Leading the integration of Physician Associates into the UK health workforce

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Keywords: Physician associate, interprofessional practice, collaborative practice, teamworking, collaborative leadership, healthcare leadership

Abstract

The introduction of Physician Associates (PAs) into the UK health workforce is one of the most significant examples of disruptive innovation in many years, and lessons can be learned from research into the introduction of advanced nurse practitioners (ANPs). Positive, forward-looking healthcare leadership is required at all levels to ensure the success of introducing the PA workforce in the UK.

This review found that organisational culture had an enormous impact on the introduction of ANPs and likewise will affect the introduction of PAs. The most effective strategies facilitated interprofessional, collaborative, collective and inclusive leadership and promoted high staff engagement, the development of proficient interprofessional practitioners, and a clear vision for collaborative practice. In terms of PAs, such an approach will improve interprofessional and collaborative practice and create the supportive, motivated environment needed to facilitate the introduction of PAs.

Key messages

- Organisational culture, which is primarily influenced by leadership, had an enormous impact on the introduction of ANPs and likewise will affect the introduction of PAs.

- Leaders must provide clarity on the role, purpose, scope of autonomy, supervision and responsibility of PAs; and offer education, training and induction specific to the speciality or role.
- Knowledge of interprofessional and collaborative practice, and enacting the shared leadership necessary to achieve these closely-related ideals, will help to facilitate the introduction of PAs and help create a culture of acceptance within teams and organisations for the role of PAs

Introduction

The UK government has committed to increasing the number of Physicians Associates (PAs) as it attempts to grow the NHS workforce to deal with rising demands on the National Health Service (NHS) (BMA, 2016). This represents one of the most significant changes to the structure of the multidisciplinary team since the introduction of advanced nurse practitioners (ANPs). This article, one in a series on the topic of PAs, focuses on the leadership approaches required at a team and organisational level to make the introduction of the PA role in the UK a success. The potential barriers to their introduction, collated from the literature and through discussions with healthcare professionals in the hospital setting, are discussed in terms of highlighting solutions needed to overcome them.

Box 1: Defining the Physician Associate role.

"a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision"

(Department of Health, 2012 cited BMA, 2016 p.2).

History, tradition and culture

History, tradition, and culture are perhaps the biggest barriers to the introduction of new professional roles in healthcare. Culture is said to "constrain, stabilises, and provides structure and meaning to the group members" (Schein, 2004 p.1) and underpins how staff behave and react to the introduction of new or extended scope of healthcare professionals.

The role and profession of a doctor is well-defined and doctors have a strong sense of identity, shored up by shared assumptions in the industry and by the public of their skills and responsibilities and their role in healthcare. Over time, other distinct healthcare roles have

developed (e.g. nursing, midwifery, physiotherapy, occupational therapy, speech and language therapy) and become professionalised. These are now well-established members of the multidisciplinary team and have distinct identities and scopes of practice. Healthcare is traditionally very hierarchical and, to date, most of these new professional roles have not challenged the traditional identity of the doctor. This is exemplified by the commonly used term 'allied healthcare professionals', suggesting that such roles are 'allied' to doctors, rather than being professionals in their own right. Over the last two decades, qualified healthcare professionals have been increasingly encouraged (supported by regulation) to extend their scope of practice so as to improve healthcare to wider groups of patients. However, this is not unproblematic. For example, the successful introduction of ANPs was shown to be highly dependent on a positive culture and the initial response from their colleagues (Lloyd-Jones, 2005).

Changing the culture at a team, organisational and system level is therefore arguably the most important potential step towards improved interprofessional and collaborative working, with leadership being the single most influential factor in achieving this (Anonson, 2009; Schneider & Barbara, 2014; NHS Improvement, 2016).

In most healthcare teams, clinical leadership falls to the doctor (GP or consultant) with whom ultimate decision-making, accountability, and responsibility lies. As was observed with ANPs, if PAs are to be fully integrated into the workforce and team, doctors in leadership roles need to promote the benefits of PAs (Imison et al., 2016).

However, these medical leaders need to be able to put aside the assumptions of the culture they trained with, including being receptive to integrating new types of healthcare professionals into the traditional hierarchical nurse-doctor model. Currently, clinical teams are inclined towards medical hegemony, with the descending grades of junior doctors being seen as the next level of decision maker beneath the consultant/GP. For example, in secondary care, consultants direct 76% of their questions to junior doctors on ward rounds (Coombs and Ersser, 2004).

Breaking down these traditional hierarchical structures and models of working and shifting the culture towards a more interprofessional and collaborative working style is therefore a priority. Senior doctors must not only realise it themselves but also help multidisciplinary team members to appreciate how and why their assumptions about the composition of the team must change, in order to adapt the culture to allow the introduction of new roles and embody a patient-centred, flat-structured, interprofessional, and collaborative service (Schein, 2010).

