worked diligently to bring this initiative to life. Together, let us continue to elevate the standards of anaesthesia care throughout India, ensuring that safety, quality, and ethical practice remain at the core of our practice.

Long Live ISA! Long Live IJA! Jai Hind!

Warmest Regards

Prof Rakesh Garg

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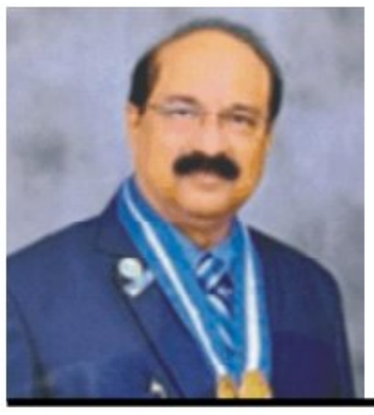

Message by the Past President and Academic Chairperson, Indian Society of Anaesthesiologists (ISA) National

Dear Esteemed Members of the Indian Society of Anaesthesiologists,

I am immensely pleased to present this practice statement meticulously framed by the Private Practitioners Forum (PPF) of the Indian Society of Anaesthesiologists (ISA). It witnesses the culmination of our collective efforts to frame position statements for anaesthesiologists in private practice in India.

Private practitioners have been at the forefront of providing perioperative care for various surgical procedures, including critical care and pain management. They are fully committed to delivering quality care and advancing the standards of anaesthetic practice across the country. In an ever-evolving healthcare landscape, all anaesthesiologists must be aligned with the best practices and the latest guidelines. This initiative by the PPF is a significant step forward in standardising and promoting safe anaesthesia practices throughout India, with a particular focus on the challenges and nuances those in private practice face. These position statements serve as a guide and a commitment to uphold the highest patient safety standards, ethical practice, and clinical excellence.

I commend the efforts of the PPF for their diligence in framing this statement and ISA for continuously working towards the betterment of our profession. I am confident that this document will be a valuable resource for all anaesthesiologists in private practice and institutional settings, inspiring them to adopt and promote safe anaesthetic practices. This document shall also be helpful in various healthcare practices, policies, and outcomes that benefit patients and the broader healthcare community.

Let us continue to work together to foster a culture of safety, innovation, and professionalism in anaesthesia.

Long Live ISA!

Warm Regards

Dr. M.V. Bhimeshwar
Past President and Academic Chairperson, ISA National
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ACKNOWLEDGEMENTS

A position statement guides any association and is the best method of protecting the interests of our members, especially in adverse circumstances. This statement will help new members work within the framework laid down and serve as a ready reference for the courts to know the standards of practice in our country. Much introspection and discussion has gone on for more than a year. After much deliberation, we thought it imperative to develop a position statement for private practitioners in India.

I must acknowledge the contributions of Dr Virendra Sharma, who inspired me to join and rejuvenate the PPF movement in the country. Together, we have been managing many new initiatives to promote unity and help achieve financial independence for all our members. This statement is another step towards a good and happy work culture for our members, especially those in private practice. With her medicolegal expertise, the ever-helpful Dr Pratibha Kane has contributed much time and effort to bringing out this statement. Dr Vikas Nair, Dr Ganesh Tendulkar, Dr Arun Mehra, Dr Mahesh Sinha, Dr Apurva Agarwal, Dr Bhadresh Shah, Dr Nilesh Naphade, Dr Rajesh Rao, Dr Pramod Manohar, Dr Pranav Gupta, Dr Salyankar, Dr Kalpesh Shah, Dr Shashidhar, Dr Ashita Rathore, Dr Manoj Kumar, Dr Gurmeet Reen and many more have contributed to discussing and laying down the various sections of these statements. Remuneration has been a problem for most practitioners, and we have suggested all modes that can be followed; laying down minimum remuneration in your city and ensuring it is followed is important.

Our immediate national past president and present academic chairman, Dr M.V. Bhimeshwar, was instrumental in initiating this booklet, and our president, Dr J.V. Divatia, has always been the guiding force and very encouraging. Our governing council members helped a lot in bringing out the final document in its present state. I thank Dr Rakesh Garg for helping me bring out this final statement and Dr Manisha K and Dr Srinivasalu D for their invaluable input. I thank our National Governing Council members who brainstormed to bring out this statement.

I should also thank the peer review committee for their valuable suggestions in giving this statement a final look.

I thank our hard-working National Hon. Secretary, Dr SJS Bajwa, and dedicated Treasurer, Dr Manoj Kumar, for helping bring out this position statement in this format.

LONG LIVE ISA

Dr Pankaj Ramkrishna Gupta,
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ISA Position Statement for Anesthesiologists in Private Practice in India-OCTOBER 2024

ISA Position Statement for Anesthesiologists in Private Practice in India Updated OCTOBER 2024

The Indian Society of Anaesthesiologists (ISA) issues this position statement to guide anaesthesiologists in India. These recommendations support sound clinical judgment and decision-making but do not supersede it.

OBJECTIVE

To standardise anaesthesia practice and optimise working conditions in the operation theatre and non-operating room anaesthesia (NORA) for the safe conduct of anaesthesia and satisfactory patient experience.

Section 1: Standards and Recommendations

The recommendations in this document are classified as ***Highly Recommended, Recommended and Suggested***.

- HIGHLY RECOMMENDED standards are the minimum mandatory standards.
- RECOMMENDED and SUGGESTED standards should only be practised in poor resource settings until resources become available.

In any setting, the goal should be to practice to the highest possible standards, even exceeding the standards outlined in this document.

HIGHLY RECOMMENDED STANDARDS

This section states minimum mandatory standards for the conduct of anaesthesia. These standards apply to all anaesthesia techniques, general anaesthesia (G.A.) and regional anaesthesia (R.A.), including monitored anaesthesia care (MAC) with or without sedation.

- Anaesthesia and related perioperative care will be conducted only by **a qualified anaesthesiologist and a medical graduate with a postgraduate qualification in anaesthesiology** recognised by and registered with the National Medical Commission (NMC) or State Medical Council.

- The anesthesiologist is responsible for the Patient's care until complete recovery from anaesthesia.
- The vital status of the patient undergoing surgery under anaesthesia, including blood pressure, electrocardiogram (ECG), and peripheral oxygen saturation (SpO2), is to be monitored continuously.
- End-tidal carbon dioxide (EtCO2) monitoring is highly recommended as a reliable test for tracheal intubation to prevent accidental oesophagal intubation.
- All operation theatres and NORA suites must have access to defibrillators in an emergency.
- The anaesthesiologist is to keep a complete, detailed record of the anaesthesia procedure and vital parameters.

The pre-anaesthesia consultation (PAC) record, separate anaesthesia consent record, intraoperative record, and postoperative record must be maintained until complete anaesthesia recovery.

- In case of transfer or handover to the intensive care unit (ICU) or higher centre, the condition at handover must be documented, and the handover document must be signed by a doctor of the sending and receiving teams.
- Important aspects of communication with patients and relatives must be documented, along with the date and time of the interaction and counselling. The Patient's name, signature, and relationship with the Patient must also be documented.

HIGHLY RECOMMENDED

These are broad recommendations to help anesthesiologists make decisions, but they can be adapted or modified according to clinical needs or resource constraints.

- Anaesthesiologists must conduct pre-anaesthetic consultation (PAC) to plan the anaesthesia, preferably at least a day before the surgery. A detailed patient history and examination are needed to decide on a safe and suitable anaesthesia plan for the Patient. History taking can also be done via telephone or video conference following Telemedicine guidelines 2022.
- PAC involves taking a history, examining all systems, and reviewing the investigations. The ISA recommends a questionnaire to ensure a detailed history, which can be answered by the Patient himself or with the help of any doctor attending. ***(Annexure 1-Preoperative Patient Declaration-page 20).***
- For patients with comorbidities, experts in the fields/speciality concerned may be consulted and involved in optimising medical conditions, and they may advise further investigations as required. ***Refer to ISA Guidelines 2022 for preoperative investigations. (Appendix 5 page 56) (Annexure 2 Pre-anaesthesia consultation - history and examination form and Preoperative patient instructions form-page 23)***
- Objective Risk Assessment is recommended ***American Society of Anesthesiologists Physical Status (ASA PS) Grading (Appendix 1, page 52) and Modified Cardiac Risk Index (Appendix 2, page 53)***

- Counselling before consent: The Patient's condition and surgical needs are considered, and options for anaesthesia care are discussed with the Patient. The procedure is explained along with its risks and benefits.
- Information about the plan for anaesthesia, options, and risks can be provided with the help of online links, videos, and information booklets. ***(Annexure 3: Informed consent for anaesthesia form; High-risk form; Blood transfusion consent form- page 30)***
- An anaesthesia plan is to be agreed upon with the Patient. This is the primary plan (Plan A). An alternative plan (Plan B) should also be discussed and agreed upon in case either Plan A fails, or additional anaesthesia requirements arise during the surgery. In case of central neuraxial block failure or failure of the peripheral block, conversion to general anaesthesia must be discussed. In the case of Monitored Anaesthesia Care (MAC) conversion to G.A., it must be mentioned in appropriate cases.
- A separate anaesthesia consent form for the agreed plan will be obtained as the risk of anaesthesia is over and above the risk of surgery. It can include alternative plans, too, if anticipated. Do not take "blanket consent". The potential need for blood transfusion, postoperative elective ventilation, ICU transfer, ICU care, and transfer to a higher institution must be mentioned explicitly on the consent form. Consent should also be obtained for central and arterial lines and other invasive procedures when indicated. ***(Annexure 3: Check Special Guidance for Anaesthesia consent-page 30).***
- A separate form for blood transfusion and central and arterial lines is recommended. These procedures can also be mentioned explicitly in the high-risk consent section.

Preoperative patient instructions:

- Nil by mouth period (NBM) is informed to the Patient following ***ISA 2020 FASTING GUIDELINES (Appendix 3, page 54)***
- At times, specific ERAS protocols may be recommended.
- Preoperative patient instructions – Dos and Don'ts ***(Annexure 2. Preoperative Instructions Form, page 28)***
- Preoperative patient instructions about medications and the need for IV fluids need to be given in writing.
- Also, the case sheet in writing should mention any other specific (non-routine) preop instructions for the nursing staff.

Intraoperative Practice Recommendations

- Equipment and drugs used for the conduct of anaesthesia and monitoring must be adapted to the complexity of the surgery undertaken. ***(Annexure 4 - O.T. Check List, page 37 & 40)***

- The anaesthesia machine/workstation and defibrillator must be in working condition in operating rooms. It is recommended that all routine and emergency drugs and difficult intubation equipment be readily available.
- Monitoring equipment: Continuous monitoring of ECG, non-invasive blood pressure (NIBP), and SpO2 are mandatory for all cases as required, i.e. MAC, sedation, G.A., central neuraxial blocks (CNB), and regional blocks.

RECOMMENDED STANDARDS

To use the ultrasonography (USG) machine, the anesthesiologist must fully comply with all PCPNDT rules, regulations, and requirements, including registration, documentation, and records maintenance.

- In institutions with speciality surgeries, monitoring equipment must be updated according to technological advances to improve patient safety. Monitoring EtCO2 is advisable for laparoscopic surgeries and essential for cardiac surgery or any high-risk surgery.
- Difficult airway cart should be available.
- Temperature monitoring is recommended for prolonged complex surgeries, geriatric patients, and pediatric patients. The use of intraoperative patient warming systems is advisable in these groups of patients.
- "Surgical time out" should be performed by the anesthesiologist, surgeon, and staff nurse before the induction of anaesthesia ***(recommended WHO Safe Surgery Checklist 2006 - Annexure 5, page 40)***

Documentation of perioperative care is the duty of the anaesthesiologist

This includes:

- PAC Record
- Record of counselling and consent
- Intraoperative Anaesthesia record: Anaesthesiologists must continuously record the vital signs every 5 minutes in physical or electronic format until complete recovery from anaesthesia. Drug dosages, timing, all anaesthesia events (induction, intubation, maintenance, reversal, extubation), and their time must be documented in the record. Adverse events and their treatment/management must be documented in detail. ***(Annexure 6 -Anaesthesia records, page 44)***

Postoperative Recommendations: Highly Recommended Standards

- The anaesthesiologist must ensure a safe postoperative period for the patient recovering from anaesthesia.
- Document the postoperative recovery from anaesthesia. Daycare surgery and recovery / shifting from PACU can also be objectively documented using the ***Aldrete Scoring system (Annexure 7 page 49).***

- Anaesthesiologists must plan for adequate postoperative pain relief.
- Plan for prophylaxis and treatment of nausea and vomiting (PONV) in the postoperative period.

