EUROPEAN UNION OF GENERAL PRACTITIONERS/FAMILY PHYSICIANS
UNION EUROPEENNE DES MEDECINS OMNIPRACTICIENS/MEDECINS DE FAMILLE

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UEMO statement on Inappropriate Physician substitution

Definitions

Task shifting refers to the transfer of specific clinical tasks from one professional group to another.

Team-based care refers to collaboration within and between professions working towards shared patient-centred goals.

Physician Substitution (PS) is the performance of tasks, roles and procedures traditionally the preserve of registered medical practitioners by those who are not registered medical practitioners. PS can be performed by MAPs or other traditional clinical professions

Medical Associate Professional is a collective term encompassing Physician Assistants, Physician Associates, Anaesthetic associates. It does not usually include roles and scopes of practice performed by those in the traditional clinical professions such as Registered Nurses, Advanced Nurse Practitioners, Physiotherapists (Not an exhaustive list)

A. Operational Principles for Safe and Effective Task Shifting

1. Patient outcomes and quality of care must be maintained

Task shifting should only be considered when patients receive care of equivalent quality, safety, and effectiveness. The professional assuming responsibility for a task must possess the necessary knowledge, skills, training, and clinical competence required for that task.

Patient complexity must always be considered. Individuals with multimorbidity, frailty, diagnostic uncertainty, or multiple interacting conditions may not be suitable for highly protocolised or disease-specific pathways.

2. Task shifting must create meaningful clinical value

The transfer of tasks should release professional capacity for activities requiring higher levels of expertise. It is inappropriate to shift responsibility for clinically complex patients merely to free physician time for activities of lower clinical value.

Healthcare systems should ensure that task shifting contributes to better allocation of competencies rather than simply redistributing workload.

3. Cost reduction must never be the primary objective

While task shifting may improve efficiency and reduce costs, economic considerations should never override patient safety or quality of care.

A lower-cost workforce cannot justify lower-quality care. Task shifting that reduces expenditure at the expense of clinical outcomes, patient safety, or continuity of care should not be implemented.

4. Adequate autonomy is essential

Task shifting is only effective when the receiving professional can perform the delegated task with a high degree of autonomy within clearly defined competencies and carry independent indemnity.

If frequent supervision or repeated consultation with the delegating physician is required, anticipated gains in efficiency, access, and cost-effectiveness may not materialise. The obligation of physicians to supervise a physician substitute cannot be a contractual obligation.

5. Risks of fragmentation and loss of continuity of care must be recognised

Task shifting can contribute to fragmentation of care. While this may be acceptable in certain well-defined clinical situations, fragmentation becomes problematic when patients have multiple interacting conditions requiring coordinated long term management.

Family doctors/general practitioners possess broad, integrative expertise that allows them to manage multiple conditions simultaneously while considering interactions between diseases, treatments, and social circumstances.

The proliferation of disease-specific clinics and professional silos may undermine continuity and holistic care, particularly for patients with multimorbidity.

6. Effects on medical competence and training must be considered

The transfer of core clinical activities away from physicians may lead to gradual erosion of competence within the medical workforce.

When physicians become occasional consultants rather than active clinicians within certain fields, opportunities to maintain expertise diminish. This may also negatively affect both undergraduate and postgraduate medical education and specialist training by reducing clinical exposure to important conditions and procedures. Physicians should take precedence for training opportunities over other medical associate professions

7. Whole-system costs must be evaluated

Evaluation of task shifting should consider the entire patient pathway rather than isolated clinical encounters.

Disease-specific clinics may achieve good outcomes for individual conditions, but patients attending multiple services often experience increased complexity, duplication, and time burden. In many cases, a single consultation with a family doctor/general practitioner can address several health problems simultaneously, resulting in greater efficiency and improved coordination.

8. Task shifting should not be used to compensate for underinvestment

Across Europe, increasing numbers of clinical responsibilities have shifted from hospitals to general practice/family medicine. In many healthcare systems, resources have not followed these expanding responsibilities.

Shifting tasks from general practice/family medicine to community services such as pharmacy along with doctor substitution is not a rationale to underinvest in general practice/family medicine.

Shifting tasks must not become a substitute for adequate investment in general practice/family medicine workforce and infrastructure. Sustainable healthcare systems require sufficient numbers of appropriately trained general practitioners/family doctors.