Leading disruptive innovation

The Christensen Institute (2013) describes the benefits of disruption, helping to improve accessibility and affordability, and how, ideally, the product should be integrated around the job to be done.

Whilst the introduction of PAs aims to bolster the frontline workforce and make the health service more accessible and affordable, it can also be seen as disruptive innovation. This shift challenges the traditional identity and role of a doctor and other healthcare professionals, and also the identity and culture of the multidisciplinary team (BMA, 2016). We would suggest however that the introduction of PAs needs to be thought of as a sustainable innovation, as the integration of new and extended healthcare roles will help provide more sustainable health and social care than traditional models. Appreciating how to facilitate such innovations will help healthcare leaders face this challenge and successfully embed PAs into healthcare teams.

However, this raises a number of professional and educational issues, both locally and nationally, which need addressing in order to ensure PAs are integrated around the job to be done. In an effort to achieve this, The Faculty of Physician Associates (FPA), part of the Royal College of Physicians, has recently produced guidance for employers on many of these issues (FPA, 2017). This guidance centres around four key issues.

(1) Role Clarity: Clarity needs to be provided to the PAs themselves, the multidisciplinary team, and to the public. Leaders need to be aware of the competencies and curriculum of PAs with strong leadership required when introducing them into a team (Imison et al., 2016); particularly to help identify their "objectives, scope of practice, individual responsibilities, and anticipated outcomes" (Lloyd-Jones, 2005). Without this, as was seen during the introduction of ANPs, there was a challenge as to whether they belonged under a nursing, medical or even a hybrid structure, which was harmful and inhibited their collaboration (Andregård & Jangland, 2015). Providing a clear role, purpose, and defined scope of autonomy will also help to motivate PAs and aid the general public's understanding as it is perhaps them, with their traditional view of the identity of a doctor, more than anyone, to which these messages need to be conveyed most strongly (Herzberg, 2003; De Zulueta, 2015).

(2) Regulation: Due to hard work by the FPA, PAs are just about to become regulated (FPA, 2017). The lack of professional regulation to date has exacerbated uncertainty regarding the role and has precipitated resistance against them, as was the case with the initial introduction of ANPs (Lloyd-Jones, 2005).

(3) Supervision, education and training: There are understandable concerns regarding PAs' supervision, ongoing education and training. Bespoke processes and

opportunities, tailored specifically for the specialty and role in which PAs will be working, as well as a suitable mentor, will likely best prepare them (Lloyd-Jones, 2005; FPA, 2017). Their continuing professional development, supervision, appraisal, feedback and performance measurement must be carefully considered, planned, and enacted (Lloyd-Jones, 2005). Peer support networks may also be helpful for PAs, as they have been shown to be beneficial for ANPs (Lloyd-Jones, 2005), particularly in harnessing connectivity as a source of intrinsic motivation (Herzberg, 2003; De Zulueta, 2015).

(4) Previous experience: Evidence shows that the behaviour of doctors and nurses in response to new professional roles can be extremely empowering but also extremely detrimental (Lloyd-Jones, 2005) and this can be heavily influenced by past experiences (Vijavaraghavan & O'Donnell, 2011). The support of doctors was incredibly important to ANPs (Lloyd-Jones, 2005) and this will be as true for PAs as it was for them. When ANPs were introduced there was concern that they would limit the training opportunities of junior doctors (Andregård & Jangland, 2015) and while this caused tension initially, trust, acceptance, and collaboration soon developed (Andregård & Jangland, 2015). As we have seen with ANPs, PAs will hopefully be seen as a source of continuity within a department, who can use their knowledge to help rotating junior doctors find their feet (Andregård & Jangland, 2015), and will quickly come to be seen by the multidisciplinary team as having a crucial role. To ensure the smooth induction of PAs and safeguard the route in for other new professions in the future careful leadership and education will be required to remind younger professionals of these similarities and our lessons learnt from the past.

Interprofessional practice

Interprofessional practice "refers to a set of competent professionals from various disciplines achieving effective, patient-centred outcomes through collaborative and cooperative teamwork" (Anonson 2009, p.18).

The challenge of introducing PAs into the multidisciplinary team provides opportunities for leaders to analyse and improve interprofessional practice, improve patient outcomes and augment individual contributions to the team (Anonson, 2009). However, to achieve 'buy-in' for this vision, strong leadership will be required to develop the interprofessional competencies of their teams (Box 2) and nurture high levels of staff engagement by providing a nurturing and positive climate; recognising contributions; providing constructive feedback; supporting innovation; trusting others; and fostering openness, transparency, and candour (West, 2014a).

Box 2: Six competencies of the interprofessional practitioner:

1.Communication
2.Knowledge of one's own profession
3.Knowledge of others' professions
3.Teamwork
4.Leadership
5.Negotiation for conflict resolution

(Ferguson, 2008).

