British-trained PAs in emergency medicine has increased from 6 to 13,[2] despite the closure of two of the four programmes educating PAs during this time frame. As of July 2014, several universities are opening new PA programmes and existing programmes are expanding their intake of students. From a nadir of 36 entrants in 2012, there should be at least 150 students entering PA education programmes in 2015. As emergency medicine is one of the most popular specialties for UK-trained PAs, the number of PAs available to practice in accident and emergency should continue to grow.

The data show that most PAs in the UK are not yet performing more invasive clinical procedures used in emergency medicine. This is consistent with the experience of PAs in the USA and is related to their relative inexperience in emergency medicine (1–2 years in post). PA practice rests on a concept of 'negotiated performance autonomy' in which doctors provide their PAs with training for increasing skills over time and allow the PA to perform these duties autonomously once the PA has demonstrated competence to the doctor's satisfaction.[3] As not all PAs are equally skilled at all tasks, the delegation of autonomy to the PA is granted by the doctor on an individual basis over time. It is also possible that the unresolved legal status of PAs is causing uncertainty among doctors about whether or not they are allowed to delegate these more invasive tasks to PAs.[4] If the regulatory issues are resolved and PAs continue to gain experience in emergency care, evidence from the USA suggests that PAs will be able to increase their contribution to the emergency medical team.[5]

The NHS desperately needs to evaluate new methods for delivering emergency care. The short postgraduate educational pipeline (2 years) for PAs, their generalist training and their ability to expand their skill set over time should make the government seriously consider regulating these professionals and expanding the number of PAs in training. ■

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Editor – As you have correctly identified, the risk of 'alternative, less stringent, models of training' is very real. The absence, at present, of any accreditation standards or external review processes for PA programmes, or even the lack of the basics of mandatory educational standards for PA programmes could very well undermine the overall progress of the profession to date. This is especially true now, given that there are three new programmes coming online in the next 6 months and several more under consideration for the next year.

Further, while it is my hope that the registration, along with programme accreditation standards by the Health and Care Professions Council, are forthcoming, they are neither a certainty nor anywhere on the near horizon. As an interim solution, I along with experienced American and British PA educators from the UK and Ireland Universities Board for Physician Associate Education are currently finalising a 'best practice' document which can serve as a template (although with voluntary compliance) for those universities considering a PA programme.

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The future of general medicine

Editor – Dr John Firth wrote thoughtfully in August's *Clinical Medicine*[1] about the future of general medicine. However, by explicitly not exploring its relationship with acute and geriatric medicine, he has inadvertently missed the most important component of the story.

He acknowledges that the acute care of largely older adults with frailty, multiple comorbidities, dementia and social vulnerability accounts for a large proportion of today's acute medical take and an even bigger proportion of occupied bed days. While he then praises geriatricians and their multidisciplinary team colleagues for being good at discharge planning, I do not believe that this is the only skill we have that general physicians fall short on, nor that we have access to some magic set of supports that other physicians cannot access. In reality, any general physician can become fairly skilled and knowledgeable in the area of post-acute rehabilitation, discharge and community services if they choose to. But too often, they regard it as an unworthy 'social' endeavour and someone else's job, and label older patients as having 'acopia' or 'social admissions', or being 'bed blockers'.[2]

Geriatricians add value to patient care in a variety of other ways by being skilled diagnosticians in the care of frail older people (such as the 'older woman who has had a funny turn' he describes). In addition, if as Dr Firth claims, the assessment of such patients is often more challenging and complex than single diseases in younger adults, it does make me wonder why generalism should be seen, as he claims as being less prestigious.

Comprehensive geriatric assessment delivers a range of benefits to patients.[3] Ensuring older people are seen at the front door of hospitals by geriatricians, as well as a relentless focus on discharge planning, can deliver big efficiencies and improved outcomes.[4] It is geriatricians who have led the way in developing the evidence base for previously neglected syndromes, such as falls or delirium, and in care of inpatients with comorbid dementia. We are also generally dually accredited in general internal medicine (GiM) and deliver more of it than most other specialities.

And despite Firth's claims of low status or popularity, we are the biggest GiM speciality in the Royal College of Physicians with the highest number of trainees.

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