Physician Associates briefing and article 5 March 2024

Introduction

Three issues have recently become more prominent and pressing, in addition to the chronic underfunding, GP shortages, escalating workload, and privatisation.

These are:

- the unregulated, under- supervised and under- supported employment of **physician associates (PAs) in primary care,** resulting in diagnosis and treatment delays, sometimes with fatal consequences.
- the **sale of Operose/Centene general practices** to HCRG (previously Virgin), largely owned by T20 Capital, a group of private equity companies.
- NW London's **splitting of primary care** by banning GP practices from offering same day appointments, diverting patients to same day access, triage hubs, staffed by non-medical staff bar one GP. These staff will be drawn from local surgeries, who are forced to sign up to the programme or lose 15-20% approximately of their income. The scheme will be introduced on the 1 April and be rolled out to other areas.

This at a time when the problems associated with the way PAs are employed and supervised has been highlighted, (1) and the benefits of seeing the same GP i.e. continuity of care, is underlined by yet another study. (2)

Campaigning points - see below for more details.

- **PAs cannot be used as GP substitutes.**
- **There should be no new Physician Associate recruitment into primary care in the current climate.**
- **GP Retention Schemes should be resourced and expanded, not cut.**
- **Priority should be given to GP and nurse training, not PA training.**
- **Barriers to GP recruitment in deprived areas must be overcome. PAs are not the answer.**
- **Perverse funding arrangements that penalise the recruitment of GPs should end.**

Suggestions for action

North Central London KONP have tried some of these. Also our MP convened a meeting between the ICS and campaigners, and is writing to the Secretary of State, and the shadow health team will be contacted.

- Ask ICBs for the number of PAs in primary care and which GP practices employ PAs
- What guidelines do they use for supervision and employment of PAs in primary care
- What training and supervision arrangements are in operation in the ICS, and how are these monitored.

- Ask ICB to produce publicity for GP practices about PAs and ensure that all staff have name and profession badges and introduce themselves so patients know who they are seeing
- Prioritize initial triage by GPs not PAs to deliver more accurate, safe diagnosis and treatment plans at the first contact
- Request figures for the number of serious incidents involving PAs, and how these are reported to NHSE
- Involve and alert councillors, local MPs and Healthwatch to problems, present deputations to JHOSCs and Primary Care Committees (PCCs), involve PPGs in collecting information.
- Use social and traditional media, street stalls etc to raise awareness of general public and patients.

1.https://www.telegraph.co.uk/news/2024/02/22/it-blunder-physician-associates-illegally-prescribe-opiates/#:~:text=Physician%20associates%20(PAs)%20are%20healthcare,legal%20right%20to%20prescribe%20drugs

2. *Harshita Kajaria-Montag, Michael Freeman, Stefan Scholtes. 'Continuity of Care Increases Physician Productivity in Primary Care.' Management Science (2024). DOI: 10.1287/mnsc.2021.02015*

Article by Pam Martin
Also available https://keepournhspublic.com/are-physician-associates-a-threat-to-nhs-general-practice/

Pam Martin, a member of the Primary Care Working Group produced this PA briefing. Pam was a GP partner in a South London inner city practice for 30 years, a GP trainer for 10 years, involved in Mental Health commissioning and alcohol harm reduction, and also Southeast London representative on the BMA General Practitioners' Committee.

Are Physician Associates a threat?

Physician Associates, a potentially excellent addition to the NHS workforce, could unfortunately, in the wrong circumstances, reduce the quality of NHS General Practice.

What are Physician Associates?

These workers (PAs) were introduced into the NHS in 2003. It was recognised that doctors were spending a significant amount of time doing things that did not require their level of expertise. Many tasks could be performed by people who did not have a comprehensive training in medicine. PAs were initially placed in hospitals, for example helping anaesthetists

by performing observations or repetitive procedures. There are now around 2000 PAs working in England, with over one third in general practice. They complete either a 2-year Masters training programme, or a 4-year undergraduate course, then need to pass an exam (The Physician Associate National Examination). They work within a defined scope of practice and must have supervision from a named senior doctor.

Until now PAs have been unregulated and were expected to join a Voluntary Register but were subject to no legal regulation of standards. There has been vociferous opposition to them being regulated by the medical profession's regulator, the General Medical Council. The BMA believe it is inappropriate to have the regulation of PAs undertaken by the General Medical Council as PAs are not doctors. However, against the advice of the BMA, the House of Lords passed legislation on 26 February 2024 to make the GMC responsible for regulating physician associates.

What are GP Doctors particularly good at?

Often people consult with stories that are complex, and their symptoms have a mixture of causes. It takes 10 years to train a GP, then learning continues throughout a GP's working life. GPs are expert medical generalists who can diagnose, treat, prioritise and manage multiple and complex conditions, often simultaneously. Their particular strength is using their communication skills and clinical knowledge to make sense of presentations which do not fall into any algorithm. They can prescribe all licensed drugs.