In critical patients, postoperative care can be handed to an ICU team. If there is no ICU on the premises, a patient needs to be shifted to a higher centre under an anesthesiologist's supervision and continuous care. Detailed documentation (including the Patient's condition and vital parameters) of handing over in the ICU or transfer to a higher centre is a Legal Requirement. A formal handover must be given to a competent clinician with details documented, and it must be signed by both the doctor transferring the Patient and the receiving doctor. ***(Annexure 8 - Formal handover form, page 50)***

ANNEXURE–1

Preoperative Patient Declaration Form

This is a document where the Patient declares his medical condition, which is important documentary evidence of information that the Patient cannot later deny. It is important in cases where patients do not disclose important medical conditions and treatments to their doctors.

A competent patient or his guardian must fill out this document. Any medical officer may help fill out the form. This is just a yes/no answer sheet with minimal details. Anaesthesiologists can get a quick overview of the Patient's medical status and history in the PAC form in Annexure 2

Preoperative Patient Declaration: (To be filled by the Patient preferably)

Please provide accurate and complete information during your preoperative assessment to ensure safe and effective anaesthesia during your surgery. If you have any questions or concerns, ask your anesthesiologist. Thank you for your cooperation.

Patient Information:

Name : .....

Age : ..... Gender : ..... Weight : ..... kg Height : ..... cm

Medical History:

Question Yes ..... No .....

1. Do you have any chronic conditions requiring ongoing medical treatment?

Mention the medications

2. Do you have any of the following conditions?
   - Headache, seizures, vertigo, loss of balance?

- High Blood Pressure. Palpitations
- Diabetes
- Kidney Disease
- Liver Disease
- Tuberculosis
- Asthma
- Bronchitis
- Thyroid Disorder
- Other (if applicable)

3. Have you ever experienced severe chest pain requiring evaluation or hospitalisation due to a heart condition

   Mention medications

4. Do you experience breathlessness while walking? Yes/No

   How many floors can you climb at a normal pace without stopping?

5. Do you have heartburn, water brash, or regurgitation symptoms? Yes/No

6. Have you undergone any surgery under anaesthesia in the past? Yes/No

   - If yes, please provide details:

   Were there any untoward events or complications? Please give details if there were any.

7. Do you have concerns about anaesthesia? Yes/No

   If yes, please specify your concerns:

8. Have you or any of your blood relatives faced problems with anaesthesia?

   Yes/No

9. Do you have any known allergies? Yes/No
If yes, please provide details:

10. Have you taken steroids in the last six months? If yes, for what condition? Yes/No

11. Have you been admitted to the hospital or received prolonged treatment for any medical condition? Yes/No

12. Have you suffered from COVID-19 in the past, and were you hospitalised for it? Yes/No

Please confirm your COVID-19 vaccination details.

13. Do you have bleeding problems? Yes/No

14. Have you received a blood transfusion in the past? Yes/No

15. Do you consume alcohol? Yes/No

16. Do you smoke? If yes, since when, how often, and when was your last smoke? Yes/No

17. Do you chew Tobacco, Pan, Gutka, supari, etc.? Yes/No

18. Do you have loose teeth or removable teeth? Yes/No

19. Do you use a hearing aid? Yes/No

20. Do you wear contact lenses? Yes/No

21. Are you pregnant or likely to be pregnant? Yes/No

22. Do you take herbal supplements or complementary/alternative medicines? Yes/No

ANNEXURE–2

Pre-anaesthesia Consultation Form

Name of Patient : .....

Reg No : .....

Age : ..... Date of Birth : ..... Sex : .....

Weight : ..... kg Height : ..... cm

Contact Number of Patient : .....

Emergency Contact: Name : .....

Relationship : ..... Phone Number : .....

Medical History:

1. History of Relevant General Medical Conditions:
   - ☐ Chronic medical conditions (e.g., diabetes, hypertension, asthma, etc.)
   - ☐ MET Score (Metabolic Equivalent of Task)

2. History of Medications:
   - ☐ Prescription medications
   - ☐ Over-the-counter medications
   - ☐ Herbal supplements

3. History of Significant Illnesses, Surgeries, or Hospitalisations:

4. History of Previous Anaesthesia: – Please provide details of any previous surgeries and a naesthesia you have undergone, including any complications or adverse reactions.

5. History of Cardiovascular System Conditions:
   - ☐ Heart disease, heart attack, or heart surgery
   - ☐ High blood pressure (hypertension)
   - ☐ Heart valve abnormalities
   - ☐ Chest pain, shortness of breath, or palpitations

6. History of Respiratory System Conditions:
   - ☐ Asthma or other respiratory conditions
   - ☐ Pneumonia, bronchitis, or a collapsed lung
   - ☐ H/O Obstructive Sleep Apnoea (OSA) - Proceed with STOP BANG history and further evaluation. ***(Appendix 4,page 58)***

7. History of Gastrointestinal System Conditions:
   - ☐ Acid reflux, ulcers, or other gastrointestinal conditions
   - ☐ Problems with swallowing

8. History of Kidney and Urinary System Conditions:
   - ☐ Kidney disease or issues related to urination.

9. History of Liver Function Abnormalities:
   - ☐ Liver disease or abnormal liver function tests

10. History of Endocrine System Conditions:
   - ☐ Diabetes
   - ☐ Thyroid disorders
   - ☐ Hormone replacement therapy

11. History of Neurological System Conditions:
   - ☐ Stroke or seizures.
   - ☐ Nerve or muscle disorders
   - ☐ Cognitive dysfunction - memory loss,

12. History of Musculoskeletal System Conditions: dystrophy

☐ Joint problems, back pain, or mobility issues

13. History of Hematological System Conditions:

☐ Bleeding disorders or blood clotting issues

14. History of Allergies and Sensitivities:

☐ Known allergies to medications, latex, or other substances.

Current Medications:

- Please list all medications, supplements, and herbal remedies you are currently taking, along with their dosages.

Social History:

☐ Smoking: [ ] Yes [ ] No (If yes, how many cigarettes per day?)

Alcohol Consumption: [ ] Yes [ ] No (If yes, how frequently and how much?)

☐ Recreational Drug Use: [ ] Yes [ ] No (If yes, please specify)

☐ Family Medical History:

Pregnancy and Reproductive History (if applicable):

- For female patients: Are you currently pregnant or trying to conceive: [ ] Yes [ ] No

PRE-ANAESTHESIA CLINICAL ASSESSMENT FORM
ASSESSMENT FOR THE CHOICE OF ANAESTHESIA

- Based on the information provided, the anaesthesiologist will assess the Patient's risk for anaesthesia and plan appropriate anaesthesia.

Vital Signs :

Pulse : [ ]

B.P. : [ ]

SpO_2 : [ ]%

Resp Rate : [ ]

Temperature : [ ]

BMI : [ ]

FRAILTY : [ ]

General Examination:

- Appearance : [ ] Alert [ ] Drowsy [ ] Anxious [ ] Other: [ ]
- General Condition: [ ] Well-nourished [ ] Obese [ ] Pallor [ ] Jaundice [ ] Cyanosis [ ] Edema [ ] Other: [ ]
- Neck circumference

Cardiovascular Examination:

- Heart Sounds: [ ] Regular [ ] Irregular [ ] Murmurs [ ]
- Peripheral Pulses: [ ] Palpable and equal [ ] Weak or diminished [ ] Absent

Respiratory Examination:

- Breath Sounds: [ ] Clear and equal [ ] Decreased [ ] Wheezing [ ] Other: [ ]
- Airway Assessment: Mallampati Class I [ ] Class II [ ] Class III [ ] Class IV[ ]

Neurological Examination:

- Consciousness: [ ] Alert and oriented [ ] Drowsy or confused GCS: [ ]
- Motor Function: [ ] Full strength [ ] Weakness [ ] Abnormal reflexes

Other Observations:

- Allergies: [ ] None [ ] Specify: [ ]
- Surgical History: [ ] Unremarkable [ ] Specify: [ ]
- Any previous anaesthesia experiences: [ ] Specify: [ ]

SPINE Assessment : .....

ASSESSMENT AND RECOMMENDATIONS:

ASA physical status: I [ ] II [ ] III [ ] IV [ ] V [ ] E : [ ]

• Suitable for General anaesthesia
• Suitable for Regional anaesthesia CNB
• Suitable for Peripheral block
• May require further evaluation or tests
• May require optimisation for :
Reference to Dr.
• High-risk Patient – discuss with the surgical team
• Contraindication for anaesthesia (Specify reason)

Anaesthesiologist's Signature:
Anaesthesiologist's Name
Date : [ ] Time : [ ]

PREOPERATIVE INSTRUCTIONS FOR THE PATIENT

General Preoperative instructions from the anaesthesiologist

Dr. ..... Prior to surgery

Do's

1. Please be "Nil by mouth" according to the instructions given to you (ERAS Protocol) or ISA Fasting Guidelines 2020

   Can have solids until ..... am/pm.

   Can have liquids until ..... am/pm

2. Know your anesthesiologist and anesthesiologist before the surgery.
3. Ask about all doubts and fears during the preoperative Anaesthesia consultation.
4. Remove all lipstick, nail polish, and ornaments before surgery.
5. Let a responsible adult stay with you for 24 hours after the surgery.
6. Keep mobile, keys, and valuables with responsible relatives.
7. Check with your doctor which medicine you should take the morning of your surgery.
8. Plan to bring glasses, hearing aids, inhalers (if you are asthmatic), or any other appliances as instructed by your doctor, and carry a case to keep them.
9. Please remove your contact lens/ loose or temporary dentures before coming in O.T.

Don'ts

1. Do not consume alcohol or tobacco, and do not smoke before or after surgery.
2. Do not take anything by mouth without the doctor's permission after surgery.
3. Do not go home alone after surgery.
4. You must not drive a vehicle or operate heavy equipment after discharge on the day of surgery.

ANNEXURE–3
Consent Forms

(A)	**Informed Consent For Anaesthesia Form And Monitored Anaesthesia Care (MAC)**
(B)	**Informed Consent For High Perioperative Risk Form**
(C)	**Consent For Transfusion Of Blood and Blood Products**

Special Guidance for Anaesthesia Consent. Important aspects of consent

Consent in healthcare is permission or an agreement given voluntarily by a competent patient for any medical procedure. The ethical foundation of consent is understanding the importance of patient autonomy. An adult patient of sound mind, not under the influence of drugs, has the fundamental right to decide what is to happen to their body. When a doctor obtains consent, he respects the Patient's right to autonomy.

Most doctors rely on implied consent for any medical examination, investigation, or treatment. Express written consent is now recommended for any intervention with risk. Consent must be procedure-specific. Blanket consent is not allowed and is not valid legally.

The Consent is A Process, Not an Act of Signing a Piece of Paper.

Some Essentials of Legally Appropriate Consent in Planned Procedures:

In Non-Emergency Situations the Patient must be competent:

- Assent should be taken from children 12yrs - 18yrs with parental consent. (Aadhar card for confirmation of age).
- Must be of Sound mind.
- Not unconscious, not under the effect of alcohol or drugs.

The patient must be given enough information about the benefits and risks. The patient must be given time to make an informed choice called shared decision-making.

The Patient must be allowed to ask questions, discuss doubts, fears, and concerns about the procedure, and seek a second (or multiple) opinion if they desire.

Consent must be freely given: No coercion, threat, or monetary incentive

Consent/refusal must be documented appropriately and authenticated.

The signature of witnesses is not legally required for valid consent but is desirable.

(A) INFORMED CONSENT FOR ANAESTHESIA FORM AND MONITORED ANAESTHESIA CARE (MAC)

Any allergies:	Yes	☐ No ☐ {Red Band, if Yes}
Vulnerable Patient:	Yes	☐ No ☐ {Pink Band, if Yes}
Name:		
I.P. No.		Age / Sex:
DOA:		Bed No.
Doctor's Name:		

Name of Surgery : .....

Anaesthesia Information

BENEFITS AND RISKS OF ANAESTHESIA

Anaesthesia is a reversible state of loss of pain accompanied by immobility, with or without sleep, allowing surgical procedures to be performed on a patient safely and without discomfort. Anaesthesiologists are trained PROFESSIONALS - medical doctors specialising in anaesthesiology and oversee planning, coordinating, and administrating anaesthesia during surgical procedures. The Anaesthesiologists, or a team member, will be responsible for patient safety and comfort throughout the preoperative, intra-operative, and postoperative periods. A preoperative visit is required once the surgery is planned, and relevant investigations are done.

RISK OF ANAESTHESIA

Most healthy people do not experience any untoward effects from anaesthesia. The treatment may require one / several of the following Anaesthesia procedures (described below). The relevant method will be explained and highlighted/ticked.

Over the past 25 years, anaesthesia-related deaths have decreased dramatically from 2 per 10,000 anaesthesia administered to 1 per 1,000,00(one lakh). Some of the common

problems are sore throat and hoarseness, nausea and vomiting, muscle weakness, and dental (teeth) damage. However, there is also a small risk of complications like allergic reactions, respiratory problems, and very rarely death. Below is a detailed explanation of the various techniques and options for anaesthesia and their anticipated potential complications and risks. Diabetes, hypertension, obesity, and cardiac disease increase the risk of anaesthesia. The surgery/procedure may require one or a combination of more than one. Anaesthesia types are explained below.

