Physician associates: New Zealand should learn from the United Kingdom's mistakes

Martin McKee, Trish Greenhalgh, Barry Monk, Henry McKee

DeWolfe and Collins' editorial advocating the expansion of physician associates (PAs) in Aotearoa New Zealand[1] makes unsubstantiated claims and appears to be based on a highly selective reading of the literature. They state that there are 170,000 physician assistants/associates globally, but they do not discuss prevailing controversies in the United Kingdom (UK) about what exactly these individuals are trained to do (and to what standard), or issues of supervision, accountability and patient safety.

In the UK, PAs have been (controversially) employed in a wide range of duties from administrative and practical assistance to doctors to laparoscopic surgery, child protection and management of undifferentiated patients in primary care. The UK's General Medical Council and the Royal College of Physicians of London, which were at the forefront of promoting PAs, have been heavily criticised for declining to define any scope of practice for them.[2] While there are many international agreements on mutual recognition of qualifications for doctors (e.g., within the European Union), none exist for PAs. The mantra that PAs are "*trained in the medical model*" is oft repeated (including in this editorial), without ever clarifying what this actually means.[3]

The authors' claim that there is an "*impressive catalogue of … studies*" that identifies "*the PA as a highly trained, cost-effective and patient-satisfying addition to the workforce*" is unreferenced and reads as magical thinking. Readers will make up their own minds as to whether someone with a 2-year training course, following a degree that could be in English literature or homoeopathy,[4] can be described as "highly trained" when compared with a doctor. One ex-PA who is now a medical student wrote disparagingly about the lack of coherence or depth in their previous PA training.[5] Many UK PA courses are assessed predominantly by multiple choice examinations, have a pass mark below 50% and achieve at or close to 100% pass rates.

deWolfe and Collins' claim that the skill set of PAs aligns closely with that of the supervising doctor is also unreferenced, as is the claim that PAs, with only 2 years of training, can move easily between general practice, paediatrics and women's health. A UK study of anaesthesia associates (AAs, who undertake a PA role in anaesthetics) struggled to find any way their employment could be made economically viable given the ongoing requirement for supervision.[6] We know of no published research study showing that PAs are cost effective; such studies are ongoing in the UK.

Patient safety should be paramount in healthcare. The growing list of tragic errors involving PAs in the UK is leading some health organisations to reconsider their use. Research on patient safety involving PAs is sparse. There is, however, considerable evidence on the analogous role of nursing associates/assistants, which consistently shows that when these roles are introduced, even when numbers of registered nurses remain the same (and especially when they are reduced), patient outcomes suffer.[7]

deWolfe and Collins do not consider the adverse consequences of expansion of PA roles on the speciality training of doctors, which is now becoming a major problem in the UK. Nor do they discuss supervision and accountability. It is widely assumed that this occupational group will work under the supervision of a doctor, who will be held accountable if anything that goes wrong. There are major unanswered questions about how lines of responsibility and accountability will play out in practice, and how these formal arrangements may be misaligned with practice on the ground (in which, for example, a PA may put pressure on a very junior doctor to "sign off" prescriptions for drugs or requests for ionising radiation). Already, Freedom of Information requests in UK have uncovered numerous cases of PAs being used as direct substitutes for junior doctors (e.g., in on-call rotas), and legal cases have

held doctors accountable for the acts and omissions of PAs.

The editorial concludes by dismissing a few "*influential individuals*" in the Medical Council of New Zealand and the medical colleges. This is exactly the same language that was used to describe those of us who first expressed concerns in the UK. Yet, as experience has accumulated, one royal college after another,[8–10] along with the British Medical Association, have called for pauses, at a minimum, to the expansion of the PA occupation, with overwhelming votes in favour of this course of action where members were consulted.

In seizing on PAs as a near-universal and problem-free solution to the growing shortage of doctors, New Zealand is presented as joining a successful international movement. Yet where it has been tried, as in the UK, numerous problems are emerging and initial supporters are having second thoughts. We strongly advise you to learn from the UK's mistakes before choosing this path.

