

Remote consultations for Physician Associates in primary care: qualitative feedback from a regional cohort study

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Abstract

The advent of the COVID-19 pandemic necessitated a dramatic shift in the traditional general practice (GP) model of consultation. General practice was forced to deliver care remotely and this workforce included Physician Associates (PAs), who may not have been previously exposed to remote consultations prior to the pandemic. A qualitative online questionnaire explored how a cohort of primary care PAs in Sheffield adapted to the use of remote consultations, how clinically safe they felt in utilising this method, supervision arrangements in their practices and how they would manage three clinical scenarios. Recommendations are limited by the small sample size, but based upon this feedback we recommend: inclusion of remote consultation as part of the student experience in Higher Educational Institutions (HEIs) that do not currently utilise it; discussion of the PA's previous experience of remote consultation at their induction in order to decide how to most effectively use their skillset whilst they transition into remote consultations, appreciating that they may have a lower threshold to invite patients in for a face-to-face appointment if newly qualified; on-demand supervision for remote consultations where possible; and reinforcement of clinical and pastoral review from the employer to manage the increasing scope of the PA.

Physician Associate (PA) training

Higher Education Institutions (HEIs) follow a central curriculum based upon the Matrix specification of Core Clinical conditions for the Physician Assistant¹ and the Competence and Core Curriculum Framework for the Physician Assistant². The General Medical Council (GMC) announced an agreement to regulate the PA profession in July 2019, and this process will include quality assurance of HEIs delivering PA courses³. Whilst this process is pending, there is likely to be some level of variation between HEIs in regards to exact delivery of their PA course. A PA course is also extremely intensive, as their two year training is based upon the medical model and encompasses clinically focused theoretical learning, and applied learning through placement exposure. On completion of the course they sit a National Exam, which then allows them to practise as a PA on the Managed Voluntary Register.

Physician Associates working in Sheffield

There is an established PA preceptorship scheme⁴ that has been running in Sheffield since the city's first PAs graduated in 2018, supported financially and with staffing by Sheffield Clinical Commissioning Group (CCG). Graduates from the two local HEI's contribute to the PA preceptorship scheme numbers, but the scheme has also attracted a minority of PAs who trained outside of Sheffield. This scheme enables practices to recruit PAs as sole employers rather than as a primary care network (PCN), and the growth of this scheme has since allowed 16 (out of the 78 practices across the city) to benefit from this initiative. Several practices within the scheme have appointed two PAs following successful integration of the first PA, and in one case, four PAs. Regular contact with PAs previously or currently employed as part of this scheme built a picture to the authors of an overnight transition into remote consultation for the majority of these PAs; many of whom informally stated they'd had little formal training or practice in remote consultations prior to the pandemic. The NHS Interim People Plan⁵ estimates that there will be 5,900 PA graduates by the end of 2023. Consequently, the authors felt a need to ensure that these new members of the workforce are working safely and effectively despite the COVID-19 pandemic. While this cohort is small, it has been selected purposefully to manage regional differences between HEI's delivering PA courses, and we hope that our findings will be of interest to HEIs and primary care employers.

Definition of/ background to the 'remote consultation'

In order to reflect current practice in primary care⁶, we define a remote consultation as a method of consulting where the patient is not physically present in the room with the clinician, but a similar amount of information is gathered through telephone or video format to guide diagnosis and management. This remains separate from what we would define as a triage, in which a shorter amount of information is gathered by a clinician to decide the next steps.

Anecdotally telephone consultations and triage were often undertaken by more experienced GPs, who had the benefit of experience and knowing their patient population to make clinical decisions over the phone. While remote consultation has much to recommend it, the way in which it has occurred due to the pandemic left little time for a considered change in the education of those clinicians preparing to enter primary care.