TYPES OF ANAESTHESIA:

1. **General Anaesthesia:** In this type of anaesthesia, the Patient is rendered unconscious during the surgical procedure, so the Patient does not feel or remember anything that happens. General Anaesthesia is commonly produced by a combination of intravenous (injectable) drugs and inhaled anaesthesia agents by placing an endotracheal tube in the windpipe or a supra-glottic device in the upper airway. The "sleep" one experiences under general anaesthesia differs from regular sleep.

   The anaesthetised brain does not respond to pain signals or surgical manipulations. During the procedure, the anaesthesiologist controls the Patient's breathing and monitors the body's vital functions (such as pulse rate, blood pressure, and urine output). They monitor the Patient continuously during the procedure, adjusting medication, breathing, temperature, fluids, and blood pressure as needed. Any abnormalities during the surgery are corrected by administering additional medications, fluids, and sometimes blood transfusions, according to the accepted standard of care.

   Risks: Mouth or throat pain, hoarseness, injury to the mouth or teeth, nausea, vomiting.

   Rare risks: Pneumonia, cardiac arrest, drug reaction, awareness of some pain or discomfort.

2. **Monitored Anaesthesia Care with sedation or without sedation:** Monitoring keeps the Patient slightly sedated, at ease and comfortable. Depending on the procedure, the Patient may remain awake and aware throughout the procedure or may be drowsy or in a light sleep.

   Rare risk: Reaction to medications.

3. **Local anaesthesia / block:** ***This involves medicine injected through a needle or catheter near a nerve. Local anaesthesia affects only the area involved in the procedure and may be used in combination with sedation. Nerve blocks require USG*** or a Nerve stimulator.

4. **Risks:** Failure of the block, reaction to the drug used.

   Rare risks: Injury to blood vessels, convulsions, infections, persistent Weakness, numbness, residual pain, sudden cardiac arrest

5. **Regional Anaesthesia:** Two of the most frequently used techniques in this field are spinal and epidural Anesthesia, both of which are produced by precise injections into the appropriate areas of the back.

6. **Epidural Anaesthesia:** An epidural is commonly used for painless labour or delivery. It is also used for lower limb and abdominal surgery and can be combined with general anaesthesia. Epidurals are often used for postoperative pain management.
7. **Spinal Anaesthesia:** Spinal Anaesthesia is used to anaesthetise the lower body. It is occasionally combined with epidural for prolonged surgeries and postoperative pain relief.

   Risks (Epidural and Spinal Anaesthesia): Headache, backache, vomiting and nausea.

   Rare risks (Epidural and Spinal Anesthesia): Injury to blood vessels, infection of the brain and its coverings (meninges), numbness, residual pain, convulsions, and sudden cardiac arrest.

DECLARATION

- I, the undersigned Patient, give my consent for .....

  .....
- I also acknowledge that I know that the practice of Anaesthesiology / Medicine / Surgery is not an exact science, and no one has given me any promises or guarantees about administering anaesthesia or its results.
- By signing this form, I am indicating that I understand the contents of this document. My concerns and queries have been addressed. I am aware of the available facilities and those not available in the hospital. I may have to be shifted to another hospital if the treating doctors feel it is required / beneficial for my treatment.
- I have seen the schedule for all anaesthesia/analgesia charges. I also undertake to pay the anaesthesia charges/bills immediately / within 24 hours of its presentation, and I agree to pay interest for delayed payment at the rate determined by the hospital/nursing home/clinic from time to time.

I have understood the following :

Name of Surgery
Plan of Anaesthesia
Alternate plan of anaesthesia
Risks explained by anaesthesiologist Dr.
Specific risks explained/counselling done for
Patient's Signature / Guardian's Signature (for minor)
Mobile No:
Patient's name (IN CAPITAL):
Date and Time
Doctor's Signature
Doctors name
Date and Time
Witness Signature
Mobile No:
Witness Name:
Date and time:

Cancellation of consent / Informed Refusal

I have been informed of the nature and risks of the proposed anaesthesia procedure and explained the risks of refusing it.

Risks explained

.....

.....

I freely and consciously express my refusal to consent to their performance, making myself responsible for the consequences that may arise from this decision.

Signature of the Patient .....

Signature of Guardian / Legal Representative .....

Signature of Witness .....

Signature of Doctor .....

Date and Time ..... Place .....

(B) INFORMED CONSENT FOR HIGH PERI OPERATIVE RISK FORM

(This consent must be taken in case of serious/complicated/high risk/ for proceeding with a surgery/procedure despite any abnormal parameters of the Patient. High-risk consent must be obtained along with general consent.)

Information about the Patient : .....

Patient's Name: Mr./Ms./Mrs. .....

Age: ..... years / Sex: .....

I have been explained about the high perioperative risk by

Dr .....

Primary disease .....

Name of the proposed treatment/ intervention/ procedure/

surgery: .....

Associated Comorbidities:

.....

.....

I have been explained the following perioperative risks:

.....

.....

I understand that my/my patient's condition can deteriorate further, and there is a risk of life-threatening complications during and after the procedure. Postoperative ICU care and life support measures may be required for patient safety.

I have signed this consent form voluntarily, out of my own free will, and without any pressure or coercion.

Patient's Signature / Guardian's Signature (for minor)
Patient's name:
Date and Time
Doctor's Signature
Doctors name
Date and Time
Information about the Patient's Relatives /guardian (proxy consent):
Date and Time

(C) CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS

Information about the Patient: .....

Name: Mr./Ms./Mrs. .....

Age: ..... Years .....

Address. .....

I.P. No: .....

I, the undersigned, do hereby state and confirm as follows:

I have not been given any transfusion in the past.

I have been given Blood transfusion/component transfusion in the past and have not had any adverse events related to the transfusion.

Blood transfusion .....

Reactions, if any Please specify .....

I have been informed of my medical condition and the need for a blood transfusion. I have been explained and have understood that the proposed blood transfusion is necessary for my medical treatment.

I have been informed about the blood transfusion process, including administering blood and its components, blood typing and cross-matching, the potential risks and benefits of blood transfusion, and the alternatives to blood transfusion.

I have been explained and have understood the risk of transmission of infections or diseases through blood transfusion, although the risk of infection transmission is low due to strict screening measures.

I have been explained and have understood that I have the right to refuse or withdraw my consent for blood transfusion at any time, and I have been explained the potential consequences of such a decision.

I have been informed and have understood that blood transfusions carry some risks, including but not limited to allergic reactions, fever, infections, and, in rare cases, serious complications like transfusion-related acute lung injury (TRALI) or haemolytic reactions.

To minimise potential risks, I have been explained and understood the importance of providing accurate and complete information about my medical history, including any known allergies or past transfusion reactions.

To my satisfaction, the doctor-in-charge/principal surgeon/principal answered all my questions regarding the proposed blood transfusion.

I have signed this consent form voluntarily, out of my own free will, and without any pressure or coercion.

Patient's Signature / Guardian's Signature (for minor)	
Patient's name:	
Date and Time	
Doctor's Signature	
Doctors name	
Date and Time	
Witness 1. Signature	Witness 2. Signature
Witness 1. Name: Mobile No.	Witness 2: Name Mobile No .
Date and Time:	Date and Time

ANNEXURE–4

List of Recommended Drugs and Equipment in Operation Room

HIGHLY RECOMMENDED: Piped Gas supply: Continuous supply of oxygen cylinders/ Gas

Pipeline for anaesthesia machine/workstation with hypoxic guard safety system.

Nitrous oxide or air supply either by pipeline or cylinders.

One emergency oxygen cylinder is mounted on an anaesthesia machine with a spanner.

- Tilting O.T. table
- Working suction machine with all connectors, suction tubing, and suction catheters of appropriate size.
- Ambu bag with all sizes of masks.
- Multi-parameter monitors with a pulse oximeter, ECG, and NIBP for continuous monitoring.
- The use of a closed circuit is mandatory for all Laparoscopic surgeries, and monitoring of EtCO2 is highly recommended as it improves patient safety.
  Temperature monitoring is recommended for children and geriatric patients.
- Defibrillator is highly recommended.
- Working laryngoscope with all sizes of blades, Miller's blades for the paediatric Patient
- Oral & Nasal airway- All sizes
- Intubating Stylet- Bougies - Adult and paediatric
- Magill's forceps,
- Endotracheal tubes- All sizes

- Supraglottic Airway DEVICES as LMA/ IGEL – appropriate sizes
- Peripheral venous cannula size 14,16,18, 20, 22, 24, 26
- Spinal needles size 23, 24, 25, 26, 27,
- Epidural set size 16,18,
- 3-way connectors & extension tubing's of required lengths.
- I.V. sets, micro drip sets, blood transfusion sets
- Scissors, ampoule cutter, torch, thermometer
- Syringe Pumps, Infusion Pumps
- Nebulization Machine
- FOR DIFFICULT AIRWAY-

  HIGHLY RECOMMENDED: Intubating Bougie, LMA, Mc Coy Blade, Cricothyroidotomy set, 14,16-gauge needle.

  RECOMMENDED: Intubating LMA, Video Laryngoscope, Fiberoptic Intubating Scope
- Radiant warmer/ blanket (Optional), Heating mattress (optional), fluid warmer (Optional)
- Postoperative Care: Patient vital parameters should be monitored till the Patient is out of anaesthesia.

  Oxygen and resuscitation equipment must be readily available.

  LIST OF DRUGS IN O.T.
- SEDATIVES: Benzodiazepines: Midazolam, Dexmedetomidine, Clonidine.

  OPIOIDS: (AT LEAST ONE OF THE LIST) fentanyl, pentazocine, nalbuphine, buprenorphine, Tramadol.
- Injectable NSAIDS: IV Paracetamol, Diclofenac, ibuprofen.
- INTRAVENOUS ANESTHETICS: Propofol, Ketamine, Thiopentone, Etomidate.
- MUSCLE RELAXANTS: suxamethonium and at least one of the non-depolarising agents like

  Atracurium, Vecuronium, Pancuronium, Rocuronium.
- REVERSAL agents: Neostigmine, Sugammadex.

  MUSCLE RELAXANTS: suxamethonium and at least one of the non-depolarising agents like

  Atracurium, Vecuronium, Pancuronium, Rocuronium

- REVERSAL agents: Neostigmine/ Sugammadex
- ANTIEMETICS & ANTACIDS: Ondansetron/Metoclopramide/ Pantoprazole,
- ANTICHOLINERGICS: Atropine, Glycopyrrolate
- INHALATION AGENTS - Halothane, Isoflurane, Sevoflurane
- LOCAL ANAESTHETICS - 2% Xylocaine, 2% Xylocaine with Adrenaline, Bupivacaine,

  Bupivacaine 0.5% heavy, Ropivacaine, Chloroprocaine, Levobupivacaine
- IV fluids- NS, RL, DNS, D5, Colloids, D25, 3% Saline, Intralipid 20%.
- SYMPATHOMIMETICS/VASOPRESSORS: Adrenaline, Dopamine, Noradrenaline, Dobutamine,

  Mephentermine, Ephedrine, Phenylephrine.
- VASODILATORS: Nitroglycerine, SNP
- BETA BLOCKERS: Metoprolol, Esmolol, Labetalol
- ANTIARRHYTHMICS: Lidocaine 2%, Amiodarone, Adenosine
- ELECTROLYTES: Sodium bicarbonate 8.4%, Calcium Gluconate, Potassium chloride (KCL), magnesium Sulphate,
- STEROIDS & ANTI HISTAMINICS: Hydrocortisone, Dexamethasone, Chlorpheniramine
- Dextrose 25%
- BRONCHODILATORS: Deriphylline, Aminophylline,
- NEBULISER Solutions: Salbutamol, Budesonide Etc. Inhaler With Connecting Device
- DIURETICS: Furosemide, Torsemide
- SURGERY SPECIFIC DRUGS: Oxytocin/ Carbetocin, Methylergometrine, Carboprost, Tranexamic Acid, Magnesium sulphate,
- Intralipid 20% whenever blocks are performed
- Adequate no of protective lead aprons and thyroid guards (If X ray/C-arm is used)
- Vein Finder Light.

