Shortage of doctors in different European countries

- **Overview of the shortage of doctors in Europe**

Hermenegildo MARCOS CARRERA (UEMO Vice President) Spain

- **Proposals from different countries to remedy the situation**

Patrick OUVRARD (UEMO Former Vice President) France

- **Role of medical assistants and task shifting**

Peter HOLDEN (UEMO Vice President) UK

Shortage of doctors in differrent European countries

Program :

- **Interactive presentation 30 mins (10+10+10)**
  - Overview of the shortage of doctors in Europe.
  - Proposals from differrent countries to remedy the situation.
  - The role of medical assistants and task shifting
- **Work in 3 groups** (1 theme per group) **15 mins** for each group
- **Presentation** of groups work **10 mins per group** (**5mn presentation** and **5 mn discussion**)

30
15
30
~~75 mins~~

Overview of the shortage of doctors in Europe

Dr Hermenegildo Marcos (UEMO Vice President)

10 minutes

Union Européenne Médecine Omnipraticienne

UEMO

Declaration of interest links

I DECLARE under my responsibility:

That I am not involved in any conflict of interest that could compromise my impartiality and independence with respect to my participation in this congress

Structure Presentation

- **Framework**
  - OECD
  - Health at a Glance: Europe 2024
  - UEMO
- **The roots of the GP shortage**
- **Impact and Repercussions**
  - Patients
  - NHS
  - GPs

"Today, it is estimated that it takes two young people to replace a doctor who retires"

More than a quarter of GPs are aged 60 and over, so this issue is going to become more prevalent in rural communities

One of the primary fears that young doctors have going into a local practice was getting locum cover that showed a **third of GPs said they could not take annual leave because they could not find cover.**

"There's an increase in workload; GPs are **working late into the evening"**

There were difficulties in **attracting a younger generation of GPs into rural practice.**

Media reports in **Norway** indicated that there was a shortage of more than 5000 doctors.

DATA POLITIQUES DE SANTÉ

FR EN DE IT ES

Pénurie de généralistes en Belgique : une crise à retardement

Poor employment opportunities forcing GPs out of the NHS, BMA survey warns

Health

Ireland facing worsening shortage of GPs as retirements loom, representative body warns

DATA HEALTHCARE POLICY

Europe is short of GPs

Union Européenne Médecine Omnipraticienne

UEMO

18E CONGRESS GENERAL MEDICINE FRANCE

CMGF

27 29 MARCH 2025 PARIS

CMG collège de la médecine générale

European Union Of General Practitioners/Family Physicians / Union Européenne des Médecins Omnipraticiens/Médecins de Famille

UEMO

Present and Future Challenges facing General Practitioners / Family Physicians in Europe

March 18, 2025

Venue: European Parliament, 60 rue Wiertz, B-1047 Brussels, Belgium, room SPINELLI 5G305

Roundtable 1: Recruitment and retention of General Practitioners / Family Physicians in Europe

Roundable 2: What policy actions do we need for European General Practice / Family Medicine?

1. **MEP: R. Jerkovic “It's a political priority”**
2. **No GP should have to choose between work and well-being.**
3. **Join forces. Have a common voice.**
4. **Turn words into actions.**
5. **MEP Andriukaitis (Former EU Commissioner for Health): "Healthcare is more important than defense."**

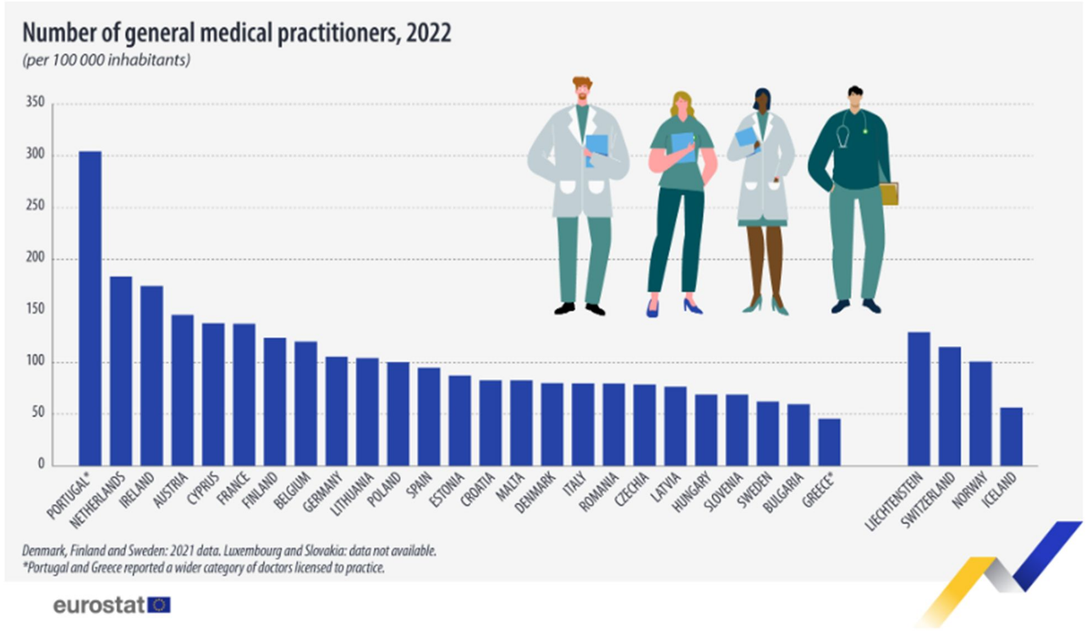
Union **E**uropéenne **M**édecine **O**mnipraticienne

