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THE CLINICAL TEACHER

Physician associates (PAs) experiencing difficulty

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1 | RATIONALE

A busy general practioner (GP) practice advertise for a physician associate (PA) to join their existing team. They familiarise themselves with the available documentation to prepare themselves for hiring this new professional. Following successful interview and references, a PA joins the practice. They seem pleasant and have ample opportunity to shadow most of the team during their induction. Three months later, they appear to be running consistently late despite 30-minute clinic appointments, leave work late most days and appear stressed. The supervising GPs wonder if there is a mismatch between their expectations of the PA and what the PA feels able to offer. There is no formal support available to the practice, leaving them unclear on how to move forwards.

2 | BACKGROUND

A doctor in difficulty is described by Health Education England (HEE) to be an individual requiring some form of additional support to complete their curricular requirements, or whose progress is causing concern.[1] In the interest of early identification and management of this, their progress is monitored beyond the clinical supervisor, often with local policies on how difficulty should be managed. A PA typically completes a postgraduate diploma or masters level course aligned to the medical model within the PA curriculum, to assess and manage patients within their scope of practice, under the supervision of a physician. They do not have any mandatory exams post-qualification or an educational supervisor to monitor their progress, leaving their clinical supervisor to manage this on top of day-to-day supervision. A rigorous understanding of a junior clinician's trajectory of development is vital for a supervisor. In contrast, the PA role is relatively new in the United Kingdom with experienced PAs being in a minority, leading to potential challenges in benchmarking a PA's competency and earlier identification of difficulty.

As a previous co-supervisor working under the named GP for preceptorship PAs, and a mentor for PAs on a primary care preceptorship scheme since 2018, I have known a handful of PAs to experience significant difficulty. This has contributed to outcomes such as their leaving primary care, exacerbation of mental health issues, burnout, dismissal and, in one instance, leaving the profession altogether. There is no data on how many PAs may experience difficulty in the United Kingdom, nor is there any standardised external support available to the PA or the clinical supervisor, or guidance on this important issue.

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3 | POTENTIAL ORIGINS OF DIFFICULTY

3.1 | Role infancy

Workforce demands and political drivers, such as the UK government's pledge for 1000 PAs in general practice by 2020, led to the rapid expansion of PA courses in the United Kingdom from 5 to 27 in 2017.[2] There were approximately 350 PAs prior to this expansion, concentrated largely in the regions where courses were located, but there will be an estimated 5900 PAs in England by the end of 2023.[3] During this expansion, a study described that PA students from one such newer programme perceived a lack of role familiarity on their placements due to few qualified PAs in their region, with the majority feeling clinical staff did not know what work they should undertake during placement exposure.[4] This lack of understanding was

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reiterated by an undercover documentary on Operose health care in 2022, in which the PAs described being treated by practice staff as if they were GPs.[5] The PA ambassador role was introduced by HEE to enable more experienced PAs to support PAs and supervisors in embedding the PA role successfully,[2] but this is now funded regionally rather than centrally, causing uncertainty about the longevity of this role and anecdotal reduction in numbers.

3.2 | Regulatory postponement

The PA profession appears to be in a state of flux, which has not been helped by regulatory and legislative delays over the last decade causing frustration and disappointment amongst PAs. PAs were formerly known as 'physician assistants', with their title changing in 2014 ahead of regulation.[2] The Faculty of Physician Associates (FPA) remains the PA's current professional membership body in the United Kingdom and sits within the Royal College of Physicians. PAs are encouraged to join the FPA Managed Voluntary Register (MVR), with the General Medical Council (GMC) intending to take on registration as part of professional regulation from the second half of 2024. In order to maintain registration requirements in the United Kingdom, PAs must complete 50 hours of continuing professional development annually and, until earlier this year, were asked to sit a recertification examination every 6 years. The exam will be replaced by a portfolio, which is in development at the time of writing, but anticipated to be launched in October 2023, and will be mandatory for PAs on the MVR. Unfortunately, there may be a cohort of PAs practising without a registration number; therefore, supervisors are encouraged to check their employed PA is on the MVR.[2]

Regulatory and legislative delays over the last decade have caused frustration and disappointment amongst PAs.

