International Journal of Surgery 36 (2016) S14–S19

Contents lists available at ScienceDirect

International Journal of Surgery

journal homepage: www.journal-surgery.net

Editorial

The non-medical workforce and its role in surgical training: Consensus recommendations by the Association of Surgeons in Training

Keywords:
Non-medical work force
Surgical training
Surgery
Education
Surgical care practitioners

A B S T R A C T

Changes in the delivery of the healthcare structure have led to the expansion of the non-medical workforce (NMW). The non-medical practitioner in surgery (a healthcare professional without a medical degree who undertakes specialist training) is a valuable addition to a surgical firm. However, there are a number of challenges regarding the successful widespread implementation of this role. This paper outlines a number of these concerns, and makes recommendations to aid the realisation of the non-medical practitioner as a normal part of the surgical team. In summary, the Association of Surgeons in Training welcomes the development of the non-medical workforce as part of the surgical team in order to promote enhanced patient care and improved surgical training opportunities. However, establishing a workforce of independent/semi-independent practitioners who compete for the same training opportunities as surgeons in training may threaten the UK surgical training system, and therefore the care of our future patients.

1. About ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialties, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations.

2. Introduction

Working hour restrictions and shift-patterns, reducing numbers of trainees, decreased hospitalisation times, enhanced recovery programmes, day-case surgery and changes to funding of healthcare have all contributed to the constantly evolving healthcare landscape. In the UK, the traditional firm structure of healthcare teams has seen little change theoretically: the Consultant is responsible for patient care and leads a team. Deputising to the Consultant are: a Specialty Trainee (StR; previously registrar), Core Trainee/Foundation Year 2 doctor (CT/FY2; previously Senior House Officer), and Foundation Year 1 doctor (FY1; previously House Officer). These individuals form the team of junior doctors who work to deliver patient care, whilst learning from each other. Each Consultant, however, no longer has three named junior doctors working in their team. Consultant Surgeons may find themselves supervising junior doctors whom they have never met before. To compound factors, members of the so-called team rotate every 4–6 months. With on-calls, night shifts, study leave, and annual leave, the time

Abbreviations: ASiT, Association of Surgeons in Training; CCT, Certificate of Completion of Training; CT, Core Trainee; FY, Foundation Doctor; ISCP, Intercollegiate Surgical Curriculum Programme; NHS, National Health Service; NMW, Non-Medical Workforce; Str, Specialist Trainee.

http://dx.doi.org/10.1016/j.ijsu.2016.09.090

actually spent in a team can be extremely limited. For patients, this can be challenging: meeting a number of different people, all of whom are looking after them can become confusing, creating the potential for discontinuity of care and difficulty in forming a trusting relationship of trust. This can also impact on education and training: jeopardising both the continuity of training and the bond between trainer and trainee that facilitates development. Trainees can often find themselves tied to ward areas, performing administrative service tasks such as completing paperwork, re-writing drug charts, requesting and chasing investigations or spending significant time co-ordinating patients through hospital processes. This hinders attendance at formal teaching, operating theatres and outpatient clinics where training and education can take place.

Much surgical work is based on day-case or enhanced recovery protocols, and in these cases trainees often provide a source of consistency. With changing rotas and shift patterns, stability in the healthcare team may not be apparent for medium term patients. The patient can expect regular consultations from professionals including Consultants, and the non-medical workforce (NMW). The latter includes the nursing staff, pharmacists, and therapists. Increasingly, the NMW includes practitioners with healthcare training but no medical degree. The National Association of Assistants in Surgical Practice (NAASP) 2003 Surgical care practitioner core syllabus London defined the surgical care practitioner as 'a non-medical practitioner, working in clinical practice, as a member of the extended surgical team, who performs surgical intervention, pre-operative and post-operative care under the supervision of a consultant surgeon' [1]. This could be applied to a number of members of the NMW. The multiple pathways into the NMW have resulted in a number of titles for such practitioners including surgical care practitioners, surgical assistants, scrub practitioners, perioperative practitioners, advanced nurse practitioners and physician (or surgeon) associates/assistants. As well as providing a constant presence on the wards, such a workforce can assist in the training of junior doctors by taking over a number of the service roles that prevent trainees from undertaking learning events. This system has been attempted in a number of surgical and non-surgical settings and although the benefits are clear, there are also potential pitfalls.