UEMO

Framework

- The shortage of GPs is a worldwide phenomenon
- This shortage imposes a threat for the entire healthcare system.
- What is the optimum number of patients per GP?: 800/900 patients [per year] per doctor is the threshold beyond which it becomes difficult to function
- Each country counts its GP workforce differently, so creating a body of comparable data is complicated.
- WHO: “There are imbalances in the geographical distribution of primary healthcare professionals, mainly between rural and urban areas”.

Framework

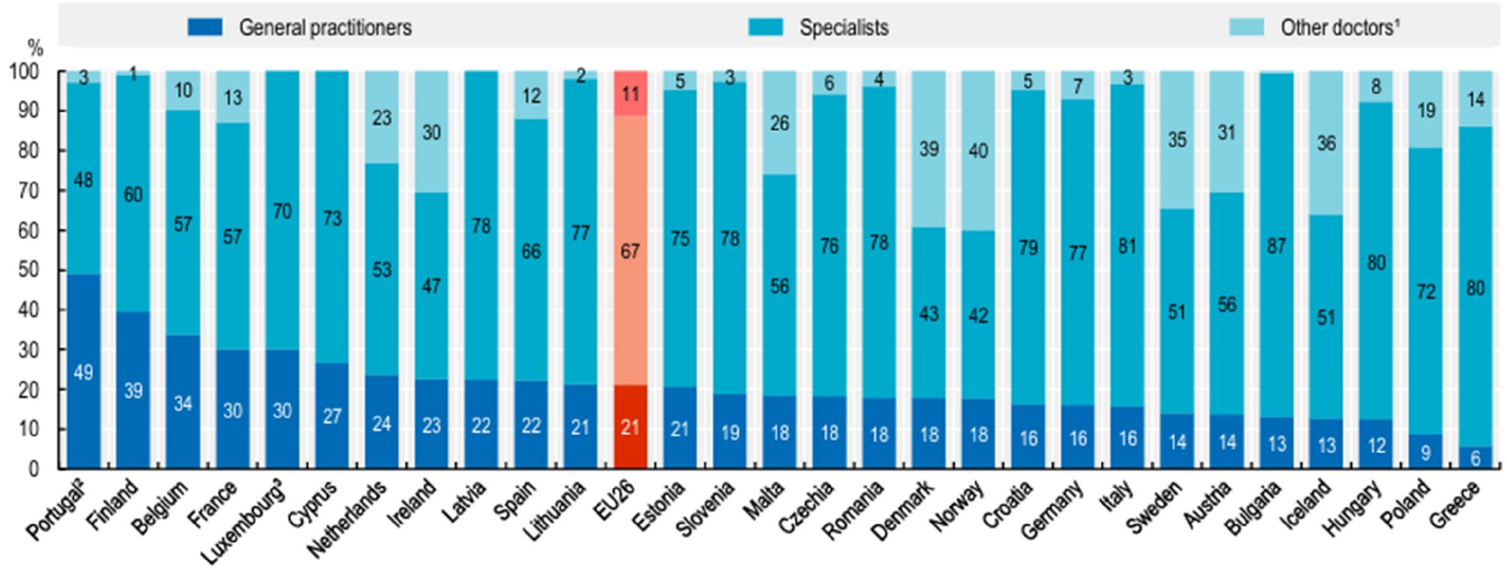


In 2022, there were an estimated 1.83 million practising doctors in the EU, of which more than 481,000 were general practitioners.

The OECD average is 10.8 GPs per 10,000

Framework
Health at a Glance: Europe 2024

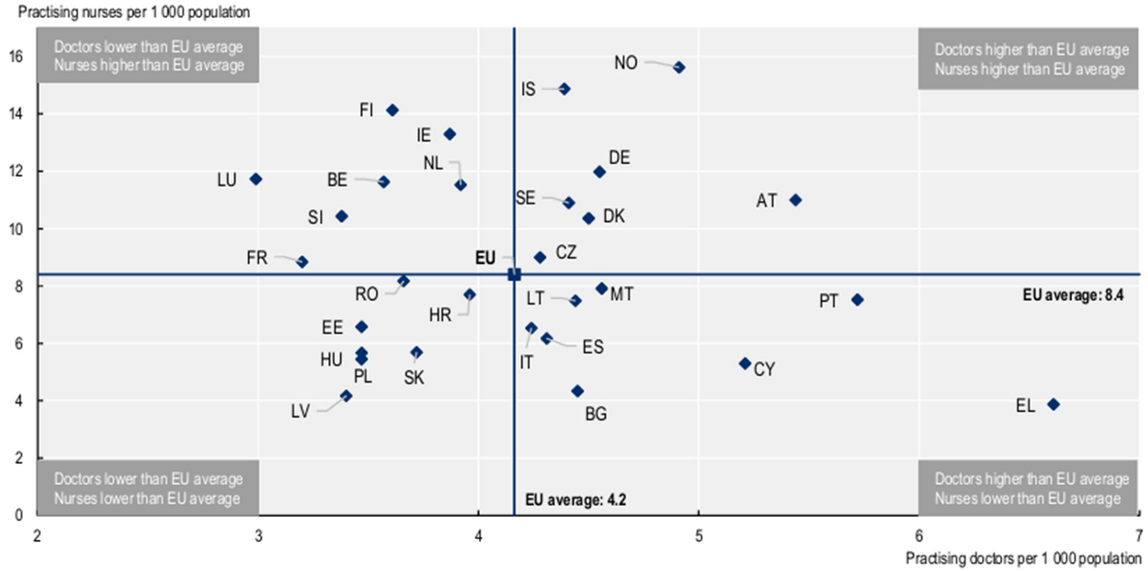
Figure 1.8. Only about one in five doctors in the EU were general practitioners in 2022