In addition to professional requirements evolving in preparation for regulation, there have been changes within the pre-qualification curricula, with the GMC also working with higher education institutions (HEIs) to achieve validation of PA courses. Over the past decade, these curricula transitioned from a Matrix of Core Clinical Conditions and Clinical Competencies Framework into a draft modernised version of the Matrix,[6] which was anecdotally used in conjunction with the former documents. In 2022, the GMC published a pre-qualification education framework amongst other documentation, which acts as the draft curriculum until regulation occurs. These changes are welcome given the intention for 10,000 PAs in the United Kingdom for 2036/2037,[7] but stability in this workforce through earlier regulation should have occurred earlier given its rapid expansion.

3.3 | Supervision burden in primary care and its financial implications

Due to regulatory delays, PAs are currently unable to prescribe medication or request ionising radiation despite the expectation that they are trained on these aspects within their programme. This increases workload for the supervising GP, who also takes responsibility for this decision. Alongside concerns around their requirement for supervision in comparison to other advanced clinical roles,[8] this has caused reticence to employ them in primary care. Financial backing was made available to mitigate this, such as salary reimbursement through the NHS England Additional Roles reimbursement scheme (ARRS)[9] and a £5000 education support payment to fund primary care PAs joining a preceptorship scheme for their first year of practice.[10] However, it seems unlikely that £5000 would enable sufficient backfill for clinical supervision in addition to preceptorship scheme release.

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HEE preceptorship guidance also suggests that the clinical supervisor should perform elements of educational supervision, such as preparing a structured development plan.[10] This will be challenging for the busy clinical supervisor, who is also familiarising themselves with this new professional. Additionally, if utilising ARRS for salary reimbursement, the PA may be required to work across a network of practices due to the funding setup. The oversight of one dedicated supervisor is therefore likely to be diluted, potentially contributing to delayed identification of difficulty. Once recognised, there is no additional financial support for a PA experiencing difficulty.

3.4 | Personal difficulties impacting clinical performance

The Kings Fund research on ARRS funded roles identified the professional isolation that may impact clinicians working across a network of

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GP practices, rather than feeling they 'belong' to a specific team.[11] This lack of belonging was felt to be detrimental to retention and staff well-being, as was not feeling able to contribute to the best of one's ability, which a lack of regulation may feed into. Attachment to a preceptorship scheme could mitigate isolation to some degree through the provision of mentorship and peer support, but this is only resourced for the preceptorship year.

Literature suggests a cohort of PA students from two HEIs lacked clarity around their professional identity, describing the negative impact this could have on a PA in their workplace.[12] Previous literature has also reported higher levels of mental health issues and caring responsibilities for PA students in comparison to undergraduate medical students.[4] This is significant given that medical students themselves have a greater prevalence of mental illness than age-comparable groups in the general population.[13,14] Additionally, the FPA Census indicated that 49% of PA respondents felt they worked under excessive pressure.[15] In conjunction with ongoing social media battles debating the value of PAs in the UK workforce, with an article from the British Medical Association (BMA) describing "resentment and anger from doctors" toward the role,[16] these factors are likely to increase burnout for PAs. The Practitioner Performance Advice Service (formerly National Clinical Advice Service) do not currently extend their services to PAs due to the absence of regulation, so PAs are unable to access centralised support available to other professionals.