Author 2 is a practising primary care PA of nearly 8 years, and noted the overnight move into remote consultations was challenging for both her and the preceptorship PA at her surgery; both having only assisted with the duty doctor's telephone triage list on an ad-hoc basis prior to the pandemic. Dealing with a higher degree of uncertainty over the telephone in addition to minimising face-to-face contact led to a discussion between the authors around how newer workforce such as the local PA community were adapting. To try and probe this further, one of the authors delivered a case-based session to the preceptorship group in June 2020 on **remote consultations**, which suggested that the more experienced PAs within the group were better able to manage patient cases over a telephone consultation, in comparison to those more newly qualified. In addition to more formally ensuring individuals within the group felt supported and clinically safe, **the authors** wanted to investigate approximately how much primary care experience a PA needed to feel comfortable in managing a patient remotely.

Methodology

A qualitative online questionnaire was sent **in Summer 2020** to 22 primary care PAs working in the Sheffield and Rotherham areas. **The questionnaire invited free text responses to gauge a starting point amongst the group, and enable inclusion of additional themes which are discussed later.** We received 13 anonymised responses from PAs, which was lower than hoped, but likely due to the increased workload during the COVID-19 pandemic. This cohort had varying levels of clinical experience, ranging from less than three months to just over three years. One additional PA with three years of experience was not able to complete the survey but shared some informal feedback with the authors regarding their views on face-to-face appointment usage which is also highlighted in the Results section. **Whilst this cohort has limitations in sample size and representation, by limiting the survey to this group we have ensured some consistency in external variables. All PAs were either currently or historically a formal recipient of the Preceptorship scheme, or voluntarily participated in its support streams; such as the weekly teaching sessions and communal group chat. These results are also limited to the responses written by the PA participants, as opposed to a verbal response in a focus group or other more rigorous qualitative methodology. The authors felt the responses given were sufficient in quickly examining our hypothesis that newly qualified PAs may be less able to manage patients remotely.**

Figure 1: Copy of questionnaire

- *How long have you been working for as a PA in primary care?*

Preparation for remote consultations:

- *Did you have any experience of remote consulting prior to working as a primary care PA; for example, as a PA student or in a previous PA/ other role? If so, please state what your*

experience was (e.g. observing others doing remote consultations or triage, performing a remote consultation or triage) and your approximate length of exposure.

- *When you were a PA student, were you given any advice or exposure to remote consultations? If Yes, please state if this occurred before or after the onset of the COVID 19 pandemic, and whether this was telephone triage or a full remote consultation. How did you feel any exposure then prepared you for practising as a PA?*
- *How were you trained to do remote consultations, if at all? Please be as specific as possible about any training you were given by your employer i.e. length of time, specific training modules. If no training was given, what do you think would have been helpful in retrospect?*

Types of consultation:

- *If you worked in primary care prior to the COVID19 pandemic, have you utilised remote consultations since its onset? If Yes, please describe how this has changed from previously; for example, how much of your time is now telephone/ video compared with face to face? If No, why not?*
- *If you are conducting remote consultations, are there limits on what patients you consult with remotely e.g. minor illness, follow ups.*
- *If you are doing any face to face consulting, since the onset of the pandemic, how do you feel about this? Are other clinicians booking face to face appointments with you? Do you think that these appointments are being utilised clinically appropriately? If you have any risk factors; such as underlying health conditions, please also state this, and whether you think this may impact your views.*

Supervision:

- *If you are conducting remote consultations, do you feel clinically safe? How does your supervisor support or safeguard you? Has your clinical supervision altered in any way since you have moved to remote consultation?*

Three clinical scenarios:

1. *Consider this scenario. A 50 year old asthmatic patient rings up with a 3 day history of productive cough, and slightly increased use of their salbutamol inhaler. They are normally well controlled on their Clenil inhaler 200 mcg BD with no previous hospital admissions. They are speaking in full sentences on the phone and sound clinically well. Would you arrange a face to face appointment, or would you manage this remotely? If remote, how would you specifically manage this patient? If face to face, why would you choose this/ what would you wish to ascertain?*
2. *Consider this scenario. A 60 year old lady rings up with a five day history of dysuria and ache below her umbilicus. She denies haematuria, fever or loin pain, and sounds clinically well on the phone, with no other co-morbidities. Would you arrange a face to face appointment, or would you manage this remotely? If remote, how would you specifically manage this patient? If face to face, why would you choose this/ what would you wish to ascertain?*
3. *Consider this scenario. A 30 year old man rings up with one month history of feeling down and anxious. He denies any suicidal ideation or self- harm. Would you arrange a face to face appointment, or would you manage this remotely? If remote, how would you*

specifically manage this patient? If face to face, why would you choose this/ what would you wish to ascertain?