Note: The EU average is unweighted. 1. The category "Other doctors" includes other generalist (non-specialist) medical practitioners not considered GPs, recent medical graduates who have not yet started post-graduate specialty training and other doctors not further defined. 2. In Portugal, only about 30% of doctors employed by the public sector work as GPs in primary care – the other 70% work in hospitals. 3. The data for Luxembourg refer to 2017.
Source: OECD Health Statistics 2024; Eurostat (hlth_rs_prs2).

Framework
Health at a Glance: Europe 2024

Figure 1.5. The number of doctors and nurses per population varies by more than two-fold and three-fold, respectively, across EU countries

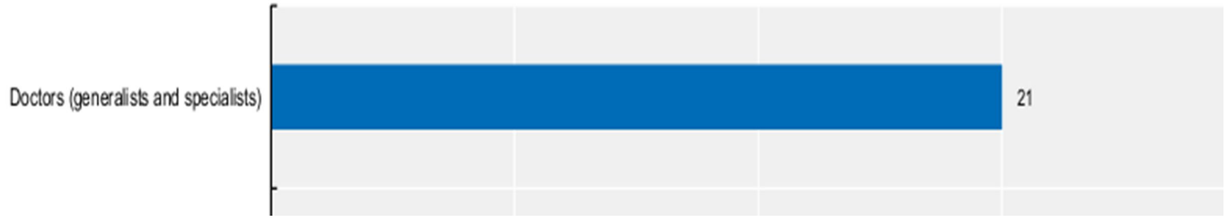


Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors. In the Slovak Republic, data refer to professionally active doctors, resulting in a slight over-estimation. In Portugal and the Slovak Republic, data refer to professionally active nurses, resulting in a slight over-estimation. In Greece, the number of nurses is underestimated as it only includes those working in hospital. The data for Luxembourg refer to 2017 (latest year available).
Source: OECD Health Statistics 2024 (data refer to 2022 or the nearest year).

Framework

Health at a Glance: Europe 2024

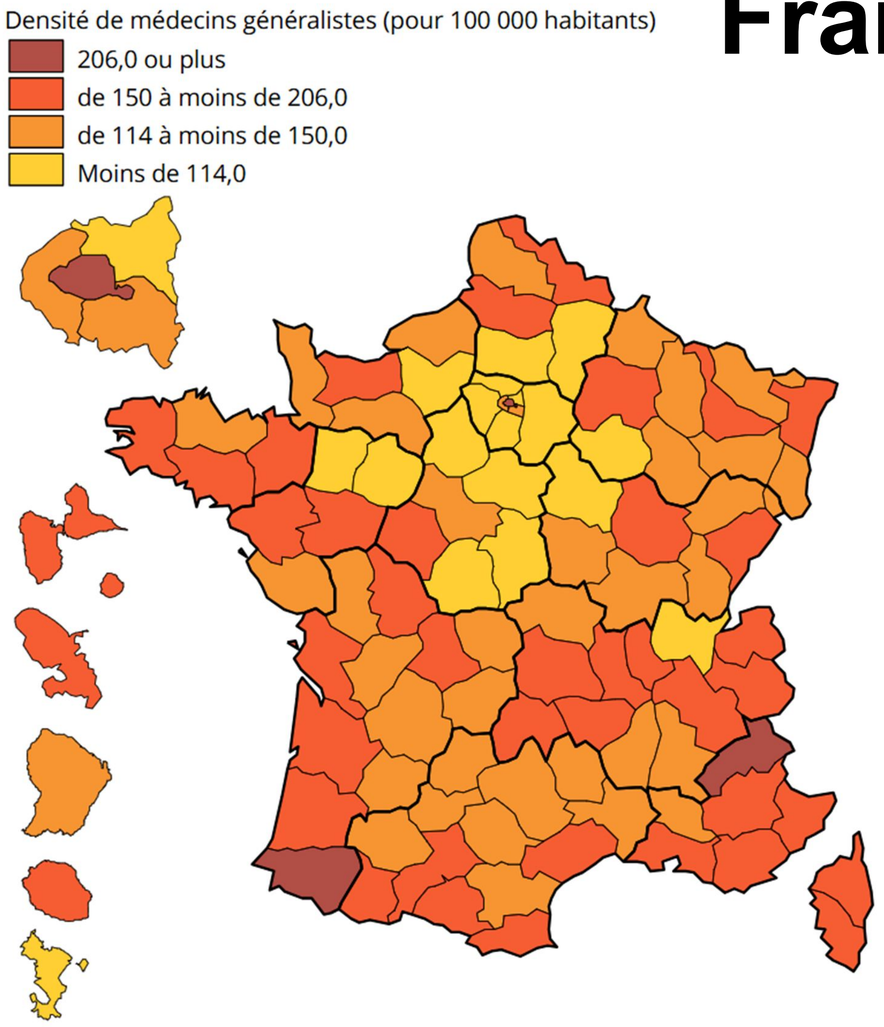
Figure 1.11. Most EU countries reported shortages of health workers in 2022 and 2023



