CHAPTER 1

The Historical Context of the Surgical First Assistant

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As a non-medical surgical assistant, the surgical first assistant (SFA) is an established role in many NHS Trusts and independent sector health organisations in the United Kingdom (UK). It is a role undertaken by registered practitioners who work as part of the extended surgical team, performing a range of established responsibilities to assist the surgeon, predominantly, in the intra-operative phase of the patient's journey but also in the pre- and post-operative phases. Traditionally, the role afforded theatre nurses and operating department practitioners (ODPs) the opportunity to expand their clinical responsibilities and provide assistance for patients undergoing surgery by undertaking post-qualifying education. More recently, an understanding of the knowledge and skills of the SFA role has been embedded into the undergraduate curricula for ODPs.

This chapter identifies the historical development of the SFA role from both clinical and academic viewpoints and affirms the SFA's expert position as a wider member of the extended surgical team today. It briefly identifies the current responsibilities of the SFA that are further explored in subsequent chapters of the book.

THE ROLE OF THE NON-MEDICAL SURGICAL ASSISTANT DURING CONFLICT

While the title 'Surgical First Assistant' has been in use since 2012, the role of the non-medical surgical assistant is not a new concept and has been active within healthcare in the United Kingdom and overseas for many centuries in one role or

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another with varied titles. Rothrock (1999) identified that the non-medical surgical assistant role has evolved significantly from the surgeons' mates, who assisted on the battlefield and in hospitals in the 19th century. The first record of non-medical surgical assistants was in the 19th Century when British nurses acted as surgeons' assistants during the Crimean War. Under the direction and guidance of Florence Nightingale, they not only assisted with operations but also undertook additional skills to meet the high demand caused by the increasing number of casualties seen within hospitals at the time. Nurses were repeatedly called upon to act as surgeons' assistants during times of conflict where, working under extreme conditions and with shortages of medical staff, the nurses perfected the role of first assistant; routinely assisting surgeons during operations but also expanding their role as required such as undertaking haemostasis and suturing (Rothrock 1999). This illustrates that non-medical assistants were a valued addition to the surgical team and were able to develop their skills and abilities to fill the gaps caused by the shortage of medical colleagues. Following the notable success of nurses acting as first assistants in field hospitals during combat, non-medical surgical assistant roles complete with certified training routes emerged from the 1960s onwards in the United States (Hains et al. 2017); however, unlike the early acceptance of non-medical roles in other parts of the world, the SFA role took longer to establish in the United Kingdom.

The professional body, the College of Operating Department Practitioners (CODPs), in providing a historical overview of the development of the ODP profession, refers to several surgical assistance roles with some overlap (CODP 2021). These include 'handlers' who were employed by surgeons in the period prior to the development of anaesthesia to hold down patients. In the 19th century, 'Surgerymen' were responsible for seeing to instruments used by the surgeon, and 'Box Carriers/ Box Boys' who were employed by the surgeon to carry boxes of instruments required by the operating surgeons. Beadles followed the surgeon and ensured cautery irons were kept heated and ready for immediate use by the operating surgeon (Pope 1962). A notable figure, Josiah Rampley, who attended approximately 40,000 operations as a surgical beadle, and whose name may appear familiar, invented the sponge holder and needle holder (CODP 2021; Pope 1962).

Lewin's Report

Walpole Lewin's report in 1970 on the organisation and staffing of operating departments recommended the training of a new grade of staff called operating department assistants who studied the City and Guilds 752 Hospital Operating Department Assistants training programme (CODP 2021). The City and Guilds' training book, often referred to as the 'blue book', identified a number of skills including assisting with skin prep, draping of patients and identification, presentation and handling of instruments that may have been interpreted differently by different training centres and operating departments, and so some operating department assistants may have assisted the surgeon at this time.

CERTIFICATION

In the 1970s, the Department of Health and Social Security (1977) recognised the increasing contribution of nurses undertaking technical tasks that were either an extension of nursing practice or delegated by doctors. This recognition allowed registered nurses to extend their role following in-house training, assessment and subsequent certification. The nurse acting as first assistant to the surgeon was one of these extended roles and certification for nurses continued through to the 1990s when the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) became concerned that nurses were taking on additional skills erroneously under the impression that accountability was transferred to the assessor (McHale and Tingle 2007). Subsequent requirements, since replaced by the Nursing and Midwifery Council's (NMC) Code of Conduct (2018), ensured that additional responsibilities undertaken by nurses were based upon the standards laid down in their professional frameworks. This guaranteed that nurses relied, and continue to rely, upon their clinical judgment supported by appropriate training to inform expanded practice.