General views:

- *This is the final question. Is there anything else you would like to say about working in the pandemic as a primary care PA, or regarding remote consultations in general?*

Results

1. How long have you been working for as a PA in primary care?

13 responses

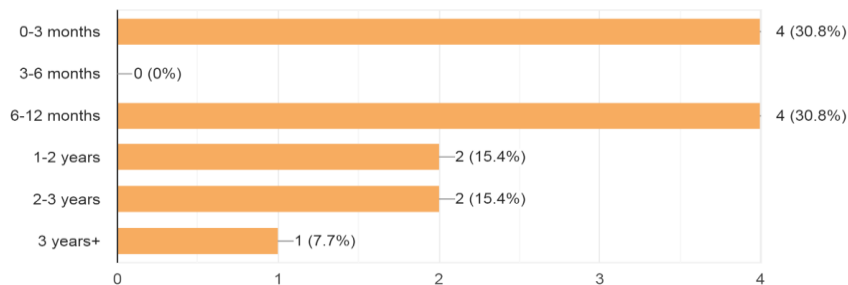


Chart showing length of primary care experience from PA respondents, n= 13. Within Results, respondents anonymised and referred to by durations e.g. A PA with two to three years of primary care experience is referred to as 'a 2-3 years PA'.

Four PAs had qualified since the onset of the COVID-19 pandemic, but due to the postponement of the National Exams from May to September 2020, three of these had their student experience prior to the onset of the pandemic. All PAs who completed the survey performed some form of remote consultation, detailed further below. Due to the postponement of PA National Exams with the onset of COVID-19 there were no 3-6 months PAs, but otherwise there was fairly equal representation across the sample; with four 0-3 months PAs, four 6-12 months PAs, and five 1+ years PAs.

Preparation for remote consultations

Out of thirteen responses, only one PA had primary care remote consultation experience. This was due to them starting their preceptorship at the onset of the pandemic. Consequently they were able to opportunistically observe GPs doing remote consultation as part of their induction for one week. In the remaining twelve responses, two had practical experience of performing remote consultations prior to the pandemic; one for many years in their work as a psychologist prior to their PA training, and the other during their student placement during the pandemic. They felt that prior experience of speaking with patients on the phone was helpful for then starting work in this environment. Another two 1-3 years PAs had prior involvement in telephone triage but not remote consultation. A further two PAs reported observation only of remote consultations and/or telephone triage on student placements. One stated "I think I observed a GP doing triage for maybe a couple of hours at the beginning of the first primary care placement early in the course. It was so little and so long ago that I'm unsure how useful it was."

Following the onset of the pandemic, two PAs were given some form of remote consultation training. For one this consisted of a handout from an established GP Continuing Professional Development company, and for the other, a two hour online module, but both felt these were less meaningful than physical experience of doing remote consultation. The remaining PAs were not

given any specific guidance, with one stating “we were expected to get on with it”. None of the cohort felt prepared to do remote consultations initially, but all stated they felt more able to do remote consultation with experience of this; with one 0-3 months PA describing it took a month for them to feel comfortable in remote consultation, describing a “steep learning curve”.

Types of consultation

All respondents estimated having 60-80% of their clinic now as remote consultation appointments, with a subset of face-to-face appointments following this; bookable either by colleagues or by themselves. All but one PA undertake remote consultations on complaints they would usually have assessed face-to-face, although some discussed being able to select from a communal list. This remaining PA was 0-3 months, stating “I don't really do on the day appointments for patients. I see patients face-to-face for learning disability and severe mental illness reviews then do long term condition reviews over the phone...the doctors mainly do on the day telephone calls...it is very different to what I imagined doing (as a PA student)”

In regards the other 0-3 months PAs, the second described that any face-to-face appointments they booked had to be discussed with a supervisor first, deeming this helpful for their learning. The third 0-3 months PA described sitting with their supervisor for a week sharing telephone calls together and thus observing each other to aid mutual confidence building. They described remote consultation as being anxiety-provoking due to absence of usual cues, but that they were getting used to it with clinical experience accruing. The final PA in this subset described just doing mental health and dermatology patients as remote consultations, but broader use of their face-to-face appointments pre-booked by others.