WFSA Standards for Facilities and equipment-2018

	HIGHLY RECOMMENDED	RECOMMENDED	SUGGESTED
Preoperative area			Dedicated space for preoperative assessment
Operating room	Adequate lighting Tilting operating table Supply of oxygen (e.g., oxygen concentrator, cylinders or pipeline) Oropharyngeal airways Facemasks Laryngoscope and appropriate-sized laryngoscope blades for both adult and pediatric patients Appropriate-sized endotracheal tubes for adult and pediatric patients Intubation aids (e.g., Magill forceps, bougie,stylet) Suction devices and suction catheters Adult and pediatric self-in?ating bags Equipment for IV infusions and injection of medications for adult and pediatric patients	Work surface and storage for equipment and system for delivering medications System for delivering inhalational anaesthesia (draw-over or plenum) For plenum systems: • Inspired oxygen concentration monitor • Anti-hypoxia device to prevent delivery of a hypoxic gas mixture • System to prevent misconnection of gas sources (e.g., tank yokes, hose connectors) Automated ventilator with disconnect alarm IV pressure infusor bag Device for warming IV ?uids, blood Examination (non-sterile) gloves Continuous waveform capnography Electrocardiogram	System for delivering inhalational anaesthesia (plenum) Adult and pediatric supraglottic airways Infusion pumps Warming blanket Overhead heater (for neonates) Infant incubator Intensive care ventilator Inhalational anaesthetic concentration monitor Intra-arterial blood pressure monitor Temperature monitor (continuous electronic)

	Equipment for spinal anaesthesia or regional blocks Sterile gloves Access to a de?brillator Stethoscope Pulse oximeter Carbon dioxide detector Non-invasive blood pressure monitors with appropriate-sized cuffs for adult and pediatric patients	Temperature monitor (intermittent) Peripheral neuromuscular transmission monitor (nerve stimulator) Dedicated space for recovering patients Examination gloves (non-sterile) Temperature monitor (intermittent)	
Postanesthesia recovery area	Adequate lighting Supply of oxygen (e.g., oxygen concentrator, cylinders or pipeline) Suction device and suction catheters Facemasks Adult and pediatric self-in?ating bags electrocardiogram Access to a de?brillator Pulse oximeter Non-invasive blood pressure monitors with appropriate-sized cuffs for adult and pediatric patients		

WFSA Standards for monitoring

	HIGHLY RECOMMENDED	RECOMMENDED	SUGGESTED
Intraoperative	Clinical observation by an appropriately trained anaesthesia provider: • Pulse rate and quality • Tissue oxygenation and perfusion • Respiratory rate and quality • Breathing system bag movement • Breath sounds • Heart sounds (e.g., use of precordial or oesophageal stethoscope as appropriate) Audible signals and alarms at all times Continuous use of pulse oximetry Intermittent non-invasive blood pressure monitoring Carbon dioxide detector for patients undergoing intubation	Inspired oxygen concentration monitor Device to prevent delivery of a hypoxic gas mixture Disconnect alarm (when mechanical ventilator used) Continuous use of an electrocardiogram Intermittent temperature monitoring Peripheral neuromuscular transmission monitor (when muscle relaxants are used) Continuous waveform capnography* for patients undergoing general anaesthesia and deep sedation	Continuous measurement of inspired and expired gas volumes Continuous measurement of inspired and expired inhalational anaesthetic concentrations Continuous measurement and display of arterial blood pressure (in appropriate cases) Continuous electronic temperature monitoring (in appropriate cases) Urine output monitoring (in appropriate cases) Processed EEG in appropriate cases
Postoperative	Clinical observation: • Tissue oxygenation and perfusion • Respiratory rate and quality • Pulse rate and quality Continuous use of pulse oximetry Intermittent non-invasive blood pressure monitoring Assessment of pain score using age appropriate scale	Intermittent temperature monitoring	Urine output monitoring (in appropriate cases)

ANNEXURE–5

Who Safe Surgery Checklist

Surgical Safety Checklist

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

Before induction of anaesthesia

(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision

(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room

(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

ANNEXURE–6

Anaesthesis Records

Your Hospital's Logo Here

ANESTHESIA RECORD

NAME	AGE	SEX ☐M ☐F	ASA Status	OR #
SURGEON	DATE		PAGE ____ OF ____	
DIAGNOSIS				
PROCEDURE				

ANESTHETIC TYPE: ☐MAC ☐General ☐Spinal ☐Epidural ☐Bier Block ☐Pain Block ☐Pain Rounds ☐Consult ☐STAT intubation ☐Other_____

ANTIBIOTIC GIVEN: ☐YES ☐NO START Time ____ END Time ____ NAME OF ANTIBIOTIC(S):

INDUCTION: ☐Pre O_2 ☐Cric Press ☐Rapid Seq. AIRWAY: ☐Oral ☐Nasal ☐LMA ____ ☐Copa INTUBATION: ☐Oral ☐Nasal ☐Trach ☐Fiberoptic ☐Blind ☐Fast - Trak ☐Bullard ☐Direct Vision Atraumatic ☐Yes ☐No View Grade I II III IV MAC ____ ETT ____ Miller ____ Taped @ ____ ☐Double Lumen ☐Breath Sounds equal Bilateral ☐End Tidal CO_2 Present

PATIENT IDENTIFICATION

____ I have reviewed patient status immediately prior to surgery, and agree with pre operative assessment and plan.

____ I was present for induction, key portions of the procedure, and emergence; and immediately available throughout procedure.

____ I assumed primary responsibility for the anesthetic at ____ and was present for the remaining key portions of the procedure and attendence; and immediately available for the remainder of the procedure.

Anesth Start	Induction	Anesth Ready	Surg Start	Surg End	Anesth End	MD #1	MD #2	CRNA

HT: WT: TIME: ← CONCURRENCY RATIO

INHALATION AGTS: OXYGEN, N_2O

EPID / SPINAL AGENTS:

ALLERGIES:

IV AGENTS:

IV FLUIDS:

LINES: Site / Size — IV ____ ____; IV ____ ____; Art ____ ____; CVP ____ ____; PA ____ ____

MISC.: ☐Eye Ointment ☐Eyes Taped ☐Fluid Warmer ☐Warming Blanket ☐Pressure Points ckd ☐Machine # ____ ☐Machine Checked

MONITORS: ☐ECG ☐TEMP Site ☐SaO_2 Room Air ☐$ETCO_2$ ☐FiO_2 ☐BIS Monitor ☐Nerve Stim. (TOF) ☐CVP (or) PA s/d ☐PCW (or) CO/CI

Urine Output (increments/total) ____

Blood Loss (increments/total) ____

BP ☐AUTO ☐A-LINE

STETH ☐PRECORD ☐ESOPH

ANATOMIC LOCATION OF LINES

IC = In Situ; DH = Dorsum Hand; L = Left; R = Right; W = Wrist; FA = Forearms; AC = Antecubital; IJ = Internal Jugular; EJ = External Jugular; SC = Subclavian

EVENT SYMBOLS

BP Cuff; A - Line; Suction; Start Anesth; I Intubation; Pulse; End Anesth; E Extubation; Start-Op; End-Op; T Tourniquet (UP); T Tourniquet (DOWN)

VENTILATION

Spont (SV); Controlled Vent (CV); Assisted (AV); Mech. Vent (MV); PEEP (PP)

POSITIONS

Supine (SU); Sitting (SY); Prone (PR); Lithotomy (LT); R lateral (RL); Trendelenberg (TB); L lateral (LL); Reverse TR (RT); Kidney Rest (KR)

