Medical Associate Professionals in the UK

In the Existential Fight over Professional Territory- there is a Missing Voice

Editorial
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Anyone who has any connection with the world of social media will be aware of the 'storm in a teacup' that has been brewing in the last few months with Medical Associate / Assistant Professionals (MAPs) in the UK as Parliament debated and swiftly passed legislation[1] related to their regulation by the UK General Medical Council. In its supporting statement, the UK Minister for Health[2] specified,

'Physician associates work under the supervision of doctors taking medical histories, carrying out physical examinations, performing some medical procedures and analysing test results. Anaesthesia associates review patients before surgery, initiate and manage medications, administer fluids and blood therapy during surgery, and ensure there is a plan for patients following their operation. Both roles can work autonomously, but always under the supervision of a fully trained and experienced doctor.'

The legislation was passed in the UK Parliament in Feb24 and will be in force from Dec'24. MAPs were introduced in the USA in the early 1960s to reduce doctors' workload, provide an alternative, more affordable solution to the burgeoning cost of medical education via a shortened training pathway and allow health services to meet increasing demands. MAPs are designed to be trained in the medical model to assess, diagnose, and commence treatment of 'undifferentiated conditions' under the supervision of a physician.

In developing progressive MAP programs, physicians and educators had free reign to create innovative approaches to medical education that included decentralised education, emphasis on psychosocial components, and creative deployment approaches. The competency-based MAP model employed ideas and elements ahead of their time in health professions education, based on non-traditional models of medical education that many believe have proven to be successful in training effective generalist clinicians, and their challenge also lies therein. [2]

In comparison with advanced nurse practitioners (ANPs), a systematic analysis demonstrated that both roles were regarded as cost-effective in comparison to doctors performing simple tasks. MAPs were less understood compared to ANPs and received a mixed reception from colleagues, which sometimes undermined their professional identity, whereas ANPs were mostly welcomed by colleagues.[3] In primary care, despite policy support for the role, General Practices' employment of MAPs in primary care is low perhaps explained by challenges in dedicated funding and supervision.[4] There is a poor understanding of the scope of practice being 'under supervision as a dependent practitioner' while practising 'autonomously'.

Globally, there have been many attempts to reduce the training period for doctors primarily to meet the needs of health services locally and provide faster and more local training. Such attempts at reducing the training required have been defended robustly by the profession on the grounds of patient safety. The same argument was used to protect the profession's identity from medical 'quacks' in the Royal Charter that King Henry V granted to the Royal College of Physicians of London in 1518. Following that, the need for regulation was included in legislation, and gradually, the entire scope of curriculum, quality of education, training, assessment, and performance became within the scope of regulation. In reiterating its commitment to the Charter in its 500th year, the RCPL reaffirmed its commitment to provide the highest standards of patient care, train, develop and support doctors, act as leaders, promote good health and prevent ill health.[5] Many of these affirmations are currently under intense scrutiny in the 3rd ever-extraordinary general meeting of the RCPL on March 24. [6]

Alongside the conception of MAPs, there has been innovation in the widening scope of nursing and midwifery professionals and allied health professionals as advanced practitioners. At the beginning of any such human resource solutions or innovations, some inevitable tremors are bound to occur as the profession takes notice, shifts, and adjusts to the new norm. The introduction has witnessed this of endoscopists, nurse consultants and an extended scope of nurse practitioners and allied health professionals. There is a delicate and often fragile balance between the extended scope of practice, autonomous practice, and an existential threat to some aspects of the physicians' practice. Governance models can range from national and decentralised to no regulation often at the discretion of employers and settings. Countries with decentralised regulation resulted in uneven levels of practice, and role clarity was limited.[7]

The system of accreditation and licensure of physicians, which includes elaborate attempts at ensuring the curricula reflect the extent, depth and range of practice combined with formal, reproducible assessment of knowledge and competencies, exists to provide confidence to the public and protect the profession from range creep or medical quacks but is not unique. [8] Hence, any attempt to introduce innovative professionals with a similar scope of practice or autonomy undermines the robust framework constructed carefully over several decades and is likely fiercely contested.