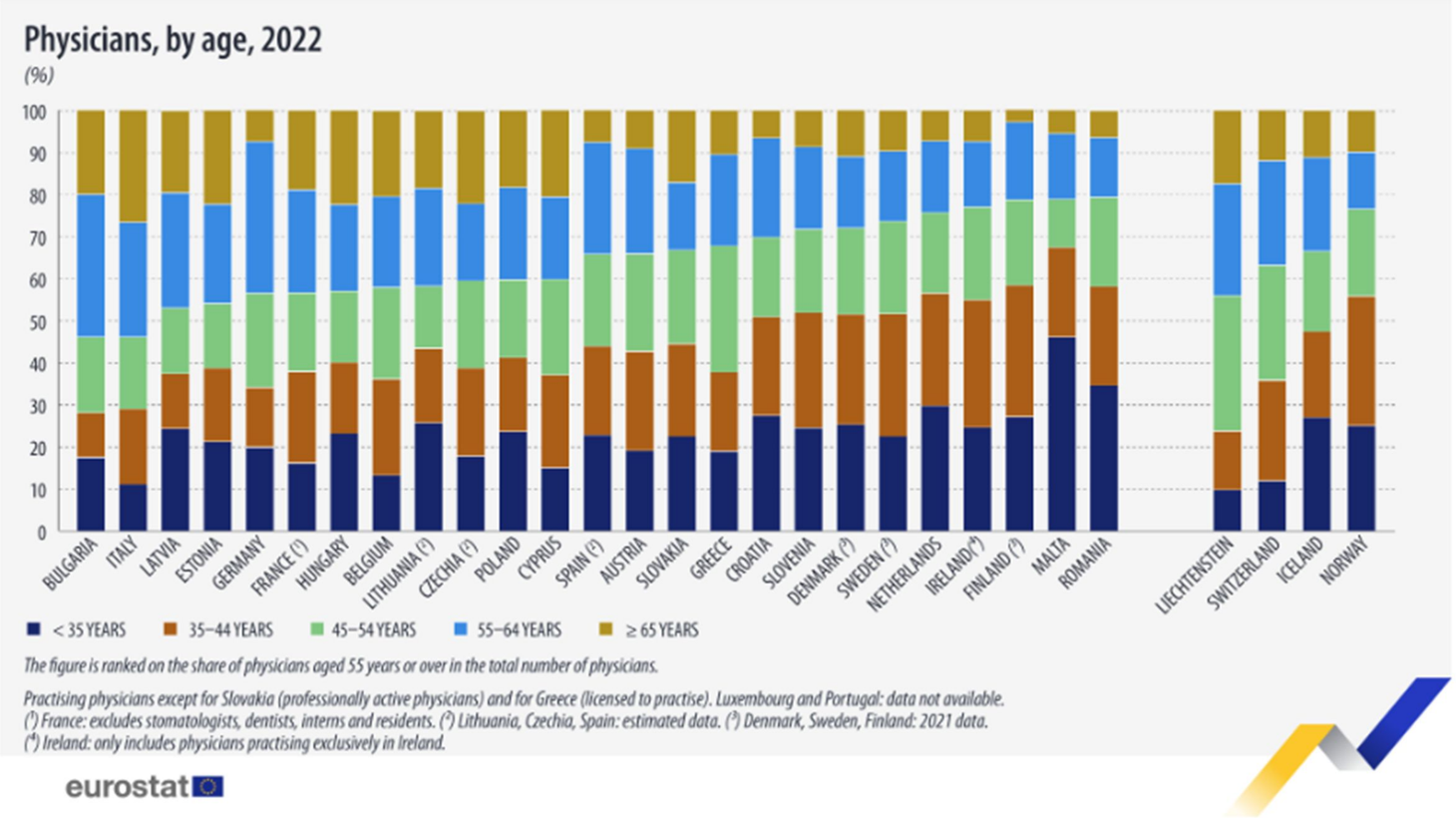
Number of countries reporting shortages (21/28)

