Physician associates: A solution for health care staff shortages or a colonial throwback?

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Credit: AI-generated image (disclaimer)

Before the COVID pandemic, the global health workforce needed as many as 6.4 million more medical doctors, and the gap between demand for health workers and supply is growing. As you might expect, the shortage is most acutely felt in low- and middle-income countries.

The latest World Health Organization (WHO) statistics show that 30 countries have fewer than two doctors for every 10,000 people. Twenty-seven of these are in Africa, while the remaining three are Pacific Island nations.

Wealthier countries are notorious for plugging gaps in their health workforce by recruiting overseas doctors and nurses. "Medical brain drain" is a complex phenomenon, driven by more than money. Yet some commentators consider it yet another instance of the west "looting" human capital from Africa and other formerly colonized regions.

In England, the government has chosen to address the health worker shortage by investing in new roles. One role that will be significantly expanded is that of "physician associate." These medics work in GP surgeries and in hospitals.

Not quite doctors

A physician associate is someone trained to a standard below that of a doctor. Though a recent title and qualification in the UK, the concept of a physician associate is not new. There is plenty of historical data about the use of medical assistants or auxiliaries to run health services on the cheap.

Much of the historical evidence about the benefits and pitfalls of "not quite" doctors comes from world regions most affected by health worker shortages today.

When European colonial powers decided to offer health services to colonized populations, especially in rural areas, they could not recruit nearly enough European doctors. Instead of improving employment conditions or expanding education for local people, colonial states opted to create subprofessional medical schools and qualifications.

They were known as "African" doctors in Senegal. Assistant medical officers in Sudan. So-called "native" medical auxiliaries in Algeria, Cameroon, Congo, Madagascar, Tanzania, Uganda and Zambia. The list goes on.

Colonial states typically restricted recruitment into subordinate medical roles to racialized men. Training varied, but usually offered an abridged university curriculum oriented towards infectious diseases (especially diseases stigmatized as "native" or "tropical," like syphilis), manual tasks and administrative skills.

Locally trained medical assistants often became linchpins of colonial health services, but they were not always accepted by patients or other medical professionals. In the 1950s, the WHO recognized their usefulness for expanding the health workforce. Yet most subprofessional medical schools closed with decolonization.

Newly independent states aspired to physician-led health services. Medical assistant roles were seen as "a colonial invention" designed to restrict opportunities for non-Europeans. Some of the professionals steering postcolonial health services had once been auxiliaries themselves and understood the challenges experienced by this category of health worker.

Deep concern

We are a historian and a medical consultant with an interest in postgraduate education. We work with very different kinds of data, but share a deep concern with how health care works.

Across our different contexts, past and present, we find similar unsettled questions. These have nothing to do with the caliber or dedication of individual physician associates. They have everything to do with

fairness.

Histories of colonial medicine suggest that when you create two-tier systems for accessing careers in medicine, the "lesser" track will map onto existing inequalities in the surrounding society. In the UK today, this may mean people from economically disadvantaged backgrounds and school leavers affected by the regional awarding gap are more likely to train as physician associates.

Are physician associates an extra pair of hands assisting the doctor, or are they a substitute for the doctor? Historically and today, the line between associate and doctor has been difficult for managers and professionals to define, let alone for patients to understand.

In Algeria under French colonial occupation, patients were often unaware that the medical auxiliary treating them was not a real medical doctor. Although French officials touted medical auxiliaries as a means of reducing health care inequalities, the result was a two-tier health care system, with restricted services in rural and neglected areas.

Colonial-era medical auxiliaries in Algeria and elsewhere confronted a limited career ladder and inferior employment conditions. Their qualifications were not recognized internationally. They were locked into subordinate roles and faced workplace harassment.

Medical training and roles in colonial states are different from that being proposed in the UK today, but inequalities have not gone away.

How will physician associates' status, responsibilities, and remuneration relate to other health workers such as nurses and junior doctors? How will they cope with negativity or confusion surrounding their position? Does career progression include filling all the roles of a doctor?

To mitigate the issues associated with changes to the health workforce, we must first acknowledge them. In the UK, at least, there is little sign that this is happening.

When US government officials and medical faculties considered a new auxiliary role from the 1960s, they learned from models in formerly colonized states. Today, physician assistants in the US are a significant and more established part of the workforce, but interprofessional conflicts and difficulties occur. It has not been shown that the US model would meet the needs of the UK.

Without an open, transparent, evidence-led approach to new professional roles, we risk damaging the trust of patients and frontline health workers . As policymakers in the UK and other nations affirm their commitment to investing in the health workforce, they should look to colonial experiences as a bellwether.

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