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Is task sharing preferred to task shifting in the provision of safe surgical care?

Recent publications in surgery literature show a growing understanding of the role of surgical care in achieving Universal Health Coverage and in the attainment of the Sustainable Development Goals. The real unmet surgical need is better understood and the guidelines for achieving access to safe, high-quality, and affordable surgical and anesthetic care are embodied in the drive to develop a national plan for surgical obstetrics and anesthetic care. Evolving metrics to measure our successes in moving toward improving surgical care are being proposed. The provision of surgical skills is central to achieving these outcomes.

This meta-analysis demonstrates very clearly the reality regarding available physician and specialist resources to provide surgical care. The cost and availability of training facilities makes it very difficult to achieve adequate specialist coverage to meet the needs for surgical care. Driven by need, a range of solutions has evolved that include heterogeneous cadres of health professionals. Specialist nurse practitioners and the development of non-physician practitioners have filled the gap in lower income countries and, as this review showed, they now provide a substantial proportion of the care.

The shifting of specific tasks in the provision of surgical care has occurred, and there are a broad range of practices that these specialist nurse practitioners and non-physician practitioners perform, as well as abroad range of training and supervision. It is time for the profession to engage with these definitions and ensure that within the context of the provision of surgical care, we can start to develop standards to ensure that the aim of safe, high-quality, and affordable surgical care can be achieved.

Task shifting was defined by the World Health Organization (WHO) in 2008 as "the rational redistribution of tasks among health workforce teams … from highly qualified health workers to health workers with shorter training and fewer qualifications." While this definition may be adequate for health care in the non-surgical disciplines, I question its adequacy in the field of surgery. Surgery is a system-based delivery of health care aimed at diseases that require, as part of their prevention and treatment, the performance of a surgical procedure. From a systems perspective, a surgical procedure requires a team of health care professionals, specific infrastructure (operating rooms), a range of equipment (surgical and anesthetic related), and procurement of so-called disposable resources including drugs, sutures, etc. TS focuses on the human resources required in this system.

TS (compared to task sharing) encompasses a range of scenarios; TS implies a greater degree of independent practice. Such independence may provide better "coverage" but may not ensure the provision of safe, high-quality care. The difference is not just based on the extent of the supervision but also on the level of training.

The education and training of surgeons has progressed and is evolving into a modular, competency-based training, which in many environments is moving away from an apprenticeship-based training. The competencies have been deconstructed to allow training to focus on the application of knowledge and the training of the required skills. Through this approach, we can better define the different types of training required. Utilizing such an approach can support a better understanding for the training and utilization of different levels of skills for the provision of surgical care.

TS has been divided by the WHO into different levels of functioning based largely on the extent of the oversight of the clinical process by the "specialist." The clinical process includes the initial diagnosis, decision-making, and determination of the indication for surgery and choosing the surgical procedure that is best for the patient. The performance of the procedure and the postoperative care also encompasses the identification and management of surgical complications. In different situations, the balancing of these imperatives differs and, as such, when assuming a systems approach to surgical care, ensures that this balance is an essential consideration.

It is proposed that task sharing is a better approach to ensuring the redistribution of tasks. This implies that the division of labor is better defined and occurs under a construct of the "team." The training of each cadre can be determined better through a competency approach. The non-physician practitioner can be trained as part of the team and the physician cadre including the specialist is trained with the integration of this cadre. Curricula for training can be standardized.

The degree of supervision will be difficult to standardizes, especially in lower income countries, but this will provide guidelines in developing new programs and improving established programs. As already defined in the review, the supervision will range from a high level of supervision to independent practice. Independent practice should still occur in the context of a team, and the supervision may be distant and provided by the integration of high-quality information technology into the process. On-site supervision may be in aspects of the decision-making process or may occur in the actual operating room. The requirements and the criteria determined for accreditation at each level will need to be defined. This accreditation may be based on the determination of the

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competencies, infrastructure, and equipment required at each level of functioning.

The strengthening of the district hospital will facilitate this process. To ensure high levels of efficiency and patient safety, a well-structured and functioning referral process will be essential in achieving the best outcomes from the integration of non-physicians into the provision of surgical care.

The acceptance of task sharing requires a substantial degree of change management within the profession. The fundamental concern relates to the safety and quality in the provision of surgical care. The better definition of task sharing can assist in addressing these concerns.

While the WHO definition of TS is broad, it is proposed here that surgery is best served through task sharing. Task sharing better ensures the integration of the non-physician surgical care provider into a team, defines the competencies required, and ensures appropriate levels of supervision within the team. For this to be efficient, the district hospital and referral systems must be strengthened.

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