



Physicians' Assistants (Anaesthesia) [(PA(A)s] Supervision and limitation of scope of practice (August 2010 revision)

RCoA Executive Summary: It remains the responsibility of those leading departments of anaesthesia, together with their constituent consultants, to ensure that PA(A)s work under the supervision of a consultant anaesthetist at all times.

1. The PA(A) must work at all times within an anaesthesia team led by a consultant anaesthetist whose name must be recorded in the individual patient's medical notes. Overall responsibility for the anaesthesia care of the patient rests with the named consultant at all times.
2. The consultant anaesthetist leading the anaesthesia team must undertake the duty of the **supervising anaesthetist**, or may delegate responsibility for this duty to another consultant anaesthetist. Supervision must only be delegated to a consultant anaesthetist who is competent to provide anaesthetic care for the patient concerned and who is aware of the duties required of a **supervising anaesthetist**.
3. The **supervising consultant anaesthetist** must check and take overall responsibility for preoperative patient assessment, suitability of the proposed anaesthetic techniques and patient consent.
4. For every case, the **supervising consultant anaesthetist** must:
 - be present in the theatre suite, must be easily contactable and must be available to attend within two minutes of being requested to attend by the PA(A)
 - be present in the anaesthetic room/operating theatre during induction of anaesthesia
 - regularly review the intra-operative anaesthetic management
 - be present during emergence from anaesthesia until the patient has been handed over safely to the recovery staff
 - remain in the theatre suite until control of airway reflexes has returned and artificial airway devices have been removed, or the ongoing care of the patient has been handed on to other appropriately qualified staff, e.g. in the intensive care unit.
5. If the **supervising consultant anaesthetist** has to leave the theatre suite for any reason, deputising arrangements must be made. A formal handover of the case to the new **supervising consultant anaesthetist** must take place.
6. A **supervising consultant anaesthetist** must not provide solo anaesthetic cover for a different specific surgical list.
7. The **supervising consultant anaesthetist** must not be responsible for more than two anaesthetised patients simultaneously, where one involves supervision of a PA(A). In such instances it is essential that the clinical complexity of the anaesthetic management is appropriate, i.e. ASA I – II cases undergoing minor to intermediate surgery only, and the cases should be in adjacent theatres within the same theatre suite.
8. There must be a dedicated trained assistant, i.e. an ODP or equivalent, in every theatre in which anaesthesia care is being delivered, whether this is by an anaesthetist or PA(A).

9. PA(A)s cannot prescribe medication. Supervising consultant anaesthetists must prescribe medication for each patient using suitable locally-developed patient specific tools that allow PA(A)s to check and administer drugs within appropriate limits.
10. The current nationally agreed curriculum¹ limits the scope of practice of PA(A)s on qualification. On completion of training they are not qualified to undertake:
 - Regional anaesthesia / regional blocks.
 - Obstetric anaesthesia or analgesia.
 - Paediatric anaesthetic practice.
 - Initial airway assessment and management of acutely ill or injured patients (except when the PA(A) is part of a multidisciplinary hospital resuscitation team called to attend a patient and is first to arrive).
11. The RCoA acknowledges that PA(A)s are not yet fully regulated as a professional healthcare specialty with appropriate registration at the Health Professions Council. Therefore, any practice falling outside of the Curriculum cannot be formally recognised by the specialty on a national scale. It is unfortunate this lack of registration prohibits appropriate recognition of these new roles and formal endorsement of each individual department where they are being utilised.
12. Several departments of anaesthesia have developed enhanced PA(A) roles through medically led local training and assessment processes; this is particularly true for the provision of regional anaesthesia. There are now clear examples of appropriately controlled enhanced roles which correctly focus on the maintenance of patient safety first, and improved service provision second. Hospitals employing PA(A)s in enhanced roles related to regional anaesthesia, have also noted the greater service provision they offer has reinforced the position of the anaesthesia department as the hub of expertise for regional anaesthesia across the Trust.
13. We have seen no evidence to suggest these enhanced roles increase risk where the medical (consultant) supervision requirements, as described above, are being met and where the local senior anaesthetists are directly involved in developing the role. Some concerns have been raised that such extended roles may reduce training opportunities for anaesthetists; however, departments involved in this development have ensured this is not the case. It is a critical consideration for this College that extended roles for PA(A)s do not negatively impact on the training of anaesthetists and College Tutors should be involved at all stages of enhanced role development. Such roles should also receive endorsement of the employing hospital/Trust/Board executive who will have responsibility for local indemnity.

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¹ www.rcoa.ac.uk/index.asp?PageID=761