An employer's guide to physician associates

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Royal College of Physicians | Faculty of Physician Associates

Introduction

The purpose of this guide is to enable healthcare providers (including acute hospital trusts, community trusts and primary care organisations) to understand the role of the physician associate (PA), how they work, where they fit into the team, and their scope of practice.

It is a resource intended to advise employers on:

- the current education and regulatory framework for the profession
- employment and supervision
- tools to help guide appraisal, career and salary progression
- recommendations for continuing professional development (CPD).

As this is a growing and evolving profession, it is expected that the guidance will change over time. The Post-registration Education Sub-committee of the FPA will endeavour as part of its remit to keep the information as up-to-date as possible.

Who are PAs?

PAs are healthcare professionals with a generalist medical education who work alongside doctors, physicians, GPs and surgeons to provide medical care as an integral part of the multidisciplinary team.

In its *Competence and curriculum framework for the physician assistant*, the Department of Health defines a PA 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'.

PAs have been practising in the UK for over 10 years. They can be found working in primary and secondary care across 20 specialty areas throughout the UK.

PAs are dependent practitioners working with a dedicated consultant or GP supervisor, but are able to work autonomously with appropriate support.

Supervision of a qualified PA is similar to that of a doctor in training or trust grade doctor, in that the PA is responsible for their actions and decisions. However, the consultant is the clinician ultimately responsible for the patient.

Why did the RCP agree to establish the FPA?

The RCP established the FPA in 2015 in conjunction with the UK Association of Physician Associates (UKAPA), Health Education England (HEE) and other medical royal colleges, in order to develop and strengthen working relationships between doctors and PAs. The RCP's Future Hospital Commission report, published in 2013, recommended developing the PA role as part of its aims to support the future clinical workforce.

The aim of the FPA is to support the educational and professional development of PAs, and thereby enhance patient safety, as well as providing resources from the RCP. The FPA is a national body, with standards that apply across the UK.

Why now?

The PA profession is growing fast, encouraged by the Department of Health and HEE, and by a number of universities introducing more PA training courses. The RCP Council decided in 2014 to oversee the FPA, to ensure that this expansion of a new clinical workforce is done as safely as possible, particularly pending formal regulation. It was seen as important to support, shape and understand the needs of the PA profession in a manner that is complementary to the needs of physicians, doctors and GPs.

Regulation

In the UK, the FPA and RCP are consistently campaigning for statutory regulation for PAs, both publicly and behind the scenes. The government and the Department of Health are considering regulation in order to provide a legally accountable framework for patient safety, set standards for the profession, protect the PA title, and ensure fitness to practise. While such standards are already in place for PAs in the UK, overseen by the FPA, they cannot be legally enforced without statutory regulation.

The FPA currently runs the Physician Associate Managed Voluntary Register (PAMVR), which allows employers to check whether an applicant or employee is a fully qualified and approved PA. The FPA strongly encourages all qualified PAs to join the PAMVR, and all trusts and practices to ensure that the PAs they employ are registered. Employers should check this at appointment and at yearly appraisals. This will help to ensure that only those who have been properly trained are able to practise as PAs.

While work towards statutory regulation is underway, the decision regarding an eventual registering body for PAs will be made by the government. All UK-based PAs are therefore strongly encouraged to join the PAMVR, as it will form the initial list of PAs to enter a statutory register when established.

The RCP and the FPA, HEE and the higher education institutes involved in training PAs continue to work towards regulation of the profession and the establishment of a statutory register. Once this is in place, the title 'physician associate' will become protected, and only those on the statutory register will legally be allowed to practise as a PA.

PAs in the UK

There are a number of countries across the world where PAs are employed. For example, although PAs are a relatively new role in the UK, the profession is firmly established in the USA, with 108,000 PAs working in 2016. In the USA, PAs are known as 'physician assistants', which was the term initially used for PAs in the UK.

The name changed to 'physician associate' in the UK in 2014 to enable the profession to proceed towards statutory regulation, and to distance PAs from another category of practitioner (still referred to as physician assistants) who work as technicians rather than clinicians – without a PA's approved education and training.

PAs have been practising in the UK since 2002, and first worked in areas where it was hard to recruit healthcare professionals (including GPs) to work in primary care. PAs qualified from the first UK pilot programmes in 2007, and the first official PA programmes began in 2008.

