A new professional in the healthcare workforce: role, training, assessment and regulation

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In recent years, both hospital practice and primary care have been under substantial pressure. There have been unprecedented changes in working practices, coinciding with a large and continuing increase in emergency admissions, as well as increased demand for access to care in all areas. The numbers of medical school graduates have not kept pace with the requirement for doctors, but some of the deficit has been met by training other healthcare professionals to undertake tasks previously performed by doctors. Nursing staff and other allied health professionals have undertaken extended roles, with benefits to patient care and job satisfaction. However, there are shortages of many of these healthcare professionals and recruiting from groups where there is already a problem in recruitment and retention does not solve the overall problems with a lack of qualified clinical staff. The difficulties in maintaining safe levels of cover with reduced medical hours and in managing the emergency workload as well as trying to continue training has generated a crisis in many hospitals, and innovative solutions have been sought across the UK.

The crisis in medical and clinical manpower is not confined to the UK, however. During the mid-1960s a new cadre of providers of medical care – physician assistants (PAs) – was developed in the USA in an effort to 'relieve a nationwide shortage of doctors in primary care and to increase access to health care for people in under-served areas'.[1] According to a description provided by the Department of Healthcare Sciences at George Washington University, physician assistants are 'highly qualified health professionals who are prepared, through a demanding academic and clinical curriculum, to provide healthcare services under physician supervision'. On graduation, physician assistants must pass the national certifying examination of the National Commission on Certification of Physician Assistants (an independent accrediting agency), must complete 100 hours of continuing medical education every two years and pass a recertification examination every six years. Selection into training, the training offered and the academic level achieved through it, and the ongoing demands of the physician assistant accrediting organisation all contribute to the creation of a group of expert professionals, able to function at a high level within the healthcare environment. There are more than 50,000 PAs practising throughout the USA and based on the success of the American model, PAs also practise in Canada, India, and in some parts of Europe.[1,2] In the USA, most physician assistants practise in primary care where studies have estimated that in such roles they can provide '80% or more of the services previously provided only by physicians – at the same level of quality'.[1]

Reversing the trend established by our Pilgrim Fathers, in 2003 two American-trained PAs crossed the Atlantic and took up posts in primary care in Tipton in the Midlands. Since then, a further 16 American PAs have been recruited, working in both primary and secondary care in Sandwell and City Hospital, Birmingham. The job descriptions of the primary care based PAs are broad ranging and incorporate some of the duties associated traditionally with that of an NHS general practitioner; recruitment to these posts was driven by an inability to recruit general practitioners to this area. This venture – along with other Changing Workforce Programme pilots – is the subject of a study funded by the Modernisation Agency to evaluate the impact of the American PA model in the NHS, and the article by Stewart and Catanzaro in this issue of *Clinical Medicine* reviews the early experience from the Midlands.[3]

But what of homegrown talent? Currently, there are no UK-trained health professionals working in healthcare in this country with the education, training and level of academic achievement of practitioners from the USA. In 2001, in its publication *Skillmix and the hospital doctor*,[4] the College recognised the need for NHS workforce expansion and explored a range of options designed to increase the flexibility of healthcare professionals, including extension of existing roles and increased emphasis on working across professional boundaries. This report suggested the creation of a new post of 'healthcare practitioner', but emphasised the need for national standards of training, leading to a recognised qualification, to ensure a proper career structure and transferability of skills as well as the importance of safeguarding standards of healthcare through regulation.

However, the workload and manpower crisis in many hospitals overtook the development of training programmes and led to the rapid establishment of a

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wide range of new posts across the country. The terminology of these posts is confused and confusing; the names are not important but the lack of clarity around roles and responsibilities is of great concern. Healthcare practitioners (HCPs), assistant HCPs, medical assistants, physician assistants, doctors' assistants, medical support workers, medical technicians, emergency care practitioners and a range of other titles abound. Their duties vary from predominantly administrative tasks to undertaking a range of clinical procedures, and may encompass duties previously undertaken by registered clinical staff. This is wholly unsatisfactory, both from the regulatory point of view with the need to ensure that clinical care is provided by a competent practitioner, and from the need to recognise, certify and reward workers who acquire new skills.

