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BMA

Dr Satya Francis
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By Email

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Dear Dr Francis,

Re: Consultation on draft anaesthesia associate scope of practice

Thank you for the opportunity to respond to the RCoA's consultation on a draft anaesthesia associate scope of practice. As you will know, the BMA has called for a pause in the recruitment of physician associates and the other MAPs professions until our serious concerns about their current deployment are addressed. We have produced a comprehensive Safe Scope of Practice guidance for MAPs and supervision guidance, while we also provide a reporting portal for doctors and medical students to raise any safety concerns about MAPs' working arrangements in their place of work or training.

We welcome the RCoA's decision to produce a scope of practice for AAs and we are pleased that the document emphasises some sensible approaches to scope limitation, as well as the clear statement that the training of doctors is to be prioritised over the training of AAs.

However, we were very concerned to read the RCoA Council minutes from July which stated that *'Council suggested the scope of practice should not be so restrictive as to make the AA role completely untenable'.* We fundamentally disagree with this approach, as patient safety should always be the dominant consideration. If it is not viable to utilise AAs in a way that is safe, then it is the use of AAs that must be reconsidered, not whether necessary restrictions can be relaxed to ensure the existence of the role.

We hope that the College will take time to reflect on the feedback we have outlined below and strengthen this guidance accordingly. Our feedback has been informed by our dedicated MAPs Steering Group, which is made up of elected representatives of the profession from across the medical specialties and throughout the UK.

We would be happy to discuss our response with you should it be helpful.

Yours sincerely,

Professor Phil Banfield
Chair, BMA UK Council

Anaesthesia Scope of Practice 2024. BMA response to RCoA draft guidance, October 2024:

Supervision requirements

- We do not believe that 2:1 supervision is ever appropriate for AAs as dependent practitioners. Patient safety cannot be guaranteed and the mechanisms for ensuring continuous supervision outlined in this draft scope are over-complicated and will pose significant practical problems.

- We do not believe it is ever safe for an AA to administer spinal anaesthesia.

- The draft scope allows 2:1 supervision for AAs giving a general anaesthetic which constitutes a non-medically qualified clinician delivering an anaesthetic.

- On the 2:1 model, it will not be possible to schedule cases in a way that avoids the high likelihood of both the cases the consultant is supervising ending nearly simultaneously, with the difficulties that will cause for adhering to the model where emergence from anaesthesia is supposed to be supervised 1:1.

- For Phase 1, "subspecialty anaesthesia" has been excluded from the scope, and while obstetrics and cardiac are given as examples, a comprehensive list is needed of what falls under 'subspecialty' in order to avoid any doubt of which tasks/patient groups are unsuitable for AAs.

- Phase 2 is to some degree written on the assumption Phase 1 content is still applicable, but some Phase 1 aspects have been included, while others have not. For clarity, the previous phase content should either be entirely included, or entirely excluded from subsequent phases.

- Even at Phase 3, AAs are still supposed to be directly supervised for induction of anaesthesia, doing spinals, and emergence from anaesthesia. It is not clear how this will work because of the likelihood of both theatres that are being supervised by the consultant coming to this key stage of their anaesthetic at the same time, particularly as these are likely to be (if they are deemed AA-suitable) high turnover lists of surgically simple cases. It is not possible for one consultant to oversee two simultaneous inductions or emergence from anaesthesia. Staggered lists necessary to accommodate the consultant fully supervising two inductions/emergences will lead to inadequate supervision and are inefficient.

- The document is not clear on how a consultant can be 1:1 supervising induction/emergence in one room and still be immediately available for 2:1 supervision in the other room, while the document explicitly mandates that if they get caught up in an *emergency* in one of their two theatres, another doctor has to come and be the supervisor for the AA in the theatre that is not having difficulties. This seems inconsistent as the induction/emergence requires the same 1:1 intensity of supervision that an emergency does. There is a real possibility of the supervisor being required for

emergencies in both theatres at the same time with no clear plan to manage this scenario.

- On page 11 it is suggested that some more complicated (ASA 3+) patients could be looked after by an AA under supervision that is both "1:1" and "local supervision". It is not clear how to distinguish between these two approaches and how 1:1 supervision can be local rather than direct. If this approach is to be pursued, and we believe it should not, the document needs to be clearer in defining how the two types of supervision should be used (ratio of consultant: AA / consultant physical distance from the AA) and how they interact/overlap.

- Paragraph 3.9

  - If a consultant supervising 2:1 has to get deeply involved with one case because of a complication requiring their 1:1 attention, the document, very reasonably, states that another doctor must be mobilised to supervise the other AA in the other theatre. Given the current situation with staffing levels, however, for many departments sourcing such a suitable doctor during such an eventuality is going to prove difficult. This leads to either a situation of inadequate supervision, which is unacceptable, or delays in the lists.

  -There is also no recommended timeframe for this additional doctor to be sourced, seemingly providing leeway for there to be no doctor available for a considerable amount of time. Given that it is not rare for these kinds of complications to occur, this seems very risky.

  -The document also does not set out how *long* an interruption in 1:2 supervisory capacity should trigger the consultant to call someone else in (i.e. how long should the supervisor be tied up before another is sourced) or who is supposed to trigger it (the consultant in question being, by definition, deeply engrossed in an evolving anaesthetic emergency, which is very absorbing of time and attention). Much more thought is needed to ensure that such a supervision ratio is safe. It is likely that that it is impossible to make it safe without affecting efficiency of theatre lists and thereby renders the use of AAs as something not helpful to the current staffing crisis in the NHS.