COMPETING INTERESTS
MMcK, TG and BM were signatories to a letter to the Royal College of Physicians of London calling for an extraordinary general meeting that changed the College's policy on physician associates. MM is a past president of the British Medical Association.

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Response: New Zealand physician associates and colleagues support regulation to provide safety first and foremost

Lisa Fitzgerald deWolfe

We wish to thank the authors (McKee, Greenhalgh, Monk and McKee) for their interest and for taking the time to write a letter to the editor. We reject their claim that our opinion is based on a highly selective reading of the literature. It has been important to develop a contemporary strategy for leveraging physician services that is reflected across the globe as we work with limited and expensive healthcare resources. The inclusion of physician associates (PAs) in national health workforce development is reflected in Europe (NL, UK, IE, DE, PL, BG, CH), North America, India and South Africa.[1] The issues raised about what "*exactly these individuals are trained to do (and to what standard), or issues of supervision, accountability and patient safety*"[2] are covered by scope of practice, and though this may vary from country to country, many have considerable similarity where resources are similar, e.g., comparable PA scopes of practice are an integral part of healthcare throughout Africa.[3]

Within the UK, "prevailing controversies" about PAs have arisen after 10 years of utilisation marred by a tragic incident about overlooking a deep vein thrombosis in a young woman.[4] But it is a tragedy not uncommon to all health systems and all who deal with an overworked and stressed urgent care situation. Improvements in health service delivery that are effective and comparable to that of doctors by using PAs are well established in the literature.[5] Physician acceptance of PAs and patient acceptance of PAs have been well examined.[6,7]

The General Medical Council (GMC) regulations and safety measures will soon be in place.[8] This strategy will address residual controversies common to a new profession, including professional identity, pay disparity, training positions and supervision. Overworked doctors compound this omission. Work stress causes misunderstandings, suboptimal scope and increases risk. It is important to note that the UK PA profession and most colleagues have been calling for regulation. There is a volunteer registry (Physician Associate Managed Voluntary Register [PAMVR]) and requirements that were carefully implemented to hold standards for the unregulated profession. One result is that UK PAs will finally have GMC accreditation, scope, standards and the mutual recognition of qualifications like doctors, conserving the profession's risks. With this improved public safety and transparency of the professional role, public safety and concerns can be alleviated. Statements and false accusations like "controversial employment" and "2-year training" are inaccurate. UK PAs are employed in hospitals, outpatient clinics, emergency departments and GP practices.[9]

International training programmes for the profession need to be recognised for their robust curriculum, intense clinical training and academic foundation. When new countries develop programmes, the accreditation standards can and should be utilised. In the UK, physician associate applicants must have high Bachelor's degree grades to be competitive, and most take CASPER and have additional science courses to be accepted. Biological, biomedical, life sciences and other healthcare-related degrees are familiar to those applying. Many hold professional degrees or have experience as paramedics, surgical assistants, lab/radiology techs, medical scribes or nurses, or sometimes a combination of these work experiences. They must take biology, chemistry, physiology and anatomy to be accepted. Experience working in healthcare is usually necessary to be competitive. PA programmes are designed to provide comprehensive medical education, with accreditation standards ensuring the quality of training. The competency of PAs is regularly assessed through national certification exams, and their performance in clinical settings is monitored

through ongoing supervision and professional development.

The heft of literature on the PA profession is extensive and published in upper-quartile peer-reviewed journals with high impact factors. In this decade alone, there have been more than 100 published analyses on PA activity, behaviour and utilisation. The burnout rate of PAs is less than that of physicians. Where PAs are employed in family practices, the physician burnout rate is lower than without PAs.[10]

The PA profession has provided high-quality, highly skilled, safe patient care for over 50 years. There are research, data banks and statistical analysis that outweigh the few critics that have surfaced to try to further delay a regulated UK PA profession to serve themselves and deny public protection.[11–13] New Zealand's workforce will benefit from expanding team-based care using PAs and not a physician imperative.

COMPETING INTERESTS
Nil.

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