The Modernisation Agency's Changing Workforce Programme

Concepts and principles similar to those set out by the College are now well embedded in government policy. The NHS Plan set out two major workforce objectives – achieving a significant increase in staff numbers and a major redesign of jobs.[5,6] The need to increase the flexibility of the healthcare workforce is key to the government's Changing Workforce Programme (CWP), which was established specifically to take on the task of facilitating role redesign and encouraging 'new ways of working' at local NHS level.[7] Role redesign covers four types of change: moving a task up or down a traditional uni-disciplinary ladder (seniors doing the work of juniors and vice versa); expanding the breadth of a job (working across professional boundaries); increasing the depth of a job (taking on more responsibility); and new jobs (combining tasks in a different way). Although the thrust of job redesign is focused on the current NHS workforce, the expectation (or hope) is that people who would not previously have considered a career in the NHS will be attracted to the organisation in the future because of the flexibility of the career structure, and because of opportunities offered for continuous development and skill enhancement. Such people would come from a variety of educational and work experience backgrounds; for example, science graduates and ex-forces personnel – backgrounds similar to the recruitment pool of the American physician assistant. In addition to attracting new staff, the initiative is expected to assist with the retention of existing NHS staff.

The Modernisation Agency's enabling Career Framework divides the NHS workforce into nine levels, with levels 1–4 being the unregulated NHS workforce, and 5–9 containing the regulated workforce and senior management. The changing workforce policy objective is to facilitate vertical, horizontal, and diagonal moves between various staff groups and framework stages – the overriding aim being always to 'improve patient care, maximise staff skills, tackle staff shortages and increase job satisfaction'. There are some excellent examples of good practice that have developed across the country, both as pilots of the CWP and as a response to the workforce difficulties in individual Trusts. However, the fluidity of the model proposed by the Modernisation Agency has inevitably resulted in currently unregulated staff doing work previously carried out by regulated practitioners, and in regulated staff groups crossing professional boundaries and undertaking duties that are outside their professional accountability. This leads to limitation of further extended roles, and to concerns about indemnity and the standard of direct clinical care.

What is the role of the Royal College of Physicians in this?

Regulation and nomenclature: A rose by any other name…?

It is the redesigned jobs that will be undertaken by the 'senior and advanced practitioners' (operating at levels 6 and 7 of the NHS Career Framework hierarchy) that will align most closely with traditional medical work. Where existing healthcare professionals take on extended roles, they may remain accountable to their parent regulatory body. When the extended scope of practice requires additional knowledge, tasks and skills such that the new role is sufficiently different from the original profession, practice needs to be regulated separately. Individuals without a healthcare profession background may be direct entrants into advanced practitioner training and their practice requires regulation. New advanced practitioner roles are being developed in medicine, surgery, anaesthetics, critical care and emergency care, but until statutory regulation is in place, those developing the new role will be accountable to those supervising them. Once the roles and competencies have been established and the training to provide them approved, it is anticipated that the Health Professions Council (HPC) will be given statutory powers to regulate advanced practitioners in medicine, surgery and anaesthesia as a distinct professional group.

However, the titles of new healthcare posts have led to confusion regarding the nature of the training and the exact roles and responsibilities. Establishing an agreed taxonomy for these practitioners is a critical factor because the titles that healthcare workers adopt define the boundaries of their practice and thus the remit against which they will be judged. The CWP had originally used the term 'physician practitioner', but consultation with the College's Patient and Carer Network highlighted that this title could mislead the public, suggesting that the individual was trained as a doctor. Additionally, practitioners working at level 8 use the title 'consultant'; thus a physician practitioner progressing up the skills escalator could theoretically be termed a 'consultant physician practitioner', a title about which Members and Fellows of this College were singularly unenthusiastic. Currently, the working title that has been adopted is medical care practitioner (MCP), reflecting uniformity with the surgical care practitioner and anaesthetic care practitioner roles being developed with the other Royal Colleges.