Initially there were five training programmes. By the end of January 2017 there were 27 programmes, with more in development. Currently there are approximately 350 PAs working across the UK. It is forecast that by 2020 there will be 3,000 qualified PAs, and potentially a further 1,000 graduating per year in the UK after that time. The current secretary of state for health has promised 1,000 PAs in general practice by 2020.

In the early days of the profession, the PA role evolved as a result of the movement of care from acute services to primary care and the European Working Time Directive, which reduced junior doctors' hours and created gaps in the service. More recently, the need for the profession has been driven by a number of factors, including:

> increasing demands for better access to care
> the desire to provide a 24-hour, 7-day service
> changes in medical career pathways and junior doctors' training
> continuing difficulty in recruiting to primary care posts in less attractive areas.

The PA role is in no way a replacement for any other member of the medical or general practice team, but works in conjunction with – and complementary to – the existing team. They are not plugging or filling medical workforce gaps, but rather helping with redistribution of the medical workload.

Education and training of PAs

PAs trained in the UK have undertaken postgraduate medical training in PA studies. These studies are spread over a period of at least 90 weeks (approximately 3,200 hours, divided into 1,600 hours of theory and 1,600 hours of clinical practice). This is an intensive 2-year course based on the *Competence and curriculum framework for the PA*, consisting of theoretical learning in medical sciences, pharmacology and clinical reasoning, as well as clinical placement experience in a wide variety of settings, including:

> acute and emergency medicine
> community medicine
> surgery
> obstetrics and gynaecology
> paediatrics
> mental health.

To enrol on a PA programme, students must already hold an undergraduate degree, usually in a biomedical or health/life science field, and have some prior health or social care experience. Most programmes offer a postgraduate diploma in PA studies, with some offering master's qualifications.

All students must pass their university programme prior to sitting the PA national examination. The PA national exam is required for entry into professional practice, and must be taken by every PA in the country, regardless of which programme they have passed. The exam sets the standards for PAs across the country and is designed, developed and administered by the FPA. It consists of 200 single best answer questions (MCQ style) and a 14-station objective, structured clinical examination (OSCE). Once a PA has passed both their university exams and the PA national examination, they are qualified and fit to practise as a PA.

PA programme accreditation

The FPA has established criteria for accreditation of PA university programmes based on the requirements of the *Competence and curriculum framework*. It is anticipated that, by the end of 2017/2018, most if not all PA programmes in the UK will be reviewed and accredited by an independent commission. This will help to set and maintain high standards of PA education across the country.

Governance structures for PAs

There are several organisations that facilitate the functioning and growth of the PA role in the UK.

The FPA

The FPA is focused on campaigning for progress and change in the profession (including regulation), as well as offering advice to the government and taking part in national debates on medical, clinical and public health issues. The essential workstreams of the FPA are around:
> education and training
> examinations (both national and recertification)
> professional conduct (including the PAMVR).

The FPA will continue to manage the PAMVR until the profession achieves statutory regulation. Employers and users of healthcare services, including patients and relatives, can check whether a PA is on the PAMVR by contacting the FPA or by accessing the register on the FPA website.

The register has a code of conduct and a scope of practice for PAs, and standards for education, CPD and recertification for the profession. The PAMVR also has a fitness to practise mechanism, whereby concerns raised about a PA may be investigated and acted upon. PAs who are on the PAMVR may add the letters 'PA-R' as a postnominal to demonstrate that they are currently on the register and have signed up to maintaining high standards of practice.

Currently, the PAMVR has no force of law and cannot stop PAs from practising should there be any suspicion of wrongdoing, although it can highlight potential problems to a PA's employer, and PAs can be removed from the register. The FPA strongly recommends that all employers require any PA they employ to be registered on the PAMVR. It is

also recommended that employers keep a record of when a PA is due to renew their place on the register, and check that membership is maintained on an annual basis, as they would for equivalent registers for nurses and doctors. This is often done as part of the yearly appraisal process, which is recommended for PAs, and mandatory in many healthcare organisations. PAs will generally pay for membership themselves.

Currently only PAs trained in the UK or USA are permitted to work in the UK. In the interests of public safety – and because of the lack of statutory regulation – the FPA will not accept a PA trained in any other country to work in the UK or to be on the PAMVR, as PAs from other countries are not able to demonstrate equivalent standards of education and training.

If a PA has qualified in another country and wishes to work in the UK, there is a process in place to facilitate their application, which can be found on the FPA website.

