Leading the integration of physician associates into the UK health workforce

ABSTRACT

The introduction of physician associates into the UK health workforce is one of the most significant examples of potentially disruptive innovation in many years, and lessons can be learned from research into the introduction of advanced nurse practitioners. Positive, forward-looking health-care leadership is required at all levels to ensure the successful integration of physician associates into the UK workforce.

This review found that organizational culture had an enormous impact on the introduction of advanced nurse practitioners and likewise will affect the integration of physician associates. The most effective strategies facilitated interprofessional, collaborative, collective and inclusive leadership and promoted high staff engagement, the development of proficient interprofessional practitioners, and a clear vision for collaborative practice. In terms of physician associates, such an approach will improve interprofessional and collaborative practice and create the supportive, motivated environment needed to facilitate the introduction of physician associates.

The UK government has committed to increasing the number of physician associates as it attempts to grow the NHS workforce to deal with rising demands on the NHS (British Medical Association, 2016). This is one of the most significant changes to the structure of the multidisciplinary team since the introduction of advanced nurse practitioners. This article, one in a series on the topic of physician associates, focuses on the leadership approaches required at a team and organizational level to make the introduction of the physician associate role in the UK a success. The potential barriers to their integration, collated from the literature and through discussions with health-care professionals in the hospital setting, are discussed in terms of highlighting solutions needed to overcome them.

The physician associate role has been defined as:

> **'a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision' (Department of Health, 2012).**

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History, tradition and culture

History, tradition and culture are perhaps the biggest barriers to the introduction of new professional roles in health care. Culture 'constrains, stabilises, and provides structure and meaning to the group members' (Schein, 2004) and underpins how staff behave and react to the introduction of health-care professionals with a new or extended scope.

The role and profession of a doctor is well defined and doctors have a strong sense of identity, shored up by shared assumptions in the industry and by the public of their skills and responsibilities and their role in health care. Over time, other distinct health-care roles have developed (e.g. nursing, midwifery, physiotherapy, occupational therapy, speech and language therapy) and become professionalized. These are now well-established members of the multidisciplinary team with distinct identities and scopes of practice. Health care is traditionally very hierarchical and most of these new professional roles have not challenged the traditional identity of the doctor. This is exemplified by the commonly used term 'allied health-care professionals', suggesting that such roles are 'allied' to doctors, rather than being professionals in their own right. Over the last two decades, qualified health-care professionals have been increasingly encouraged (supported by regulation) to extend their scope of practice so as to improve health care to wider groups of patients. However, this is not unproblematic. For example, the successful introduction of advanced nurse practitioners was highly dependent on a positive culture and the initial response from their colleagues (Lloyd Jones, 2005).

Changing the culture at a team, organizational and system level is therefore arguably the most important potential step towards improved interprofessional and collaborative working, with leadership the single most influential factor in achieving this (Anonson et al, 2009; Schneider and Barbera, 2014; NHS Improvement, 2016).

In most health-care teams, clinical leadership falls to the doctor (GP or consultant) with whom ultimate decision making, accountability and responsibility lies. As was observed with advanced nurse practitioners, if physician associates are to be fully integrated into the workforce and team, doctors in leadership roles need to promote the benefits of physician associates (Imison et al, 2016).

However, these medical leaders need to be able to put aside the assumptions of the culture they trained with, including being receptive to integrating new types of health-care professionals into the traditional hierarchical nurse–doctor model. Currently, clinical teams are inclined towards medical hegemony, with the descending grades of junior doctors being seen as the next level of decision maker

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beneath the consultant or GP. For example, in secondary care, on ward rounds consultants direct 76% of their questions to junior doctors (Coombs and Ersser, 2004).

Breaking down traditional hierarchical structures and models of working, and shifting the culture towards a more interprofessional and collaborative working style is thus a priority. Senior doctors must both realize it themselves and also help multidisciplinary team members to appreciate how and why assumptions about the composition of the team must change, to adapt the culture to allow the introduction of new roles and embody a patient-centred, flat-structured, interprofessional and collaborative service (Schein, 2004).

Leading disruptive innovation

The Christensen Institute (Wanamaker and Wheeler, 2013) describes the benefits of disruption, helping to improve accessibility and affordability, and how, ideally, the product should be integrated around the job to be done.

While the introduction of physician associates aims to bolster the frontline workforce and make the health service more accessible and affordable, it can also be seen as disruptive innovation. This shift challenges the traditional identity and role of a doctor and other health-care professionals, and also the identity and culture of the multidisciplinary team (British Medical Association, 2016). The authors suggest that the introduction of physician associates needs to be thought of as a sustainable innovation, as the integration of new and extended health-care roles will help provide more sustainable health and social care than traditional models. Appreciating how to facilitate such innovations will help health-care leaders face this challenge and successfully embed physician associates into health-care teams.

