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Physician associates in the UK: some fundamental questions that need answers now

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Healthcare in the UK is facing a crisis. At issue is the creation of new groups of health workers called physician associates (PAs) and anaesthetic associates (AAs).[1] Originally PAs and AAs were envisaged as assistants to doctors to increase their productivity by relieving them of some routine tasks. However, in many hospitals and general practices they are being deployed to replace doctors, taking on increasingly complex roles, including the assessment and management of patients with undiagnosed problems.[2] This is despite them having completed only a two year training programme. While most will also have a science degree, this need not be in a subject related to medicine. Concerns have been exacerbated by the simultaneous reduction in medical specialty training posts,[3] the fact that many PAs and AAs are paid substantially more than foundation doctors despite much less training than the doctors they work with,[4] evidence that they are illegally prescribing and ordering tests using ionizing radiation in some hospitals,[5] and alarm about patient safety, including deaths.[6]

These concerns culminated in an Extraordinary General Meeting of the Royal College of Physicians (RCP) on 13 March 2024.[7] The RCP hosts the Faculty of Physician Associates. At the meeting motions to clarify the roles of PAs were debated along with one motion that sought a pause in their expansion. This was only the third such meeting in the college's over 500 year history. Unfortunately, rather than calm the situation, it has only exacerbated it, with real worries about how the meeting was run and the misleading way in which data were presented.[8]

Many of the actions of the college have been discussed elsewhere.[9] Sadly, amidst the polarisation that has been generated, we seem to have lost sight of some of the fundamental questions around the rollout of PAs in the NHS.

It is important to recognise that the challenges to which physician associates are seen as a solution are not unique to the United Kingdom. Health systems in many countries are struggling to maintain and build their health workforces. The situation is especially critical for doctors. While medicine has long been a career choice for young people with the highest exam grades at school, these individuals now see many more rewarding opportunities, both financially and in terms of work-life balance, in areas such as technology or finance. An even greater problem is retention.[10] High levels of exhaustion and burnout,[11] unsupportive working conditions, and, in some countries, erosion of pay levels by inflation have driven many to leave the workforce prematurely, either to pursue other opportunities or to migrate to those countries that demonstrably value their skills, exemplified by the many British doctors moving to Ireland or Australia.[12]

The resulting pressures, coupled with changes in the nature of healthcare, have encouraged policymakers in many countries to look to opportunities offered by task shifting. Put simply, at a time when healthcare is becoming increasingly complex, as a consequence of both the growth of multimorbidity in ageing populations and scientific advances creating new opportunities to intervene, the challenge is to assemble the right mix of people, with the right skills and equipment, in the right place, at the right time to meet the needs of the patient.[13]

This is not simply a matter of distributing tasks between different types of health workers. Rather, it involves looking at how roles can be rearranged among those health workers, between them and the patient and their carers (who now may have access through wearable technology and other innovations to equipment that once was the preserve of the hospital), and, increasingly, technology, including devices using artificial intelligence.[14]

It also involves looking not just at the immediate problem, but to the long term. The concept of stewardship,[15] a core responsibility of those in charge of health systems, includes ensuring that the long pipelines delivering future health workers are functioning. It also requires clear lines of responsibility and accountability, something found to be lacking by a recent systems analysis of another element of NHS workforce planning—medical school expansion.[16] This is a situation not helped by the confused accountability of some of the key players.[17] Finally, it requires careful thought, including scenario testing, recognising the abundant scope for unintended and undesirable consequences. None of these exercises have been done to inform the debate on physician associates. Instead, the argument seems to be that the process is now inevitable so it must continue. This is the sunk cost fallacy,[18] a cognitive bias that can produce sub-optimal outcomes. It is more prevalent among older people, offering an insight into why this issue is proving to be a much greater concern to trainees than to medical leaders.[19]

While the detailed assessment of workforce planning called for above will take time, a few questions need answers now. Firstly, while recognising the value of multidisciplinary teams, what discipline do physician associates bring? The contributions of nursing, pharmacy, dietetics, physiotherapy, occupational therapy, health psychology, speech and language therapy, and others are clear, each with their distinct body of skills and knowledge. If it is medicine, then surely they exist in a hierarchy, not as a separate

discipline? And if so, what should their scope of practice be?[20]

Secondly, what is unique about the profession of medicine? Diagnosis involves a combination of scientific knowledge about how the body works or fails to do so, gained during early medical student years in anatomy, physiology, and pathology for example, along with examination skills, gained in the clinically focused years, and pattern recognition, often informed by the patient's social or occupational circumstances.[21] Faced with the constraints of a two year course, which elements are expendable?

There are many other questions, such as whether physician assistants reduce doctors' workload[4] or are cost-effective,[22] who recruits and creates job descriptions, who is responsible when things go wrong,[23] what is their proposed career progression, and does anyone have a clear vision of the future NHS workforce? The last of these is particularly important given the plausible suspicion that some of those promoting this development see the medical profession as a barrier to a free market in healthcare.[24] But for now, answers to these two questions would be a start.

Competing interests: MM is a Fellow of the Royal Colleges of Physicians of London, Edinburgh, and Dublin and is one of the signatories to the motion presented to the Royal College of Physicians of London calling for an Extraordinary General Meeting. He is also a member, and Past President, of the BMA, was co-rapporteur of a report on task shifting for the European Commission and is Research Director of the European Observatory on Health Systems and Policies, where he has written extensively on the health workforce internationally, and an advisor to WHO Europe on issues including the health workforce. He is also a Senior Fellow at the Center for Health Outcomes and Policy Research at the University of Pennsylvania, with whom he conducts research on multidisciplinary working environments in hospitals, and in particular the contribution of nursing, including the Horizon Europe MAGNET4Europe study.

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