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Physician associates in primary health care in England: A challenge to professional boundaries?

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ABSTRACT

Like other health care systems, the National Health Service (NHS) in England has looked to new staffing configurations faced with medical staff shortages and rising costs. One solution has been to employ physician associates (PAs). PAs are trained in the medical model to assess, diagnose and commence treatment under the supervision of a physician. This paper explores the perceived effects on professional boundaries and relationships of introducing this completely new professional group. It draws on data from a study, completed in 2014, which examined the contribution of PAs working in general practice. Data were gathered at macro, meso and micro levels of the health care system. At the macro and meso level data were from policy documents, interviews with civil servants, senior members of national medical and nursing organisations, as well as regional level NHS managers (n = 25). At the micro level data came from interviews with General Practitioners, nurse practitioners and practice staff (n = 30) as well as observation of clinical and professional meetings. Analysis was both inductive and also framed by the existing theories of a dynamic system of professions. It is argued that professional boundaries become malleable and subject to negotiation at the micro level of service delivery. Stratification within professional groups created differing responses between those working at macro, meso and micro levels of the system; from acceptance to hostility in the face of a new and potentially competing, occupational group. Overarching this state agency was the requirement to underpin legislatively the shifts in jurisdictional boundaries, such as prescribing required for vertical substitution for some of the work of doctors.

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1. Introduction

A new health professional group, physician assistants (PAs), is developing in many countries around the world (Hooker et al., 2007). In the United Kingdom (UK), where they are now known as physician associates (also abbreviated as PAs), this new group has been growing over the past ten years (Ross et al., 2012). They are a type of mid-level or non-physician advanced practitioner (World Health Organisation [WHO] 2008). Given that the UK already has a well-developed panoply of health professions, recognised by the state and employed in the National Health Service (NHS), it raises questions as to how a new professional group fits with other already established professions? What are the work practices the jurisdictional boundaries and the occupational relationships of this new profession in relation to the other established professions? This paper explores these questions from a study of the contribution of physician associates in general practice in England, from which issues of patient outcomes, patient safety and costs have been reported elsewhere (Drennan et al., 2015). Our inquiry, reported here, is framed by theories of dynamic systems of health care professions, which we outline first before describing our methods and presenting our findings.

1.1. Shifting boundaries between health care professions

Middle and high income health care systems are characterised by complex delivery models provided by teams with overlaps in the

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roles of different occupations (Ono et al., 2013). Managers in all health care systems have sought flexibility between occupational groups and the use of subordinate, technical posts to address issues of workforce shortage, cost containment and increase productivity (Buchan and Dal Poz, 2002). However, health professions are part of an inter-dependent system (Abbott, 1988) in which the activities and developments of one occupational group impact on others and are tied up with issues of power, status and control. Accomplishing professional status is a strategy of limiting entry to and defending jurisdictional boundaries supported by state legislation to ensure the highest financial and social rewards; with medicine as the most successful exemplar (Larkin, 1983).

Abbott (1988) suggests that professions are shaped by three types of interaction: contests for jurisdiction between professions (inter-professional), the stratification and creation of hierarchies within a profession (intra-professional) and the influence of societal changes and state agency. He offers a range of possible settlements to jurisdictional disputes between groups. These include: the legal right of only one group to perform certain tasks, the subordination of another group, splitting the jurisdiction into two parts, and advisory control over the tasks of others. He argues that subordination without contest is common below dominant professions and cites physician assistants as one example of a group to have emerged in this way (p 83). Nancarrow and Borthwick (2005) have elaborated on ways to conceptualise shifts in boundaries. They suggest that *intra*-professional jurisdictional shifts can be viewed as either diversification or specialisation. Empirical studies of intra-professional shifts within medicine in the UK, promoted by state policy, while demonstrating specialisation, have demonstrated continued forms of stratification into elite and other groups (McDonald et al., 2009; Martin et al., 2009). Nancarrow and Borthwick (2005) conceptualise *inter*-professional shifts as vertical or horizontal substitution between occupations. Vertical substitution is the substitution by occupations for others above them in a hierarchical pyramid, with attendant acquisition of some of the status or reward of the higher order group. Horizontal shifts are between occupations at the same level within the hierarchical pyramid and consequently do not confer higher status or reward.

