WORKFORCE

Physician associates: an asset for physician training and a 21st-century NHS?

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ABSTRACT

The introduction of physician associates in the UK reflects a need within our healthcare system to continue providing high-quality care amid a backdrop of ever-increasing demand, while acknowledging a medical workforce demanding flexibility and choice in their training alongside a well-resourced working environment. This article looks at the fundamental benefits that could be drawn from the physician associate workforce, while highlighting the historical progress of the profession and emphasising ongoing issues and limitations that will provide insight for the future development of the profession.

KEYWORDS: Teale essay, physician associates, training

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'A problem shared is a problem halved.' The challenges of 21st-century healthcare in the UK have placed ever more pressure on fulfilling the fundamental principles of the NHS: to meet the needs of everyone, be free at the point of delivery and reflect clinical need. Physician associates are trained as autonomous medical healthcare professionals to work alongside doctors, providing access to quality and timely care for a population with ever-increasing healthcare needs. The year-on-year decrease in progression into specialty training following the foundation programme reflects a medical workforce keen on flexibility around traditional career progression,[1] yet the demand for high-quality healthcare with efficient specialist services necessitates that we provide tangible solutions to uphold healthcare delivery.

The quality of physician training relies on multiple factors. These include quality of postgraduate medical education, ability to attend education sessions without compromising service delivery and the development of day-to-day skills in an environment that facilitates efficient learning. While most doctors are very positive about the quality of their teaching and clinical supervision, many report the impact of rota gaps together with heavy, intense workloads affecting their training.[2] This reflects a need to introduce measures to tackle the balance of resources within working environments such that training is not compromised by a lack of capacity.

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Currently, physician associates are able to support physicians in numerous ways. The ability to perform a history and examination, formulate differential diagnoses and management plans together with performing diagnostic procedures offers a remarkable overlap with the regular duties of a physician. This can help doctors in a number of ways: differentials and plans can be discussed with a valuable member of the clinical team, the doctor may be free to attend a training session necessary for development, or to focus on other important areas such as family discussions, prescribing or surgical management.

One of the key facets of a physician associate's work schedule is familiarity with one ward or specialty, having a regular presence to ensure continuity of care for patients. Physicians, as part of their training, will frequently have weeks where they will not have a continuous presence on the ward. This may be due to on-call acute medical shifts, study leave for mandatory training or redeployment to another part of the specialty or hospital. Familiarity with ward patients can thus rely on physician associates having valuable input at board rounds or morning meetings, to inform the physician team for the day and ensure that key clinical issues are not missed by fluctuations of number or grade of physicians.

Currently, regulation of the physician associate profession is in a nascent period, with the General Medical Council (GMC) being selected as the regulatory body only recently in 2019. While this is a step forward for quality assurance, accountability and protection of both the public and practitioners, this still carries risks regarding the safety of autonomous practice, where physician associates can often be left to make important decisions regarding vulnerable patients. Furthermore, it is as yet uncertain to what extent physicians may have to carry the financial cost for regulation of the physician associate programme, although the GMC has insisted that it will not seek to place this cost on physicians. Barriers to success also exist within physician prejudices towards a profession which shares a common method of practice. In a setting where physicians and physician associates will have to work closely and in a coordinated fashion, opinions by one profession regarding the other may have an impact on the provision of patient care, be that through communication between physician associates and physicians or a lack of understanding of training level and competence.

The established physician assistant programme in the USA, where physician assistants number more than 100,000 in the medical workforce since their introduction in the 1960s,[3] provides a benchmark and years of research evidence that can be used

as a basis for comparison. Physician assistants provide more care for older citizens, for those without private healthcare insurance and for rural populations than their physician counterparts, as such being often emphasised as playing a role of 'social good' in America.[4] With a sharp decline particularly in medical student interest for family practice in the USA, especially in the rural setting,[5] physician assistants have been well-placed to uphold the standard of care in these areas suffering a physician shortfall. Indeed, a great wealth of research evidence in the USA suggests improved continuity of care and cost benefits alongside comparable outcomes in safety, efficacy and patient satisfaction.[6] While great differences in the provision of healthcare exist between the USA and the UK, common problems such as provision of healthcare to under-served populations or specialties with a physician shortage suggest that the introduction of physician associates would serve a common benefit, irrespective of overarching healthcare structure.

Looking at the introduction of physician associates in general practice, numerous studies have evaluated the integration of physician associates and issues surrounding implementation of the role.[7,8] Rates of re-consultation, referrals, prescriptions issued and patient satisfaction have been shown to be similar in physician associate consultations and general practitioner consultations.[7] Negative aspects revolved around the limitation of the job role (physician associates not being able to prescribe) and having to consult a physician in particularly complex consultations.[8]

While the physician associate role has been designed to complement and support physician practice in a busy and complex work setting, discussions within the British Medical Association (BMA) have hinted that physicians do recognise a limit to which physician associates should be working. Physicians have resolutely voted against physician associates being treated equally to them for the purposes of medical staffing, and also oppose physician associates being able to sit postgraduate medical exams to become more senior decision makers.[9] Quite pertinently, the issue of staffing remains a pressing concern in many physician specialties, and it is perhaps surprising that junior doctors would be reluctant to introduce suitably experienced physician associates to support rota gaps at their level. It is therefore clear that there appears to be a distinct line where physicians will oppose the growing autonomy of physician associates, and establishing this boundary of practice will be a subject of significant debate in the years to come.

With the global pandemic, our NHS has not faced a greater challenge in peacetime, and this will no doubt be a test of both our need for physician associates and their ability to integrate within the system at a critically challenging time. As clinicians are being asked to come out of retirement and a broad spectrum of specialties are being recruited to urgent care services as a response to the COVID-19 pandemic, the rationale for creating the physician associate role will perhaps now see its greatest justification.

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