Whatever name is finally agreed, the aim is for the HPC to set up a separate register for the protected title for this new professional group. In order for a profession to be eligible to be regulated by the HPC, there are a number of criteria that must be

met.[8] These include demonstration that the scope of practice is distinct from the scope of practice of other occupations and that there is a distinct body of knowledge underpinning the activities (although there may be some overlap). The occupation must have defined routes of entry to the register, with independently assessed entry qualifications and defined knowledge and skills, as well as a requirement for all registrants to undertake Continuing Professional Development.

Maintaining standards of clinical care: Role, scope of practice and supervision of the medical care practitioner

The purpose of regulation is to protect the public. In general, the HPC regulates health workers who practise autonomously, make professional and independent judgements on treatment and take full responsibility for their actions. Such workers are not directly supervised by physicians. However, it is an essential requirement of the practice of the American physician assistants that they work under physician supervision. The Royal College of Physicians, London (RCP), Royal College of GPs (RCGP), Royal College of Surgeons of England (RCSE) and Royal College of Anaesthetists (RCA) have been unanimous in their belief that the advanced practitioners must work under the supervision of a medically qualified practitioner. This principle has been agreed with the CWP, who have confirmed that the MCP will work under the supervision of a general practitioner or consultant physician and only accept delegated duties that they are confident and competent to perform. The principles of delegation will be as stated in the General Medical Council guidance, *Good medical practice*:[9]

> *Delegation involves asking a nurse, doctor, medical student or other healthcare worker to provide treatment or care on your behalf. When you delegate you must be sure that the person is competent to carry out the procedure or therapy. You will still be responsible for the overall management of the patient.*

In accordance with current legislation, individual MCPs will be accountable for their own practice within the scope of conduct from their regulatory body. This situation is analogous to that of a trainee doctor, who is accountable for his or her own practice but who works under the supervision of a GP or consultant physician. Anaesthetic care practitioners (ACPs) will work under the supervision of a medical anaesthetist, and a medically qualified surgeon will always supervise surgical care practitioners (SCPs).

Training and assessment of advanced practitioners

The detailed curriculum for the anaesthetic training programme has been designed by a working group from the RCA, in partnership with the University of Birmingham, and under the umbrella of the NHS University, and the curriculum framework for the surgical care practitioner, drawn up by a working party under the auspices of the Council of the RCSE, is currently out to consultation,[10] both pieces of work commissioned by the NHS Modernisation Agency. The Modernisation Agency has now commissioned the RCP in partnership with the RCGP to lead on the development of a curriculum framework and competencies for medical care practitioners, and a Steering Group has been established to undertake this work, chaired jointly by the Clinical Vice-President of the RCP and the Vice Chair of the RCGP. The Steering Group includes members from the University of Birmingham Medical School, representing other interested higher education institutes (HEIs), Skills for Health (the UK's Sector Skills Council for Health), representatives from the RCP and RCGP education departments, an American physician assistant, and representatives from the Trainees Committee and from the Changing Workforce Programme.

The Steering Group has defined the role, remit and scope of practice of an MCP. An MCP needs to be educated to formulate a detailed differential diagnosis and develop a comprehensive patient management plan, having taken a history and completed a physical examination. This requires a high level of critical thinking. They will be able to perform many diagnostic and therapeutic procedures, prescribe medications, request and interpret diagnostic studies and undertake patient education, counselling and health promotion. Therefore the competencies must reflect a significant knowledge base and understanding of scientific principles, acquired through a rigorous academic and clinical curriculum. MCP students will be drawn from a variety of backgrounds, but it is intended that a major pool of applicants will be science graduates, thus recruiting from a sector currently under-utilised by the NHS. Other areas for recruitment include the armed services, nursing and professions allied to medicine.