However, this raises a number of professional and educational issues, both locally and nationally, which need addressing in order to ensure physician associates are integrated around the job to be done. In an effort to achieve this, the Faculty of Physician Associates, part of the Royal College of Physicians, has produced guidance for employers on many of these issues (Faculty of Physician Associates, 2017). This guidance centres around four key areas.

Role clarity

Clarity regarding the role needs to be provided to physician associates themselves, the multidisciplinary team, and to the public. Leaders need to be aware of the competencies and curriculum of physician associates with strong leadership required when introducing them into a team (Imison et al, 2016), particularly to help identify their 'objectives, scope of practice, individual responsibilities, and anticipated outcomes' (Lloyd Jones, 2005). Without this, as was seen during the introduction of advanced nurse practitioners, there was a challenge as to whether they belonged under a nursing, medical or even a hybrid structure, which was harmful and inhibited their integration (Andregård and Jangland, 2015). Providing a clear role, purpose and defined scope of autonomy will also help to motivate physician associates and aid the general public's understanding as it is perhaps them, with their traditional view of the identity of a doctor, more than anyone, to which these messages need to be conveyed most strongly (Herzberg, 2003; de Zulueta, 2015).

Regulation

Physician associates are soon to become regulated (Faculty of Physician Associates, 2017). The lack of professional regulation to date has exacerbated uncertainty regarding the role and has precipitated resistance against them, as was the case with the initial introduction of advanced nurse practitioners (Lloyd Jones, 2005).

Supervision, education and training

There are understandable concerns regarding physician associates' supervision, ongoing education and training. Bespoke processes and opportunities, tailored specifically for the specialty and role in which physician associates will be working, as well as a suitable mentor, will likely best prepare them (Lloyd Jones, 2005; Faculty of Physician Associates, 2017). Their continuing professional development, supervision, appraisal, feedback and performance measurement must be carefully considered, planned and enacted (Lloyd Jones, 2005). Peer support networks may be helpful for physician associates, as they have been shown to be beneficial for advanced nurse practitioners (Lloyd Jones, 2005), particularly in harnessing connectivity as a source of intrinsic motivation (Herzberg, 2003; de Zulueta, 2015).

Previous experience

Evidence shows that the behaviour of doctors and nurses in response to new professional roles can be extremely empowering but also extremely detrimental (Lloyd Jones, 2005) and can be heavily influenced by past experiences (Vijavaraghavan and O'Donnell, 2011). The support of doctors was incredibly important to advanced nurse practitioners (Lloyd Jones, 2005) and this will be equally true for physician associates. When advanced nurse practitioners were introduced there was concern that they would limit junior doctors' training opportunities (Andregård and Jangland, 2015) and while this caused tension initially, trust, acceptance and collaboration soon developed (Andregård and Jangland, 2015). As was seen with advanced nurse practitioners, physician associates will hopefully be seen as a source of continuity within a department, who can use their knowledge to help rotating junior doctors find their feet (Andregård and Jangland, 2015), and will soon be seen by the multidisciplinary team as having a crucial role. To ensure the smooth induction of physician associates and safeguard the route in for new professions in future, careful leadership and education will be needed to remind younger professionals of these similarities and the lessons learnt from the past.

Interprofessional practice

Interprofessional practice 'refers to a set of competent professionals from various disciplines achieving effective, patient-centred outcomes through collaborative and cooperative teamwork' (Anonson et al, 2009).

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Table 1. Six competencies of the interprofessional practitioner
Communication
Knowledge of one's own profession
Knowledge of others' professions
Teamwork
Leadership
Negotiation for conflict resolution
From Anonson et al (2009)

The challenge of introducing physician associates into the multidisciplinary team allows leaders to analyse and improve interprofessional practice, improve patient outcomes and augment individual contributions to the team (Anonson et al, 2009). To achieve 'buy-in' for this vision will require strong leadership to develop the interprofessional competencies of teams (*Table 1*) and nurture high levels of staff engagement by providing a supportive and positive climate, recognizing contributions, providing constructive feedback, supporting innovation, trusting others, and fostering openness, transparency and candour (West et al, 2014).

A perceived lack of competence of any stakeholder erodes trust and respect among other stakeholders (Anonson et al, 2009). This often stems from the individual lacking knowledge of the competencies and roles of others or from poor interpersonal competencies, e.g. good communication, collaborative decision making, teamwork, conflict resolution and good coping mechanisms (Anonson et al, 2009).

Effective interprofessional leaders must encourage open, honest and reflective feedback, and demonstrate Anonson et al's (2009) six traits of an effective interprofessional leader:

1. Optimism and vision
2. Morality
3. Crisis and conflict resolution
4. Ability to develop a personal connection with team members
5. Ability to facilitate professional growth and empower team members
6. Ability to actively communicate and participate in teamwork (Anonson et al, 2009).

