

Improving support for doctors in the UK: The development of a modified physician assistant model in primary care and internal medicine

Nigel Sparrow, Mayur Lakhani

Introduction

In the United Kingdom, there has been a demand over the last few years to increase the workforce in both primary and secondary care to meet the requirements of the government's ambitious plan for the National Health Service.¹ The NHS plan stated that staffing constraints rather than lack of funding, posed the greatest threat to NHS modernisation. There is a shortage of doctors in the UK. As a result there has been a development of new and extended roles. In this article we wish to describe the development of a new health care worker called the medical care practitioner based on the physician assistant model that is commonly found in the USA.

Physician Assistants

During the 1960's physician assistants were developed in the United States to "relieve a nationwide shortage of doctors in primary care and to increase access to health care for people in under-served areas."² Physician assistants undergo 2 years of intensive training after a first degree and must pass a national certifying examination. They also have to complete 100 hours of continuing education every 2 years and pass a re-certification examination every 6 years.³

Recently several NHS organisations in primary and secondary care in the UK have developed new posts to address problems of workload. This has often been a localised response to address a particular local need. Their duties vary from mainly administrative tasks to detailed clinical work previously undertaken by registered health professionals. The titles of these new posts vary, leading to confusion and lack of clarity of roles and responsibilities. This is a very unsatisfactory situation with a multitude of unregulated practitioners providing care for patients with varying degrees of supervision.

Keywords

Medicine, physician assistant

Nigel Sparrow FRCGP *

Vice- Chairman, RCGP and Visiting Professor
General Practice, University of Lincoln, UK
Email: Nigel.Sparrow@nottingham.ac.uk

Mayur Lakhani FRCGP (Edin) FRCGP

Chairman of Council, RCGP, London, UK
Email: mlakhani@rcgp.org.uk

*corresponding author

It is with this background that the medical care practitioner role has been developed. There is an undoubted need to increase the range and flexibility of the NHS workforce as outlined in the NHS Plan 2000.¹ The medical care practitioner role will attract people who would not have previously considered working in the NHS. The Royal College of General Practitioners and the Royal College of Physicians have worked closely together to develop this new role and define the standards for education and training. The two colleges have worked with the NHS to develop a competence and curriculum framework for medical care practitioners. This document has now been released for public consultation.⁴

Definition of a medical care practitioner

The medical care practitioner role has been developed from the physician assistant model in the United States and is defined as "a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision."⁴

Benefits of medical care practitioners

In primary care, the development of the medical care practitioner role provides an opportunity to improve and develop the skill mix in health care teams, whilst emphasising the unique skills and knowledge of general practitioners who are highly skilled professionals with expertise in managing patients with complex co-morbidities and the evaluation of unselected, undifferentiated problems. When developing a new role, such as the medical care practitioner, it is important to recognise the skills of other health care professionals so that patients are treated safely, effectively and with equality.

The competence and curriculum framework for medical care practitioners describes the role of this new health care professional who will work under the supervision of a doctor. The document outlines the standards, education and assessment of medical care practitioners enabling qualification from a UK university. It outlines the knowledge, skills and core competences expected at qualification and it is anticipated that a fully trained medical care practitioner will deliver care and treatment at the level of a junior doctor in their second foundation year.

What will medical care practitioners do?

A medical care practitioner will be able to perform many tasks which are currently carried out by doctors, enabling doctors to be able to concentrate on the complex problems which require the particular skills and knowledge of a GP or hospital

consultant. The medical care practitioner will be able to:

- Take a detailed history, perform a physical examination and develop a differential diagnosis within the limits of their competence
- Develop a patient management plan taking account of the particular circumstances of the patient
- Perform some diagnostic tests, therapeutic procedures and prescribe (subject to legislative changes)
- Request and interpret some diagnostic tests and undertake patient education, counselling and health promotion

This is a comprehensive range of skills which will be required of medical care practitioners. It is essential therefore that both the entry requirements and training programme are rigorous and intensive. The training programme runs over 90 weeks with 3150 hours of teaching of which 1600 hours is designated as clinical learning. This is equivalent to a three year degree programme. Entrants to the course will be recruited mainly from science graduates but is also open to existing health professionals. This is a new profession and it is important that standards and level of competence is clearly defined which will enable criteria to be developed for statutory regulation. The purpose of regulation is to protect the public.

Supervision and governance

A key principle which has been agreed is that a medical care practitioner will always work under the supervision of a general practitioner or consultant and will only delegate tasks which they are competent to perform in accordance with guidance set out in the General Medical Council's document, *Good Medical Practice*.⁵ This is similar to the situation of a junior doctor who whilst accountable for their actions, works under supervision.

The recognition of when a clinical condition is beyond the expertise of a medical care practitioner is a vital competence which is discussed and clearly set out in the Competence and Curriculum Framework. This is essential to safeguard the public. Medical care practitioners will be trained to work to the medical model so that they will be able to apply their knowledge and skills to the needs of the individual patient, rather than working to pre-determined protocols. The document includes a model for categorising clinical conditions on the basis of required competence. Competences are elements performed to a predetermined standard, which combine to create professional competence in a defined role.⁶ Using this model there are conditions which a medical care practitioner (MCP) can diagnose and treat; those conditions which when already diagnosed can then be managed by an MCP; those situations when referral to the supervising doctor is required and those conditions which a MCP can monitor which has been diagnosed and a management plan developed by the supervising doctor.

The experience so far

There are currently 9 medical care practitioner trainees working in England, in both primary and acute care settings. The Changing Workforce Programme (now the National Practitioner Programme) began piloting these roles in South West London and North West London in 2004. These trainees are undertaking supervised clinical practice and attend university. The pilot sites have adapted the role of medical care practitioner according

to their local circumstances. The curriculum framework will in future ensure that medical care practitioners are all trained to the same standard but then they will be able to adapt their work in either primary or secondary care according to needs of the locality.

In 2002, Tipton and Rowley Regis Primary Care Trust in the Black Country recruited initially three physician assistants from the United States in response to problems of recruitment of GPs. These physician assistants are currently unregulated and responsibility for their actions is taken by the supervising doctor. Birmingham University Health Services Management Centre has evaluated this trial.⁷ They noted that physician assistants had expanded the skill mix in primary care and worked well in the primary care team under supervision of the GP. Patients responded very positively to this new health professional. They concluded that appropriate regulation is required to allow the full potential of the role to be realised. The report emphasised the need to retain the dependent practitioner status as this was recognised as essential for patient centred care. Stuart and Catanzaro reviewed the experience of 12 US physician assistants working in Sandwell, West Midlands.⁸ They concluded that the physician assistant model worked well in the UK. They emphasised the need for high quality educational courses based on national standards and competences to ensure the credibility of this new profession in the UK. They suggested that "this group of practitioners can provide a high standard of care to patients as well as help to support the medical multidisciplinary team".

Conclusion

The development of the medical care practitioner role should benefit both patients and other health professionals. It will provide an opportunity to further enhance the skill mix within the primary care and acute secondary care team. This will allow doctors to be able to spend more time with patients with multiple complex problems. It will give patients more choice of healthcare professional and by having a national curriculum and competence framework medical care practitioners will achieve a level of competence to agreed national standards helping to ensure that patients receive high-quality patient centred care. Further evaluation and research is needed to establish the utility of the medical care practitioner model.

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