There is likely to be variation in knowledge levels and experience of different entrants. Some entrants may need access programmes to enable them to follow the proposed intensive university course. The curriculum framework will set out a national standard for training, including minimum placement experience and indicative methods of assessment of clinical competencies. Assessment will include a national knowledge-based examination, as well as objective structured clinical examinations, direct observation and direct questioning by the local assessors in each HEI. Each student will maintain a portfolio of evidence containing a record of progress and including reflective accounts of critical learning encounters. The balance of national versus local (HEI) assessment is still under consideration, but each MCP will have to meet the national required standard for qualification and entry to the register.

In order to specify competencies, it is necessary to break down the clinical role into a series of component parts. The MCP works to a medical model; that is, by the flexible application of knowledge and skills to the needs of the individual patient, rather than working to predetermined protocols. Therefore, considerable emphasis has been placed on history-taking and consultation skills, on physical examination, and on clinical judgement in diagnosis and management. The recognition of when a clinical situation is beyond their expertise and the need to seek appropriate help is a key competence, as is the importance of team working and the relationship with the supervising physician.

A model has been developed to categorise knowledge of core

clinical conditions and clinical skills in relation to competence in diagnosis and taking responsibility for management. Thus, an MCP may be able both to diagnose the condition at presentation and to manage it without routine referral to the supervising physician, or manage the condition after the condition has been diagnosed, or identify a possible diagnosis, initiate investigations or stabilisation and refer appropriately, or assist in the management with the supervising physician. Experience post-qualification may draw diseases into a higher category by agreement with the supervising physician, and reflecting additional specialist training. It is key to the MCP role that they maintain competence in the breadth of clinical conditions, so that they may practise in a range of settings within the general medical and general practice teams.

Continuing Professional Development (CPD)

A further role for the RCP may be in providing a range of support for the CPD requirements of MCPs. A proposal was agreed at the AGM in March 2005 to allow certified MCPs to become Associates of the RCP, under Bye-Law 127. The College would set up a database to maintain their CPD records as well as accrediting educational events and there is potential to provide some shared educational programmes with medical trainees. We have been in discussion with the continuing medical education (CME) department of the American Academy of Physicians Assistants to agree criteria for accrediting programmes, so that we can support the American PAs currently working in the UK. United States CPD criteria match our own very closely and we hope to agree reciprocal accreditation. Associateship of the RCP would not permit use of the post-nominal ARCP, however, which reflects Affiliateship of the College.* The RCA is considering that ACPs will become Affiliates of the Anaesthetic College, and is proposing to hold the voluntary register of practitioners, until the planned statutory regulation of the profession by the HPC.

The future

There remain a number of unresolved issues, not least the availability of funding for training, and the potential numbers, so that HEIs may develop detailed curricula and Workforce Development Confederations may commission places. There may be difficulties with capacity for clinical placements, particularly for interested HEIs without medical schools. The training will not be cheap; as the President of the RCA has said: 'this is not simply a range of extended roles which existing staff can obtain, rather like Scout proficiency badges'.[11] The training includes a rigorous scientific background and extensive clinical training and is likely to take around 28 months of study. Nor will the salaries be cheap, although the roles will be subject to the NHS pay scheme, Agenda for Change. Other professional groups, including some doctors and some of the nursing profession, have expressed unease, and view this development as a threat to both their own profession and to standards of care for patients. Others, including Professor Ara Darzi, writing in the *British Medical Journal* recently, believe the new roles would be effective in selected surgical settings and can offer benefits.[12] The experience from the USA suggests that provided the training and assessment is robust, these individuals can, and will, provide a very valuable addition to our health service. This College welcomes them.

*Affiliateship may be granted to Fellows and Members of other Colleges of Physicians working in this country, or to non-medically qualified senior scientists such as Fellows of the Institute of Physics and Engineering in Medicine, through a nomination process approved by Council.

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