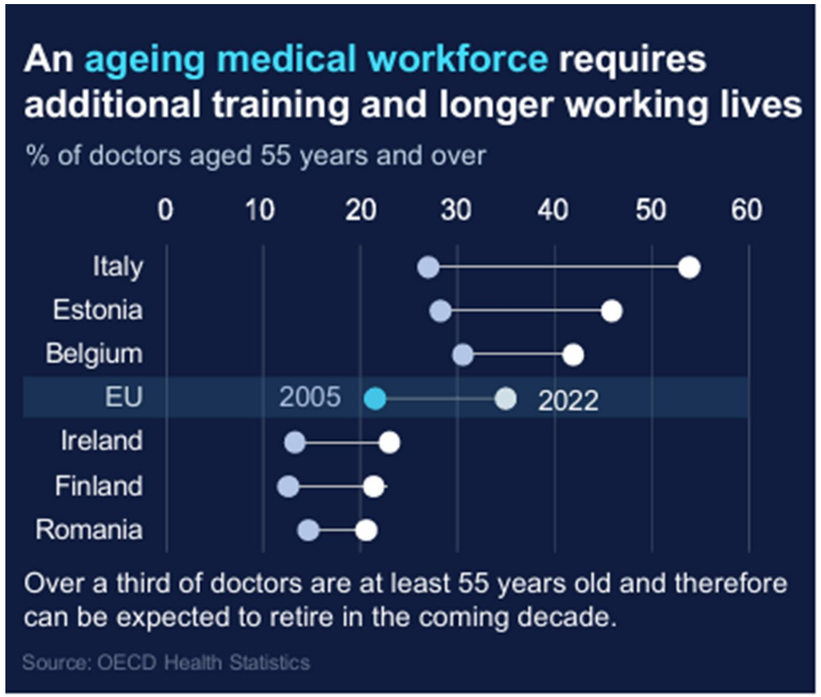
- 75% of the surveyed countries (21 out of 28) reported a shortage of doctors (either generalists or specialists) in the second half of 2022 and first half of 2023
- "In many countries, the main concern about doctor shortages has been the growing shortage of general practitioners, particularly in rural and remote areas, which limits access to primary healthcare." The report mentions Lithuania, Latvia, Hungary, Slovakia, Slovenia and France as countries with particularly striking rural-urban disparities in medical density.

Framework


Densité de médecins généralistes (pour 100 000 habitants)
206,0 ou plus
de 150 à moins de 206,0
de 114 à moins de 150,0
Moins de 114,0

Framework



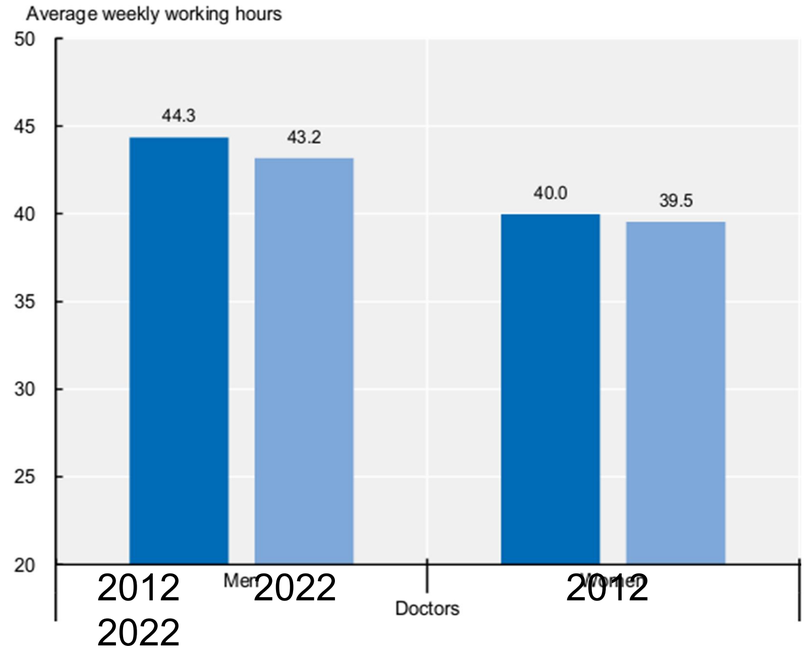


.TH AT A GLANCE: EUROPE 2024 © OECD/EUROPEAN UNION 2024

Framework

Average weekly working hours

The working hours of doctors have reduced over the past decade in the EU



Framework

GP/FD shortage. Estimated data from some UEMO countries

- At least 2000 in Romania
- In Spain about 5000 in a study of CGCOM
- If UK GPs were to work a 40-hour week we would need over 70,000
- In Norway: 160.000 lack a GP
- 1400 to 1600 GPs needed in Ireland
- In Italy: shortage of approximately 4000 GPs
- At least 500 GPs in Croatia
- Around 200 in Iceland
- In Croatia, more than 500 GPs
- In Macedonia, 1200
- Finland needs 1000 GPs more in public health care centers. Now there are about 4000.
- Sweden lacks about 50%, so around 5000.

91.000 and increasing…

Framework

What do we know about current shortages of health workers in EU countries?