What changed in the last few months of 2023 so that the MAPs issue has captured the forefront of doctors' social networks and initiated a range of furious posts not commonly seen in this sphere?

Analysis of this trend reveals several contributors and time-sensitive issues that have peaked simultaneously. The first is the timing of the legislation which enshrined the MAPs in the UK Parliamentary statute books, firming up the regulation responsibility with the General Medical Council, which was conceived and created purely for the regulation of doctors. Juxtaposing MAPs in the register for doctors, albeit with a 'prefix', brings them close to blurring the professional boundaries. The discussion that the 'medical professionals' are not an exclusive title protected by law has only undermined the confidence of the anxious professionals. The UK Parliament passed the statute with little debate and undoubtedly little evidence of public consultation.

Secondly, there is emerging evidence of the phenomena described as 'scope creep', assessment of 'undifferentiated patients' and

'professional autonomy'. They were mainly deployed to undertake inpatient ward work in the medical/surgical team during core weekday hours. They were reported to positively contribute to continuity within their medical/surgical team, patient experience, and flow, inducting new junior doctors, and supporting the medical/surgical teams' workload, which released doctors for more complex patients and their training. The contribution of MAPs to productivity and patient outcomes was not quantifiable separately from other members of the team and wider service organisation. Patients and relatives described MAPs positively, but most did not understand who and what a MAP was, often mistaking them for doctors.[9] From a position of being created to be dependent practitioners with shorter, superficial curricula and training and for assisting the burgeoning burden of a health service struggling to manage the balance between workload and delivery - the claims that MAPs can function independently, undertake surgical procedures and manage undifferentiated patients on doctors' rotas or in primary care has raised alarm bells across the doctors' professional bodies. The primary outrage appears to be linked to the risk to patient safety. It is argued that professional boundaries become malleable and subject to negotiation at the micro level of service delivery.[10]

Thirdly, there are concerns regarding the risk posed to junior doctors who are often requested or required to order investigations involving ionising radiation or prescribe medication for patients they have not reviewed or assessed. This practice is necessitated as MAPs are not allowed to prescribe at present. However, this flies in the face of the need for safe prescribing; the recent introduction of prescribing assessments and messages extolling the virtues of checking for interactions and allergies and explaining why each medicine is prescribed to patients. In addition, there is a perceived mixed experience of the impact on training.[11]

Finally, the straw that appears to have broken the camel's back is the comparison of the agenda for changing pay scales for MAPs with that of doctors in training. This came at a time of prolonged industrial action walkouts affecting all grades of doctors and the apparent lack of willingness of the authorities to negotiate.

Theoretical analysis reveals that a clear role for MAPs is the essential facilitator and an unclear role is the primary barrier to the integration of MAPs into secondary care services in the NHS. [12] To address some of the concerns the doctor associations and their trade unions raised, the GMC[13] and Academy of Medical Royal Colleges trainee groups [14] have issued public statements that support the government's aspiration for a multi-professional workforce and justify the inclusion of MAPs in the GMC register. Also designed to answer concerns and allay fears, the effect of such statements has been the opposite. There appears to be further escalation of the concerns with different members and fellows of the individual royal colleges moving their councils to extraordinary general meetings- resulting in resolutions seeking to limit the role, scope and autonomy of MAPs. The Royal College of Physicians discussed the issue of MAPs at the Extraordinary General Meeting on 13 March. There have already been controversies regarding information issued to fellows describing the financial risk that a potential restriction of hosting the Faculty of Physician Associates might pose for the college, should the voting in the EGM turn away from the favourable position. Voting results are due on 25 March, however, those who attended the EGM reported their frustrations and disappointment on social media regarding the lack of a real debate at the EGM, describing the affairs as an affirmation of the College's official position from the leadership.

In two commentaries carried by the British Medical Journal in the days leading to the EGM, the President of the RCP London[15] and one of the Councillors[16] provided their rationale on why the position of the MAPs should be continued but with clarifications based on the proposals. The fourth motion at the EGM, [6] which the RCPL leaders supported asked

'The RCP to explore, document and address the impact on training opportunities of doctors resulting from the introduction of PAs.'

