Physician Assistants: non medically qualified clinical support staff
A FSSA discussion paper

Physician Assistants / Associates

A physician assistant (US) or physician associate (UK) is a healthcare professional who provides healthcare within the medical model as part of a team with physicians and other providers, holding a qualification that can be gained in less time than a medical degree. In the United States, physician assistants are nationally certified and state licensed to practice medicine under the supervision of a physician.

The occupational title originated in the United States in the 1960s; similar occupations outside the US include clinical officers in part of Africa and fieldshers in countries of the former Soviet Union.

The position of physician associate (PA) has been established in the United Kingdom since 2005.

Regulation

At present, there is no formal regulatory body for PAs, such as the General Medical Council (GMC) for doctors. The only current method of regulation within the professional body is membership to the Managed Voluntary Register (MVR) for Physician Associates. This database, run by PAs for PAs, aims to identify all qualified PAs who are able to practice in the United Kingdom. It is designed to regulate the profession to maintain high standards and to prevent non-Physician Associate qualified individuals being employed in as a Physician Associate in the UK.

Physician associates in the United Kingdom are required to re-certify every 5–6 years and maintain up-to-date practice through attendance of training accumulating CPD hours (Continuous professional development), which need to be completed on an annual basis.

In 2015, the RCP launched the Faculty of Physician Associates, a professional membership body for the physician associate profession. This replaced the previous membership body the UK Association for Physician Associates (UKAPA). Membership of the Faculty endures inclusion on a Managed Voluntary Register.

All agreed that the issue of regulation is the most important outstanding issue with these posts which needs urgent attention. There is a need for a central regulatory body for all assistants i.e. obligatory and that in all likelihood the public would demand this.

There are approximately 250 in post in the UK, 250 in training and about 100,000 in USA

There are also approximately 150 PA(As) in the UK who are currently trained at the University of Birmingham. Despite the Royal College of Anaesthetists running the examination for the PAAs, these individuals are not regulated.

Training

PA training in the UK is through a 2-year MSc or Postgraduate Diploma in Physician Associate Studies. Many Universities offer such a programme including St George’s, University of London, Aberdeen, Birmingham, Wolverhampton, East Anglia, Leeds, Sheffield, Canterbury Christ Church, Anglia Ruskin, Reading.

Aberdeen requires a science-based degree minimum 2:1 grade achieved and St George’s require a science-based degree with a minimum 2:2 grade achieved. This includes Sport Science, Biology, Geology, Psychology and Biomedical based degrees. Applicants should preferably have experience in the health care industry, such as a HCA, auxiliary nursing. Applications from other professionals such as Nurses, radiographers and paramedics will also be considered.
At present RCP and RCA have individual programmes for specialty specific assistants. RCS(Eng) at present has none but the examination for cardiac surgical assistants is run by SCTS and RCSEd. Training, which is comprised of a minimum 90 weeks study over 2 years includes interpreting evidence, clinical judgement in diagnosis and management, therapeutics and prescribing, clinical planning and procedures, documentation and information management, risk management, teamwork and time management. In UK they get 3200 hours training over 2 years with a national exam and 50% hands-on experience.

Responsibilities

Clearly these will vary according to speciality. In a general sense roles include formulating and documenting a differential diagnosis, clinical examination, clinical management, a limited range of diagnostic and therapeutic procedures and the ability to request and interpret diagnostic tests.

A Department of Health working party report entitled “Matrix specification of Core Clinical Conditions for the Physician Assistant by category of level of competence” went into considerable detail about possible competencies.

Clearly the curricula for PAs will vary depending upon their area of specialist interest.

College involvement

Last year the English College received funding from HEE (EWTR working group) for a project (Extended Surgical Team Project RCS England) to identify what tasks and roles could be done by the non-medical workforce, and could support existing trainees. A report on the project and recommendations will be completed by the end of February and that will be presented to the English Council later this year.