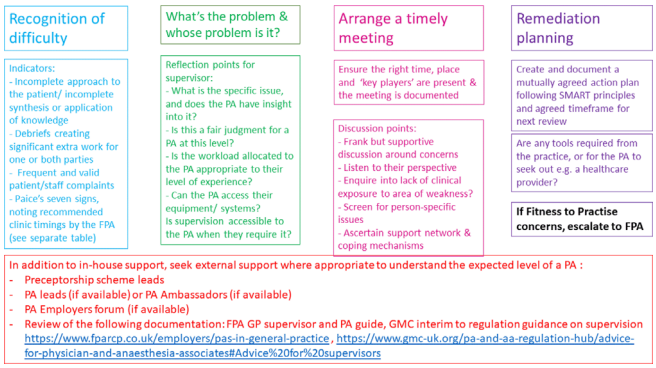
An article from the BMA describes "resentment and anger" toward the role[16] these factors are likely to increase burnout for PAs.

In summary, whilst regulatory processes are pending, and noting the significant growth of this profession in a short time, there are a range of risk factors that could contribute to a PA experiencing difficulty in the workplace, and no standardised resource to address it.

4 | A PROPOSAL TO IDENTIFY AND MANAGE DIFFICULTY IN PRIMARY CARE

Following a review of policies and literature for doctors in difficulty alongside personal observations of this issue in PAs, the diagram below proposes an in-house strategy for the identification and management of a PA experiencing difficulty. A review of guidance for doctors was chosen as they are an established profession with a vast amount of associated literature. These points are not dissimilar to literature for other healthcare professionals, but offers some specific points bespoke to a PA in primary care, given that this cohort may work with a greater degree of autonomy at an earlier level.

A *model for the recognition and management of difficulty in PAs*:



Step 1: Recognition

The clinical supervisor may begin to recognise difficulty through debriefs or other aspects of supervision, and examples of what the clinical supervisor should look for are proposed in the above. Paice's seven signs of a trainee in difficulty[17] provides a helpful summary that is applicable to PAs:

-The 'Disappearing Act
-Low work rate
-'Ward Rage'
-Rigidity
-'Bypass Syndrome'
-Career problems
-Insight failure

For example, a PA who is perceived to be underperforming may not be well-utilised by their colleagues, or patients themselves may 'bypass' the PA and present to another clinician for a second opinion. In terms of Paice's 'low work rate', the FPA recommend primary care preceptorship clinic timings of 10–15 minute appointment slots at the end of Year 1,[18] with Hoskin et al. suggesting 12–15 patients per clinic at this stage.[19] In my experience, a PA experiencing difficulty will likely struggle to reach these targets, although these numbers may vary depending on other factors, such as the nature of the PA's appointments. For example, pre-triaged minor illness appointments are more realistic in 10-minute appointments in comparison to a first presentation of a mental health complaint, but the patient demographic may dictate how much of the latter the PA may see. Leaving late frequently or perceiving oneself to be slower than their peers will

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also require further exploration regarding the PA's scope of practice, and whether they are seeing appropriate complaints for their level of experience. As described below, this may also reflect issues with systems and the supervisor's expectations, rather than the PA themselves.

Step 2: What is the problem and whose problem is it[20]?

Following identification of what the specific problem is, the supervisor should reflect on whether the problem is individual, organisational or both. Steinert's 'teacher/learner/systems' framework for analysis of difficulty[20] reminds us in the case of a PA, the problem could arise from a supervisor's lack of knowledge on this new role. There is available guidance from the FPA[18] and GMC[21] on supervising PAs in primary care as a starting point, but discussion with wider colleagues is valuable. These include, but are not limited to, local preceptorship scheme leads, regional PA leads, PA ambassadors and/or regional employers networking forums, although there is regional variation in resource.

The logistics of practice 'systems' should be considered when difficulty is observed, such as an absence of protected time for PA supervision, or the PA not knowing how to seek advice in a timely manner.[19] Practical considerations such as a lack of equipment, unfamiliarity with the computer system or receptionists feeling unclear on how the PA role may differ to other professionals will undoubtedly cause issues. These could be addressed by a thorough induction programme for both the PA and practice team as per both FPA and GMC guidance.