A perceived lack of competence of any stakeholder erodes trust and respect amongst other stakeholders (Anonson, 2009). This commonly stems from the individual lacking knowledge of the competencies and roles of others or from poor interpersonal competencies such as good communication, respect of others, collaborative decision making, teamwork, conflict resolution, flexibility, accountability, and good coping mechanisms (Anonson, 2009).

Effective interprofessional leaders must therefore encourage open, honest and reflective feedback, and demonstrate Anonson's six traits of an effective interprofessional leader: optimism and vision; morality; crisis and conflict resolution; the ability to develop a personal connection with team members; facilitate professional growth and empower team members; and actively communicate and participate in teamwork (Anonson, 2009).

Collaborative practice

Interprofessional practice becomes collaboration when there is a shared purpose, integration of ideas, and interdependence amongst stakeholders (Makaram, 1995; Orchard, 2005; VanVactor, 2012; Schreiman, 2014).

Whilst effective collaborative practice takes time to develop and requires mutual trust, respect and commitment, the benefits are clear. Improvements in patient care (satisfaction, acceptance, and outcomes – including complications, mortality and length of stay) are observed, alongside reductions in clinical errors, staff injuries, harassment, bullying, absenteeism, turnover and service costs (World Health Organization, 2007; West 2015). Furthermore, it strengthens social networks, develops a trusting environment, and increases the diversity, skill mix, creativity, innovation, empowerment, and job-satisfaction within teams (VanVactor, 2012).

To develop and promote collaborate practice, 'The Center for Creative Leadership', and 'The King's Fund' stress the following three conditions that leaders should strive to develop in their team (Browning 2011; West 2014a; West 2015):

- direction (agreement on the mission, vision, and values)
- alignment (co-ordinating the collective's outputs)
- commitment (responsibility, selflessness, and seeing the bigger picture)

VanVactor (2012) also outlines the importance of authenticity and how leaders should behave in line with the values that they are trying to develop in their team.

Shared leadership

The current drive for collective and inclusive leadership (West, 2014a; NHS Improvement, 2016; West, 2017) draws much from interprofessional leadership theory, where the flat, situational, relational, and shared leader-follower model (as opposed to the traditional hierarchical model) is the core theme (Anonson, 2009).

Shared, inclusive and collective leadership approaches are deemed most effective in today's increasingly complex healthcare environment as it is unlikely that an individual can hold all of the skills necessary to solve adaptive challenges (Heifetz, 1994; Academy of Medical Royal Colleges, 2010). These approaches are also associated with improved team performance (West, 2014a). Interprofessional practice requires each team member to be able to step up to lead (individually or collectively) when appropriate depending on the needs of the task at hand: always to achieve the best outcome for the patient (Anonson, 2009; Browning, 2011). Importantly, they must also know when to step down and pass the leadership baton onto others (Anonson, 2009). Leadership must develop and encourage this practice.

Nevertheless, Reeves et al. (2010) describe how "the need for a clear leadership role has been found to be central to effective interprofessional collaboration and teamwork". Traditionally, this has been the doctor, usually a consultant. However, the Center for Creative Leadership argue that true leadership is commonly "independent of formal roles and responsibilities" (Browning, 2011). Other respected team members viewed as either "extremely competent clinicians or as extremely creative problem solvers" may therefore at times be considered best in the leadership role despite falling outside of the traditional formal, hierarchical positions (Orchard et al. 2005)

The key challenge is for leadership (whatever form it takes) to be hands-on enough to facilitate collaboration but, at the same time, hands-off enough to promote shared leadership. Giving the team this freedom requires a significant amount of trust and the balance of leadership between team members will change as time goes on, as the team moves through its stages of development, and as individuals develop their leadership capabilities (Anonson, 2009). In order to integrate PAs into the team and enable them to take on leadership roles, leaders will have to work hard and pay attention to nurturing the needs and abilities of the multi-professional team members. Leadership in this setting may

therefore be viewed as stewardship (Anonson, 2009): guiding and developing the team based on a shared vision for collaborative practice, but also providing oversight, support, accountability, and ultimate responsibility.

Conclusion

Leadership is the single most influential factor determining the culture of teams and organisations and will play a crucial role in whether and how PAs are successfully integrated into the UK's healthcare workforce. Clinical leaders and managers must consider how to facilitate this, the most significant example of a potentially disruptive innovation in the healthcare workforce for many years. Consideration of lessons learned from the literature analysing the introduction of nurse practitioners will be crucial in this endeavour. Whilst such innovations can be a positive force, system-level support is needed which flows down to organisational and team-level leadership to achieve buy-in from consultants, management, and the rest of the interprofessional team.

Knowledge of interprofessional and collaborative practice, and the leadership necessary to achieve these closely-related ways of working, will not only help to facilitate the introduction of PAs through the creation of supportive and motivated environments, but also allow leaders to improve how their teams function for better patient care. Leaders will also require development and opportunities to develop appropriate inclusive, collective and shared capabilities in themselves and their team so as to utilise the introduction of PAs to improve patient care and health outcomes.

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