NATIONAL ACCREDITATION

The implementation of national and international directives (National Health Service Management Executive 1991; Calman 1993; European Community 1993) in the early 1990s saw a number of clinical hours worked by medical staff reduce, and the time spent by surgical trainees in the clinical area condense. This led to a decline in the availability of doctors to assist routine operating lists. To overcome these shortages, theatre nurses – like nurses before them – stepped up to fill the gaps created by these directives. Taking on additional responsibilities ensured surgical services were maintained. Nurses, however, rapidly came under pressure to provide a level of assistance for which they were ill equipped. Hospitals introduced in-house training programmes that Farrell (1999) argued were extremely varied and resulted in little or no standardisation of non-medical surgical assistant roles. The National Association of Theatre Nurses (NATN) (now the Association for Perioperative Practice, to reflect the multidisciplinary theatre team) raised concerns over the sustainability of such practice and introduced guidelines to support nurses undertaking surgical assistant roles (NATN 1993, 1994). NATN issued additional guidance on developing non-medically qualified roles within the perioperative environment that recommended clearly identified posts and nationally acceptable training programmes (NATN 1997). Consequently, the English National Board (ENB) for nursing, midwifery and health visiting which had the legal responsibility for nurse education, provided approval of the first nationally recognised first assistant course for nurses wishing to train as surgical assistants which were delivered by Schools of Nursing. The ENB also approved training for the Surgeon's Assistant, the fore runner to the surgical care practitioner, a role undertaken by registered healthcare professionals who work as a member of the surgical team, but unlike the SFA, can perform some surgical interventions (RCS n.d.).

In the early 1990s, a consultation to assess the contribution of all non-medical surgical assistants was undertaken and following positive reviews a joint working party was set up between the Royal College of Nursing (RCN) and the Royal College of Surgeons of England (RCS) to advance the concept of non-medically qualified surgical assistants in practice. This group proposed that both nurses and allied health professionals could be safely trained to perform a variety of perioperative skills including assisting with surgery (RCS 1994). The addition of a non-medical surgical assistant to the surgical team was considered to expedite surgery and improve patient care (DH 1999).

NATIONAL ASSOCIATION OF ASSISTANTS IN SURGICAL PRACTICE

In 2001, a voluntary professional body, the National Association of Assistants in Surgical Practice (NAASP), emerged to provide guidance and support for practitioners undertaking non-medical surgical assistant roles or looking to implement them. NAASP published the advanced scrub practitioner (ASP) toolkit which defined the knowledge, skills and standards of the ASP role (Thatcher 2007). For the first time in the history of non-medical surgical assistants, national accredited training programmes accessible to *both* registered nurses and ODPs undertaking training as a surgical assistant were rolled out by universities throughout the United Kingdom, endorsed by NAASP. The NAASP portfolio included an initial module which allowed registered practitioners to provide surgical assistance and after successful completion of this module, practitioners could then undertake the second module which saw them acquire extended surgical skills which allowed them to perform additional responsibilities detailed in Table 1.1. Both modules were run successfully until endorsement ran out when NAASP was dissolved in 2012 and amalgamated with the Association for Perioperative Practice to form part of the specialist interest group for advancing surgical roles (Clinical Surgery Journal 2012).

In 2003, the newly formed perioperative care collaborative (PCC) that represented different perioperative professional groups, published their position statement on the role of the ASP (see Table 1.2 for current PCC members). This statement advised practitioners to use the title of ASP to reflect the expert practitioner status of non-medical surgical assistants to assist with evaluation of job profiles being undertaken as part of the Agenda for Change proposal and the NHS Lifelong Learning Strategy developed by the Department of Health (2001).

TABLE 1.1 Extended skills set of the SFA (Adapted from PCC 2018).

Suturing of skin layers
Administration of prescribed, superficial local anaesthetic
Suturing and securing wound drains
Superficial haemostasis including surgical diathermy

TABLE 1.2 List of PCC members (Adapted from PCC, 2018).

Association for Perioperative Practice
Association of Independent Healthcare organisations
British Association of Day Surgery
British Anaesthetic and Recovery Nurses Association
College of Operating Department Practitioners
Royal College of Nursing

CALL FOR CLARITY OVER NAMES

Despite NAASP and the PCC promoting the use of the ASP title from the early 2000s, several different titles used by non-medical surgical assistants continued to be used in practice. A position statement by the Royal College of Surgeons (RCS) in 2010 recommended the public be informed about the background and meaning of job titles in use within the surgical setting (RCS 2010). The RCS then issued another position statement that recognised how crucial non-medical surgical assistant roles had become to the delivery of some surgical services but called for clarity regarding the varied titles in use by practitioners who were assisting with surgery to prevent confusion for patients and clinicians (RCS 2011). See Quick et al. (2015) for titles that have previously been used. With NAASP dissolved, the PCC responded by issuing an updated position statement in 2012 that provided a consensus in the United Kingdom regarding the job titles appropriate for perioperative practitioners who provide three different levels of assistance (PCC 2012). Each of the three roles recognised by the PCC (2012) in Figure 1.1 can be undertaken by a registered perioperative practitioner.

