# Physician associates - just what we need? Or a danger to the profession?

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There has been a lot of coverage lately on social media, in the academic press, in meetings, and in the popular press about the strength and depth of feeling among junior doctors, which is hard to ignore, following the arrival of the physician associate (PA).

The narrative, however, is unhealthy. The language used in many cases is rooted in exclusion, rather than differences in training. It would be remiss of me not to provide some form of personal commentary on where we are, and try to unpick some of the issues. These are my personal opinions, not those of any organization I am associated with.

I am fortunate in my academic life to be Associate Pro-Vice-Chancellor at the University of Nottingham, a post that makes me a senior leader in the faculty of Medicine and Health Sciences. Our faculty includes the full breadth of healthcare professions from veterinary surgeons to nurses, physiotherapists, sports therapists, occupational therapists, and doctors. All are usually one very happy family and many of our graduates – apart from vets – eventually end up in extended-scope roles. So why all the fuss about PAs? These are a different group of allied health professionals. Being in common practice in every hospital in the USA, our friends across the pond perhaps do not appreciate how PAs fit into our healthcare system here. For example, they undertake a three-year degree which teaches a 'medical model' of healthcare, rather than a nursing or therapies model, with the intention that they form part of the medical team. PAs are to doctors what therapy assistants are to therapists, or operating department practitioners (ODPs) are to anaesthetists.

There is controversy in several areas, and I think it is important to understand this; it is also important to work constructively to ensure these new members of the team are welcomed, and bolster the quality of care for patients without devaluing doctors or removing training opportunities.

The first area of controversy is in understanding what a PA is: after all, patients tend to understand the role of a nurse and therefore an extended scope nurse, but may not be as familiar with the newer PA role. There is good evidence that patients are confused about how to treat them, as they struggle to understand that the person in the room with them is not a physician. It has become so controversial, particularly in general practice, that there is now a helpful position statement from the Faculty of Physician Associates on how and when PAs should introduce themselves to patients, document their input in the appointment notes, and generally explain the nature of the role.[1] I would recommend anyone with new PAs in their practice to encourage their teams to read and take on board this guidance.

Salary has also been a big and polarizing point of discussion. PAs in the UK earn £40,000,[2] whereas in the USA it is a whopping $120,000; however, there are concerns in the UK that this is more than the FY1 starting salary (£32,389 without being on call and other overtime commitments), although less than the core trainee salaries.[3] To me, this highlights the need to increase junior doctors' salaries, not decrease PA salaries. It is also important to remember that PAs are on the agenda for changing pay scales, and so have benefited from an agreed salary settlement with the UK government, which (at the time of writing) is still elusive for medical professionals. I do not feel it is a valid argument that because one group is undervalued, others should be as well – the solution here is clearly to reach an amicable agreement with the UK government about junior doctors' salaries.

Then we come to perhaps the thorniest topic of all: training opportunities. It is my personal belief that having a recognized pathway for extended-scope allied health practice could be of huge benefit to trainees in the UK. With the move from on-call to shift work, teams everywhere are understaffed. In my practice, I often have to scrub in simply to be an assistant in theatres; there is rarely a skilled assistant to help the trainee, making that step to independent practice in the latter stages of the training programme difficult. A consultant over the table, no matter how much they are trying only to assist, is always a consultant over the table. During on-call periods, the protocolization of emergency department pathways moves rapidly and directly to specialities – this has added a burden to our junior doctors. The team, trainees, and most importantly our patients, would benefit from a new cadre of enthusiastic, appropriately trained workers able to support these 'two-person' jobs.

When I was a houseman, I had to give intravenous medicines, take all the bloods, do all the cannulas, and pretty much every male catheter on the wards I worked on. It was a different time, and while I remember it fondly, those basic tasks (now considered nursing or healthcare assistant tasks) usually kept me in the hospital until 10.00 pm most days, regardless of whether I was on call. Most of us would not want to go back to that system, but I do remember the suspicion that the movement of these straightforward tasks away from the junior doctors caused at the time.

The key, however, to these arrangements being successful was an appropriate set of competencies being developed, with buy-in from all

sides. Nobody worries about a surgical first assistant (be they an operating department practitioner, nursing, or physiotherapist) wanting to do the surgery, as they are appropriately regulated and have local competencies. There is resounding support for these allied health professionals across the board. However, in various parts of the country they are doing things such as nurse endoscopy, lumps and bumps lists, and carpal tunnels (I understand there are even some places with surgical first assistants who open chests for cardiac surgery), all of which were introduced according to local arrangements and without a nationally agreed governance position.

I would urge everyone who is involved in the debate, or works with PAs, to welcome them as new members of the team but, at the same time, take the opportunity to help shape the discussion around the definition of a doctor (or, in our case, a surgeon). What is our responsibility? Where would patients benefit from our input? We have an opportunity to ensure that all medically allied health professionals, whatever their background, to contribute in a meaningful, patient-centred, and appropriate way to the delivery of trauma and orthopaedic care. As the role of PAs has been clarified by the government,[4] and the expansion of PA roles is part of the long-term NHS workforce plan, we are better placed at the table, shaping the future, than digging our heels in and saying "no" – that horse bolted long ago.

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