United Kingdom and Ireland Universities Board for Physician Associate Education (UKIUBPAE)

The UKIUBPAE evolved out of the Higher Education Steering Group, which followed the successful certificate level pilot programmes. Members of this group are drawn from all the PA education programmes in the UK. The remit of the board is to:

> develop the education of PAs in the UK
> advance and support academic governance
> continually improve education standards.

Employing a PA

It is imperative for employers to ensure that the role and remit of a PA are what is needed by your team/organisation, so that you do not employ a PA where an alternative healthcare professional would be better suited (eg an advanced nurse practitioner, doctor, GP, practice nurse or other healthcare professional).

It is advisable to write a clear job plan to allow both employer and PA to understand what is expected of them. The job plan should indicate hours of work, opportunities for development and required duties. Newly qualified PAs or those moving from one specialty to another will need more close supervision, and so the job plan will need to allow for regular reviews with their supervisor. In both primary and secondary care, it is useful to have one dedicated GP/consultant supervisor. Although the PA will not work directly with the GP/consultant each day, it allows both parties to get to know each other and form a professional relationship.

The benefits of employing PAs are realised over a period of time, as the relationship between the PA and their clinical supervisor develops. Therefore, it is important to ensure that the job being advertised allows for variation in daily work and for opportunities to develop. If possible, the employer should provide the PA with opportunities for study leave to attend training courses, to help them maintain their requirement for CPD and recertification (see *Support and development of PAs* (p6)). Offering a study budget also makes a post attractive, as well as the ability to support their profession (by work with the FPA, university PA courses and PA national examinations).

Pre-employment considerations

Qualifications and professional registration

To be appointed to a post, a PA must have successfully passed the final examinations of a recognised PA course in the UK or USA, and have successfully sat the UK PA national examination. Evidence of this must be provided and checked at interview. They must also be registered on the PAMVR, which will be checked prior to appointment, and reviewed each year at appraisal by the PA tutor or line manager. US-trained PAs are required to have, and maintain, their certification by the National Commission on Certification of Physician Assistants (NCCPA) in order to work in the UK.

Indemnity arrangements

In primary care, PAs must take out professional negligence insurance from one of the medical defence organisations: Medical Protection Society (MPS), Medical Defence Union (MDU) or Medical and Dental Defence Union of Scotland (MDDUS). Alternatively, this may be covered under a group arrangement in general practice. For secondary care, the current practice of PAs is covered by the Department of Health 2012 Clinical Negligence Scheme for Trusts (CNST). Qualified PAs are strongly recommended to have their own personal professional negligence insurance, which can be arranged through MDDUS.

Salary

This is dependent on the skills and experience of the PA. In secondary care, the PA post has been evaluated under the Agenda for Change at band 7. Higher-level PAs with appropriate levels of experience have been banded at 8a. Agenda for Change contracts are based on 37.5 working hours per week and job plans should be based on this. Additional payment would be required for working out of hours or at weekends. Some trusts employ recently graduated PAs at band 6, but give more support and supervision in the first year of practice. On completion of their first year, these PAs then move up to band 7.

In general practice, a PA's salary can be negotiated, although there is a suggested range:

> new graduates (up to 2 years postgraduate): £30,000–£34,000
> 2–5 years post-qualification: £34,000–£40,000
> 5+ years: £40,000 upwards.

This is for a 37.5–40-hour working week, and would include out of hours and weekends.

Some US-trained PAs may be offered some stipend or relocation package to move to the UK, and a flight back to the USA every 1–2 years, along with funding for CPD as part of their employment package. However, most US-trained PAs can maintain their CPD in the UK through FPA conferences, which are accredited by the American Academy of Physician Assistants (AAPA). Continuing medical education (CME) is also available online and PAs can take their recertification exams in the UK, as there is a Pearson testing centre in London. This helps them maintain their certification with the NCCPA, which they need to practise in the UK.

Interviewing

An interview should seek to understand the current level of practice of the PA, as well as their background and experience. It should also seek to understand the personal development plan of the PA. If possible, it is useful to include a qualified PA in employment on the interview panel.

Considerations during the first year of employment

A newly qualified PA should be provided with a supportive learning environment, in which they can consolidate and expand their skills and competencies in their chosen field. While a newly qualified PA should be able to deliver service, they will still require training and supervision, as would any new member of staff in a first job.