9. Responsibility and accountability must be explicit

Every task-shifting arrangement must clearly define professional responsibility and indemnity, clinical accountability, and supervision requirements.

This principle is particularly important where non-physician professionals assess patients, monitor treatment, or request that physicians authorise prescriptions or investigations.

Clinical accountability cannot be assumed simply because a physician possesses the authority to prescribe or investigate. Responsibility must reflect actual clinical decision-making and patient management.

Clear escalation criteria must be established to identify situations where physician involvement becomes necessary.

10. The role of Physician Substitutes

Recent developments in several European countries, particularly the United Kingdom, have highlighted the need for clear governance and responsibility regarding Physician Associates/Assistants and similar professional roles.

UEMO supports multidisciplinary teams but emphasises that:

- Physician substitutes are not medical doctors.
- Physician substitutes should be presented to patients in a manner that does not create confusion regarding professional qualifications with suitable identification.
- Physician substitutes scope of practice must be clearly defined and proportionate to their education and training.
- Complex diagnostic assessment, management of diagnostic uncertainty, and responsibility for undifferentiated patients must remain physician-led activities.
- Workforce shortages must not be addressed through substitution models that compromise patient safety, continuity, or professional standards.

B. Operational Principles for Effective Team-Based Care

1. Teamwork is based on shared goals and shared responsibility

Teams may be multiprofessional or consist of members from the same profession. Effective primary care teams commonly include general practitioners/family physicians, nurses, psychologists, physiotherapists, pharmacists, dietitians, social workers, and other allied healthcare professionals.

2. Teams require structured collaboration

Successful teams do not arise automatically by assembling individuals. Effective teamwork requires clearly defined roles, communication channels, decision-making processes, and opportunities for interaction.

The organisational structures supporting teamwork should be proportionate to the team's purpose and patient population.

3. Teamwork is a means, not an end

Teams should be established because they improve patient outcomes, quality of care, continuity, and/or efficiency—not because multidisciplinary working is fashionable, politically attractive or for economic reasons.

Healthcare organisations should avoid creating team structures that add complexity without delivering measurable benefits.

4. Teamwork does not eliminate the need for more general practitioners/family physicians

While experienced general practitioners/family physicians can extend their expertise through team-based models, teamwork cannot compensate for an insufficient medical workforce.

Expecting multidisciplinary teams alone to solve shortages of general practitioners/family physicians is unrealistic and will compromise patient care.

5. Mutual respect for competencies and limitations is fundamental

Effective teams require a clear understanding of each profession's expertise, responsibilities, and scope of practice.

All team members should recognise when care can be managed independently, when collaboration is required, and when escalation to another professional is necessary.

Respect for professional competencies and boundaries is essential for patient safety, quality of care, and efficient use of healthcare resources.

Conclusion

UEMO supports both task shifting and team-based care when they improve patient outcomes, strengthen continuity, and make appropriate use of professional competencies. However, neither approach should be viewed as a substitute for adequate investment in general practice/family medicine or for ensuring sufficient numbers of well-trained general practitioners/family physicians.

Patient safety, quality of care, continuity, accessibility and professional accountability must remain the guiding principles for any workforce redesign.

C. Political Actions

That UEMO

1. Endorses supports and promotes the operational principles outlined above
2. Notes the rise of Physician Substitution arising throughout Europe driven partially by physician shortage but also by pressure to reduce healthcare costs.
3. Recognises the valuable work performed by suitably qualified, experienced and registered allied healthcare professionals working within their approved scope of practice in support of physicians.
4. Is greatly alarmed by the serious adverse outcomes for patients including death caused by **inappropriate** physician substitution (PS)

5. Calls upon all European Medical Organisations and their constituent National Medical Associations to come together to co-ordinate with specialist societies, and professional regulators to
    a. Publicise the serious risks and hazards of **inappropriate** Physician Substitution for
        i. Patients
        ii. The medical profession
        iii. Allied healthcare professionals
        iv. Health services
    b. Agree common definitions of what constitutes the training knowledge and experience required for roles involved in Physician Substitution
    c. Define specialty by specialty the acceptable tasks and roles suitable for physician substitution
6. Insists that every patient has the right to be assessed by a physician where that physician accepts that it is appropriate for the purposes of initial diagnosis and treatment planning and for review prior to discharge for each episode of care.
7. Insists that (except for ambulance emergencies) Physician substitutes must NOT diagnose or treat any undifferentiated patient presentation without specific prior physician review