Oxford

helen.salisbury@phc.ox.ac.uk Follow Helen on X @HelenRSalisbury

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PRIMARY COLOUR

Helen Salisbury: Training our replacements

Helen Salisbury *GP*

Are there limits on what people should be allowed to do in the medical or surgical field when they're not a doctor and not training to be one? We teach someone our skills so that they may one day exercise them independently, and almost from the moment we qualify as doctors we start training our replacements.

The time available for this training is finite, so we should think carefully about how we spend those precious hours and who exactly will replace us. If a medical associate practitioner (anaesthesia associate, surgical care practitioner, or physician associate) should never be in a position where they're expected to perform a particular task unsupervised, does it make practical or economic sense to train them to do it?

A recent paper in the journal of the Royal College of Surgeons, about a case series of 170 laparoscopic cholecystectomies performed by surgical care practitioners (SCPs), raised many eyebrows (and a few blood pressures).[1] It prompted a response from the college stating that, for patient safety reasons, SCPs shouldn't be performing this surgery whether supervised or not and that it falls outside the set curriculum.[2] The logical conclusion of training an SCP to operate is that they'll eventually do their own lists and that their supervision may dwindle from someone standing over them, directing every move and ready to intervene if anything goes wrong (safe but expensive), to having someone available if needed, in the next theatre or even elsewhere in the hospital (cheaper but dangerous).

In general practice there's evidence that physician associates frequently receive only minimal supervision, contrary to the latest NHS England guidance.[3] Supervision requirements vary at different stages of a doctor's training. When I'm supervising a fifth year medical student I have a 10 minute slot booked out for each patient they see, so that they can present the patient, I can ask further questions and redo the examination if necessary, and we can agree on management. I also supervise specialist trainees, and although I'm always available my input is mostly through a discussion of each patient at the end of the session.

Formal training for physician associates lasts two years, after which they're fully qualified and able to apply for jobs in hospitals and general practice. Clearly, given the brevity of this training—and the medicolegal responsibility that supervisors carry for their actions—the associates' supervision requirements will be closer to those of medical students and a long way from those of specialist trainees.

We need to think again about how medical associate practitioners are used. In general practice we either use them as stipulated in the primary care network contract[3]—seeing undiagnosed, undifferentiated patients, in which case we must thoroughly oversee their work—or we find them another role that can be fulfilled without this supervisory burden. Anything less is not safe for patients.

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