Initially, a PA will require some structured learning and planned supervision, although with time this should become less necessary, as their skills and knowledge grow and your confidence and trust in the PA and their ability to make good clinical decisions increase. The employer should meet with the PA in their first week as part of the induction process, and assess their skills and knowledge around general practice or hospital medicine. This assessment can then be used to design a structured programme of specific educational goals that will be reviewed on a 3–6-monthly basis, and appraised at the yearly review.

PAs should also have access to experiential learning in the clinical areas in which they are working, and should maintain a portfolio of cases and case discussions with clinicians, reviewed with their clinical supervisor.

In secondary care, all Agenda for Change staff undergo a probation period of 6 months. The designated line manager must ensure a review prior to completion of the probation period. If the PA has failed to achieve the skills, knowledge and/or attitudes that are required to undertake the PA role, this would give cause for a probationary hearing to potentially dismiss the employee for failing their probationary period, following usual hospital protocol. Alternatively, the probationary period may be extended if there are extenuating circumstances.

Employing an experienced PA in a new specialty or a US PA

Entering a new specialty as a PA initially necessitates more supervision and guidance from the supervising doctor. PAs who may have been practising for several years in varying areas of medicine or surgery will undoubtedly have picked up a breadth of skills and knowledge. However, there will be new skills and procedures to be learned and knowledge to be gained, therefore it may be appropriate to follow a review timetable, similar to a PA in their first year of qualification. However, an employer should once again assess their knowledge and skills – this steep learning curve may be much shorter in duration than for a newly qualified PA.

If you have an experienced US PA, they too will need time to bed into the system and get used to the way the NHS works, systems and processes, culture and differences in language, medications and guidelines for treatment.

What can PAs do in primary care?

PAs in general practice can undertake a variety of jobs. They are trained in the medical model and can assess, manage and treat patients of all ages with a variety of acute undifferentiated and chronic conditions. They can see patients presenting with acute/same-day problems, as well as offering rebooked appointments. PAs are able to triage patients, carry out telephone consultations, make referrals, and review and act on laboratory results. Many PAs also carry out home visits or visit nursing and residential homes. Some PAs offer specialised clinics following appropriate training, including (but not exclusively) family planning, baby checks, COPD, asthma, diabetes and anticoagulation. PAs are also able to teach and supervise students. The level of competence at which the PA can work will depend on their skills and experience, and the skills and experience of their supervising GP.

All PAs are trained to be aware of the level of their clinical competence, and to work within their limits accordingly. Each GP practice runs differently, so a PA's role may vary across primary care. Newly qualified PAs can see the range of patients that present to general practice; however, initially they may need more supervision and support. The level of support and supervision required should lessen in time as the PA grows in confidence, knowledge and skills.

As PAs become more experienced, they can become involved in a wide range of activities including service design and development, becoming clinical placement leads for students, undertaking minor operations and becoming involved in practice-wide education and quality improvement projects.

A mix of sessions is ideal and ensures a broad scope of practice. For instance, if a PA works ten sessions per week, there should be a mix of session types. PAs who only see acute, on-the-day cases will never progress clinically. To ensure continued interest and long-term job satisfaction, a PA would ideally be involved in the entire scope of GP practice. PAs should be allowed to see any patient who presents, with their supervising GP assisting or intervening if required. This is key to the development of a PA.

What can PAs do in secondary care?

PAs can perform a variety of functions in secondary care. All PAs have a core set of skills that they will perform on a regular basis as part of their role within the trust, regardless of the specialty in which they work. Core skills include being able to:

> take medical histories
> conduct comprehensive physical examinations
> request and interpret certain investigations
> diagnose and treat illness and injuries
> counsel, or offer preventative healthcare.

The supervising clinician (consultant or registrar – see *Supervision* (p6) for more information) must ensure that the PA is assigned to a patient who does not exceed their competence or confidence. However, PAs should not be restricted to one category of acuity, and should be encouraged to see a variety of acute and chronic diseases, including resuscitation patients and those with acute deterioration (providing both supervisor and PA are confident and competent to do so).

Ward rounds will be a key activity for most PAs working in secondary care. A PA is able to perform most tasks that a junior doctor would perform on a ward round and can lead the clinical review without direct supervision, providing a qualified and registered doctor is also working in the clinical area, and the supervising doctor is happy for them to do so. This is to ensure that there is not a delay in investigations and prescription of medications, given the current limitations on practice of PAs (see *Current limitations of the PA role* (p6)).