One of the questions to be addressed is whether the English College should provide a professional home for members of the extended surgical team and the extent to which they should be supported by the College through education and training. Members commented that there had already been considerable discussion in Council and that a faculty had been agreed in principle; the sticking point was status.

It was noted that the Royal College of Physicians had received considerable funding from HEE to support the introduction of Physician Associates (PAs) and had established a faculty; and that universities were already establishing programmes and employers looking to recruit.

It is anticipated that there will be 400-500 PAs trained per year from 2018 onwards (across the specialties).

Advanced Nurse Practitioners

Nurses are increasingly extending and expanding their scope of practice beyond initial registration in all health care settings. In many areas nurses are now commonly working at an advanced practice level. Since 1980 the RCN has actively promoted advanced nursing practice through the development of competences and accreditation. A considerable amount of work has already been undertaken on advanced nursing practice, which provides a solid foundation for further future developments.

In contrast, in Urology the RCN has resisted attempts to regulate scope of practice or accreditation for nurse specialists in urology. The British Association of Urological Nurses has tried to engage with RCN but without real success.

The Society of Clinical Perfusion Scientists of Great Britain and Ireland is the recognised professional body for
Clinical Perfusion in the UK and Ireland. According to their web site “due to a lack of political will and despite numerous documented incidences and, more recently convictions, we are not, even with support from the HCPC and recognition from the DoH, statutorily regulated. We have been negotiating with DoH to get regulation for over 15 years, most optimistically during the last 2 when we engaged in discussions to become part of Modernising Scientific Careers. 15 months ago, our membership unanimously voted to withdraw from this process due to a lack of assurance regarding our professional regulation”.

The College of Clinical Perfusion Scientists holds the register for all Clinical Perfusion Scientists who practice in the UK and Ireland and annual registration is compulsory in order to practice. They also accredit centres for the safe provision of Cardiopulmonary Bypass and training of our trainee members.

**Surgical Care Practitioner**

Needs to be distinguished from Physician assistant.

**Post Certification**
- Act within a predetermined level of supervision and guidelines with named supervisor
- May develop expertise through experience and CPD
- 2 year CPD cycle after. Specialist and general
- CPD and recertification based on knowledge and skills Framework and submitted to Voluntary registration commission
- Planned 5 yearly recertification in general and specialist areas (in planningphase)
- Yearly appraisal (local)

**Comments / Issues**

**Strengths**
- Department of Health policy: there is no doubt that one driver for the support of PAs is the anticipated reduction in the need for locums. The Government has made no secret of its' intention to reduce locum costs. “We are growing the workforce further with a new class of medic so busy doctors have more time to care for patients” – so said Jeremy Hunt recently!
- As permanent members of staff they improve continuity and consistency of care
- Foundation doctors: creation of PAs will reduce dependency on F1 and F2 doctors.
- PAs need to be distinguished from Specialist Nurse Practitioners and Surgical Care Practitioners, who will have parallel but distinct roles.
- Benefits of PAs ; these include the possibility that continuity of clinical care in maintained (in contrast to the absence of any continuity with respect to trainee doctors), they may function as key members of MDTs integrating the MDT and will contribute to the resurrection of the “Firm Structure”
- By undertaking some of the routine tasks traditionally carried out by F1, F2, CT1 and CT2 doctors they may improve training opportunities for these doctors.

**Weaknesses**
- The role of PAs will become less attractive if they have no defined career progression. Few will be satisfied to remain in a post which remains unchanged for their entire professional lifetime
- Lack of prescribing limits the role significantly.
- Definitions: there is widespread agreement that there is confusion surrounding the roles of PAs, advanced nurse practitioners and many other similar non medically qualifies groups. This necessitates an urgent review of definitions. There is agreement, however that all such posts should only be working within a clinical led guidance structure supervised by a substantive consultant.