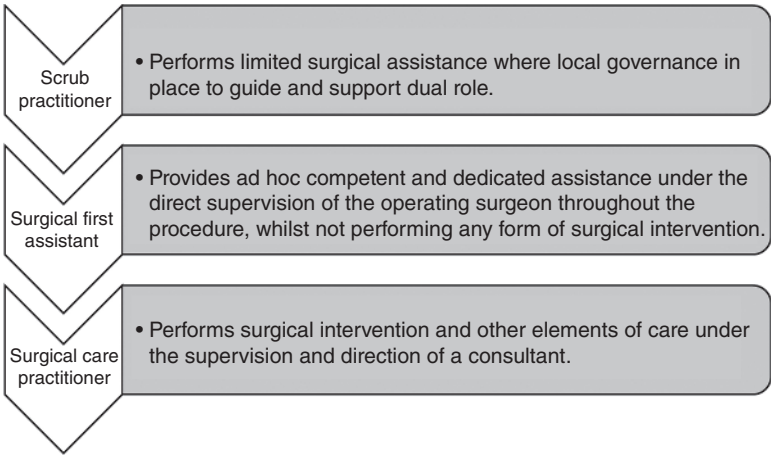

FIGURE 1.1 The three levels of surgical assistance as clarified by the PCC (2012).

In an updated position statement in 2018, the PCC defines the SFA as,

> *... the role undertaken by the registered practitioner*[1] *who provides continuous, competent and dedicated surgical assistance to the operating surgeon throughout the surgery: Surgical First Assistants practice as part of the surgical team, under the direct supervision of the operating surgeon.*
>
> (PCC 2018)

A NATIONAL SFA TOOLKIT

Despite a clear new title as well as clear responsibilities previously set by NAASP, the number of universities who offered the accredited SFA post-registration modules declined after 2012, most likely due to the dissolution of NAASP. Consequently, practitioners struggled to find national-accredited courses and healthcare organisations developed their own in-house courses for registered theatre staff. One problem with in-house courses is that that they are not usually transferable from one employer to another, and so in response to their pledge to continue the work started by NAASP, AfPP performed an extensive update to the NAASP ASP curriculum and published the first edition of the AfPP surgical first assistant toolkit. The purpose of the toolkit was twofold: in the absence of university-accredited courses, it primarily acted as a national training tool for practitioners by defining the knowledge and skills required by SFAs. Practitioners completed the toolkit alongside in-house or other SFA training packages. Second, it acted as a reference source for employers to assist with the strategic planning and roll out of the SFA role in the operating theatre.

ACCREDITED UNIVERSITY COURSES

With the role of the SFA becoming widely accepted within the NHS and Independent Healthcare Sector, a number of universities once again offered post-registration modules. The updated PCC SFA statement (PCC 2018) states that the role of the SFA should only be undertaken by someone who has successfully completed a validated university programme of study. There was also demand from employers and practitioners as registered nurses and ODPs looked to expand their skill set for personal and professional development. In a service evaluation conducted by Lowes et al. (2020), ODPs indicated that in relation to continuing professional development (CPD), surgical first assisting was a popular area for further study. It is envisaged that demand by ODPs to undertake SFA post-registration training will eventually decline with the PCC (2018) statement recognising the College of Operating Department Practice (2018) Bachelor

[1] A nurse registered with the NMC or Operating Department Practitioner or other AHP registered with the HCPC.

of Science (Hons) in ODP (Bachelor of Science in Operating Department Practitioner in Scotland) now being a validated programme of study for SFA training.

While the current Standards of Proficiency for ODPs (HCPC 2023) identifies that ODPs need to 'understand the role of the surgical first assistant in assisting with surgical intervention', the professional body for ODPs expect ODP learners to also 'demonstrate proficiency in enhanced surgical skills, commensurate with a surgical first assistant' (CODP 2018: 29).

THE RESPONSIBILITIES OF THE SFA

The PCC set out the technical and non-technical responsibilities of the SFA in 2012 but in 2018 updated it to reflect the development of the SFA role in extended surgical teams (PCC 2018). The responsibilities of the SFA are listed in Table 1.3 this list is not a definitive list of skills required in every surgical speciality but rather general guidance on the SFA's role which means that the SFA will need to liaise with their manager and surgical teams to identify their exact duties based on these responsibilities which should be reflected in their job description, person specification and supported by organisational policy (PCC 2018). Part two of this book examines the responsibilities of the SFA role throughout each phase of the patient's perioperative journey.

This historical development of the SFA role has been presented from the early days of international nursing to the UK-specific role definition of a registered practitioner who performs assistance to the operating surgeon throughout a patient's surgery. Furthermore, the history of the ODP role development and the incorporation of SFA roles at both pre- and post-registration levels have been discussed. The perspectives of professional bodies and their contribution as a collaborative have also been identified and are a useful starting point for the preceding chapters of this book.

TABLE 1.3 Responsibilities undertaken by the SFA (Adapted from PCC, 2018).

Assisting with patient positioning, including tissue viability
Skin preparation and draping prior to surgery
Superficial skin and tissue retraction with cutting of superficial sutures
Handling of tissue and manipulation of organs for exposure or access
Nerve and deep tissue retraction (The SFA can only move or place retractors under the direct supervision of the operating surgeon)
Cutting of deep sutures and ligatures under direct supervision of the operating surgeon
Assisting with haemostasis to secure and maintain a clear operating field including indirect application of surgical diathermy by the surgeon
Use of suction as guided by the operating surgeon
Camera manipulation for minimal invasive access surgery
Applications of dressings as required

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