The job plan for a PA working in secondary care will depend on the reason for their employment. Typical reasons for employing a PA in secondary care include:

> ensuring a level of continuity and added value at ward level
> the need for a permanent staff member (while most medical staff rotate)
> enhancing clinic services
> increased regular theatre support.

In addition, typical roles carried out by PAs in the secondary care setting include:

> attending ward rounds with junior doctors and consultants
> working in acute assessment (in the emergency department or on call)
> providing in- or out-of-hours ward cover
> working in outpatient clinics – seeing patients under supervision
> assisting first or second in theatre
> taking part in audit/quality improvement work.

Core procedural skills

PAs have trained in several core procedural skills, and have been assessed as competent to perform these at qualification. Some of these include:

> venepuncture and blood culture sampling
> cannulation
> arterial gas sampling
> cauterisation (male and female)
> peak flow examination
> urine dip stick.

Training pathway for extended skills

As part of mutual agreement between a PA and their clinical supervisor, PAs may be trained in a range of extended skills over a period of time. Information on extended skills being undertaken by UK PAs is collected annually by the FPA in its annual census. These extended skills include:

> ascitic drain insertion or tap
> backslab application
> lumbar puncture
> fracture reduction
> surgical first assisting
> joint aspiration/injection
> nerve blocks
> pleural tap
> incision and drainage of abscesses.

An employer wishing to train PAs in extended skills should expect the PA to acquire these extended skills in a manner that upholds a high standard of care, and to safeguard the patient, practitioner and employer.

To be trained in extended skills, the PA should receive training from a qualified and competent practitioner in that skill, and then undergo a period of supervised practice. Both the initial training and supervised practice should be documented and form part of the PA's work-based yearly appraisal. Competence to continue practising the extended skills should also be reviewed during this appraisal.

The format that this training and supervision takes will vary according to the procedure; however, it is highly recommended that a Directly Observed Procedural Skills (DOPS) assessment is used to record the supervised elements, and documented in a personal development record. Copies of these are available for use on the FPA website. The employer would also be expected to write a rigorous governance policy around the practice of each extended skill.

PAs are able to obtain verbal consent for the extended skills listed above, providing that the verbal consent is documented in the medical notes. Please note that PAs are unable to obtain consent from patients for operative procedures which require anaesthesia.

Current limitations of the PA role

Due to the lack of statutory regulation, PAs cannot currently prescribe medications or request ionising radiation.

Ionising radiation

The use of ionising radiation has been subject to specific legislation since 1988. Guidance on the Ionising Radiation (Medical Exposure) Regulations 2000 and amendments made in 2006, known as IR(ME)R, can be found on the Department of Health website. The 2006 amendments state that only registered healthcare professionals are able to order ionising radiation. Therefore, as PAs lack statutory regulation, they are unable to make requests for ionising radiation. However, PAs are encouraged to take IR(ME)R training as part of their professional development, in anticipation of attained regulated status in the future.

Prescribing

PAs in the UK are currently not able to prescribe medication. This is similar to the situation in the early days of physician assistants working in the USA.

Close work with supervising physicians, and arrangements developed individually, allow for flexible ways of working and the continuation and expansion of quality patient care. For instance, many PAs working in general practice have the ability to quickly interrupt their supervising GP for a signature and then continue their work. If further advice on a case is required, the GP and PA take time out to discuss it and/or see the patient together to come to a decision on further treatment.

In terms of transcribing medications, close work between PAs and supervising physicians enables individual arrangements to be developed to allow for flexible ways of working, and the continuation and expansion of quality care. In secondary care, PAs are able to write drug charts – which require countersignature from a doctor – or propose medication on an electronic prescribing system. This should exclude cytotoxic or controlled medicines.

Support and development of PAs

Supervision

The PA is described as a dependent practitioner and will always work under the supervision of a designated doctor. Their detailed scope of practice in a given setting is circumscribed by that of the supervising doctor. Although there may be circumstances when the supervising doctor is not physically present, they will always be readily available for consultation. Like all other regulated healthcare professionals, the PA is responsible for their own practice, although the supervising doctor always maintains the ultimate responsibility for the patient.