European Employment Services (EURES)

- Despite the widespread concern about workforce shortages in most EU countries, there is a **scarcity of robust data** to accurately quantify the shortages of various categories of health workers at **both national and subnational levels.**

- This lack of data makes it **difficult to determine to what extent these shortages** might have worsened over time:

  - **Unfilled or hard-to-fill job vacancies**: very **few countries** routinely collect and report data on this indicator

  - **Population-reported unmet healthcare needs** due to a lack of available health workers

The roots of the GP shortage

- The causes are numerous and complex, and the situation is becoming pervasive
- Not just a problem of pay and working conditions": Norway and Denmark. Despite a high quality of life and good wages, both these countries are also facing shortages.

- Problems of attraction and retention
  - GP career is not attractive enough
  - Programme for International Student Assessment (PISA) survey: in about half of EU countries, health sector jobs have become less attractive to 15-year-old students.
- The pandemic led to a deterioration of the working conditions for many health workers that persist today
- Prestige: The low regard for general medicine compared to other specialties
- Long travel times

The roots of the GP shortage

- **Ageing of the population:** This demographic shift is likely to lead to a sharp increase in demand for healthcare and long-term care

- **Health at a Glance: Europe 2024**: “The ageing of the physician workforce is a growing concern in many EU countries

- “Today it is estimated that it takes **two young doctors to replace one on their retirement**” To simply replace a retiring doctor with another one may not be enough: **youths GP more likely to work part-time**

The roots of the GP shortage

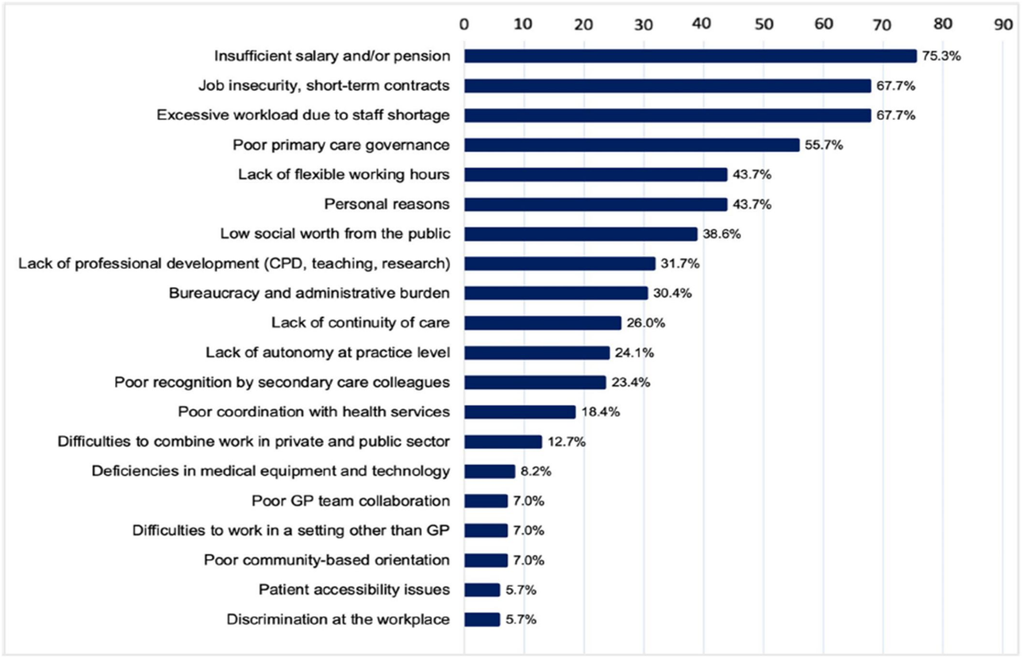
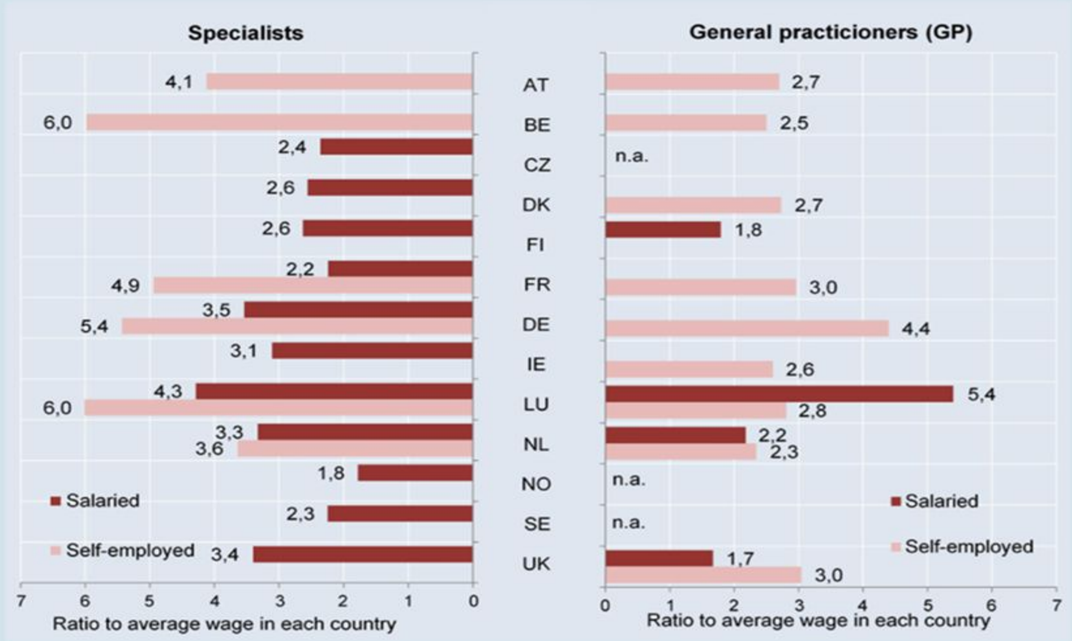