Step 3: Arranging a meeting

Arranging an early meeting with the PA to discuss and document concerns with a 'warning shot' ahead of this meeting is recommended. Reflecting on whether the PA has any insight into the area(s) of difficulty noted is a helpful starting point prior to then discussing these openly. Noting the potential origins of difficulty discussed previously, there is a need to assess the underlying issue(s), which could include lack of clinical exposure to specific presentations. Person-specific issues could include health (physical, mental, diagnosed and undiagnosed), neurodiversity or learning difficulties (diagnosed or undiagnosed), burnout, cultural/language barriers and home life factors, and these should be sensitively explored.[20,22–24] Ascertaining support networks and coping mechanisms will assist identification of further external support required. Written documentation shared with the PA is likely to be helpful for greater reflection of the matters discussed.

Step 4: Remediation planning

Depending on the exact issue requiring remediation, the tools required are likely to bear similarity to other professional groups, such as case-based discussions, consultation observation and multi-source feedback.[20,22–24] Sharing information sensitively with local preceptorship scheme or PA leads may help to identify external practical support regionally, such as peer support and wider learning opportunities. Following a period of remediation, it could be that progress has been made or they may continue to struggle. Dismissal is unlikely to be desirable by either party, but it could be that the PA thrives in an alternative environment more suited to their skillset or competencies. If there are any concerns about the PA's fitness to practise, this must be escalated to the FPA through this email address: fpaconduct@rcp.ac.uk.

5 | RECOMMENDATIONS WITHIN AND OUTSIDE OF THE WORKPLACE

External resource availability to every employer of PAs, particularly in general practice and regardless of region, is vital. A comprehensive solution could include a central dedicated team of clinically experienced PAs to oversee the development of all newly qualified PAs centrally, akin to the educational supervisor setup for doctors in training. An educational supervisor is likely to be a helpful safety net for the PA whilst familiarity in the profession builds amongst clinical supervisors. Their presence may also aid earlier identification of difficulty through a more rigorous and collaborative supervisory arrangement.

An educational supervisor could also act as a mentor, with routine enquiry about mental health and burnout as part of a structured mentorship process. As this is not unique to PAs, a professional support unit, including services available through Practitioner Performance Advice, would be ideal for supporting underlying causes. Additionally, if the PA moves to an alternative workplace or has faced dismissal, the presence of an educational supervisor is key in supporting and monitoring their progress.

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Mental health difficulties should be explored at HEI level in preparation for practice,[13,14] in addition to embedding professional identity into the PA curriculum. Centralised pastoral initiatives to address these at intervals during a PAs career are likely to aid well-being and retention within this profession, such as peer support initiatives like First5 for GPs. These opportunities should be available throughout the PAs career, as opposed to the current setup of regional and time-limited pockets of funding.

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Mental health difficulties should be explored at HEI level … in addition to embedding professional identity into the PA curriculum.

Within the workplace, adequate financial reimbursement must be made available to more comprehensively resource what is expected from the clinical supervisor's time. In addition to the supervision guidance from the FPA and GMC, there should be peer support between newer employers of PAs and those with more expertise to facilitate a PA's integration into the multidisciplinary team and aid earlier identification of difficulty. The intended mandatory portfolio is welcomed, with protected time for clinical supervisors to review this as part of supervision and appraisal, with clear guidance from the FPA on these portfolio requirements.

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With our current workforce pressures, clinicians are in demand. However, it is paramount that resource is provided for them to be properly supervised and supported, and the delay in regulation has been unhelpful in achieving this. This paper seeks to identify why PAs may experience increased difficulty above other professions, with a proposed model for the clinical supervisor to recognise and address this. Recommendations are given for a more thorough regional approach to aid earlier identification of difficulty and a more comprehensive remediation strategy, but relies on wider investment. As this profession expands, urgent steps must be taken to identify, support and resource PAs experiencing difficulty given the significant consequences for the PA, the strain upon the clinical supervisor and, ultimately, concerns for patient safety.

AUTHOR CONTRIBUTIONS

Ria Agarwal: Conceptualization; writing—original draft; writing—review and editing.

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The authors have no conflict of interest to disclose.

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The authors have no ethical statement to declare.

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