**Opportunities**
• Medical manpower: whilst there is little doubt that the numbers of consultants within the NHS will continue to increase it is probable that this will occur with a commensurate decrease in trainees. The gaps will be filled by PAs. The end result will be a consultant delivered and led service. It is more than likely therefore that the role of the consultant will change and resident on call is one likely consequence.

**Threats**

• The appointment of PAs may undermine the position of trainees who may feel threatened by their appointment. There is concern that they may detract from training opportunities. There has already been some resistance from junior doctors over the inclusion of PAs in units. This could be result of the fact that PAs earn a very good starting salary which exceeds the junior doctors’ salary. Some junior doctors and PAs compete for time with consultants which could contribute to the dissent.

• Although the presence of PAs may improve training opportunities for trainee surgeons. An additional concern is that they will be perceived as a cheap way of providing clinical care. At present salaries are circa £30 – 40,000 per year. Salary grade is Band 7 National scale. Appointment of PAs may result in inappropriate delegation of clinical authority and responsibility. Already, for example, there are Neonatal Nurse Practitioners who are on the Registrar rota. There are massive implications to this, particularly in smaller units. Some clinicians have serious reservations about their ability to make clinical decisions as opposed to following guidelines.

• Some teach medical students which might undermine the role of clinicians within the medical school Anaesthetic view: many anaesthetists are opposed to the appointment of PAs because they take away training opportunities from trainee anaesthetists.

• Indemnity: the presumption is that PAs will be covered by Crown Indemnity but within the firm structure such that the consultant carries ultimate responsibility. This needs confirming.

**Speciality review**

• Cardiac surgery: this speciality is already very dependent on non-medically qualified staff including perfusionists, advanced nurse practitioners and cardiac surgical assistants. Perfusionists have a clearly defined role to run the heart lung bypass machine used during cardiac surgery. Perfusionists do not undertake tasks traditionally performed by doctors. Advance nurse practitioners and cardiac surgical assistants have broadly separate roles but these vary within units and there may be some overlap. Generally advanced nurse practitioners have undertaken training in non-medical prescribing, physical assessment and x-ray interpretation. They work on the wards, including critical care areas, out-patient and pre-assessment clinics. They will generally be able to prescribe and take on roles performed by doctors up to CT2 level. Cardiac surgical assistants typically work in theatre where they harvest long saphenous vein and radial arteries for CAGB operations, first assist and teach basic surgical skills to junior surgical staff. In some institutions they operate beyond this level. They will typically have undergone 2 years training with assessment at the end of this by examination.

• Orthopaedic surgery: also has a wide range of health care professionals who are not medically qualified. One of the major issues in orthopaedic and musculoskeletal care is that we have a range of extended scope practitioners within service already. These include physiotherapists acting as extended scope practitioners screening patients referred by G.P.’s, some nurses undertaking the same role. Podiatrists being used by CCG’s again in the same screening role. Though this system has some virtues it has arisen in a very ad hoc basis. The CCG’S have made use of it to deny access to care, so we have seen imposed random non-scientific rules on referral activity and these practitioners are often exposed to abuse by being told that these rules apply without dialogue and that they have to enforce them. As a consequence there are a wide variety of ways in that patients are at risk firstly and most obviously around the issue of diagnosis. (I have recently had a patient arrive in clinic with a letter from a very willing physio ESP explaining that there has been an enormous fight to get the CCG to agree to the referral of this ganglion but the patient does seem to in a lot of pain. This was a renal cell ca secondary arise at the back of the ankle.) Secondly the use of inappropriate treatments because they are primary care based despite lack of any evidence of therapeutic
benefit. Thirdly the excessive use of expensive investigations which actually have no purpose. For these practitioners they need to be brought into joined up thinking as a genuine useful source of conservative treatment in primary care.

• In secondary care we have ESP’S working in support of surgeons in outpatients already extensively these include large numbers of physios, podiatrists, nurse practitioners and of course for us plaster technicians. These roles are largely supported by the equivalent of their own professional organisations but there are issues about how they work for example advising on listing for surgery etc.