BASELINE: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40

TIME			
Hb/Hct			
pH			
PO_2			
PCO_2			
Na			
K			
Gluc			

EVENTS

VENT: TYPE; TV; RATE; PIP

POSITION

MD ATTENDING

REGIONAL BLOCK: Position: ☐Sitting ☐Lateral __L __R

☐Sterile Prep/Drape

☐Epid: loss of resistance, Tuohy_____ g

☐Test Dose_____ Cath_____ cm

☐Spinal: Whitacre_____g Other_____

CSF __Y __N; Heme __Y __N; Paresth __Y __N

TRANSPORT: O_2: ☐N/C ☐FM ☐ETT Monitors: ☐ECG ☐O_2 Sat ☐A-Line

PACU Arr Time ____ O2 Sat ____

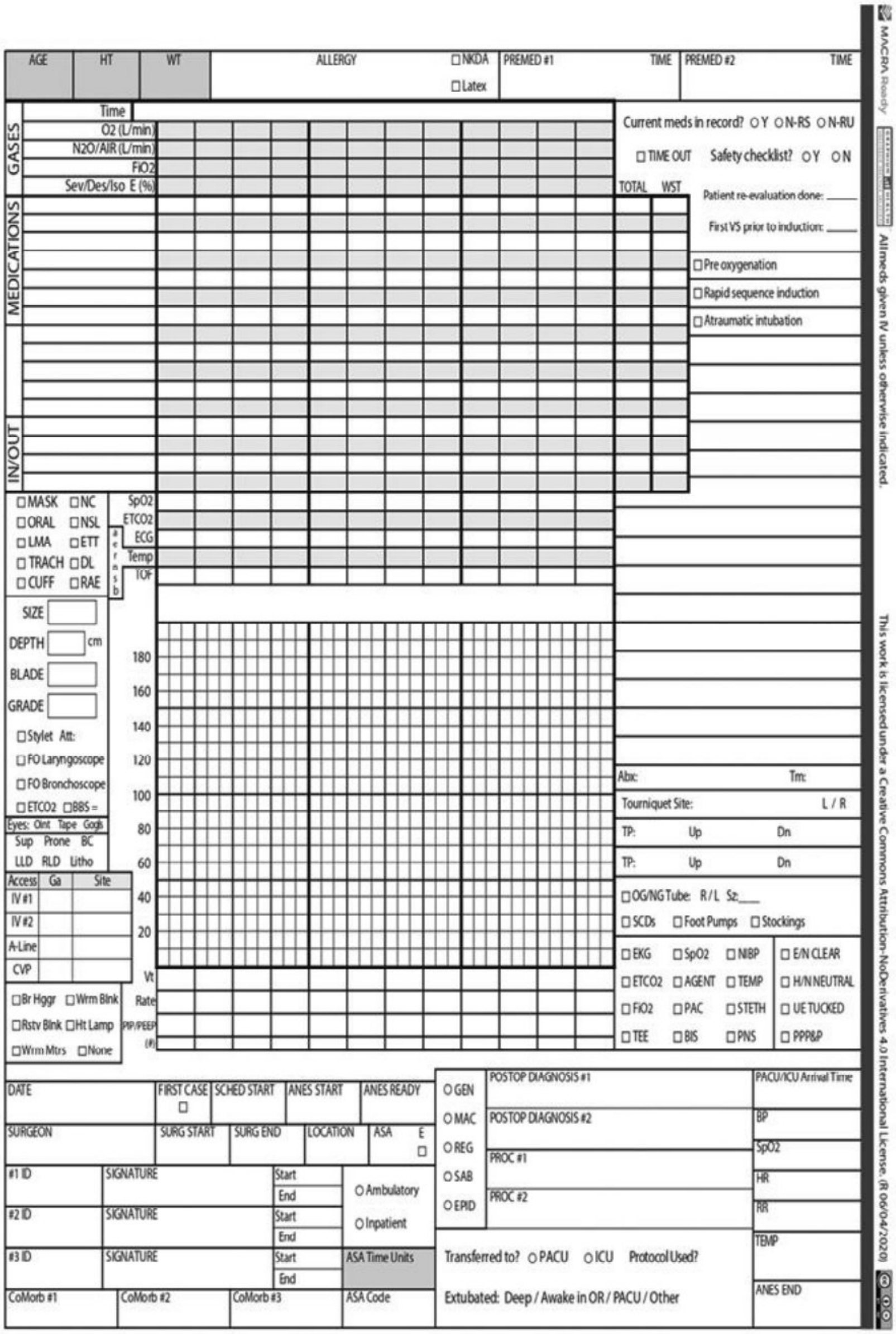
BP ____ Pulse ____ RR ____ Temp ____

Airway: ☐Oral ☐Nasal ☐ETT ☐T-Bar ☐Vent ☐TV ☐Rate ☐N/C ____ l/m ☐FM ____ % ☐FiO_2

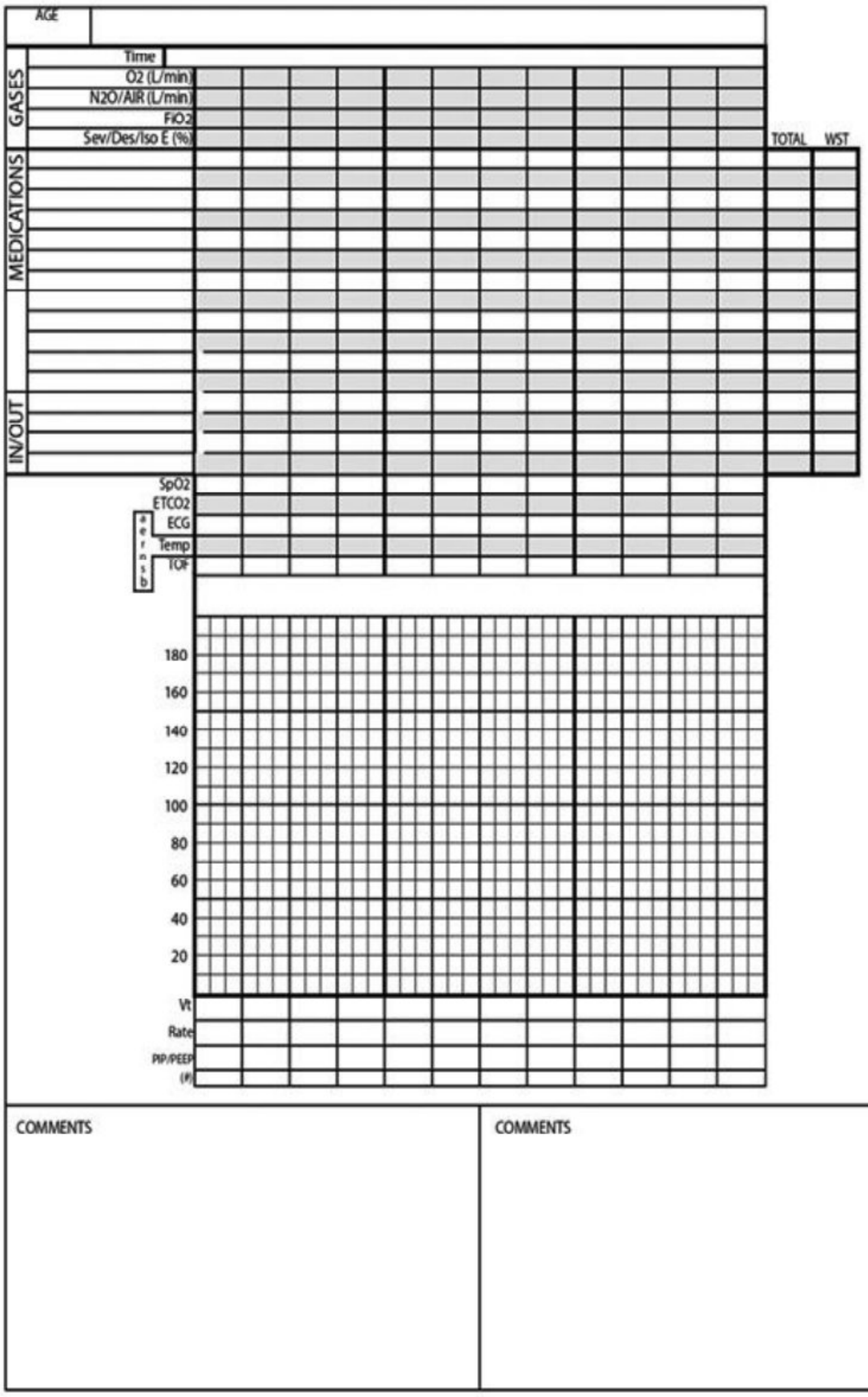
WHITE = Medical Records
YELLOW = Billing

Anesthesia Record Rev. 10/05

NOTES PROFORMA 2 PAGE 1



NOTES PROFORMA 2 PAGE 2



COMMENTS

COMMENTS

INDIAN SOCIETY OF ANAESTHESIOLOGISTS

Anaesthesiologist : R. No.

ANAESTHESIA RECORD

Date : Time :

Patient's Name Age : Sex :
Height : Weight :

Operation / procedure
Elective / Emergency ASA Grade NBM - Consent
Surgeon 1) 2)

Preopreative Assessment :

P - Pallor / Cyanosis / Clubbing / Oedema / Icterus
BP - Mouth Opening - Spine -
RS - Teeth -
CVS - MPC Grade
CNS - P/A -

History - HT / DM / TB / MI / IHD / Asthma / Jaundice / Epilepsy / Allergy / Pacemaker / Bleeding disorders / Alcohol / Smoking / Tobacco
Previous Surgery / Anaesthesia
Drug History

Investigations - Hb	BUN / S.creat	S. Bil	Blood Gr.	X-ray Chest
TLC	PT / INR	S.Alb.	HIV	ECG -
Platelet	PTTK	S.Na+	HBsAg	2 Decho
BSL	BT / CT	K+	Urine	

Premedication - Atropine ..... Glycopyrolate ..... Ranitidine ..... Ondansetron ..... Fentanyl .....
Butarphanol ..... Pentazocine ..... Midazolam ..... Clonidine / Dexmeditomidine .....

ANAESTHESIA PLAN - GA / SA / EA / Nerve Block / MAC

Regional Anaesthesia (Under all aseptic precautions)

Spinal - needle No. Space Position Drug
Epidural - Tuohy needle No. Space Position Drug Catheter No.
Nerve Block Drug
Tourniquet - Y/N Time - Pressure

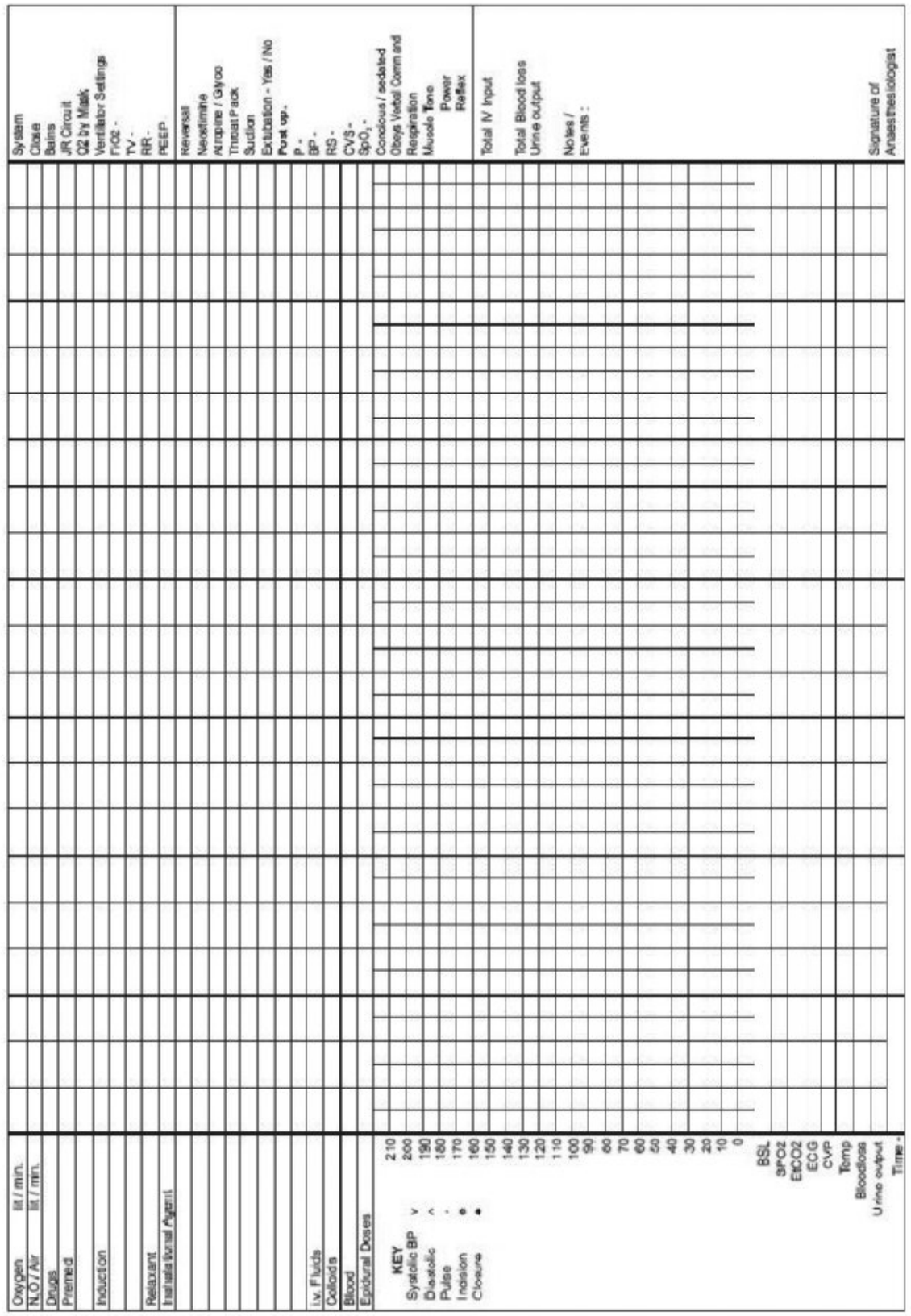
General Anaesthesia -

Preoxygenation with 100% for - min.
Induction -
Ventilation on mask - Easy / difficult
Endotracheal Intubation - Oral / Nasal ET No.
Cuffed / Uncuffed
Easy / difficult / Trauma. Throat Pack +/-

Special tubes - LMA ..... / I-gel - no. ..... / Combitube .....
Respiration - Spontaneous / Controlled / Assisted
Maintenance - O_2 / N_2O / Ar / Inhalational Agent .....

Post operative orders

NBM
I.V. fluids
Shift to post op. room / ICU
O_2 by mask lit / min
Leg elevation / supine / propped up / Lateral
TPR / B.P. / Urine output 1/2 hrly / Pain
Postop Analgesia by
Inform SOS



NOTES PROFORMA 3

NOTES PROFORMA FOR REGIONAL ANAESTHESIA

REGIONAL	Start:	End:	☐ Time Out	REGIONAL	Start:	End:	☐ Time Out
☐ Block for Post op pain control / surgeon request ☐ Block for surgical anesthesia			Code: Code:	☐ Block for Post op pain control / surgeon request ☐ Block for surgical anesthesia			Code: Code:
ASSISTED BY: _____				ASSISTED BY: _____			
BLOCK:			U/S ○ Yes ○ No	BLOCK:			U/S ○ Yes ○ No
OTHER:			○ Left ○ Right ○ Bilat	OTHER:			○ Left ○ Right ○ Bilat
POSITION: Sit / LLD / RLD / Sup / Prone U/S: Y / N Attempts: _____ PREP: Beta / Alc / HIB / CHP Draped: Y / N ☐ Full monitors used LOCAL WHEAL: Y / N Needle Size: _____G NEEDLE MANUFACTURER: _____ Size: 17 G / 20 G / 21 G / 22 G / Other: _____ Length: 80mm / 100mm / Other: _____ N Stim to _____mA (*if applicable*) Blood Asp: Y / N Easy Inject: Y / N Parasth: Y / N Inc Injection: Y / N				POSITION: Sit / LLD / RLD / Sup / Prone U/S: Y / N Attempts: _____ PREP: Beta / Alc / HIB / CHP Draped: Y / N ☐ Full monitors used LOCAL WHEAL: Y / N Needle Size: _____G NEEDLE MANUFACTURER: _____ Size: 17 G / 20 G / 21 G / 22 G / Other: _____ Length: 80mm / 100mm / Other: _____ N Stim to _____mA (*if applicable*) Blood Asp: Y / N Easy Inject: Y / N Parasth: Y / N Inc Injection: Y / N			
☐ Catheter tunneled at: _____ Dressing: Tegaderm / Op-Site / None SUCCESS: On/Q Infusion Pump ☐ Complete ☐ Partial ☐ Failed ☐ Eval Pending MEDICATIONS				☐ Catheter tunneled at: _____ Dressing: Tegaderm / Op-Site / None SUCCESS: On/Q Infusion Pump ☐ Complete ☐ Partial ☐ Failed ☐ Eval Pending MEDICATIONS			
1.		3.		1.		3.	
2.		4.		2.		4.	
Other:				Other:			
COMMENTS				COMMENTS			
ID#	SIGNATURE	DATE	TIME	ID#	SIGNATURE	DATE	TIME

ANNEXURE–7

Aldrete Scoring System for Postoperative Recovery

	Assessment Interpretation	Score
Activity	Able to move all extremities voluntarily or on command	2
	Able to move two extremities voluntarily or on command	1
	Unable to move extremities voluntarily or on command	0
Respiration	Able to breathe deeply and cough freely	2
	Dyspnea or limited breathing	1
	Apneic or on the mechanical ventilator	0
Circulation	Blood pressure ± 20% or less of the preanesthetic level	2
	Blood pressure ± 20% to 49% of the preanesthetic level	1
	Blood pressure ± 50% or more of the preanesthetic level	0
Consciousness	Fully awake	2
	Arousable on calling	1
	Not responding	0
Oxygenation	Able to maintain oxygen saturation >92% on room air	2
	Needs supplemental oxygen to maintain O2 saturation >90%	1
	Oxygen saturation <90% even with supplemental oxygen	0

ALDRETE SCORE

1. Ding D, Ishag S. Aldrete Scoring System. [Updated 2023 Jul 8]. In: StatPearls [Internet]. Treasure Island (F.L.): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK594237/

ANNEXURE–8

Postoperative Handover/ Discharge/Shift to Higher Centre Form

PACU Handover Notes

Patien: Information:
Name:
Age:
Sex:
Medical Record Number:
Surgery/Procedure:
Anesthetic Technique:
PACU Admission Date Time:
PACU Discharge Date Time:
PACU Course:

Initial PACU Assessment Findings On receiving the patient

Level of Consciousness:
Vital Signs: BP HR, RR, SpO2, Temp
Airway: Intubated Yes No
Breathing: Spontaneous Assisted Volume Controlled
Circulation: Stable, Interventions/Supports
Pain: Pain Scale
Analgesics Given-
Nausea/Vomiting: None,
Vomiting Treated with
Urine Output:
Drain Output:
Surgical Site Assessment -bleeding