Fig. 1 Main reasons for leaving Spanish general practice ($n = 158$)

GPs' migration in Spain. Sara Calderón: *Centre for Primary Care, Wolfson Institute, Queen Mary University of London, UK*

The roots of the GP shortage

Figure 3: GPs earn less than other specialists in most countries



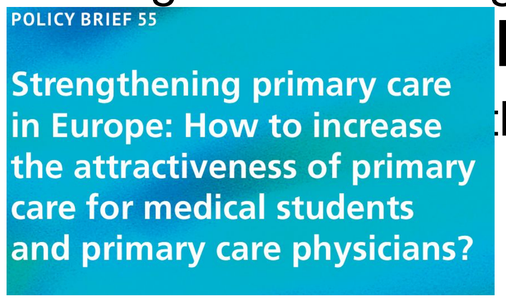
Source: OECD Health Statistics (2018)

Notes: Data from 2016 or the nearest year. Composition of the income data provided differs between countries (including differences in weekly working hours and definitions of income), and for many countries deviates from the official definition of OECD.

Thomas Czypionka, Institute for Advanced Studies, Vienna

The roots of the GP shortage

- The imperative of strengthening primary health care (PHC) has been widely acknowledged, yet **many countries in Europe struggle with shortages and geographical maldistribution of general practitioners** (GPs).
- One of the root causes for these challenges is the **perception among medical students and doctors that PHC is not an 'attractive' career option**. This is reinforced by pay differentials and perceived low status between GPs and specialists..
- On the whole, strengthening PHC will require a **multifaceted strategy that employs a range of measures and targets**
- Crafting such a strategy will re **ext**



better **ous**

the evider

Bundesministerium Arbeit, Soziales, Gesundheit und Konsumentenschutz

European Commission

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Union Européenne Médecine Omnipraticienne

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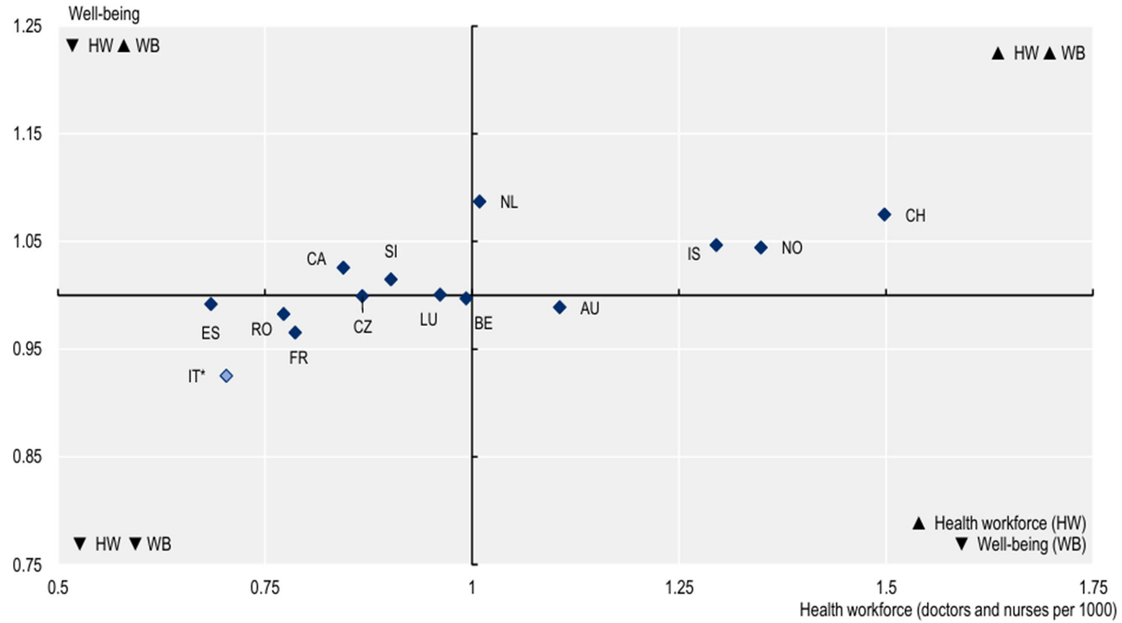
Impact and Repercussions

- BMA Primary Care Survey (2022)
  - 99% of GPs feel overworked
  - 94% are experiencing mental health challenges as a result
  - 67%say they have witnessed violence or abuse from patients.
- Increased wait times
- Diagnostic delays
- Short time to care for patients
- Overmedicalization
- Increased spending

Impact and Repercussions

Figure 1.11. Countries with a larger health workforce also report higher levels of well-being