Supervision

All surveyed PAs felt supported by their supervision arrangement, which was fortunately available on demand for all PAs. A 0-3 months PA went on to say “I feel safe because I know I can talk to someone whenever I need to. Over the phone you can search something online quickly, message someone on the computer or ask the patient if you can call them back...”

Face-to-face consultations

One 0-3 months PA felt unhappy seeing patients booked by other clinicians and felt more prepared speaking to the patient first directly, but other PAs were happy that face-to-face appointments booked by other clinicians were appropriate; some PAs even stating that they appreciated the exposure for their examination skills. Another 0-3 months PA felt face-to-face appointments booked by other clinicians overran as they felt the need to retake the history again. All PAs who saw their own patients following their own remote consultation reported feeling satisfied with this process. Three PAs felt they were seeing face-to-face appointments booked in by other clinicians which could have been dealt with remotely, with one being unhappy they had more face to face appointments than other clinicians. Another stated some of these patients were not appropriately screened for COVID, and at times felt at risk.

Responses to the clinical scenarios

Scenario 1

The 0-3 months PAs suggested bringing in the respiratory patient for a face-to-face COVID assessment appointment (colloquially known as ‘hot hub **assessment**’) or alluded to not feeling totally comfortable managing this scenario remotely. Fuller histories or video consultations were also suggested by this cohort and some 6-12 months PAs suggested use of investigations such as

sputum culture and peak flow. Despite this, those with more than 6 months experience were otherwise happy to manage the patient remotely with antibiotics +/- oral steroids.

Scenario 2

All but one of the 0-3 months PAs and half of the 6-12 months PAs wanted a urinalysis first before treating, with another 0-3 months PA requesting a renal function check too. The remaining PAs felt comfortable with remote management via antibiotics, with all PAs beyond 12 months **experience** not requesting urine samples prior to treatment. Of note in this example, the PA that had primary care placement experience during the pandemic did manage the patient in the same way as the 12 months+ cohort.

Scenario 3

All **PAs** were happy to manage this patient remotely with antidepressants and psychological therapy choices based upon the exact history. **However** one 0-3 months PA suggested requesting blood tests prior to treatment, and another 0-3 months PA suggested they would see the patient **in personal protective equipment (PPE)** to encourage rapport building if this was requested by the patient. Other PAs suggested video consultation for this purpose.

Discussion

Based on the submissions from this cohort, PAs generally lacked experience of remote consultation prior to working in their practices, yet this cohort moved into this way of working at the onset of the COVID-19 pandemic. Based on the response, the feeling was that practical exposure to remote consultation **was** superior to any online learning or written advice that was provided. Three out of the four 0-3 months PAs were sheltered in varying degrees from 'on the day' remote consultations. Interestingly this appears to be reinforced by the survey responses which demonstrated that the 0-3 months PAs did have a lower threshold for wanting face-to-face assessments **or investigations** than those with more primary care experience. Small sample size **and the selection of cases provided** limits any generalisations that can be made, but our findings point to the fact that newly qualified PAs are likely to be inexperienced decision makers. Unnecessary face-to-face consultations may also risk exposing patients, their families, clinicians and practice staff to harm.

