Physician Associates; Death Row for the Family Doctor

It is clear that doctors in our NHS are increasingly unhappy and the workforce is crumbling from demoralisation and abandonment. This situation has been gestating for many years. Government and planners have hoped to substantially remedy this problem by depressurising doctors by delegating substantially more of their workload to other staff and agencies. This 'substantially more' will, almost certainly be counterproductive.

Here is why.

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Previous delegation – but milder – has a long history in general practice: many decades ago Practice Nurses performed procedures, then responsibilities were widened, with more recent Nurse Practitioners and Health Care Assistants. The most recent expansion of this idea is to turn receptionists and 111 telephone operators into diagnostic 'Triagists': they make the original 'sorting decisions': how serious is the presenting problem? What is the urgency of their need? What sort of practitioner should the patient see?

In the past it was the patient, mostly, who decided these things, and then would usually book to see the GP they knew. Those were the days when personal continuity of care was considered a bedrock of general practice, alongside their widespanned medical knowledge: the former constituted the *art* and ethos of practice, the latter its *science* and procedures. That period was a high point for the

popularity, stability, morale and competent efficiency of general practice.

That culture would be doomed by the successive neoliberal reforms that started in the Thatcher era. Since then, over the last three decades, the NHS has been modelled increasingly on competitive manufacturing industries: this has rendered a service, generally, of more advanced technology and science but of radically degraded continuity of care and thus of art and ethos.

So, these zealous attempts to achieve industrial efficiency have actually achieved the reverse – an exodus and malfunctioning of unhappy doctors who find little work satisfaction in such alienated work … and, inevitably, the destructive fallout for patients.

Hence the current crisis.

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And now we have the most recent salvaging initiative of government and its planners – to train and employ many more Physician Associates (PAs), much lesser and faster trained practitioners than doctors. The idea is that they can be widely employed at low cost to do much of the work of higher paid, slower trained GPs, and thus free up the remaining GPs to concentrate on more complex and 'serious' complaints.

That complexity and seriousness is assessed by the Triagists and PAs, not the GPs. And certainly not the patient. And these Unterdoctors are increasingly unlikely to

have personal familiarity and knowledge of the patient.

There is another seriously distinguishing feature of this PA initiative: unlike the employment of Practice Nurses or Nurse Practitioners, the expanding tranche of PAs are employed not just to help GPs, but significantly to *replace* them.

This is substantially different.

Why?

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Firstly, it disregards a tried-and-tested primary care axiom: that assessing presenting complaints with relative rapidity and a high level of accuracy is a highly nuanced and complex skill; it requires much breadth and depth of knowledge, and – importantly – is even better performed when practitioners are well-acquainted with their patients.

For example, complaints such as headaches, chest pain, backache, abdominal pain, lassitude, loss of appetite, dizziness, lack of energy: these are all extremely common presentations in primary care, yet only a small fraction will be serious. How is this best decided?

The erstwhile family doctors had some great advantages: they were likely to know the nature of the patients, their stories and circumstances. They had (relatively) greater depth and breadth of medical knowledge. And, importantly, they provided

flexible continuity of care, so monitoring and follow-up could be arranged with little bureaucracy or formality.

Contrast that with the likely experience of a PA and their patients who do not have such benefits of more extensive medical or personal knowledge, nor the flexibility to easily watch-and-wait: in their large corporate healthcare conurbations this may be their first and only consultation.

What happens under such deskilled, depersonalised and pressured working conditions? The answer is the practitioners – PAs here – become understandably error-fearful and thus defensive: this is already reflected in the greatly increased rates of investigation, specialist referral, use of urgent ambulances to A&E departments … all of which, of course, cause increased expenses, overload-stresses and breakages elsewhere in the service. As well as frequent patient-anxiety and the inevitable iatrogenesis.

Yes, PAs may seem cheaper than GPs to train and to pay, but these are short-term economies compared with the funds and resources that judicious and experienced GPs can save the NHS when working in smaller, stable teams with good personal continuity of care. An erstwhile aphorism said: *GPs save patients from hospitals and hospitals from patients*.

It is hard to see how this radically pared-down industrial system of PAs can ever perform this so well.

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The second major loss we are likely to see in a PA-weighted primary care service is to the quality of experience of both patients and practitioners. We have noted that before the serial NHS reforms – prior to the 1990s – general practice saw a couple of decades of great popularity, stability and accessibility. This was reciprocated by trust and popularity demonstrated by patients.

Most GPs at that time appreciated and enjoyed both the *variety* of human and technical problems they encountered and how this both generated and depended on *relationships* with those they had care for. They were stimulated by the challenge of discerning between likely minor and major problems: being able to despatch the former with friendly and helpful alacrity, while reserving much slower thoughtfulness for the latter. Those doctors were also nourished themselves, by the affective bonds of trust and resonance that could grow with each encounter with a known patient.

Such was the art, the heart, the spirit, the ethos of erstwhile GPs – 'Family Doctors'. And this was what mostly motivated them.

This *élan vital* is already seriously weakened. It will be almost eliminated by PAs destroying GPs' functions of primary diagnosticians and personal continuity of care doctors. How many GPs will want to work only with patients deemed 'complex' or 'serious' by lesser-trained practitioners in a system which, increasingly, no-one-knows-anyone-but-just-do-as-you're-told-and-follow-the-algorithm?

The result?

GPs will feel more and more like siloed, captive technicians governed by corporate protocols and algorithms. The sense of being at the centre of a community of colleagues within a community of denizens will seem like an unlikely fable. Staff recruitment and retention – already parlous – will ail and fail even more.

These will be the consequences of Physician Associate expanded colonisation.

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So, what to do?

The most straightforward, if limited, countermeasure to this predicament is to redesignate PAs. 'Physician Associate' can easily sound like some kind of unusual or posh doctor, and already many patients have believed that they have seen doctors. A redesignation as 'Medical Assistant' (MA), would largely remove this ambiguity.

And what responsibilities should these MAs have?

Well, for the reasons already considered they should not do frontline diagnostic work. They could perform procedures: biometric measurements and monitoring, wound and surgical dressings, doctor-prescribed blood and urine tests, minor injuries, vaccinations, ear-syringing… All these require particular, more circumscribed skills.

But nurses can be trained to do all these things: why spend our resources and

finances on training and employing yet another cadre of healthcarers?

Why not instead employ nurses and GPs (né family doctors) in conditions where they can work best – in smaller units with colleagues and patients they can get to know, and to care for, and care about?

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