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Viewpoint: A Proposed role for physicians associates (PAS) in palliative care

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Viewpoint: A proposed role for Physician Associates (PAs) in palliative care

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Abstract:

GPs and primary healthcare teams have a key role in the delivery of end-of-life care in the community, much of which requires a generalist approach, supported by hospice and specialist palliative care colleagues. Consequently the role of primary care in the delivery of end-of-life care in the community is integral, but can be overlooked in policy and service development, including in pandemic planning for primary care. Owing to the diminishing workforce and a need to look at alternative solutions to address this, Physician Associates (PAs) are a relatively new member of the medical team in the UK. They assess and manage patients in the medical model, with supervision from senior colleagues when they initially qualify, but as they grow in skills and experience this can be provided as required. PA numbers are expanding across primary and secondary care in both generalist and specialist settings, especially due to additional roles reimbursement and funded preceptorship schemes. As PAs grow in clinical experience as permanent team members, could they become more involved in a multi-disciplinary team approach to end-of-life care? There are examples of PAs working in palliative care services overseas, particularly in the USA due to the vast PA numbers there, but little research has been published on the efficacy of this, and there are no known examples in the UK.

Main piece:

Primary care is changing at an unprecedented pace and the COVID19 pandemic has shown how being adaptable is vital to the future of general practice. Collaboration at RCGP SYNT (South Yorkshire North Trent) is leading to new perspectives on our shared future, an example of which is discussed here:

As a primary care PA for seven years my depth of practice has increased, and I have come to know the patients at my surgery well. I recall one particular patient who came into my clinic regarding acute onset of jaundice. Following a 2 week wait referral, MRI showed terminal pancreatic cancer. Despite being palliative, as we had a good rapport he requested my input rather than my GP colleagues for his acute issues. Due to my lack of knowledge of palliative care needs at the time, I discussed this with a GP and we decided to 'co-manage' him together, until he passed away. I have since done some work into learning more about palliative care, which has also enhanced my own awareness of acute complications in palliative patients. (perspective from Ria Agarwal- Physician Associate)

Prior to the pandemic, GPs described a range of barriers to the effective provision of end-of-life care in the community including a lack of time with patients, limited social care and practical support in the community. The need for more education and training for primary care staff and more access to community nursing and specialist palliative care services was described[1]. Given the increased need for end-of-life care in the community during COVID19, and the pressures already on an overstretched primary healthcare team, there is an urgent need to consider all options for the future delivery of this care.

Physician Associates (PAs) are a relatively new healthcare professional; a science graduate trained within the medical model, who post-qualification will go on to work as a generalist clinician in a generalist or specialist setting. It is estimated by the end of 2020 that there will be around 2800 PAs in the UK[2]. PAs undertake clinical duties including, but not limited to, taking histories, examining patients, diagnosis, requesting and interpreting investigations and developing management plans with knowledge to prescribe. Whilst this is under supervision from a doctor, as their clinical experience grows, the need for supervision reduces. The Faculty of Physician Associates 2018 census[3] showed that around 28% of PAs in 2018 were working in primary care, and this percentage is likely to have significantly increased by 2020 due to the increase in Higher Education Institutions training PAs between 2018-2020, and the political push to see 1000 PAs in primary care by 2020.

PAs are permanent members of the primary care team, and as experience grows at their surgery may be well placed to provide continuity of care for patients. For example they could be the first port of call for acute medical issues, passing complex issues outside of their scope of practice to a GP. They are slightly less time and workload- constrained than doctors, so have the potential to offer listening and holistic support to patients and families, in addition to liaising with palliative or social services. Additionally, as the entry criteria to the majority of PA programs include a pre-requisite of some form of clinical experience prior to embarking on the two-year PA course, they tend to attract mature individuals with some life experience compared to traditional undergraduate medical courses. PAs may have had experience of dealing with bereavement on a personal or professional level, which may better equip them for dealing with this emotionally demanding area of medicine.

Additionally some PAs are keen to progress further clinically but reach the ‘peak’ of their specialty within just a few years, causing them to leave their specialty or the profession altogether. Whilst it can be invaluable to employ a PA in one specialty with previous knowledge of another, opportunities for development of a special interest would be welcomed by PAs. Some PAs are already in dual clinical roles following some years of experience in one role, such as general practice combined with a secondary care specialty, or teaching.

There could be potential for PAs to expand the multi-disciplinary team and work across the interface between primary and secondary care, as seen in established PA roles in the USA[4]. As the need for end-of-life care in the community grows, and with the new challenges that have arisen through the pandemic, extending the skillset of a PA into the holistic realms of end-of-life care, where patient relationships are a priority, could be hugely valuable.

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