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davidoliver372@googlemail.com Follow David on X @mancunianmedic

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ACUTE PERSPECTIVE

David Oliver: Senior medical leaders have mishandled doctors' concerns over physician and anaesthesia associates

David Oliver *consultant in geriatrics and acute general medicine*

On 13 March the Royal College of Physicians (RCP) held an extraordinary general meeting of fellows to discuss the role of physician associates (PAs) in the NHS.[1] Such meetings have been rare events in the college's history. Its members and fellows aren't known for being radical firebrands, and medical royal colleges are not trade unions or single issue campaigning charities.

We seem to have reached a tipping point on PAs and other medical associate professionals such as anaesthesia associates (AAs).[2] I believe that this topic is a lightning rod for a host of other issues doctors are concerned about.

I've worked happily with PAs for several years and always found them to be professional and valued members of the clinical team. I know from many conversations how upsetting the current febrile atmosphere is. They didn't bring the current controversy on themselves, and the nature of some attacks on social media is disturbing. Nonetheless, the concerns being raised are valid, overdue, and in need of urgent resolution.

The problems so hotly discussed among doctors include: newly qualified PAs being paid a considerably higher base salary than foundation doctors; PAs and AAs being used in hospital departments or general practices (through the Additional Roles Reimbursement Scheme), where registered doctors can't get training posts or permanent employment; the impact on doctors who must supervise dependent practitioners such as AAs and PAs; and associates' scope of practice, such as appearing on the same medical on-call rotas as doctors, carrying out procedures, or having other roles such as seeing undifferentiated patients in primary care—things that usually require a medical degree and considerable supervision, with feedback from consultants or GPs.

Clarity is also perceived to be lacking for patients about associates' qualifications and experience. And doctors have questioned whether the General Medical Council is the appropriate regulatory body for them, considering its specific remit in regulating medical practice, as well as the plan to expand PAs and AAs in the NHS long term workforce plan despite no clear parallel plans to increase postgraduate training numbers.[3]

The Royal College of General Practitioners debated the subject in its governing council and recently issued guidance on PAs' scope of practice, with "red lines" on roles they shouldn't be allowed to take on without supervision.[4] The guidance also emphasised that training and retaining GPs must be prioritised and that support for GPs' responsibilities when supervising PAs must be appropriately resourced. PAs should never be seen as substitutes for GPs, it advised, or as an alternative to expanding and retaining the GP workforce. The college also called for greater public understanding of the PA role and for the formal regulation and registration of PAs to happen quickly—but not by the GMC.

Qualifications and requirements

Last week the BMA put out its own very detailed position paper on PAs' scope of practice,[5] which placed further pressure on the royal colleges, NHS England, and the GMC to respond with something equally explicit.

To be fair, the GMC has issued detailed resources[6] on the education, training quality assurance, scope, and supervision of PAs. But it has muddied the waters by discussing these in terms that appropriate the language of medical practice. The 36 UK schools offering postgraduate diplomas in PA studies have also been criticised on social media for the way they describe courses and skills in terms of equivalence to medical training. A highly competitive five to six year undergraduate (or four year postgraduate) medical degree can't be compared to two year postgraduate PA training, followed by no further formal qualifications or requirements to progress. And—unlike nurses, pharmacists, or allied health professionals—PAs have no specific skill set or knowledge base that doctors don't have, which has led doctors to question their unique contribution to multidisciplinary teams.

Meanwhile, the Academy of Medical Royal Colleges issued a statement on 4 March that appeared to anticipate the BMA document published only days later but to double down in support of PAs.[7] The academy, in my experience, tries to stay close to government agencies and is keen not to disrupt that relationship. The GMC's tone has to my mind been equally defensive. And some people at the RCP's extraordinary general meeting this week found the response quite authoritarian, closed, and procedural. This was compounded by a survey of members' views on PAs being presented in a way that was strongly criticised as being spun and misleading.[8]

The RCP's by-laws also prohibit members who aren't fellows from voting, which leads to a serious democratic deficit. Junior doctors, early career consultants, and many specialty doctors are unlikely to be fellows and can't vote in the college

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elections—whereas long retired fellows can. This hardly reassures doctors in their 20s and 30s.

Avoidable damage

I think that the senior medical leadership community has handled this issue very badly. It has failed to "read the room" among junior doctors, GPs, and some consultants—partly by failing to engage in or understand social media, where many of these matters are raised and which the newer generation of doctors has embraced. Sadly, such a domineering, overly conservative, reactive, and out of touch attitude will alienate members of medical royal colleges and lead to membership cancellations, in organisations where membership is a main driver of income and support for members is a key charitable mission. This has already destroyed trust in those organisations, as well as in the GMC and the NHS England workforce team.

In the face of a major morale and retention crisis in the NHS medical workforce, this avoidable damage needs urgent repair, starting by listening to and acting on concerns. Voting on the five motions[1] discussed at the RCP's meeting—regarding scope of practice, accountability, evaluation, impact on postgraduate medical training opportunities, and a pause in the pace and scale of rollout of the PA role—will be an interesting litmus test.

Competing interests: See bmj.com/about-bmj/freelance-contributors

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2 NHS. Health Careers: Be part of a growing NHS workforce as a medical associate professional.https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions
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