This is the one that needs comprehensive scrutiny and will have the maximum impact on all doctors. The British Association of Physicians of Indian Origin (BAPIO) is leading a survey [17]and workshop designed to have a 360-degree review of the impact of MAPs on training and career progression for all doctors, including the missing voice of several thousands of doctors who are not in formal training, are locally employed on shorter-term contracts, are considered as speciality doctors by the GMC. A vast proportion of these doctors are international medical graduates, and a significant proportion belong to cohorts who are under-represented in leadership positions (including those that were previously considered from Black or minority ethnic groups). The workshops and focus groups will include representation from all under-represented groups of doctors across the spectrum, patient representatives, nursing, and allied healthcare professionals who form an integral part of the MDT, medical leaders, higher education institutions, NHS workforce Training and Education and NHS employers. The results of the independently facilitated focus groups and survey results will be published with recommendations for all stakeholders in May 2024, and aim to provide a framework for action, reflecting consultation and views of the whole healthcare profession.

1. Draft Anaesthesia Associates and Physician Associates - Hansard - UK Parliament. https://hansard.parliament.uk/Commons/2024-01-17/debates/bde42233-6731-4370-96db-6836666abbab/DraftAnaesthesiaAssociatesAndPhysicianAssociatesOrder2024 (2024).
2. Written statements - Written questions, answers and statements - UK Parliament. https://questions-statements.parliament.uk/written-statements/detail/2023-12-11/hcws113.
3. Wang, H. *et al.* The roles of physician associates and advanced nurse practitioners in the National Health Service in the UK: a scoping review and narrative synthesis. *Hum. Resour. Health* **20**, 69 (2022).
4. Ownership power and managing a professional workforce: General practitioners and the employment of physician associates - Krachler - 2023 - Human Resource Management Journal - Wiley Online Library. https://onlinelibrary.wiley.com/doi/full/10.1111/1748-8583.12464.
5. RCP500 Charter. *RCP London* https://www.rcplondon.ac.uk/rcp500-charter (2017).
6. Extraordinary general meeting (EGM) information pack circulated to fellows. *RCP London* https://www.rcplondon.ac.uk/news/extraordinary-general-meeting-egm-information-pack-circulated-fellows (2024).
7. Maier, C. B. The role of governance in implementing task-shifting from physicians to nurses in advanced roles in Europe, U.S., Canada, New Zealand and Australia. *Health Policy* **119**, 1627–1635 (2015).
8. Szalados, J. E. Regulation of Provider Practice: State Oversight, Licensing, Credentialing, Peer Review, and the National Practitioner Data Bank. in *The Medical-Legal Aspects of Acute Care Medicine: A Resource for Clinicians, Administrators, and Risk Managers* (ed. Szalados, J. E.) 137–169 (Springer International Publishing, Cham, 2021). doi:10.1007/978-3-030-68570-6_6.
9. Drennan, V. M. *et al.* What is the contribution of physician associates in hospital care in England? A mixed methods, multiple case study. *BMJ Open* **9**, e027012 (2019).
10. Drennan, V. M., Gabe, J., Halter, M., de Lusignan, S. & Levenson, R. Physician associates in primary health care in England: A challenge to professional boundaries? *Soc. Sci. Med.* **181**, 9–16 (2017).
11. Roberts, S., Howarth, S., Millott, H. & Stroud, L. Experience of the impact of physician associates on -postgraduate medical training: A mixed methods -exploratory study. *Clin. Med.* **19**, 4–10 (2019).
12. Ritsema, T. Barriers and Facilitating Factors to the Integration of the First UK-Trained Physician Associates onto Secondary Care Services in the British

National Health Service. *Theses Diss.* (2019).
13. PA and AA regulation. https://www.gmc-uk.org/pa-and-aa-regulation-hub.
14. ATDG_statement_Physician_and_anaesthesia_associates_in_healthcare_191223.pdf.
15. Re: There is a role for physician associates in the NHS. (2024).
16. Kar, P. Partha Kar: Sorting out the mess around medical associate professionals. *BMJ* **383**, p2689 (2023).
17. Impact of Physician Associates on International Medical Graduates. *BAPIO | British Association of Physicians of Indian Origin* https://www.bapio.co.uk/impact-of-physician-associates-on-international-medical-graduates/ (2024).