Collaborative practice

Interprofessional practice becomes collaboration when there is a shared purpose, integration of ideas and interdependence among stakeholders (Makaram, 1995; Orchard et al, 2005; VanVactor, 2012; Schreiman, 2014).

While effective collaborative practice takes time to develop and requires mutual trust, respect and commitment, the benefits are clear. Improvements in patient care (satisfaction, acceptance and outcomes – including complications, mortality and length of stay) are seen, alongside reductions in clinical errors, staff injuries, harassment, bullying, absenteeism, turnover and service costs (World Health Organization, 2007; West et al, 2015). It also strengthens social networks, develops a trusting environment, and increases the diversity, skill mix, creativity, innovation, empowerment and job satisfaction within teams (VanVactor, 2012).

To develop and promote collaborate practice, three conditions are outlined that leaders should strive to develop in their team (Browning et al, 2011; West et al, 2014, 2015):

1. Direction (agreement on the mission, vision and values)
2. Alignment (coordinating the collective's outputs)
3. Commitment (responsibility, selflessness and seeing the bigger picture).

VanVactor (2012) also outlines the importance of authenticity and how leaders should behave in line with the values that they are trying to develop in their team.

Shared leadership

The current drive for collective and inclusive leadership (West et al, 2014, 2017; NHS Improvement, 2016) draws much from interprofessional leadership theory, where the flat, situational, relational and shared leader–follower model (as opposed to the traditional hierarchical model) is the core theme (Anonson et al, 2009).

Shared, inclusive and collective leadership approaches are deemed most effective in today's increasingly complex health-care environment as it is unlikely that an individual can hold all of the skills necessary to solve adaptive challenges (Heifetz, 1994; Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2010). These approaches are also associated with improved team performance (West et al, 2014). Interprofessional practice requires each team member to be able to step up to lead (individually or collectively) when appropriate depending on the needs of the task at hand, always to achieve the best outcome for the patient (Anonson et al, 2009; Browning et al, 2011). Importantly, they must also know when to step down and pass the leadership baton on to others (Anonson et al, 2009). Leadership must develop and encourage this practice.

Nevertheless, Reeves et al (2010) describe how 'the need for a clear leadership role has been found to be central to effective interprofessional collaboration and teamwork'. Traditionally, this has been the doctor, usually a consultant. However, Browning et al (2011) argue that true leadership is commonly 'independent of formal roles and responsibilities'. Other respected team members viewed as either 'extremely competent clinicians or as extremely creative problem solvers' may therefore at times be considered best in the leadership role despite falling outside of the traditional formal, hierarchical positions (Orchard et al, 2005)

The key challenge is for leadership (whatever form it takes) to be hands-on enough to facilitate collaboration but hands-off enough to promote shared leadership. Giving the team this freedom requires a significant amount of trust and the balance of leadership between team members will change as time goes on, as the team moves through its stages of development, and as individuals develop leadership capabilities (Anonson et al, 2009). In order to integrate physician associates into the team and enable them to take on leadership roles, leaders will have to work hard and pay attention to nurturing the needs and

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abilities of the multiprofessional team members. Leadership in this setting may be viewed as stewardship (Anonson et al, 2009): guiding and developing the team based on a shared vision for collaborative practice, but also providing oversight, support, accountability and ultimate responsibility.

Conclusions

Leadership is the single most influential factor determining the culture of teams and organizations and will play a crucial role in whether and how physician associates are successfully integrated into the UK's health-care workforce. Clinical leaders and managers must consider how to facilitate this, the most significant example of a potentially disruptive innovation in the health-care workforce for many years. Consideration of lessons learned from the literature analysing the introduction of nurse practitioners will be crucial in this endeavour. While such innovations can be a positive force, system-level support is needed which flows down to organizational and team-level leadership to achieve buy-in from consultants, management and the rest of the interprofessional team.

Knowledge of interprofessional and collaborative practice, and the leadership necessary to achieve these closely related ways of working, will help to facilitate the introduction of physician associates by creating supportive and motivated environments, and also allow leaders to improve how their teams function for better patient care. Leaders will also need development and opportunities to foster appropriate inclusive, collective and shared capabilities in themselves and their team so as to best use the introduction of physician associates to improve patient care and health outcomes. **BJHM**

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KEY POINTS

- Organizational culture, which is primarily influenced by leadership, had an enormous impact on the introduction of advanced nurse practitioners and likewise will affect the introduction of physician associates.
- Leaders must provide clarity on the role, purpose, scope of autonomy, supervision and responsibility of physician associates, and offer education, training and induction specific to the speciality or role.
- Knowledge of interprofessional and collaborative practice, and enacting the shared leadership necessary to achieve these closely related ideals, will help to facilitate the introduction of physician associates and help create a culture of acceptance within teams and organizations for the role of physician associates.

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