Governance Statement regarding patient safety issues in relation to practical procedures carried out by physicians in training

1. There is an absolute patient safety requirement that no trainee should be required to undertake, unsupervised, a procedure that they have not been trained to do and shown to be competent to undertake.

2. Successful completion of Core Medical Training requires trainees to demonstrate competence, to the level of independence, in advanced cardiopulmonary resuscitation (including external pacing), diagnostic ascitic tap, lumbar puncture, nasogastric tube placement and checking, pleural aspiration for pneumothorax or insertion of an intercostal drain for pneumothorax.

3. Intercostal drain insertion for fluid using the Seldinger technique with US guidance, elective DC cardioversion, central venous access or transvenous cardiac pacing are listed as *desirable* CMT competences, in which trainees may be expected to have *some* experience. Some trainees may not be competent for unsupervised independent practice of these procedures.

   The experience may have been gleaned in a skills lab/course training facility or in a clinical setting with supervision. They may also not have competence in abdominal paracentesis, knee aspiration (not a curricular requirement until the end of first year General Internal Medicine at ST3+ level) and skin biopsy.

4. It follows that *no* organisation employing training-grade doctors at ST3 level or above should *assume* that the medical registrar leading "the acute medical take" is independently competent to perform the procedures listed in item 3 above at the start of their training.

5. Careful review of competency at the point of placement of trainees to a Local Educational Provider who are contracted to undertake an acute medical role is vital. Hospitals admitting acute medical patients must ensure that they have explicit arrangements for the above procedures (or indeed other procedures as required), particularly out of hours. If competence cannot be confirmed or targeted training provided before the first out-of-hours shift, the involvement of other specialties will be required. For example, with regard to the establishment of central venous access, the expertise will likely be found within anaesthetic or intensive care teams.

6. The 3 Medical Colleges, through JRCPTB and its parent Medical Colleges, will be asking Deaneries and the CQC to monitor these important patient safety issues.

When consenting a patient for a practical procedure it is a doctor`s duty to ensure that the patient is aware of any material risks involved in that procedure. It is not sufficient simply to reduce a risk to percentages as the significance of a given risk is likely to reflect a variety of factors besides its magnitude. The doctor`s role involves a dialogue with a clear risk/benefit analysis of the proposed procedure. However, patients should also have the opportunity to discuss the risks that they consider relevant.

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To be reviewed in 3 years