• On the wards a number of units do make use of nurse practitioners some of whom do have protocol based prescribing rights. A problem with these posts can be their 9-5 nature. This can have the effect that the trainees are used excessively at night diminishing their training opportunities. We do have surgical care practitioners who are largely senior theatre staff converted to these roles they are useful but..... Maybe there is a slight conflict with training. That can be managed out of the system. So where would we see the PA’S fitting in. There seems to be two possible areas 1) which could be described as generic surgical support revolving round ward work and possibly outpatients, 2) more specific orthopaedic roles including swelling the number of orthopaedic surgical care practitioners. We see there are a number of problems but also opportunities. Proper definition of role and job plan for all of these practitioners remains paramount, that should include appropriate CPD. Mentoring and training development is important. Making sure that surgical training is facilitated by their presence and activities is similarly critical. Everyone’s jobs have good parts and bad parts and there had been a tendency not to solve the issue of too many bad parts in the juniors jobs because there are certain things that ‘just have to be done by a doctor ’ when service configuration would solve that problem and give better structure all round.

• BAOAMS there are no equivalent roles in this specialty

• Urology – aware of just one urology PA so far. In dialogue with him and via the BAUS Education committee to find a way of developing a specific urological curriculum.

• Anaesthetics (see also Appendix 1, Scope of practice from R CO A)

The following is a joint statement issued by RCoA and AAGBI in April 2016 on the subject of Physician’s assistants (Anaesthesia):

Physicians’ Assistants (Anaesthesia) (PA(A)s) are an established group of healthcare professionals, currently numbering about 150 across the UK. Both the RCoA and AAGBI acknowledge that the issue of non-physician anaesthetists continues to polarise opinion within our specialty. Statutory registration and regulation (currently not in place), scope of practice, supervision, development of enhanced roles and the potential impact on training opportunities for medically qualified anaesthetists are some of the areas of concern that have been expressed by Fellows and Members of both organisations and more widely.

The current economic and manpower situations are very different to those that applied when the PA(A) role was first piloted. That early cohort of PA(A)s now has more than a decade of experience, and is fully integrated into the anaesthetic departments where they work. Latest predictions of changing demographic of the UK indicate a need for a 25–40% expansion in the number of anaesthesia providers by 2035. The AAGBI and RCoA believe that registered, regulated PA(A)s, supervised by medically qualified anaesthetists, can make a valuable contribution towards a sustainable anaesthetic workforce.

Consequently, in collaboration with the Association of Physicians’ Assistants (Anaesthesia) (APA(A), the RCoA and AAGBI have drawn up the agreed scope of practice for PA(A)s on qualification which acknowledges and addresses many of the concerns raised. This document replaces the previous RCoA position statement of May 2011, and means once again that both our organisations have an aligned policy on Physicians’ Assistants (Anaesthesia).
The AAGBI and RCoA (and PA(A)s themselves) agree that statutory registration, and regulation are essential for the future of this group. The RCoA intends to administer the existing voluntary register as a prelude to achieving statutory regulation for PA(A)s by a national healthcare regulatory body. Until statutory registration and regulation are achieved, the AAGBI and RCoA will only recognise PA(A)s who have qualified having completed the approved UK training programme and have subsequently been entered on the voluntary register. The AAGBI and RCoA recommend that only individuals who appear on the voluntary register should be employed in the PA(A) role. Both organisations would support a Member or Fellow who declined to supervise a PA(A) who was not on the voluntary register.

Finally the AAGBI and RCoA acknowledge that development of PA(A) enhanced roles is taking place and that this remains a controversial issue. The AAGBI and RCoA would only consider supporting role enhancement when statutory regulation is in place. Responsibility for such role enhancement, where it exists, currently remains a local governance issue. Patient safety remains the priority of the AAGBI and RCoA; both organisations will keep this policy under review, as the evidence continues to develop.

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