3. Current experiences of the non-medical workforce

3.1. The non-surgical field

The non-medical workforce is far from a novel concept: obstetric patients have benefitted from midwives for millennia. Currently midwives complement obstetric training by monitoring otherwise well, uncomplicated pregnant women, supporting ladies through labour and delivering babies, and performing venepuncture and cannulation, while documenting the progress of their patients. Patients requiring a higher level of care are highlighted to the medical team to allow an assessment and management plan to be made. The patient benefits from improved continuity of care and the trainee is afforded the opportunity to learn from both the midwife and, in the more challenging scenarios, the doctors.

The Emergency Practitioner (also known as the Emergency Nurse Practitioner or Advanced Nurse Practitioner) is now commonly employed in the Emergency Department. The precise role of this professional varies but can include the assessment and triage of patients, management of minor ailments and injuries, requesting and interpreting investigations, and prescribing medications. Evidence suggests that this group of practitioners can be clinically equivalent to the senior house-officer grade in a number of specific tasks [2–5]. Again, they can facilitate training by managing the simpler cases, allowing junior doctors to focus on learning events, under the supervision of senior medical staff.

3.2. Night nurse practitioners

With the advent of the 'Hospital at Night' Team [6] (the skeletal workforce which manages night shifts in many hospitals) came the Night Nurse Practitioner. Typical duties include venepuncture, IV cannulation, assessment of unwell patients (escalating to medical staff if necessary), ordering investigations, and in some cases, prescribing analgesia and intravenous fluids. Removing such tasks from the junior doctors' workload improves the educational quality of these often service-oriented shifts and augments the prompt assessment and early intervention of unwell patients improving patient safety.

3.3. Anaesthetic Nurses/practitioners

A number of countries including the USA, the Netherlands and Sweden, employ the services of Anaesthetic Nurses (or Practitioners). This workforce comprises mainly individuals from a nursing background, who undergo 1–3 years of training, and monitor anaesthetics independently. Importantly, an anaesthetist or trained doctor is required to be present on induction and reversal of each anaesthetic [7]. To draw parallels with surgery is challenging: it is difficult to compare an operation with basic life-saving manoeuvres, implemented while senior support is sought if an untoward event occurs.

3.4. The surgical field

The surgical field also benefits from a NMW and indeed the role can be much more versatile with the potential for diverse career pathways. Such opportunities vary from: Assisting on the wards and in elective and emergency clinics, to independent emergency and elective operating [8].

Endoscopic procedures are commonly performed by non-medical practitioners. Nurse endoscopists and nurse cystoscopists have been shown to be as good as surgical trainees or Consultant Urologists in terms of pathology detection [9]. It has been shown that the use of a non-medical surgical assistant does not affect outcome in low-risk cardiac surgery [10]. The acute positive effects of the NMW are important but do not reflect the fact that this is not sustainable in the longterm. The training of junior doctors, in order to provide consultant surgeons of the future, is an investment. Models permitting both the NMW and trainees to work efficiently and effectively together do exist. Cardiothoracic surgery has employed cardiac non-medical practitioners who are trained to assist and independently harvest vein grafts. Although there is some crossover between the exact roles of such practitioners and surgical trainees, there may well be a middle-ground compromise whereby not only can the practitioner provide a service, they can also help to train junior doctors [10]. It is important, however, that such training is done under the supervision of a Consultant Surgeon who can take responsibility for the training and development of the junior doctor.

4. Current guidelines/curricula

Training and development has been regulated by Universities, a number of which offer courses for the surgical-NMW, although there are guidelines for such training set out by various bodies [11,12]. The role is very much service driven, with professionals filling areas of perceived need, with potential for career progression