- Aspects of supervision

  -The document tries to distinguish between two aspects of supervision: ratio of supervision (1:1 versus 2:1) and supervisor distance (direct/local/on-site supervision). This is not always successful and should be revisited throughout to ensure absolute clarity.

  The descriptors of direct, close, and local supervision in section 3.10 are unclear. As mentioned previously, in a scenario where a consultant supervisor is busy helping an AA with one patient in a 2:1 scenario, do they automatically call for another person (delegate) to come and supervise the other AA (as presumably that AA is now unsupervised)? Or will this be the remit of another staff member? The theatre coordinator? An ODP? This must be clarified.

The use of local supervision for some scenarios (PICC and femoral blocks) is also problematic. Who is prescribing the local anaesthetic in this scenario? If the AA requires help to deal with a complication, who comes to help them if the supervisor is in another theatre? Or is there a pool of reserve supervisors that may be called upon in such a scenario? If so, does the NHS currently have sufficient staff for this? What is the time scenario for such people to be found and arrive in the theatre/ED? This will either lead to unacceptable delays in treatment or unsafe practices where AAs are working unsupervised.

This is why the BMA has recognised that local supervision is not sufficient and requires that supervisors be available to review immediately or very quickly and may not be engaged in another task that may prohibit them for doing this (therefore must be freely available to supervise). We suggest that RCoA reconsider the use of local supervision or indeed, the use of a 2:1 supervision scenario at all, because the staffing shortages in the NHS makes this prohibitive and there are many possible situations where 2:1 is unsafe.

Practicalities of allocating AAs to lists

- Paragraph 4.3
  - The choosing of cases to match skill mix is already very difficult to carry out successfully for the surgical side and the anaesthetic side. We have serious doubts about the capacity for most hospitals to consistently and correctly select patients for theatre lists based on the skill mix of the anaesthetic team. Lists are regularly filled based on waiting time, primarily with very little input from clinicians.

- Paragraph 4.4
  It will be up to the anaesthetist in charge to decline to proceed if there is a change of patients and no accompanying change of personnel. The guidance needs to be more explicit that changes to the list must be discussed with the supervising anaesthetist so they know the supervisory demands may have changed and can plan the list accordingly.

Limits around location and type of anaesthetic given by AAs

- Paragraph 4.11
  -This states that any GA/sedation given outside of theatres will need 1:1 supervision. This is sensible and appropriately limits the AA's role in remote site anaesthesia to being an assistant.

Paragraph 4.12

-We do not believe planned [ortho] trauma lists of pre-assessed patients should fit the criteria for 2:1 supervision. Pre-assessed or not, trauma patients are often some of the frailest patients in theatres and a significant number of incidents, and indeed cardiac arrests, occur in ortho trauma theatres. Hospitals can be hesitant to let senior residents carry out these lists without direct consultant supervision, so letting AAs do them 1:2 is not appropriate.

Scope of Practice broken down by year of postgraduate experience (pages 9-18)

It is not clear where the timeline for these phases of supervision and scope of practice have been drawn from. Widening the scope of AAs after heterogenous on-the-job training with variability in local oversight does not fit with the call from the medical profession for nationally defined scopes of practice that are standardised for all types of medical associate professions. There is nothing that requires an AA to have career development that means them working in a way that is unsafe or inappropriate for someone with only a two-year postgraduate course. The AA course does not provide a wide enough understanding of the underlying anatomy/physiology/pharmacology to be performing tasks that are usually within the remit of doctors. There is no justification for moving to a mostly 2:1 supervision model after 4 years of work and we have seen no evidence to suggest this is safe. As covered earlier in this response, there are multiple possible problems with 2:1 supervision in the current NHS with severe staffing shortages, which will render such a situation unsafe.

Plan for transition to 2024 Scope of Practice for AAs post qualification section (starting page 18)

As it is written, this guideline suggests that AAs that are currently working vastly out of the proposed scope limits (part 3) will be allowed to continue to do so according to local protocols and that there is a need to continue to employ them in this way. This is completely unacceptable as it legitimises the status quo of non-doctors giving an anaesthetic. The staffing needs of local departments should not be a reason to compromise patient safety. Existing AAs working outside of safe scope parameters are owed an apology from the stakeholders and employers that have allowed them to practice medicine without a medical degree. They should be compensated for having been miss-sold a career trajectory, but it should not be a reason to make decisions that are unsafe for patients and detrimental to the training of medical doctors.

Patient information

- It is unclear from the draft whether patients would be informed of the arrangements for anaesthesia during the procedure / operation and who would be controlling sedation. The scope talks about introducing and explaining roles but is not clear on whether a patient would be told exact details about a 2:1 scenario (which should happen if consent is to be "informed"). If patients are not aware of what an AA is and who exactly will be performing the anaesthesia, the consent obtained may not be valid. An option must be given for a patient to decline being administred an anaesthetic by someone who is not a doctor, with no consequtn detriment to their care.

- It is not clear how it would be assessed that an AA has "sufficient knowledge ...and the risks involved" (p.10) to take consent, given that they are not medically qualified.

- The use of the term ‘physician anaesthetists’ is not in common usage and could cause confusion with ‘physician associates’ for the lay person. Our patient liason group is certain that this term should not be used as patients will believe this terminolgy would be misinterpreted by patients as meaning they are being anaesthetised by a medically qualified doctor.