Major system level shifts in jurisdiction between established professions are best exemplified by the legislated authorisation of nurses in some countries to prescribe medicines, which has intra country variation, reflecting differences in macro level settlements between the professions of medicine and nursing (Kroezen et al., 2012). Linked with this jurisdictional settlement has been the extent to which advanced nurse practitioner (ANP) roles have developed in primary care (Delamaire and Lafortune, 2010). ANPs are one type of mid-level non-physician clinicians who undertake some of the activities of doctors (World Health Organisation, 2008). At the micro level there have been many studies of attempted changes between the work of doctors and nurses in hospital settings with evidence of enforced, accepted, contested, and negotiated boundaries (see for example Allen, 2001). Within primary care, studies have been reported in Canada, the US and the UK in which GPs were concerned about the jurisdiction of ANPs (Schadewaldt et al., 2013). These concerns included: the extent of ANPs' capabilities, the level of training, the scope of responsibility, the impact on GPs' supervisory workload, inefficiencies in dealing with patient work flow and threats to the employment of doctors. More positive views were reported in studies in which doctors had worked with ANPs (Schadewaldt et al., 2013).

The evidence above is drawn from studies of shifting work roles and jurisdiction between *existing* health care occupations rather than the introduction of a *novel* health care occupational group. The introduction of physician associates within the UK NHS offers the opportunity to investigate the ways in which existing professional groups perceive shifts in work roles, jurisdictional boundaries and relationships when a completely new occupational group is introduced.

Physician assistants, as physician associates were first called, were introduced in the 1960s in the US by physicians in response to primary care medical shortages and uneven access to healthcare (Mittman et al., 2002). PAs were designed to be legally dependent on medicine i.e. a subordinate group (Sadler et al., 1975). A sociologically informed analysis of publications concerning PAs demonstrated the evolutionary processes from a designed programme of education to a PA occupation (Schneller, 1976). Schneller argued that PAs '"*challenged the task, status and prestige of other paramedical personnel*" (1976 p465) and reported confrontation with the nursing profession. Today PAs in the US "provide healthcare services typically performed by a physician, under the supervision of a physician. Conduct complete physicals, provide treatment, and counsel patients. May, in some cases, prescribe medication. Must graduate from an accredited educational program for physician assistants" (The Occupational Information Network, 2015). They have to be registered in the state they work in, each of which has separate regulations and limitations on their prescribing authority (American Academy of Physician Assistants, 2016). Over the last two decades other countries such as Australia, Canada, India, Kenya, the Netherlands, Saudi Arabia, South Africa and the United Kingdom have been introducing and developing PAs in their health care workforce to varying degrees (Hooker et al., 2007). In the UK PAs have been suggested as one solution to workforce shortages in general practice. General practices are small to medium size businesses owned by GP partners who receive NHS contracts to provide primary health care (NHS Employers et al., 2016). Occasionally practice managers, and more rarely nurses, are partners too (The Queen's Nursing Institute, 2016). Partners in the general practice make the decisions about staffing and the division of labour.

Within a wider study of PAs in general practice in England (Drennan et al., 2014) we investigated the question: what are the jurisdictional boundaries and relationships of a newly introduced occupational group into health care services, both at the system and workplace level?

2. Methods

Using a broadly interpretivist approach (Crotty, 1998), a mixed qualitative methodology was used to encompass macro, meso and micro levels of the health care system. Data collection was in overlapping phases to contribute iteratively to the overall analysis. Data were gathered and analysed at the different levels, and then synthesised using the theoretical frame of shifting professional boundaries. .At the macro level, a document and text analysis (Silverman, 2011) informed semi-structured interviews with a purposive sample of key macro and meso level stakeholders (Patton, 2002). This, in turn, informed semi-structured interviews with staff at the micro level of general practice.

The macro level document and text analysis drew on published (electronic or print) UK policies, reports, opinion pieces and response letters from the 1980s to March 2013. They were identified through: journal database searches (reported in Drennan et al., 2014), repeated internet searches using the Google™ search engine, repeated scanning of UK government websites, and follow up of cited sources. Search terms related to the topic of interest e.g. health care workforce. A data extraction form was used systematically to categorise types of evidence, opinion and policy on physician assistants/associates. This was undertaken by two researchers independently and any difference in view resolved through discussion. A narrative synthesis was developed in

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