The PA will be employed as a member of the medical team in primary or secondary care and will have a clinical supervisory relationship with a named doctor, who will provide clinical guidance when appropriate. It is expected that the supervisory relationship will mature over time, and while the doctor will remain in overall control of the clinical management of patients, the need for directive supervision of the PA will diminish.

The PA will always act within a predetermined level of supervision and within agreed guidelines.

Qualified PAs may develop specialist expertise that reflects the specialty of their supervising doctor. This will be gained through experiential learning and CPD. However, a PA is expected to maintain their broad clinical knowledge base through regular testing of generalist knowledge and demonstrated maintenance of generalist clinical skills. Therefore, it is likely that equivalent structures and processes to those used in the USA to test the maintenance of generalist knowledge will be introduced in the UK.

CPD

All PAs are expected to maintain their CPD with a minimum of 50 hours annually, as required by the FPA. It is expected that a PA will establish a formal educational needs plan with their supervisor, which will be reviewed on a regular basis. PAs are required to keep an up-to-date CPD diary, which is available as part of the membership of the FPA.

On commencing employment, PAs and their supervisors should draw up agreements on allocation of CPD-dedicated work hours, including an agreement on the frequency of tutorials (as appropriate). It is anticipated that these agreements would need to be reviewed on a regular basis.

Offering training and education to PAs to enable their development is a good way of retaining PAs over a period of time. This not only benefits the PA, but allows the relationship between supervising consultant and PA to develop by retaining a continuous team member.

Many employers offer a study budget and allocation of study leave in addition to salary, to allow the PA to meet their CPD and personal development plan objectives for the year. The funding of this budget will depend on available resources of the employer and should be offered to PAs meeting their contractual requirements for internal mandatory training and appraisal targets.

Appraisal

All PAs should have an annual appraisal with their supervisor. In reality, the PA will have worked with different consultants – or in primary care with other members of the general practice team – as well as their supervisor. Feedback from the team prior to appraisal would be both appropriate and useful, and give a complete picture of the PA. Many primary and secondary care organisations also have their own appraisal documentation or achievement review systems, which have alternative or additional documentation to complete. Those PAs who are coming into primary or secondary care from another healthcare setting (or are new graduates) should also have an induction meeting to identify their learning needs, and determine how these will be addressed in the first year and beyond.

There are a number of forms available on the FPA website for PAs and employers to use to supplement the employer's appraisal documentation, including forms for collecting patient and colleague feedback, evidence/case-based discussions and confirming direct observation of procedures.

Recertification

Although PAs will acquire some specialist knowledge relevant to their field of practice, they are expected to maintain the same level of general competence across the whole scope of PA practice, as tested by the PA national examination and recertification examination.

In line with the *Competence and curriculum framework for the PA* – and as stipulated by the PAMVR – a PA must recertify every 6 years in order to remain on the register.

PAs are given three attempts to sit and pass the recertification examination, with the first opportunity at the beginning of their fifth year since qualification.

If any PA fails the recertification exam on three occasions within the 2-year period, they will be removed from the PAMVR and their employer notified of this change. They will then have to retake the qualifying exam.

The FPA recommends that registration on the PAMVR should be a requirement of employment for PAs. Therefore, employers should put in place a disciplinary and dismissal process for failure to comply with this requirement.

Career development

Most PA careers develop laterally rather than vertically. After 5–7 years, some will be classed as senior PAs; however, career progression for a PA is more closely aligned with the advancement of their knowledge and skills in practice, rather than with time.

Over time, a PA will start to see more increasingly complex patients and take on more responsibility. In secondary care, this may mean seeing patients in clinic or performing advanced procedures. PAs may also be offered management roles, for example in leading audit or service development. In primary care, this may mean running some specialist clinics. PAs may become a partner in the practice. Many PAs are involved in activities related to PA education, for example secondment to university PA programmes, or activities related to advancing the PA profession, for example working on sub-committees at the FPA.

FAQs: PAs in primary care

How much time do PAs have with a patient per appointment?

This is dependent on a PA's experience. If registrars with 8 years' experience (five years of medical school, two foundation years and an ST year) start on 30-minute appointments, then it follows that new graduate PAs should be given similarly reasonable times. They may also need time to get signatures for medications or imaging. Appointment times should decrease every few months in the beginning – with negotiation and based on a PA's comfort and experience.

Over time, PAs should have 10-minute appointments, but how the individual surgery deals with signing medication/imaging will affect times. If a PA is required to discuss medication, but only has a 10-minute appointment, then in essence they are being asked to see patients faster than a doctor, as a PA has to wait to speak about the medication with their supervising GP within the 10-minute appointment time.

