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The role of physician associates in the NHS

A lesson in how not to do workforce reform

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Over recent months, a fierce and sometimes toxic debate has been taking place in the UK about the introduction of physician associates and anaesthetic associates as a new group of regulated health professionals working alongside doctors, nurses, and other health professions.[1] However, with many physician associate training programmes already well established in universities for more than a decade, with the regulation of this staff group by the General Medical Council having already started in December 2024, and with more than 3250 people having undergone training in good faith and now in physician associate or anaesthetic associate roles in the NHS, it seems rather late in the day for Royal Colleges,[2] the British Medical Association,[3] and other stakeholders to be raising fundamental concerns.

The government has asked Dr Gillian Leng to lead a review of physician associates (and anaesthetic associates) in England that will report later this year. It is focused on the safety of the roles, team working, and the delivery of high quality and efficient patient care.[4] Its brief excludes consideration of the training curriculums, how and by whom they are regulated, future workforce projections, and pay levels. A linked rapid review paper (doi:10.1136/bmj-2025-084613) aimed at the Leng review examines the evidence base on the safety and effectiveness of physician associate and anaesthetic associate practice in the UK and finds it seriously wanting,[5] although it does not review the larger evidence base on similar roles internationally.

So how did we end up in this mess, and what should we do about it? Firstly, we have massively underinvested in research on the healthcare workforce for many years. Many unmet research needs to inform policy and practice exist, of which physician associates/anaesthetic associates are just one example.[6] We should have a large standing NHS research and development programme aimed at providing the evidence for workforce reforms such as role redesign, new and changed roles, and so on.[7] No new medical intervention would enter mainstream clinical practice on the basis of the scanty, small scale, and underpowered studies we have on physician associates and anaesthetic associates in the UK. We need much larger and more methodologically robust studies, with more effective evidence synthesis. The National Institute for Health and Care Excellence (NICE) is the obvious national body to provide some leadership in the development of clear, research based guidance on workforce reforms, but since its controversial work on staffing levels a decade ago[8 9] it has largely steered clear of guidance on workforce matters—this needs to change.

Secondly, NHS workforce planning has been for some time prone to vague aspirations and largely uncosted future plans for workforce expansion.[10 11] Initiatives to promote new or changed roles (for example, in general practice or extended roles for nurses) have been long on rhetoric but short of clarity on what those roles actually are in terms of scope of practice, supervision and authority, legal responsibility, and their place in the wider clinical team. As a result, their implementation has often been bedevilled by ambiguity and confusion about what they were intended to achieve and what actually happened in practice.[12]

Thirdly, the statutory arrangements for regulating the health professions—with nine separate regulatory bodies and a complex web of legislation that has grown piecemeal over the past 150 years—are simply not fit for purpose. The Law Commission produced sensible proposals (and a draft bill) for a wholly new single regulatory legislative framework in 2014,[13] but successive governments have failed to enact them. In the UK, we regulate by title (controlling, for example, who can call themselves a doctor, a registered nurse, or a physiotherapist) but we largely do not define explicitly the scope of practice of health professionals—what they can and cannot do, and in what circumstances. This makes introducing new roles such as physician associates and anaesthetic associates much more difficult, as no clear statement of their scope of practice from the regulator exists.[14] Often, this is left to employers to determine, which leads to many inconsistencies and variations in practice. Physician associates have been working in the NHS for two decades and should have been properly regulated long ago.

It seems likely that a messy compromise will be found to resolve the debacle over physician associates and anaesthetic associates, setting out a clearer and more limited scope of practice that, for example, constrains what patients they can see, how they are supervised, and what actions they can take. The prospects for extending their role (for example, into prescribing drugs, ordering and interpreting blood tests and imaging, or undertaking some surgical procedures) now seem remote. Practically, as physician associates and anaesthetic associates have been graded at NHS band 7 (the same level as much more clinically experienced advanced nurse practitioners, and a higher salary than an FY1 doctor), the economic case for expanding their numbers may not now add up.

We need to do these kinds of workforce reforms much better in the future—both for the safety of patients and for the wellbeing of staff. A new research and development programme from the National Institute for Health and Care Research focused on the workforce, an explicit role for NICE in institutionalising evidence in formal workforce

guidance, and comprehensive reform to the regulation of health professions would be a good start.

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