Summary of Intraoperative Events: To be informed to the PACU Nurse./ ICU consultant :

Pre-Existing Medical Conditions
Pre-Existing Medications:
Unique Patient Needs:
Anaesthetic Agents Used:
Fluids and Transfusions:
Complications/Interventions
Blood Gas and Laboratory Results:
Airway Management:
Neuromuscular Blockade:
Temperature Management:
Analgesia Provided:
PACU Care Provided:
Medications Administered:
Fluids Given:

Blood Products Transfused:
Analgesia Regimen:

Post-Anesthesia Recovery Status:

Vital Signs Trend:
Level of Consciousness Improvement:
Pain Control:
Nausea/Vomiting Status:
Surgical Site Assessment:
Neuromuscular Function:
Temperature Management:
Special Considerations:
Allergies:
Recommendations:
Discharge Criteria Met:
Post-Discharge Instructions:
Medications:
Activity Level instructions
Diet instructions
Wound Care:
Accompanying person Name:
Accompanying person Tel No
Follow-up / readmission in case of : Headache, bleeding, fainting

While shifting patient to Higher Centre :
Reasons:
Any Concerns or Issues: Emergency?
Patient/relatives informed of reasons for transfer
Consent for high-risk revisited / take relevant signatures from patient and relatives.
Transferring to Hospital Name
Handover to Receiving Healthcare Team:
Time of Handover:

Anaesthetist's Signature:
Anaesthetist's Name:
Receiving Healthcare Team's Signature:
Receiving Healthcare Team's Name:

APPENDIX 1-ASA PHYSICAL STATUS

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations. One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN. COPD. morbid obesity (BMI≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (<3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/ thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

Table 1 ASA physical status (PS) classification and definition (Taken from https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system)

1. Doyle DJ, Hendrix JM, Garmon EH. American Society of Anesthesiologists Classification. [Updated 2023 Aug 17]. In: StatPearls [Internet]. Treasure Island (F.L.): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK441940/
2. https://www.asahq.org/standards-and-practice-parameters/statement-on-asa-physical-status-classification-system

APPENDIX 2 -REVISED CARDIAC RISK INDEX FOR NON-CARDIAC SURGERY SURGERY

Risk Factors	Points
History of ischemic heart disease	1
High-risk type of surgery	1
History of congestive heart failure	1
History of cerebrovascular disease	1
Preoperative treatment with insulin	1
Preoperative serum creatinine >2.0 mg/dL	1

RISK OF MAJOR CARDIAC EVENT

Points	Class	Risk
0	I	0.4%
1	II	0.9%
2	III	6.6%
3 or more	IV	11%

Figure 1: Revised Cardiac Risk Index.

1. Shalini Dhir, Achal Dhir, The Global Perspective of Cardiovascular Assessment for Noncardiac Surgery: Comparisons from Around the World, Journal of Cardiothoracic and Vascular Anesthesia,Volume 33, Issue 8, 2019,Pages 2287-2295,ISSN 1053-0770, https://doi.org/10.1053/j.jvca.2019.03.003.
2. Fayed N, Elkhadry SW, Garling A, Ellerkmann RK. External Validation of the Revised Cardiac Risk Index and the Geriatric-Sensitive Perioperative Cardiac Risk Index in Oldest Old Patients Following Surgery Under Spinal Anaesthesia; a Retrospective Cross-Sectional Cohort Study. Clin Interv Aging. 2023 May 10;18:737-753. doi: 10.2147/CIA.S410207. PMID: 37197404; PMCID: PMC10183631.
3. Vernooij LM, van Klei WA, Moons KG, Takada T, van Waes J, Damen JAAG. The comparative and added prognostic value of biomarkers to the Revised Cardiac Risk Index for preoperative prediction of major adverse cardiac events and all?cause mortality in patients who undergo noncardiac surgery. Cochrane Database of Systematic Reviews 2021, Issue 12. Art. No.: CD013139. DOI: 10.1002/14651858.CD013139.pub2. Accessed 16 September 2024.

APPENDIX 3 – FASTING GUIDELINES ISA 2020

Recommendations: Fasting & Feeding – Adults

Clear liquids should be allowed up to 2 h prior to administration of sedation or anaesthesia.

The volume of clear liquid consumed may be restricted to <450 mL, 2 h prior to administration of sedation or anaesthesia.

Non-clear liquids may be allowed up to 4 h prior to administration of sedation or anaesthesia.

Light meals may be allowed up to 6 h prior to administration of sedation or anaesthesia.

If the Patient has consumed heavy meals, it may be prudent to wait for at least 10 h prior to the administration of sedation or anaesthesia.

Heavy meal consumption is not advisable the night prior to surgery

Recommendations: Aspiration prophylaxis – Adults

Routine use of aspiration prophylaxis in adequately fasted patients is not advised prior to the administration of sedation or anaesthesia.

Aspiration prophylaxis is advised in high-risk patients as identified by the anaesthesiologist.

H2 receptor blockers, proton pump inhibitors and prokinetic drugs may be used as prophylaxis in high-risk patients.

Recommendations: Fasting & Feeding – Obstetric

Women in early or late pregnancy, when administered sedation or anaesthesia, may be at high risk for aspiration

Clear liquids may be allowed up to 2 h prior to administration of sedation or anaesthesia in pregnant women.

Non-clear liquids may be allowed up to 4 h prior to administration of sedation or anaesthesia in pregnant women.

Light meals may be allowed up to 6 h prior to administration of sedation or anaesthesia in pregnant women.

Heavy meal consumption is not advisable the night prior to surgery in pregnant women.

Recommendations: Aspiration prophylaxis – Obstetric

Pregnant women requiring sedation or anaesthesia should be administered aspiration prophylaxis.

H_2 receptor blockers and proton pump inhibitors can be administered alone or in combination with prokinetic drugs for aspiration prophylaxis.

Recommendations: Fasting & Feeding — Bariatric

Obese individuals may be at higher risk for aspiration in comparison to non-obese individuals when administered sedation or general anaesthesia.

In obese individuals, the advice on preoperative fasting practices may be the same as in non-obese individuals prior to the administration of sedation.

Recommendations: Aspiration prophylaxis

Aspiration prophylaxis may be administered in obese patients prior to the administration of sedation or anaesthesia.

H_2 receptor blockers and proton pump inhibitors can be administered alone or in combination with prokinetic drugs for aspiration prophylaxis.

Recommendations: Fasting & Feeding — Paediatric

Consumption of water, up to 3 mL/kg, should be allowed until 1 h prior to administration of anaesthesia.

Consumption of clear liquids other than water, up to 3 mL/kg, can be allowed until 2 h prior to administration of anaesthesia.

Human milk and fully skimmed non-human milk can be allowed until 4 h prior to administration of anaesthesia.

Non-clear liquids, non-human milk, formula feeds, light breakfast or light meal may be allowed until 6 h prior to administration of anaesthesia.

Recommendations: Aspiration prophylaxis — Paediatric

The attending anaesthesiologist can decide for or against administering aspiration prophylaxis in adequately fasted children.

REF-Dongare PA, Bhaskar SB, Harsoor SS. Garg R, Kannan S, Goneppanavar U, et al. Perioperative fasting and feeding in adults, obstetric, paediatric and bariatric populations: Practice Guidelines from the Indian Society of Anaesthesiologists.Indian J Anaesth 2020;64:556-84.

APPENDIX 4 -STOP BANG SCORE

TABLE 2
STOP-BANG questionnaire*

STOP		
S (snore)	Do you *snore* loudly (louder than talking or loud enough to be heard through closed doors)?	Yes/No
T (tired)	Do you often feel *tired*, fatigued, or sleepy during daytime?	Yes/No
O (observed)	Has anyone *observed* you stop breathing during sleep?	Yes/No
P (blood pressure)	Do you have or are you being treated for high blood *pressure*?	Yes/No
BANG		
B (body mass index [BMI])	*BMI* > 35 kg/m^2?	Yes/No
A (age)	*Age* > 50 years?	Yes/No
N (neck)	*Neck* circumference > 40 cm?	Yes/No
G (gender)	*Gender* male?	Yes/No

Yes to ⩾ 3 questions = high risk of obstructive sleep apnea
Yes to < 3 questions = low risk of obstructive sleep apnea
*Adapted from Chung et al.[20]

1. Hwang, M., Nagappa, M., Guluzade, N. et al. Validation of the STOP-Bang questionnaire as a preoperative screening tool for obstructive sleep apnea: a systematic review and meta-analysis. BMC Anesthesiol 22, 366 (2022). https://doi.org/10.1186/s12871-022-01912-1
2. Nagappa, Mahesh MD*; Patra, Jayadeep PhD†; Wong, Jean FRCPC†; Subramani, Yamini MD*; Singh, Mandeep FRCPC†; Ho, George BSc†; Wong, David T. FRCPC†; Chung, Frances FRCPC†. Association of STOP-Bang Questionnaire as a Screening Tool for Sleep Apnea and Postoperative Complications: A Systematic Review and Bayesian Meta-analysis of Prospective and Retrospective Cohort Studies. Anesthesia & Analgesia 125(4):p 1301-1308, October 2017. | DOI: 10.1213/ANE.0000000000002344

Preoperative Investigations: Practice Guidelines from Indian Society of Anaesthesiologists (ISA)*

		Complete Blood Count (CBC)	Renal Function Tests (Serum Creatinine)	Liver Function Tests (LFT)	12 Lead Electrocardiogram (ECG)	Chest X-ray (CXR)	- Serum Electrolytes (Na^+, K^+) - Coagulation Profile - Blood Sugar	Preoperative routine airway ultrasound evaluation for predicting difficult airway (laryngoscopy)
Nature of Surgery	Minor				≥ 45 years			
	Intermediate				≥ 45 years	≥ 50 years		
	Major				All	≥ 50 years		
VTPIN (Validity Time for Previously done Investigations)		2 months	2 months	2 months	12 months	12 months		

* For non-diabetic ASA PS 1 and 2 adults scheduled for elective surgery, based on the nature of the surgery

- Green Boxes: Investigations to be ordered routinely.
- Amber Boxes: Investigations to be considered on an individual basis, as per patient evaluation.

(The attending anaesthesiologist may consider individualising the decision on further investigations. Eg: patients receiving diuretics or patients scheduled for monopolar TURP surgery require serum electrolytes estimation; patients with features suggestive of underlying active lower respiratory pathology may require Chest X-ray irrespective of age; patients on anticoagulant medication require coagulation profile testing)

Minimum investigations to be done in non-diabetic ASA PS 1 and 2 patients prior to elective surgery

- **Minor surgery – CBC, 12 lead ECG (for all patients aged ≥ 45 years)**
- **Intermediate surgery – CBC, Serum Creatinine, 12 lead ECG (for all patients aged ≥ 45 years), CXR (for all patients aged ≥ 50 years)**
- **Major surgery – CBC, Serum Creatinine, LFT, 12 lead ECG (for all patients aged ≥ 45 years), CXR (for all patients aged ≥ 50 years)**

VTPIN: Blood investigations (2 months), 12 lead ECG (12 months) and CXR (12 months)

1. Additional investigations to be considered by the attending anaesthesiologist on an individual basis, as per patient evaluation.

2. Repeat investigations within VTPIN to be considered if there is a change in patient physiology.

REF-PREOP INVESTIGATIONS guidelines ISA 2022

Umesh G, Bhaskar SB, Harsoor SS, Dongare PA, Garg R, Kannan S, et al. Preoperative investigations: Practice Guidelines from the Indian Society of Anaesthesiologists. Indian J Anaesth 2022;66:319-43.

SECTION 2 – FUNCTIONING OF CITY BRANCHES

The time has come for us to stand united and progress to take our speciality and its honour to new heights. We are true Angels of God, and as perioperative physicians, we can improve the outcome of any surgery. Today, the only way to create a healthy working atmosphere in your city is to unite against all the adversities we face. To achieve this, ISA recommends the following:

1. Regular monthly meetings are necessary; clinical topics, difficulties in practice, set-ups, and black sheep should always be discussed.
2. Public awareness of our speciality is woefully lacking; every member should take it upon himself to promote this activity. Some suggestions are
   (a) Start your pre-anaesthesia clinic in each hospital or visit the Patient during the preoperative and postoperative periods.
   (b) Anesthesia-specific consent forms with a preoperative questionnaire to be handed over to the Patient once he has been posted for surgery (in the local language)
   (c) Designing and pasting posters to impart knowledge about anaesthesia with the pictorial demonstration of its modes and techniques.
   (d) Designing interactive websites related to anaesthesia with thorough knowledge about anaesthesia, with experts replying to queries from the public.
   (e) Making a film about anaesthesia techniques and showing it on a public platform like cinema theatres.
   (f) Organise conferences on anaesthesia, analgesia, and pain management wherein all specialists exchange their thoughts and ideas on managing pain with public involvement.
   (g) Press releases for all events should be routine so that local media always publish our events, thereby ensuring wide public knowledge.
   (h) Invite State /National dignitaries to your city.
   (i) Teach cardiopulmonary resuscitation (CPR)/Disaster management to all public, media persons, paramedical staff and police officers through the Indian Resuscitation Council Federation (IRCF).
   (j) World Anaesthesia Day should always be celebrated in great pomp and ceremony on a public platform. Make a deal with the local radio/television stations.
   (k) Wear colour-coded T-shirts with stimulating captions such as "WE CARE WHEN YOU ARE NOT AWARE". The colour of these T-shirts can be of our National ISA flag, and we wear them regularly, be it professional or social events; what better way to promote ourselves?
   (l) Anaesthesia card postop can be effective, especially if the Patient has had some problems during anaesthesia.

