Caution ahead: the risks with regulating physician associates in Aotearoa

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Our medical workforce shortage in Aotearoa is at a crisis point, struggling with growing unmet health need and increasing acuity of patients presenting at emergency departments.[1,2] In response, there have been calls from a small but vocal physician associates (PAs) group to invest in their regulation and training. Such calls are a misguided attempt at plugging crucial health workforce gaps and are underpinned by the flawed logic that more **un**qualified doctors are better than not enough qualified doctors.

However, a recent *New Zealand Medical Journal* editorial implies some medical colleges and the Medical Council of New Zealand have "*concerns that regulation can wait, risk can be ignored, and regulation is not essential at this time*."[3] This is disingenuous at best. Far from opposing regulation and risk management, as evidence-based practitioners we simply have yet to be presented with a robust case that PAs are the solution to our medical workforce crisis. We are already seeing the consequences of this failed experiment play out overseas, with substantial costs—both financial and to human lives. As such, we believe this discussion warrants a balanced argument.

Risks to patient safety

Regulating and training PAs under a condensed medical model is dangerous and will result in clinical judgement, patient safety and quality of care being compromised. In fact, over 87% of doctors surveyed by the British Medical Association (BMA) believe the way PAs worked in the National Health Service were a risk to patient safety.[4] The rush to regulation in the United Kingdom should serve as a cautionary tale, as it has resulted in the deaths of several patients who were misdiagnosed by PAs and who, at the time of being treated, were unaware they were not being seen by a doctor.[4,5] This is in addition to over 70 instances of "*avoidable patient harms and near misses*"; at least 22 occasions of illegally prescribing controlled medications; and the ordering of over 1,000 unauthorised hospital scans by PAs.[6–8]

Misleading title harms patient trust

Adding to the harm is the intentionally deceptive use of "physician" in the PA title, violating the principle of informed consent for patients while posing clear risks to their safety.[4] We have already had cases of medical error and patient confusion in Aotearoa, with a patient who nearly went blind after being misdiagnosed by a PA.[9] In the long term this confusion—and resultant patient harm—will deteriorate public trust and confidence in our health system.

Regulation does not equal accountability

The medical profession has well-established, robust accountability frameworks—both professional and legislative. However, accountability does not lie solely in regulation. It lies in clinical competence and the responsibility for delivering an expected standard of safe care, grounded in the significant breadth and depth of training—and resultant clinical experience—that doctors have over PAs.

There is also the matter of whether it is appropriate for the regulatory body for medical practitioners to serve as the regulator for PAs, as this will further blur professional boundaries.[4] Calls to have PAs as a regulated workforce in New Zealand miss the point because we are still left with risks to patient safety and issues around public confusion.

"Cost-effective" or a false economy?

Next, we turn to the oft-lauded efficiencies gained from employing this lower-cost workforce. In fact, a quality trade-off has already been demonstrated with the use of PA workforces, and cost savings are largely clawed back through PAs practising more defensive medicine to compensate for limitations in medical diagnostic knowledge.[10] There are also costs with regulating an entirely new

workforce without an existing training programme. Given the current austerity climate and significant health funding shortfall, how will funds be prioritised toward establishing and monitoring rigorous education programmes, regulating the workforce and ensuring adequate resourcing for supervision and continuing professional development? And at whose expense? On balance, the growth and regulation of a PA workforce represents a false economy in the long term.

"Workforce multiplier" or fuelling the healthcare divide?

PAs have been touted as a "workforce multiplier", allegedly (we are unable to find a source for this claim cited in the editorial), substituting up to 50–75% of a doctor's work in a hospital setting—despite 55% of doctors in a BMA survey reporting their workload had increased with the employment of PAs.[3,11] This claim also begs the question, *which* workforces need multiplying? Our healthcare issues stem from a lack of staff, not a lack of professions. As our population health needs become increasingly complex, we need more medical practitioners to meet this rising demand, rather than resorting to the cheapest skill mix. Further, a greater use of PA workforces—especially in rural areas—only serves to exacerbate existing inequities as entire population groups struggle to access appropriate medical care.

The opportunity costs and impacts on our existing workforce

Lastly, there are opportunity costs of investing in regulation. Given the limits to PAs' medical and diagnostic capabilities they will always need a level of oversight from qualified medical practitioners, who are already at or beyond capacity for supervising our own resident medical officers.[12] Supervising PAs should not come at the expense of training our future doctors.

PAs also do not offer a unique or additive skillset beyond what a doctor, nurse or allied scientific and technical (AST) professional can do. If anything, the use of PAs to triage undifferentiated patients and hand over more complex and serious cases to doctors fragments the work of the medical profession. Continuously dealing with only the most complex and difficult cases strips doctors' work of genuine connection and meaning, disrupts continuity of care, makes the process more prone to errors and contributes to burnout of this workforce.[13]

Alignment with the local context

Those lauding the benefits of PAs primarily cite studies out of the United States, where expansion of this workforce has been fuelled by economic incentives of for-profit health providers.[14] We must therefore be cautious about generalising these findings to Aotearoa and seriously probe whether this model of "care" is well suited to our local context, with its long-standing health inequities for tangata whenua.

Even the limited evidence of PA demonstrations in Aotearoa has been critiqued for its flawed methodology and resulting conclusions. It has also yet to definitively conclude that PAs are the best option for addressing our healthcare staffing crisis and meeting our population's complex health needs.[15]

Conclusion

As evidence-based practitioners, we are alarmed at the speed with which we seem to be barrelling down the path of regulation, in the absence of any evidence of the economic or labour market value of PAs as a workforce in Aotearoa. If we continue down this path, we are doomed to repeat the same mistakes we've seen play out overseas.

Instead, we should be working to fix the root causes of our medical workforce recruitment and retention issues and supporting PAs to retrain as nurses or AST professionals or encouraging them into local medical school training to bring them up to the standard we expect. This is a clear win–win to bolster our health workforce through existing education pathways and registration, while maintaining faith in our medical professionals.

COMPETING INTERESTS
Nil.

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