Is one GP assigned for cases that need discussion with a PA, or is this decided dependent on which GP is next available?

PAs should be able to discuss patients with any GP. If a surgery runs a duty doctor system, that person should be the supervisor for the session.

Is one GP assigned for providing prescriptions for a PA, or is this done by the next GP with free time?

This depends on how the surgery works and if they discuss the medications. Ideally, this should be the next free or duty doctor. A new PA should always discuss every medication recommendation until the doctor is completely happy with the medication proposals.

Do any PAs do minor surgery / coil insertion / specialist clinics?

Some PAs run the minor surgery weekly clinic, but *only* if the one GP with up-to-date skills is in the building. The clinic cannot run if the appropriate doctor is not in the building. This is a safety issue.

What is the difference between a PA and an advanced nurse practitioner (ANP)?

A PA has a biomedical science background, and is trained in the medical model specifically for the position in medicine. The PA is not an extended practitioner. They do not work to set protocols and can see a wide variety of undifferentiated patients.

An ANP has trained in nursing and has usually spent many years in healthcare learning the skills for the job, completing courses to advance their knowledge, with many gaps potentially still remaining in basic medical science. They tend to work in a specialist area and have a mixed skill set.

ANPs tend to be able to prescribe. PAs have the requisite knowledge and skill to prescribe, although lack of statutory regulation currently renders them unable to do so. There are enough patients in the system to enable all professional groups to work in a complementary way to deliver high-quality patient care.

FAQs: PAs in secondary care

What level of doctor is a PA equivalent to?

PAs do not fit into the hierarchical system used for grading doctors. While this may seem confusing, it is important to remember that the seniority of the PA is dependent on their skills and experience. For example, a PA who has worked in secondary care since qualification may have skills and experience more superior for their work area than a PA who has 5 years' experience in general practice who has only recently begun work in secondary care. Equally, a PA who has been working in one particular specialty may become very skilled in that clinical area, but must maintain their generalist skills in order to recertify every 6 years. Employers should be mindful of this, and create job plans that allow continued practice of a PA's fundamental clinical skills.

How do trainees feel about PAs entering the medical workforce?

As more PAs enter the workplace, trainees are becoming more aware of the role that a PA can play within a team. Employers seeking to employ PAs should be aware that trainees can be misinformed on what a PA can do, as well as the variability of a PA's practice dependent on their level of experience. It is suggested that trainees are made aware of the role that PAs are playing in the organisation at their induction, so that any misconceptions or concerns are dealt with early on.

How do trusts fund posts for PAs?

The funding for PA posts will vary dependent on the reasoning for employing them. Typical reasons include the need to reduce excessive locum spends and reconfigured rota systems, which could reduce ward-level continuity. PAs are not an alternative to doctors. PAs can add value and offer a continuous presence, as they do not tend to rotate. Consequently, the benefit of a PA becomes more apparent over a period of time.

Does the fact that PAs cannot order ionising radiation or prescribe affect their ability to function in a hospital setting?

PAs enable the workforce to work more efficiently. The limitations of their scope of practice should be borne in mind when designing a job plan for a PA working in secondary care. PAs will need to work alongside healthcare professionals who can order radiation – and prescribe – to prevent delays in access to investigations or treatment. This could be pertinent, for example, if PAs are working out of hours. On a day-to-day level, it is unlikely that these limitations have any direct disadvantages, as most PAs work alongside medical teams. It is suggested that PAs work alongside doctors of at least full GMC registration, rather than pre-registration foundation year doctors.

Many trusts allow PAs to transcribe medications to drug charts, but each transcription requires the signature of a fully registered doctor who assumes ultimate responsibility for the prescription. A move to electronic prescribing may prevent this inconvenience in the future. It is strongly recommended that PAs do not use any form of electronic prescribing, in order to prevent any practice outside their competence. When the PA profession is regulated, the regulator will determine what additional training is required for PAs to be allowed to prescribe.

References and useful resources

Competence and curriculum framework for the physician assistant, Department of Health (2006) revised version (2012), is available to download from the FPA website.

The Faculty of Physician Associates – www.fparcp.co.uk
American Academy of Physician Assistants – www.aapa.org
National Commission on Certification of Physician Assistants – www.nccpa.net

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