(m) Social communities like Rotary and Lions Club can be used as interactive platforms.

3. Frequent non-academic meetings with family, ladies' specials, picnics, and treks should be encouraged.
4. Attending conferences /CMEs as a group, so you spend more time with each other.
5. Organise conferences/workshops on anaesthesia, pain, and labour analgesia, bringing all specialists together on a common platform.
6. Celebrate festivals of all communities together.
7. Frequent meetings and interactions help in a cohesive, stress-free atmosphere.
8. New and junior colleagues should be welcome and seniors duly respected.
9. A grievance cell should also be set up in each city as a rescue team to help members in distress in the operation theatre and intensive care units.
10. If possible, having an office is beneficial for routine work.
11. Set up minimum monitoring standards and a uniform charge structure in each city, as recently advised by the national headquarters.
12. Use media to your advantage; actively involve your members in disaster management events such as Kumbh-Mela or large public gatherings.
13. Increase your self-esteem by thinking that the following should be non-exploitable and full of self-esteem. Anybody should think 100 times before labelling us guilty. We should be well-focused in operation theatres hours and should never feel insecure. We should strike a balance between family and professional life and should be eager to work unitedly. We should be full of energy and have command of our professional skills. Today's world is a world of sharing responsibilities. Nobody will give you any medal for the extra risk you are taking, but if anything goes wrong, you will be fired alone, so take calculated risks.

ISA recommends that we unite against diversity, love our profession, make our lives the best by changing our attitude, and surround ourselves with like-minded colleagues and surgeons. We only have one life, so make the best of it.

PPF OF ISA IS DOING ALL TO IMPROVE OUR WORK CULTURE AND HOPE THAT TOGETHER, WE CAN IMPACT AND CHANGE OUR TODAY FOR A BETTER TOMORROW.

SECTION 3 – ETHICAL CONDUCT OF ANAESTHESIOLOGIST

The ISA always advises and expects thorough, ethical conduct from its members. Professional conduct helps avoid landing in unwanted situations, overcome adverse circumstances, and help in case of litigations.

The ISA recommends following to its members.

1. Perform a preanaesthetic check-up (PAC) of the Patient before taking the Patient for Surgery. Ask all your surgeons to send all patients of elective Surgery for PAC. Use the ISA-recommended questionnaire and PAC format for documentation of PAC. Performing PAC helps in establishing a rapport with the patients and their families. Do not forget to 'Communicate, Document, Communication of documentation, and Documentation of Communication' as this is the key to success in medicolegal cases.
2. Continuously optimise the Patient before posting for surgery. Get proper investigations and references for the type of surgery and patient and document them.
3. Consent- Always obtain separate consent for anaesthesia from the Patient after explaining the technique and alternatives and answering his queries. ISA recommends the use of a consent format (Annexure 1).
4. Do not indulge in the undercutting of remunerations.
5. Do not share professional responsibilities with Ayurvedic anaesthesiologists.
6. Take special care and caution with your record keeping if you deliver professional services to an Ayurvedic surgical specialist.
7. The ISA recommends that members consistently implement the WHO surgical safety checklist before inducing the Patient and document it in the ISA-recommended intraoperative record-keeping chart.

Guide on how to use the ISA consent form:

Enter Patient's demographic details: This can be entered by any hospital staff/Patient himself. After filling in the patient details, the date and time must be noted, and the form must be handed over to the Patient.

Questionnaire: The patient must fill this out in his handwriting, with the help of a relative/ guardian or any other well-wisher they rely on. This, if filled, will ensure that all significant history is brought to attention. There is also a tendency for some people to ignore specific medical histories for various reasons. This will be difficult once we get the answers in written form from the patients. The Patient is expected to make an appointment with an anaesthesiologist and report with a completed questionnaire and all medical records, present and past. The Patient or relative is to sign the form after answering all the questions. In an emergency with insufficient time, the anaesthesiologist will include this in his pre-anaesthetic check-up and may have to rush through this to save time.

PAC: This needs to be done by a qualified anaesthesiologist.

History: write here whatever is significant. It is the duty of the anaesthesiologist to ask for all related medical history, irrespective of whether it was answered as unfavourable in the questionnaire. For medical history written in adequate detail by the Patient, the anaesthesiologist may only mention that it was noted.

Examination: This will be done in detail; all the positive findings will be entered.

Anaesthesia plan and alerts: Write here the plan of anaesthesia best suited as per your judgement and patient counselling, as well as if there are any anticipated difficulties or special preparations to be done. For example, general anaesthesia with regional blocks (include block name) and low haemoglobin will need to arrange blood.

After the Patient is seen and counselled by the anaesthesiologist, the anaesthetist will sign the form and give it back to the Patient. The Patient will read it at leisure and, if willing to undergo surgery, sign it and come for admission at the appointed time. The Patient will sign the consent if he is an adult capable of giving consent. In cases of minors and people not fit to give consent, the consent will be signed by guardians/parents. If the patient is not fit to sign the consent form, in cases of emergency where no known relative is present, it will be signed by a competent hospital authority as prescribed by law.

SECTION 4 – REMUNERATION OF ANAESTHESIOLOGIST

One of the greatest inventions for humanity since the printing press, anaesthesiology has come a long way since October 1846. Newer techniques have improved outcomes so that high-risk patients considered inoperable can be saved today, and surgeries earlier that were assumed impossible can be done quickly. As perioperative physicians, we handle trauma, ICU, airway, and pain management, apart from administering high-tech and sophisticated anaesthesia and monitoring. Today, our working environment looks almost like the cockpit of an aircraft and demands even more in-depth and vast knowledge, experience, and vigilance. Sadly, our recognition and our remunerations are still disgracefully low.

There has always been a concern amongst the city branches (especially the newly formed ones) on what system to adopt to calculate anaesthesia fees. Hence, ISA has taken a step forward in suggesting three systems the city branches can adopt (Annexures 8,9 and 10).

The government hospital salaries are equal for all specialities, but discrimination is pervasive in the private sector. In the last 20 years, the number of Anaesthesiologists in private practice has increased substantially due to the growth of Nursing Homes and Corporate hospitals. However, the psychological insecurity, combined with a lack of confidence in our value and worth, prevents many of us from taking firm steps to negotiate a more dignified and independent payment policy for our invaluable work. The situation is not very different from that of the rest of the developing world. However, in the United States, Australia, New Zealand and South Africa, the anaesthesia payment is based upon a logical and consistent system called the Relative Value Guide (RVG). This system allocates Units to an anaesthesia service based on the complexity of the surgery (e.g., a laminectomy earning more units than an appendectomy), the time taken (e.g., every 15 minutes get counted as one unit), and the Modifiers (e.g., age and ASA status) that increase the risk profile of the Patient. These COMPLEXITY, TIME, and RISK units are added, and then the total is multiplied by the pre-decided $ value to arrive at the total anaesthesia fee for the said procedure. Each anaesthetist, individually or as a group, decides the $ value of their unit. This $ value is revised yearly, considering inflation and the cost of living. The average per-unit fee in the U.S. is between 140 and 190 dollars per unit.

Through consistent and tireless efforts of their respective anaesthesia associations since 1990, the practising anaesthesiologists of the UK, Ireland and Malaysia have also arrived at a decent and respectable payment system like RVG. An app has been developed to calculate RVG and keep other records.

In India, the ISA is also trying to bring the remuneration of our anaesthesiologists' colleagues to a more dignified and decent level. The ISA endorses three systems for anaesthesia fee calculation.

City branches can choose any of the three methods to fix their city branch charges.

1. **Hourly basis charges :** The anaesthesia fees can be calculated according to the hourly charges fixed plus the add-on of any procedures ***(ANNEXURE 9, page 64)***

2. **Surgery-specific charges:** The anaesthesia fees can be based on the types of surgeries. It has a range of fees. The anesthesiologist can charge anything between that structure depending on his seniority or the complexity of the procedure ***(ANNEXURE 10, page 65)***
3. **RVG System:** The Relative Value Guide is an independent, transparent system that arrives at anaesthesia remuneration. The ISA will work towards the implementation of RVG by talking to various stakeholders, including insurance companies, corporations, CGHS, and others. The resultant transparency would eradicate rampant exploitation of our privately practising colleagues in the hands of private hospitals, who arbitrarily keep anaesthesia fees for such cases at very low levels. For the Calculation of RVG, ISA city branches will suggest a range (e.g., from Rs.300 to Rs.600) as their city's rupee value of ONE UNIT. This would be done yearly or every two years. Practice groups and freelancers will be guided by this range while choosing the value of ONE UNIT for their fee calculations ***(ANNEXURE 11, page 66).***

ANNEXURE–9

Remuneration on Hourly Basis

INDIAN SOCIETY OF ANESTHESIOLOGIST

---------- CITY BRANCH

(PAN----------)

Dr. President Ph:	Dr. Patron Ph:	Dr. Hony. Secretary Ph:

Vice President
Dr.

Scientific Secretary
Dr.

Editor News Letter
Dr.
Dr.

Treasurer
Dr.

Executives
Dr.
Dr.
Dr.
Dr.
Dr.
Dr

Legal advisory panel
Dr.
Dr.
Dr.
Dr.
Dr.
Dr.

Ex official
Immediate past president
Dr.

Immediate past secretary
Dr.

Revised Fee structure of ISA ----------

All anaesthesiologists under the banner of Indian Society of Anaesthesiologists, ---------- have reached to the decision to follow these minimum fee structures for operations which is going to be applicable with effect from ----------

1. Operative time would be considered from induction to the last stitch.
2. Spinal, GA, Brachial, Epidural, Sedation Analgesia
   a. For 1st hour – Rs
   b. Next consecutive hours – Rs per 30 mins
3. Neuro, Pediatric, Geriatric, Onco, Obese, High Risk Cases(ASA 3/4), Night cases (10.00 PM – 06:00 AM)
   a. For 1st hour - Rs
   b. Next consecutive hours – Rs per 30 mins
4. Minor Cases (less than 15 mins) - Rs
5. Special Circumstances
   Mediclaim cases- If paid immediately then charges are same, If paid later then charges will be double
6. All cases must undergo Pre-anaesthetic Checkup (PAC) which is chargeable upto Rs.
7. Upto 24 hours after induction – no visit fees for complication of anaesthesia.
8. ICU visit Fees – Rs per visit per patient
9. Any other Procedure in Ward/ ICU- Rs
10. Labour Analgesia charges- Rs for first 2 hrs , thereafter Rs for 30 mins.

Regards

Dr. President ISA, ---------- City Branch	Dr. Secretary ISA ---------- City Branch

ANNEXURE–10

Remuneration on Case Basis

INDIAN SOCIETY OF ANAESTHESIOLOGIST (ISA) CITY BRANCH

MINIMUM ANAESTHESIA FEES/ CHARGES (W.E.F. 202)

1) Thesearetoidate charges as guidelines, which should increase as per patient Category (General/ Tatkal/ Delhaze), Risk involved, Duration of surgery and special requirement (instruments)

2) These are General Ward charges and 25-30% increase in case is Pvt. room.

3) Anaesthesia charges are irrespective of surgeon charges. Charges will be based on Relative value guide (RVG) for all cases above 2 hours.