There is a lack of definitive guidance with respect to what patient complaints **are** deemed unsuitable for remote consultation⁷. **This** is likely to be the case for some time due to variation in clinician judgment and the complexity affecting such decision making. **A range of factors were identified by Greenhalgh et al. in use of remote consultation in primary care. These include, but are not limited to: patient group factors, the reason for consulting, the clinical relationship with the patient, and practice ethos⁸. It was interesting to note that most PAs were happy to manage the mental health scenario remotely, regardless of their experience level. This may be due to an increased number of clinical clues being available remotely, with the option to obtain further clues in a video consultation where required. Given this data and the authors' experience, a stepped approach to telephone consultation for 0-3 months PAs seems an appropriate safeguard as their confidence builds, especially if they have minimal student experience of performing remote consultation. As remote consultation is likely to be a feature of general practice in the future, guidance on how to ensure students from all HEIs receive consistent exposure to this method would be welcomed.**

Previous work has established these new entrants to the primary care workforce have a great contribution to make in supporting access and fulfilling patient demand⁹. **We were delighted that all of the PAs who responded to the survey felt supported by their employers. The comment regarding on-demand supervision being helpful has been supported by more recent feedback from two PAs on the scheme who have since identified a lack of on-demand supervision making timekeeping difficult.**

Consequently we would recommend on-demand supervision through a senior colleague at the practice, but we recognise this must be balanced against resource and time constraints of the employer.

It was concerning that some additional comments made in the survey suggested that a minority of this cohort's motivation to remain in general practice have been impacted by the change to remote consultation and/or the stress of the current environment, although none have suggested an alternative work environment/ role that they would pursue, and at the time of writing all remain in primary care. Some of these views may have been impacted by general dissatisfaction; such as the example given of the PA with more face-to-face appointments than their colleagues, alongside other anecdotal issues such as limitations in salary or clinical progression.¹⁰

Recommendations for practice

Whilst not all PAs will work in primary care upon qualification, remote consultation is an increasing feature in some secondary care specialities, and a unique aspect of the PA role is their ability to move between primary and secondary care. There may be a transitional period in which PAs will need to gain exposure and confidence in remote consultations. Previous research on clinical supervision of primary care PAs recommended a formal induction period to enable the PA to become embedded in the practice's ethos¹¹. Following the onset of the pandemic, a further recommendation within this Induction period would also be to ascertain how familiar the PA is with remote consultations, and discussion of strategies to support the PA in this if required. Some strategies included by the practices employing PAs in this study were: an observational period with a supervisor; shared telephone consultation lists allowing observation of the PA; or a stepped approach to telephone consultation commencing with a few areas with which the PA felt confident and competent, and where more clinical clues were available. As clinical experience develops, the list of appropriate consultations should then expand where safe to do so, and this could be discussed at periodic supervisor reviews. During these reviews, the PA's clinical progression could also be explored, for example; would they be happier with more face- to-face appointments to increase their confidence in certain complaints¹², or would they prefer more autonomy to book their own face-to-face appointments.

Periodic pastoral care in PA supervision is likely to be of utmost importance during the pandemic to ensure the safety and continued progression of this workforce member. Such mentoring should also be malleable to match the growing confidence of the PA and decisions should be collaborative. Adopting this approach not only allows workload to be adjusted appropriately, but can help with early recognition of problems or issues that might affect the retention of PAs in primary care.

Future work

Where the PA has access to a preceptorship scheme, focused sessions may also help build confidence in this area, although differences in opinion are likely to reflect the approach of their employing practice. Further discussion within practice regarding agreement of clinical thresholds to bring patients in for face-to-face assessment may be beneficial for all clinicians to engage in to ensure consistency at practice level.

Based upon our findings we have recommended that trainees should be encouraged to embrace remote consultation in preparation for their future working environment. A larger study would be needed to make any formal recommendations around this, so at this stage we simply wish to raise awareness of the realities of working as a PA in primary care. Where this is not already being utilised, HEIs could support this process through formally introducing the concept of remote

consultation into curricula, shared remote consultations in placements, and use of simulated patients within a remote classroom environment.

A limitation from this research is the absence of any 3-6 months PAs, which in this case has allowed us to clearly distinguish 0-3 months PAs from the PAs with more than six months of experience. It would be interesting to note how attitude to remote consultation changes throughout through the first year of practice in a larger group. A larger thematic analysis would have stronger validity in future work, but we feel this data provides a starting point in clinical literature around this topic.

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