The role of the physician associate in the modern NHS workforce

Health care is changing internationally. Stimulated by a combination of sociopolitical, technological, environmental and economic changes, new and extended professional roles are emerging to fill unmet needs across the service and support an existing workforce which is quite simply struggling to meet demand.

This editorial introduces two articles looking at the role of the physician associate in the UK. The first is a scoping review which considers the barriers and facilitators for integrating physician associates into the workforce. The second considers how the widespread introduction of physician associates might impact on ways of working, leadership, interprofessional teamworking and collaborative practice.

Physician associates originated in the USA in the 1960s, primarily as a response to workforce shortages. At the time, many were former military personnel who were trained to provide medical support in the field during their service and wanted to continue to use these skills when returning to civilian life. Similarly, the rise of physician associates in the UK is part of a wider workforce development plan which has introduced the 'medical associate professions', i.e. practitioners who work under a doctor's direction and supervision. These are new roles and have emerged alongside a variety of other new and expanded roles for existing health professionals, including advanced critical care practitioners, advanced scope of practice nurses, physiotherapists, pharmacists, speech and language therapists, and occupational therapists (Saxon et al, 2014; Butterworth et al, 2017; O'Mahony and Blake, 2017; Campaner, 2018) (*Table 1*).

Across the UK, physician associates are now working in primary and secondary care with many more in training:

'The Physician Associate profession is a growing and evolving one ….there will be just under 600 qualified Physician Associates in the UK by the end of the year [2018] … expected to grow to up to 3,200 by 2020. Physician Associates, in addition to existing members of the healthcare team, are here to add value, capacity and generalist skills to the clinical teams

Table 1. Primary distinctions between new health worker roles and extended or advanced scope of practice

Rationale for alteration in scope of practice	New health worker roles, e.g. physician associates, surgical care practitioners	Extended or advanced scope of practice, e.g. advanced critical care practitioners
Service needs or changes	Designed to meet service needs usually in specific contexts (e.g. ambulatory or primary care)	Designed to meet service needs in specific contexts, or clinical specialties or client groups (e.g. diabetes, dialysis, primary care, perioperative care, eye care, ear care, basic anaesthesia)
Scope of practice	Entirely new roles for which individuals are directly trained, usually by completing a Bachelors-level degree and then a postgraduate programme	Extended roles can refer to narrow or broad scopes, e.g. nurses with prescribing rights or the right to provide advanced care in a specialty or service
Previous qualifications	Often from non-health backgrounds, such as bioscience	Always drawn from existing practitioners, predominantly nurses, but also from other allied health professionals (e.g. prescribing pharmacists, interventionist radiographers)
Supervisory and reporting relationships	Designed to assist doctors in specific contexts and always perform under medical supervision with the doctor taking responsibility for their practice	Usually autonomous practitioners with a defined scope of practice (and registered as such) and who often work independently in parallel with doctors, referring only to a doctor when needed (e.g. out of hours care)
	Have primarily been developed to support doctors and perform routine tasks while under the supervision of a medical practitioner, thus freeing up the doctor to perform more specialized work	Advanced practitioners are registered and regulated by their professional body or council with a defined scope of practice (e.g. nursing councils)
Training requirements	Formal training programmes and regulatory frameworks exist in some countries, in others the assistant or associate roles are not yet formally defined and regulated	Advanced practice roles require postgraduate qualifications

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providing care for patients across primary and secondary care' (Faculty of Physician Associates, 2018).

Health Education England plans to have 1000 physician associates working in primary care by 2020 as part of implementing the General Practice Forward View (NHS England, 2016) and the Welsh government sees the development of physician associates as a key part of its strategy to maintain primary care services. Meanwhile, in secondary care, while no specific targets have been set, the need to diversify the workforce to support hospital services is widely recognized.

Regulation

Currently, the Royal College of Physicians hosts the Faculty of Physician Associates, and physician associates are regulated via the physician associate managed voluntary register which requires mandatory regular continuing professional development. This lack of statutory regulation has been seen as a potential risk by all four UK governments. Therefore, the recent announcement by the Department of Health to present the 'Physician Associate (Regulation) Bill' (House of Commons, 2018) before Parliament provides an important foundation throughout England and Wales, Scotland and Northern Ireland, to ensuring that patients receive the highest quality of care from the NHS and is strongly welcomed by all.

Impact of physician associates

It is still too early to fully evaluate the impact of the introduction of physician associates into the NHS workforce but the rapid growth of this role reflects an international shift towards a more flexible health-care workforce to which different countries have taken slightly different approaches.

In 2013, McKimm et al carried out an international review of expanded and extended health practitioner roles which is a useful open access summary of the various approaches taken to provide a workforce capable of delivering care in various geographical situations with growing health needs and changing demographics. The review highlighted that a range of 'mid-level' health-care roles is required, and the workforce should comprise a combination of 'traditional' roles (e.g. doctor, nurse, midwife), extended roles for existing registered professionals (e.g. nurses, radiographers, pharmacists) and new roles (e.g. physician associates).

The review found that the latter two types of role can substitute for doctors in certain specific roles or geographical areas as these health workers are generally cheaper as a result of differences in salary and training costs, and quicker to mobilize because of the shorter duration of their basic and/or post-basic training. Sometimes, however, these new roles are supplementary and arise from advances in medicine, for example new technologies, procedures and knowledge.

Supporting this, more recently, a systematic review of physician associates in secondary care found that, although many studies were observational and methodologies varied in quality, when physician associates were compared with doctors there was little or no negative effect on cost or health outcomes (Halter et al, 2018). It was also noted that in emergency medicine and trauma and orthopaedics, when physician associates were part of the team, positive effects were seen through reduced waiting and process times, equivalent readmission rates and good acceptability by patients and staff.

Moving forward

More research is needed in different settings to fully evaluate comparisons between physician associates and the roles for which they might be substituting or supplementing, and the wider impact of introducing physician associates into the NHS workforce. However, there is no doubt that over the coming years, the composition and functions of the NHS workforce will change radically. While this has advantages in terms of flexibility and enabling patients to access care more easily, during the transition stages, this may lead to a blurring of role boundaries and some confusion. It will require the existing health workforce and structures to adapt and change to accommodate new ways of working rather than seeing new and extended roles as a threat and challenge.

The authors hope that these two articles provide some ideas as to how practitioners and managers might work together to smooth these transitions and use these new roles most effectively to improve patient care and health outcomes. **BJHM**

KEY POINTS

- The rise of physician associates in the UK is part of a wider workforce development plan which has introduced the 'medical associate professions'.
- When passed, the 'Physician Associate (Regulation) Bill' will provide an important foundation to ensuring that patients receive the highest quality of care from the NHS and is strongly welcomed by all.
- More research is needed in different settings to fully evaluate comparisons between physician associates and the roles for which they might be substituting or supplementing, and the wider impact of introducing physician associates into the NHS workforce.
- The existing health workforce and structures will be required to adapt and change to accommodate new ways of working rather than seeing new and extended health-care roles as a threat and challenge.

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