4) Emergency and High risk patient should be charged 50-55% extra. 5) Pre operative visit will be Rs.800 – 1000

	OBS /GYNAE	
1	MTP/D&C	
2	LSCS	
3	TL=a) Open b) Lap c) MTP & TL (open) (Lap)	
4	Hysterectomy a) Open abdominal b) Vaginal c) Lap d) vaginal repair	
5	TUBAL/OVARIOTOMY/CYST	
6	Tuboplasty (Open) (Lap)	
7	Hysteroscopy a) Diagnostic b) Therapeutic (Septum, Ras, Polyp)	
8	Hysterolaparoscopy a) Diagnostic b) Therapeutic	
9	Ova ruptured ova cyst a) Open laparotomy b) Lap repair	
10	Ectopic pregnancy a) open c) lap	
11	Myomectomy/Hysterectomy	
12	MRP	
13	Episiotomy suturing	
14	Labour Analgesia a) Basic b) epi/ para/ spinal	
15	Stand by call for dr. delivery for 24-25 min	

	ENT	
1	Adenoid	
2	Tonsilectomy	
3	Septoplasty / SMR	
4	Nasal bone reduction	
5	Tympanoplasty	
6	Mastoidectomy	
7	FESS	
8	FOB Ear / Nose	
9	Rhinoplasty	
10	Vocal cord Nodule/Polyp	
11	Cs Layro. Radioscopy/ Laser	
12	ST Radioscopy	
13	Cochlear implant	

	CARDIAC	
1	PTCA	
2	Device closure	
3	CABG	

	GENERAL SURGERY	
1	Appendicectomy - Open	
2	Appendicectomy - Lap	
3	Inguinal hernia - unilateral	
4	Inguinal hernia - bilateral	
5	Umbilical / Epigastric hernia	
6	Incisional hernia	
7	Lap inguinal hernia	
8	Lap umbilical hernia	
9	Piles / Fistula /Pilonidal /Lords	
10	Exploratory laparotomy	
11	Varicose vein unilateral/ Laser	
12	Thyroid	
13	Cholecystectomy - Open	
14	Cholecystectomy - Lap	
15	Fibroadenoma excision	
16	Simple mastectomy	
17	AK/ BK Amputation	

	COSMETIC SURGERIES	
1	Liposuction	
2	B/L Gynaecomastia	
3	Abdominoplasty	
4	Breast Reduction/ Breast Implant	

	ORTHOPEDIC	
1	Close reduction/ K-wire	
2	DHS/ Bipolar/ Femur plate-nail	
3	Tibia plating / nailing	
4	Biopsy	
5	Humerus nailing -plating	
6	Radius / Ulna Plating –nailing	
7	ACL Repair	
8	PCL Repair	
9	Shoulder Arthroscopy(Bankart)	
10	Diagnostic Arthroscopy Knee Shoulder	
11	TKR unilateral Bilateral	
12	THR	
13	Ankle malleolus	
14	TBW Patella	
15	Fibula/ Sternal	
16	Cervical	

	INTERVENTIONS	
1	ICU Central line	
2	Intubation	
3	Lumber Puncture	
4	Arterial line	

	OPHTHALMOLOGY	
1	Cataract a) Stand (Adult) b) Pedia GA	
2	Squint a) standby-Adult-Unilateral Bilateral b) Pedia GA Unilateral Bilateral	
3	Corneal Tear/Eye Trauma	
4	DCR/DCT a) Open b) endoscopy	
5	Vitrectomy (Stand By)	
6	Glaucoma Surgery	
7	Cataract with Glaucoma (stand by)	
8	Probing under GA (Pedia)	
9	VR Surgery	
10	Ptosis	
	Orbitotomy	
	DCR (GA)	

	ONCO SURGERY	
1	Ca cheek/ Tongue (RND) With Flap	
2	Wide local excision (Oral wa cancer)	
3	MRM	
4	APR	
5	Laryngectomy	
6	Ca Esophagus	
7	Whipples	

	URO SURGERIES	
1	Diagnostic Cystoscopy	
2	Stricture Urethra	
3	URS	
4	Prostatectomy/Pyeloplasty	
5	PCNL	
6	Nephrectomy open Lap	
7	TURP/ TURBT	
8	ESWL	
9	Radical Cystectomy/ Neobladder	

	NEUROSURGERY	
1	Craniotomy - EDH	
2	SDH	
3	Meningioma-ICC	
4	Burr hole	
5	Lumber discectomy Single	
6	Cervical discectomy	
7	Spinal instrumentation	

	PEDIATRIC SURGERY	
1	Hypospadias Repair	
2	VP Shunting	
3	Circumcision	
4	Hernia / Hydrocele Bilateral	
5	Orchidopexy	
6	Bronchoscopy	
7	Pyloromyotomy	
8	Laparotomy	
9	TOF/ CDD	
10	Thoracoscopy	
11	Lap VAT	
12	Dental procedure under GA	

	PLASTIC SURGERY	
1	Mandible/ maxilla	
2	Rhinoplasty	
3	Cleft lip/ palate	
4	Debridement + SSG	
5	Tendon suturing	
6	Microvascular surgery	
7	Burn contracture release	
8	Burn dressing	

	ENDOSCOPY	
1	Upper GI scopy	
2	Colonoscopy	
3	Gastric variceal banding	
4	Polypectomy	
5	ERCP	
6	FB Removal	
7	Oesophageal dilatation	

	RADIOLOGY	
1	IVP/ CT Contrast	
2	CT Scan Sedation	
3	MRI Sedation	
4	Cardiac CT	
5	PET	

President Secretary

ANNEXURE–11

RVG

Based on a simple formula of DIFFICULTY level and TIME taken

Logical, consistent, transparent calculation coupled with flexible reimbursement

How to derive the TOTAL analysis fee for any procedure?

FEE = (Number of Base Units + Number of Time Units + Number of Modifying Units) Multiplied by the Rupee value of the UNIT

METHOD OF CALCULATING TOTAL UNITS WILL REMAIN THE SAME ALL OVER INDIA.

1. BASE UNITS: Based on simplicity or complexity of procedure — pre-assigned and published on the ISA website.
2. TIME UNIT: The 15-minute length of anaesthesia service will equal a one-time unit. (1hr = 4 units; 40 min=15+15+10=3 units)
3. MODIFYING UNITS:
   - ADD-ON: Age: less than 1 or more than 70 - 3 units.

   Obesity: BMI 35-40 -2 extra units, more than 40 -3 extra units; Arterial/Central line: - 4 extra units.

   Postoperative visits: (in the ward) 2 units per visit, (in ICU) 4 units.

MULTIPLIERS: High Risk: ASA 3 (+25%,) ASA 4 (+50%), Other Risk Factors (+50%); Emergencies: in the daytime (+25%), Odd hour (10 pm to 7 am) (+50%);

Mahurat (fixed time by Astrologer) cases at any time (+ 50%);

Seniority and experience: add 25 to 50% depending on years of experience

NOTE:

1. The time UNIT count will begin from induction and end at extubation stabilisation or the end of surgery for regional blocks.
2. PAC will be charged per the prevailing visit/consultation fee.

BASE UNITS: The list is only representative. Similar surgeries may be given the same number of units.

- 4 units: Minor procedures, D&C, LN biopsy, Cystoscopy;
- 5 units: Diagnostic Radiology, ERCP.
- 6 units: Lap Chole, LSCS, Lap Ectopic, Lap Ovarian, TURP, TURBT, URS, MRM, DHS, PFN.
- 7 units: Lumber Decompression, PCNL.
- 8 units: TLH, Liposuction, Ant Cervical Spine, THR, TKR.
- 10 units: Major Head & Neck, Commando;
- 12 units: TOF, Diaphragmatic Hernia, Meningomyelocele, Rectal Pull through.
- 14 units: Cystic Hygroma, ICSOL.
- 16 units: CABG, Whipple's;
- 20 units: Intracranial Vascular

Examples of applying RVG to derive Anesthesia fee: (If 1unit=300)

- 31 F for MTP, time 15 minutes BASE UNITS 4

TIME UNITS 1

TOTAL UNITS 5 (300*5=1500)

- 28 F for LSCS, ASA 2, time 1 hour, Mahurat -fixed time by Astrologer BASE UNITS 6

TIME UNITS 4

MODIFIER -Mahurat (50% more)

TOTAL UNITS 10 + 50% = 15

(If the Rupee value of a UNIT is 300, the Anesthesiologists fee = 4500)

- 45 F, ASA 2, BMI 37, TLH done in 120 minutes BASE UNITS 8

TIME UNITS 8 MODIFIER 2 (for BMI)

TOTAL UNITS 18

(If the Rupee value of a UNIT is 300, the Anesthesiologists fee = 5400)

Testimonials

I fully endorse the Private Practitioner Positional Statement, which advocates for the interest of private practitioners and strikes a balance in the practice of anaesthesia in our diverse country. It also highlights the evolving needs of our profession. It ensures a balanced and ethical approach. This statement is a guiding framework for improving practice standards and patient care."

– DR REKHA DAS – NATIONAL GC

This position statement has covered every topic and will help all practising

anaesthesiologists across India. This will improve the Patient Safety standards even in resource limited rural areas. This Position statement also focused on the remuneration of anaesthesiologists and mental well-being.

– Dr RAMA KRISHNA REDDY MUDIGANTI – NATIONAL GC

Congratulations, Dr Pankaj Gupta and team, for preparing the "POSITION STATEMENT FOR ANAESTHESIOLOGISTS IN PRIVATE PRACTICE IN INDIA", an initiative from PPF (Private Practitioners Forum). I am confident this will help the practising anaesthesiologist, particularly in the semi-urban and rural set-up, to provide safe anaesthesia for patients with various surgical and comorbid conditions. I sincerely appreciate your hard work. Long live PPF of ISA!

– Dr SRINILAVASU D – NATIONAL GC

This document is a culmination of my dream, which a few of my like-minded colleagues and I saw in 1983 when we formed the Association of Practicing Anesthesiologists in Hyderabad. Your hard work and commitment and those who worked on this position statement are laudable. I wish more and more practising anesthesiologists join this movement with devotion like yours to bring it to fruition. My best wishes are with all of you.

– Dr. ABHAY PATWARI – FOUNDER PPF 1989

PPF, under the leadership of Dr. Pankaj Gupta, has drafted these guidelines for practising anesthesiologists. Adherence to these guidelines will improve patient safety and reduce the probability of medicolegal litigation.

— Dr SC PARAKH — FOUNDER PPF 1989.

The much-needed guidelines for private practitioners were reviewed by Dr Harsoor, Dr JG Divatia, and me 2017 before their release. It gives me great pleasure and satisfaction that the present position statement is more elaborate and covers all the important aspects of protecting the interests of our private practitioners. I congratulate Dr MV Bhimeshwar, Dr JG Divatia, Dr Pankaj Gupta, Dr Virendra Sharma, Dr Pratibha Kane, Dr Bhadresh Shah, Dr Apoorva Agarwal, Dr Nilesh Naphade and all others for their valuable contribution.

— Dr (Brig) T PRABHAKAR, VSM. PAST PRESIDENT ISA NATIONAL.

I am very happy to express my feelings about the Private Practitioners Forum of ISA. In 2014, as President of ISA, I declared the Private Practitioners Forum of ISA as the Theme of the year. I travelled far and wide to know the practising conditions and the remuneration of the qualified Anaesthesiologists at that time in various cities. I congratulate the Nashik city branch, which is a step ahead in unity, uniformity, and the preservation of the self-respect of an anaesthesiologist. I am also a founder member of PPF, but due to the burden of other activities, I could not participate much. My heart is with the group. I congratulate Dr. Virendra Sharma, Dr Pankaj Gupta, and many others who were actively involved in developing the software to assess our remuneration on an hourly basis, case-based RVG system, etc. I also congratulate all of you for evolving different guidelines, assessing the Patient's recovery, preoperative check-ups, different consent forms, etc. Despite all your efforts, many of our colleagues hesitate to demand their justified fee. I am sure any medical speciality never made this type of effort, and this document will be a master document for all. I hope the PPF group will strengthen, motivate others and improve communication skills.

Long Live ISA! Jai Bharat! LONG LIVE ISA & IRCF!

— DR. S.S.C. CHAKRA RAO
Chairman, IRCF
Past President & Past Secretary ISA & WFSA Ambassador

Private practice is a roller coaster ride, especially for younger anaesthesiologists in modern practice in developing countries such as India. They must navigate through unchartered territory, as far as the private practice scenario is concerned, shifting from structured and supervised training to independent practice. The 'Position Statement for Anaesthesiologists in Private Practice in India' is a de novo but comprehensive effort of the PPF, covering the entire gamut of the challenges, opportunities, risks and pleasures related to patient and personnel care. The team led by Dr Pankaj Ramkrishna Gupta, National Coordinator, PPF, ISA, has succeeded in putting together the best document as of date, with attention to all considerations related to private practice, with contributions from senior and seasoned practitioners and drawing material from societies such as WFSA. The statement focuses mainly on patient safety and outcomes. However, it is tinged with rational advice and

guidance as the practitioners face personal and professional well-being issues in modern times. I congratulate the PPF and the ISA Governing Council on this endeavour and hope that this will promote the practitioners' better work-life balance.

— Dr S BALABHASKAR, PAST PRESIDENT ISA NATIONAL

It is heartening to see that the first guidelines issued by ISA in 2018 have been revised and released as a position statement during WAD celebrations this year. This was the need of the hour as we had to keep updating ourselves, so we needed revised guidelines. I congratulate you and the whole team involved in revising the guidelines. I also thank and congratulate President Dr Divatia and the whole Governing Council team for helping release this position statement. I hope our practitioner colleagues will utilise these updated guidelines.

— Dr VIRENDRA SHARMA
NATIONAL COORDINATOR PPF OF ISA