The physician associate will see you now – new role to assist patients in primary care

Case study summary

By 2020 there could be as many as 1,000 physician associates working in primary care, but regulation of the profession is seen as crucial in the development of this new role.

Chris Deane's day starts like any other at the busy Warwickshire practice where he works. First he triages calls from patients, decides those who will need a home visit later in the day, and books others into free slots in his morning or afternoon surgeries.

Like his GP colleagues, he deals with around 60 patients a day, but unlike them he is not a family doctor. Instead, Deane is a qualified physician associate – a new breed of healthcare professional taking pressure off hard-pressed doctors and providing patients, especially those with long-term conditions, the continuity of care they need.

"I have my own patient list, I can diagnose and make referrals and the GPs refer patients to me as I have an interest in paediatrics and mental health," he says. "I do work in a similar way to a GP, but it's important that patients understand we have a different role, we are not doctors."

Deane, now a partner at his practice, was one of the first handful of physician associates to qualify in the UK a decade ago. Today there are approximately 350 practising in both primary and secondary care and another 550 in training, with numbers in training predicted to rise.

Currently, around 20% of graduate physician associates are recruited to roles in primary care. But that is about to change. By 2020, the Department of Health and Health Education England (HEE) – the organisation responsible for NHS workforce training – want to see a total of 1,000 physician associates recruited to primary care roles. This is because of the potential they have to address GP shortages and help deliver the five-year plan for primary care, as outlined in the General Practice Forward View.

Professor Liz Hughes is the director and dean for education and quality for HEE, working across London and the south-east, and co-chairs the HEE board leading on developing the physician associate role and its regulation.

"Physician associates have an increasing role to play in primary care as part of a multi-skilled workforce, alongside pharmacists and advanced nurse practitioners," she says. "They can provide that continuity of care for patients with long-term conditions, which patients value as they don't have to keep retelling their story and where it's important for them to see the same person long-term; often that can be quite difficult for GPs in terms of their time."

Whereas practice nurses traditionally specialise, physician associates are generalists; medically trained across a wide range of conditions. This means they are able to diagnose and treat children, as well as adults, with a range of clinical problems.

The physician associate role developed in the UK is fashioned on the model established in the US around 50 years ago. Today, 100,000 physician associates work in primary and secondary care across the US.

In the UK, physician associates must complete a full-time post graduate diploma, which is offered by 25 universities. Applicants must already have a degree in a life or healthcare science and experience of working in the health service. Programmes must all meet the national standards laid down in the competence and curriculum framework approved by the Faculty of Physician Associates, which is part of the Royal College of Physicians.

The course lasts a minimum of 3,600 hours over two years and is split equally between theory and practice. Students have to complete a minimum of 1,600 hours of clinical training across a range of specialities; community and general medicine, mental health, surgery, obstetrics and gynaecology and paediatric services are standard.

There is no national funding scheme for the physician associate postgraduate diploma but HEE says that is changing. “We are beginning to see innovative funding models emerge because there is now a very significant demand for this work, and people want to attract them,” explains Hughes.

Physician associates, who can expect to start on a £27,000 salary, are currently an unregulated healthcare profession but, once qualified, are strongly encouraged to join the physician associate managed voluntary register. Once on the register they have to complete 50 hours of continuing professional development annually and pass a re-certification examination every six years.

Professional regulation is seen as crucial in the development of this new healthcare role. Currently, physician associates are able to work under supervision of a doctor but are unable to prescribe medicines or refer patients for an x-ray or CT scan. In practice this means physician associates like Deane have to ask a GP colleague to sign a prescription or x-ray referral form on his or her behalf.

Regulation, it is expected, would lead to physician associates being given the power to prescribe – on completion of additional training – as well as bring protection to the title. Jeannie Watkins, a physician associate who, with Deane, was one of the first qualified in the UK, has worked both in primary and secondary care and is now president of the faculty board, says: “Professional regulation is vitally important; it would protect the physician associate title and provide the legal and professional accountability and authority for the standards of behaviour, competence and education that they must meet. This will mean that the public are appropriately protected, and encourage public and professional confidence in the role.”

Deane agrees: “Regulation will make a huge difference, we can then work towards prescribing rights. This will also give us the assurance that all physician associates are working to the same framework, the role is standardised and that the physician associate title is protected.”