Why campaigners should be concerned about Physician Associates

Although on qualification PAs earn more than newly graduated doctors (£41,659 for 37-42 hour working week compared with £32,398 for a 48-hour working week), doctors end up earning substantially more than PAs by the time they are established in General Practice (£66,000 based on 6 x 6-hour salaried sessions, although there is widespread variation across regions and practices). The more that primary care is run primarily for a profit motive, the more the management will be under pressure to employ the cheapest possible skill mix. It is easy to see systems developing in which GPs act more like managers, and sick people cannot see a doctor in general practice unless they pay to go privately. In the US it is Insurance Company protocols that decide who can see a doctor.

Are Physician Associates cost effective?

It is notable that Operose (the shareholder profit-making company currently supplying general practice to about 640,00 patients, and who has recently sold its stake due to lack of profitability) has employed a significantly higher ratio of PAs to GPs than the national average. See Panorama's 'Undercover: Britain's biggest GP chain'. Operose were employing six times as many PAs as the NHS average in 2022, and half the number of GPs per thousand patients. The PAs were seen to be largely unsupervised. Professor Phil Banfield expressed the BMA's concern recently.

The judgement of cost effectiveness requires an understanding of the intended effect. In health care this must be improved health outcomes, not measures of process such as

numbers of appointments. In primary care people will often seek help under one label, for example “headache”, “joint pains”, “abdominal pain”, when the real problem is something else, for example “depression”, “domestic abuse”, “menopause”, “angina”. Effective primary care quickly identifies the truly significant problem to target health improvement activity appropriately, and avoids going down the wrong track of unnecessary, potentially harmful and costly investigations.

It may appear that consulting with a PA is “cheaper” than with a GP, but not if the first consultation is ineffective, and leads to a series of repeat consultations, and possibly unhelpful treatment.

A further consideration is that PAs are not authorised to and cannot work independently. They must be supervised. Any employer seeking to employ PAs should demonstrate which work any supervising doctor is going to stop doing in order to give the space for adequate supervision. This will obviously reduce the apparent “cost saving” of employing PAs instead of doctors. A recent BMA survey with 18,000 respondents found that over half of respondents reported that their workload had increased since PAs were employed in their workplace.

What would be needed to make the best use of Physician Associates?

In well-defined roles, with clearly defined scopes of practice, quality control and appropriate regulation and with adequate supervision, PAs can become key members of multidisciplinary teams. This is hard to achieve in the current circumstances where a shortage of senior clinicians leads to a lack of supervision. This is key. An overwhelmingly high clinical workload in a team puts all members under pressure. A fully funded retention programme to encourage existing GPs to remain in the profession as called for by the Royal College of General Practitioners is needed. The share of NHS spend going into primary care needs to increase. The disparity of resources that multiply the problems of deprivation needs to be redressed.

The BMA (British Medical Association) called for an immediate pause on recruitment of PAs in November 2023 until such time as their scope of practice is properly and nationally defined, agreed, and quality assured.

PAs do not become doctors, so they do not address the need to widen access to medical training. The key to that would be to reduce the prohibitive requirement of incurring huge debts during medical education and the lack of maintenance grants for students.

Dr Pam Martin, Keep Our NHS Public Primary Care Working Group

Campaigning points

1) PAs cannot do the job of doctors. There are plans to expand the number of PAs to 10,000 by 2037 in the NHS Long Term Workforce Plan. (3). This will not raise the quality

of primary care unless the number of GPs is also substantially increased. GPs are needed to do the work that only GPs can do and to enable continuity of care when that adds to quality of care. They are also needed to provide adequate supervision.
There should be no new Physician Associate recruitment into primary care in the current climate.

2) Integrated Care Boards should be pressurised into giving practices the support they need to retain and recruit GPs.
GP Retention Schemes should be resourced and expanded, not cut.
3) Until such time as new PA recruitment into primary care is stopped, there needs to be enough education and training capacity to train GPs and PAs (and nurses, although nurses are not the subject of this paper).(4) This is in contrast to what happened in 2016 when commissioners invested in new PA training schemes because there was no central funding to train more GPs (2)
Priority should be given to GP and nurse training, not PA training.
4) Targeting deployment of PAs in deprived areas with the greatest GP shortages will lead to increasing inequalities as people cannot access doctors. Instead, the reasons for GP shortages must be addressed.
Barriers to GP recruitment in deprived areas must be overcome. PAs are not the answer.
5) PAs should always be extra staff not replacement staff. There is plenty of work for PAs and GPs and nurses. General Practice needs more resources.
Any practice proposing GP redundancies should be challenged vigorously with the local councillors and MP understanding the danger of the situation.
PAs cannot be used as GP substitutes.
6) **Perverse funding arrangements that penalise the recruitment of GPs should end.**

References

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