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From the editor

Physician assistants revisited

Last year *Clinical Medicine* published Ross *et al's* article 'The case for the physician assistant'.[1] These professional health workers in the UK have a training background involving a two-year postgraduate diploma, equally split between theory and clinical practice. While over 80,000 physician assistants (PAs) are employed in the US, where the profession first developed and has been growing for over 40 years, Ross *et al* cited a figure of 130 graduates from UK programmes at the time of writing. They pointed out the immense potential value to the NHS of a cohort of professionals, with generic competencies, providing continuity of care as they work under the supervision of qualified doctors. In this edition of *Clinical Medicine* White and Round publish a qualitative analysis of the experience at St George's Hospital in London following the introduction of PAs into the paediatric intensive care unit.[2] Despite some, not unexpected, teething problems – many of which reflected a lack of clarity and uncertain expectations of the role that PAs would play – they report that after time had passed PAs had become 'an indispensable part of the team'.

The Department of Health, as long ago as 2006, published *Competence and curriculum framework for physician assistants*,[3] prepared in association with the Royal College of Physicians and the Royal College of General Practitioners, and to many it seemed that this was a step on the way towards establishing a statutory framework for the profession. This process has now stalled, as part of a wider government decision against statutory regulation of further health professions in the future.[4] This is despite the fact that at first glance the PA profession appears eminently appropriate for regulation under the Health and Care Professions Council, which regulates many groups of health workers with the common attribute of well-delineated professional qualifications. While the tide of events a few years ago might have foretold a steady increase in the number of courses training PAs, the reverse has happened, with only St George's University of London and Aberdeen currently accepting students. It seems likely that the lack of progress on statutory regulation plays a significant part in this unexpected trend reversal. Universities may feel uncertain about running, and NHS Trusts about supporting, these courses, which, although they lead to an academic qualification and acquisition of defined competencies, do not bring with them entry into a profession as recognised as, for example, physiotherapy or nursing. Students may well be deterred and prefer the option of training for entry into a statutorily regulated profession. Despite this, growth in PA employment in the NHS continues and demand will continue to outstrip supply until new courses are developed. And the lack of statutory regulation brings with it clear limitations in the fulfilment of the role that PAs could reasonably be expected to play – most notably an inability to prescribe, but also, for example, barriers to ordering radiological examinations.

The training followed by the deployment of PAs mirrors in an interesting manner the training and deployment of physicians. PAs, like medical students, receive a clinical training that is very broad – though clearly much shorter than the medical students'. However, thereafter, particularly in hospitals, they adapt to fill the requirements of the services within which they work, be that orthopaedics, neurology, orthogeriatrics or acute medicine (for more detail of fields in which PAs are employed, see the UKAPA website at http://ukapa.co.uk/). The report of White and Round reflects that this period of role-definition and training, and indeed this adaptation, not only to the branch of medicine, but also to the particular arrangements in a particular service in a particular location, may well underlie the worth that PAs may bring. Nonetheless recertification in clinical knowledge 'across the board' is a requirement for them and maintaining this broader medical perspective is one distinction from both nurse practitioners and indeed from most doctors in the hospital service. Another key difference also from those cadres is that PAs remain under supervision by doctors.

Much past debate concerning the provision of emergency medical care, the staffing of acute medical units and indeed the training of generalist vs physicians has taken place against assumptions of a traditional background of consultants and doctors in the training grades, and the reality, therefore, that much of the assessment and treatment of acutely ill patients will be done by, in some cases, very recently qualified medical staff. At certain times in the yearly cycle, as tyro staff commence working, the burden of supervision on senior staff accelerates – only slightly ameliorated by the recent introduction of a period of shadowing by new trainees before they take up their substantive posts. While the task of training the next generation of doctors may, in grandiose terms, be described as a privilege, it seems unlikely that senior staff would regret the presence of a more permanent tier of health workers, working under their supervision, with skills that would become adapted to the environment within which they work. Adding to any medical team

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one or more trained individuals who have adapted to the particular workload and the specific environment within which they are working, are familiar with local custom and practice, and are working long-term in that environment, providing continuity to the service, would benefit care and provide a valuable resource for trainees passing through what, for them, is unfamiliar territory. There is a legitimate argument that the lack of statutory regulation may be inhibiting the development of this.

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Action on obesity: comprehensive care for all

John Wass and Nick Finer

Obesity, a mostly lifelong condition, is increasing in prevalence in the United Kingdom, such that approximately 26% of adults are obese.[1] Similar proportions of children are also obese. The rates in the United Kingdom are some of the highest in the world, exceeded only by the United States.[2] While obesity has a strong heritability, environmental changes interacting with this genetic susceptibility are driving a rapid increase in the prevalence and severity of the condition. Obesity causes, and is linked to, many complications, including type 2 diabetes, hypertension, ischemic heart disease, sleep apnoea, asthma and non-alcoholic fatty liver disease, as well as increasing the risk of several cancers and even dementia.[3] Obesity is also modifying the presentation of, and treatment algorithms and strategies for, these associated morbidities.

About nine months ago an obesity working group was set up within the Royal College of Physicians (RCP) to consider and develop recommendations on the illness, and the report of this group has just been published.[4]

While some services for prevention and early community-based management exist (tier 1 and 2 services), there is inadequate provision for the multidisciplinary management of patients in the UK with obesity, especially when their condition is severe or complex (tier 3 and 4 services). A survey carried out for this report shows that only 37% of the population has recourse to a multidisciplinary bariatric team. There are currently also widespread differences in the rate of bariatric surgical operations in the country. In PCTs in England, the rate of bariatric procedures in hospital per 100,000 ranges from 0.4 to 41.3,[5] reflecting rationing decisions rather than clinical need. These inequalities need to be rectified.

The report advocates a multidisciplinary approach to weight management and bariatric surgery. All members of the multidisciplinary team should be trained and experienced and should interact with primary care and tertiary centres. The primary care team has an important role in signposting to relevant services which are known to be effective. Long-term care of patients who have had bariatric surgery is important to avoid potentially serious complications.

Bariatric nursing is an important sub-specialty within obesity management that needs to be developed in collaboration with the Royal College of Nursing. Audit and research are also important, as well as translational and health services research.

Physicians should take a central role in commissioning obesity services for patients with what is best called 'severe and complex obesity', rather than concentrating solely on body mass index (BMI). Some patients with a BMI below 35 may have far more complex management needs than those with BMI >40 (previously termed 'morbid' obesity). In every NHS Trust, there should be a medical obesity spokesperson who is involved in communication with commissioners, providers and the community and is responsible for the local development of effective care pathways. The role of the general practitioner is key in facilitating access to weight management support care.

Currently weight management support for health service employees with an obesity problem is not adequate.[6] Employers should encourage healthy eating amongst staff and encourage physical activity.

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