Task transfer: the view of the Royal Australasian College of Surgeons

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ABSTRACT

- The Royal Australasian College of Surgeons (RACS) supports the evolution of appropriate task transfer in a team environment led by the most experienced clinician — in our case, the surgeon.
- A clear requirement needs to be identified for task transfer; it should not be used to avoid redressing the current inefficient use of existing surgeons resulting from ongoing underfunding.
- Maintenance of standards, defined curricula, professional titles and monitored outcomes are essential.

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For several years, a gradual evolution has been taking place in the traditional roles played by different health professionals. Nurses have taken on some of the roles previously limited to doctors, and other health professionals now undertake tasks formerly carried out by nurses, radiographers, physiotherapists and technicians. Much of this task transfer has been driven by workforce shortages, particularly in non-metropolitan areas, but also by the recognition that a number of different health professionals can share a multitude of care competencies in addition to those unique to their own roles. This is most obvious in the skills exemplified by nurses working in intensive care departments, where they are often preferred to the frequently transient and, at times, inexperienced junior doctors.[1] Nevertheless, these qualified nurses still report to the doctors who have primary responsibility for the individual patient's management plan.

Surgeons work predominantly within multiskilled and multidisciplinary teams, and are dependent on the unique attributes and skills of team members such as theatre nurses. Surgeons are also the first to recognise and acclaim the skills of nurses and others involved in the perioperative care of surgical patients. Evolution of roles in a safe framework of defined knowledge and competencies should be discussed, and possibly supported, within a debate which has at its centre evidence, quality of care and safety of patients.[2]

International experience

In the Western world, some tasks in surgery previously considered the province of medical graduates are now shared by others. Nurse endoscopy clinics have been successfully implemented,[3,4] and have become a vital component of screening and diagnostic services. Historically, surgeons have been assisted in theatre by nursing staff and by medical graduates, including trainees. The role of the nurses has evolved from a passive function to one of undertaking some degree of intervention under appropriate supervision, as exemplified by the roles of surgical physician assistants in the United States[5] and surgical care practitioners in the United Kingdom.[6] The success of a pilot project in Oxford, in which a non-medically qualified member of the surgical team harvested the long saphenous vein for coronary artery bypass grafting,[6] led to the development of similar roles in some other surgical specialties. In the UK, the curricular framework for the surgical care practitioner has been developed by representatives of the Royal College of Surgeons of England and the National Association of Assistants in Surgical Practice.[7] The program is aimed at non-medical practitioners who will not only manage the clinical care of patients but will also perform technical and operative interventions under defined levels of supervision by surgeons.[8] Not surprisingly, these developments have not been supported unanimously.[9]

Important considerations

Considerations to be broached in any discussions of transfer of tasks within the surgical environment include the tasks being transferred; the possible impact on educating tomorrow's surgeons; the recruitment, training and supervision of involved individuals; the importance of medical education in decision making; where responsibility will lie, particularly with respect to the judgement needed to outline a management plan; and, most importantly, how the public can be assured that their management remains the responsibility of surgeons. Some of these considerations are discussed below.

Impact on educating future surgeons

The Royal Australasian College of Surgeons (RACS) has no shortage of young doctors who aspire to be surgeons. Indeed, many have completed the requirements of the early part of the training program and now find themselves unable to finish their training because of the lack of available and accredited hospital posts.[10]

It is a principle of surgical education and care that surgical trainees should be provided with opportunities to assist and participate in operations. This is becoming more difficult in Australian public hospitals. The current limiting factor in most hospitals for carrying out more surgery lies in budget constraints, shortage of beds and limited numbers of ward, theatre, intensive care and high dependency unit nurses. The RACS is actively seeking training opportunities in the private sector, and this is hardly a reflection of the need for surgeon substitutes, but rather the need to develop additional opportunities for trainees. There is currently little capacity for training more surgeons, let alone training non-surgeons. Junior doctors object to the wider role suggested for surgical care practitioners when this would lead to diminished training opportunities for trainee surgeons.[11]

Training and supervision

Surgeons who are available to train the future surgical workforce are a valuable resource and must be used efficiently, as the time they spend training and supervising trainees is considerable, and in competition with the other demands of their clinical practice. There is some evidence, albeit limited, that it takes longer to train surgical care practitioners than medical graduates.[12] Worldwide, the health workforce is understaffed, and while the strategy of

substituting nurse practitioners for doctors can solve some problems, it creates others. An absolute requirement is to allow current surgeons more time to operate.

Importance of medical training

A further consideration is the difference medical training makes in the ability to make independent decisions. Surgeons, like many other medically qualified professionals, must deal with complexities and uncertainties where judgement and decision making are paramount. Such judgement is based on an educational process begun in medical school and continued after graduation. This education is designed to prepare graduates for unknown or unpredictable outcomes and to allow them to deal with and solve a broad range of problems.[13] Medical education covers more than known outcomes and repetitive skills,[13] rather, imparting the capacity for independence in decision making. It is for this reason that the College does not support referral of patients to non-medically qualified practitioners working independently.

The RACS supports the tenet that "diagnosis and decisions for or against surgical treatment should remain in the hands of medically qualified surgeons, as these elements lie outside the narrower realm of operative technique".[14] It is of considerable concern to the RACS that independent surgical practice by non-surgeons will denigrate standards of care, and will create a two-tier system at the expense of some patients.

Responsibilities of care

In most countries, surgical care practitioners work within a surgical team, and in the UK, this team is led by a surgeon who is required to take overall responsibility as he or she would for surgical trainees. However, who will take responsibility for surgical tasks undertaken by surgical care practitioners if they practise independently? It is our view that the person performing an operation in such a scenario must do so. Therefore, the indemnity issues would need to be clarified.

Public rights and perceptions

A further difficulty lies in what members of the public perceive, and their right to clear information. Job titles and nomenclature need to be explicit and clear, or patients will not be aware of who is or is not medically qualified. In an English survey of patients attending outpatient clinics, 82% believed incorrectly that surgical care practitioners were medically qualified.[15] In any event, "patients must know who they are seeing, what their role is in the surgical team and which qualifications they possess".[16] This is an essential part of preserving the trust patients have in their health care professionals. It is therefore vital that further discussions on the role and title of non-medically qualified health care professionals include patient and community representatives.

Conclusion

The RACS supports the evolution of new health care roles in surgery provided a clear need is identified, a proper curriculum and standards are developed, and provided these health professionals work under supervision as part of a surgical team and in situations where clinical outcomes are monitored continuously.

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