Thank you for giving the Obstetric Anaesthetists' Association (OAA) the opportunity to contribute to the discussion on the potential role of Anaesthesia Associates (AAs) in obstetric anaesthesia. After careful consideration, we would like to share our views on this matter.

Our position remains that obstetric anaesthesia should continue to be excluded from the scope of AA practice, primarily due to significant concerns regarding patient safety. We have outlined below the key points that we believe should be considered in the RCOA 2024 AAs Scope of Practice document:

Patient safety and risk management

Obstetric anaesthesia is a highly specialised field that requires the ability to respond rapidly and effectively to sudden changes in the clinical status of both the mother and the baby. The unpredictable nature of obstetric emergencies demands that anaesthetic care is provided by professionals with extensive training, autonomy, and the ability to make rapid, informed decisions.

Under their current scope of practice, AAs lack the independent clinical experience required to manage these complex scenarios without direct supervision. Ensuring the highest standards of patient safety necessitates that obstetric anaesthesia remain the domain of highly trained anaesthetists who can operate independently and handle the full spectrum of clinical situations, from routine procedures to life-threatening emergencies. Clinical work in obstetric practice cannot be considered as truly elective, as planned elective care can quickly become time-sensitive emergency care. The American Society of Anesthesiologists has graded pregnant people as ASA 2.

The College will be aware that there is national attention on quality of care in obstetric practice with maternity care being the source of the highest value and the largest number of clinical negligence claims reported to the NHS Litigation Authority (NHSLA).

The increasing complexity of cases

While the obstetric population has traditionally been composed of young and healthy women, this demographic is shifting, as demonstrated by the 7th National Audit Report and successive MBBRACE Reports. Increasingly, obstetric anaesthesia involves managing older patients with higher BMI and associated comorbidities, which complicate both anaesthesia

and delivery. The incidence of postpartum haemorrhage has tripled in the past 20 years and the proportion of caesarean births has nearly doubled in the same period. The increasing complexity of cases requires advanced decision-making and technical skills that AAs may not possess or may require extensive additional training to develop.

Given the rising complexity of cases, the involvement of AAs in obstetric anaesthesia could introduce risks, particularly in situations where rapid adjustments in care are needed to manage unexpected complications. It is imperative that these cases are managed by clinicians who have the depth of training and experience to anticipate and manage the full range of potential complications.

Consultant Supervision and the 1:1 Model

The current requirement for 1:1 supervision of AAs by a consultant or an autonomously practising anaesthetist underscores the limitations of AAs in managing complex or emergent cases on their own. This level of oversight is necessary to mitigate the risks associated with their limited scope of practice, but it also raises questions about the efficiency and practicality of their deployment in the high-stakes environment of the labour ward. This is particularly relevant for current obstetric practice which already places a burden on current consultants consultant or an autonomously practising anaesthetist limiting their availability to provide 1:1 supervision which does not lessen their work burden.

Furthermore, there is ambiguity in what 1:1 direct supervision entails. For example, if an AA is performing a spinal or managing a patient under spinal anaesthesia while the consultant is outside the theatre but within the suite, does this truly constitute direct supervision? The potential for misinterpretation of supervision requirements further complicates the safe integration of AAs into obstetric anaesthesia.

The OAA believes that employing AAs under direct supervision does not offer a clear patient safety advantage over anaesthetic trainees, who are on a structured educational pathway to becoming independent practitioners. Trainees not only contribute to immediate patient care but are also developing the skills and experience necessary to ensure the future safety and quality of obstetric anaesthesia.

The nature of quality obstetric care is that it is multidisciplinary with the anaesthetist, obstetrician and midwife required to work very closely together in complementary and supporting professional roles. In a high pressure environment of obstetric practice, the limitations of the AA role may not be appreciated or understood leading to delays or harms in delivering patient care.

Impact on Training and Education

In addition to the primary focus on patient safety, it is important to acknowledge that the labour ward serves as an essential source of training opportunities for anaesthetic trainees. It is where they gain essential experience in epidural placement, spinal anaesthesia, and the management of complex obstetric cases. Introducing AAs into this environment could reduce training opportunities for trainees to acquire skills and experience and reduce the time available for trainee supervision, potentially impacting their readiness to handle complex cases as independent practitioners in the future.

Out of Hours Cover

The issue of out of hours cover is another important consideration. Labour wards, particularly during evenings and weekends, are often busy with anaesthetic activity, especially as the caesarean section rate continues to rise. There are insufficient consultant numbers to provide the 1:1 supervision that AA would require if they were to work out-of-hours. Therefore it is difficult to envisage that AAs could usefully contribute to staffing during these times.

It is the view of the OAA that there should be a focus on expanding training programs to increase the number of doctors trained as anaesthetists available to provide versatile high-quality and safe medical care. By investing in the training and development of additional anaesthetists , we can ensure that labour wards are adequately staffed with clinicians who are fully trained and experienced to provide safe, efficient, and high-quality care, both now and in the future.

Conclusion

In conclusion, while the role of AAs in the broader field of anaesthesia may continue to evolve, their involvement in obstetric anaesthesia presents significant risks that must be carefully considered. Patient safety must remain our paramount concern, and the complexities and unpredictability of obstetric anaesthesia require the expertise and autonomy of fully trained anaesthetists. Expanding the role of AAs in this setting could undermine the quality and safety of care , that our patients expect to receive.