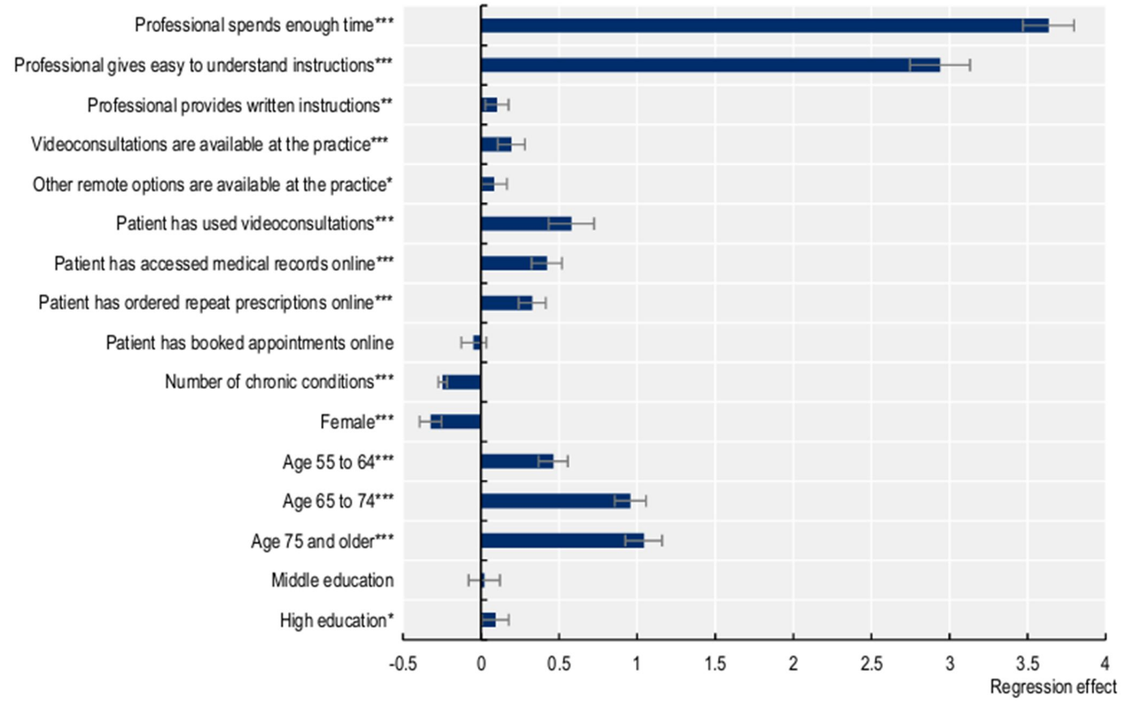
Note: Values on both axes were divided by the OECD PaRIS average, meaning that 1 stands for the OECD PaRIS average and values above and under 1 respectively for above and under the OECD PaRIS average. * Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. AU: Australia, BE: Belgium, CA: Canada, CZ: Czechia, FR: France, IS: Iceland, LU: Luxembourg, NL: Netherlands, NO: Norway, RO: Romania, SI: Slovenia, ES: Spain, CH: Switzerland, IT: Italy.
Source: OECD Stat; OECD PaRIS 2024 Database.

Impact and Repercussions

OECD: Results from the Patient-Reported Indicator Surveys **(PaRIS)**

Figure 1.15. Sufficient consultation time, effective and accessible communication, and use of digital tools are all associated with more person-centred care

Estimated effects and 95% confidence intervals of practices' and patients' characteristics on person-centred care



Conclusions

- **Despite a steady increase in the number of doctors** most countries grappling with significant shortages due to **growing demand for healthcare** as well as a **reduction in the working hours** aiming to achieve a **better work-life balance**
- These workforce shortages **may be exacerbated in the coming years**, driven by the **double demographic challenge of an ageing population and an ageing health workforce**, posing a serious threat to the sustainability and resilience of European health systems.
- **High levels of job dissatisfaction and burnout** among current health workers, exacerbated by the COVID-19 pandemic,
- **Declining interest in health careers among young people.**
- **Addressing health workforce challenges will require a multi-faceted approach**, with some policies having impact in the short term, while the impact of other policies may be felt

Thank you

Merci beaucoup

Proposals from different countries to remedy the shortage situation

Patrick OUVRARD (UEMO France Vice President) France

10 minutes

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Declaration of interest links

I DECLARE under my responsibility:

That I am not involved in any conflict of interest that could compromise my impartiality and independence with respect to my participation in this congress

Shortage of doctors in different European countries

Most European countries are facing shortages of doctors, especially general practitioners. (but other countries outside Europe are also affected).

This situation is exacerbated by the **ageing of the physician population** (numerous retirements) and the **feminization of the profession** (female GPs are more likely to work part-time).

There is also a significant **imbalance between rural and urban areas**.

This shortage is a threat to Europe's healthcare systems, which could lead to **excessive waiting times for treatment, delayed diagnoses and an increase in the number of deaths**.

Shortage of doctors in different European countries

Another factor is to be taken into account:

the **aging of the population**, this generates

- an increase in consultation needs,
- an increase in patients with chronic disease

Shortage of doctors in different European countries

For some years now, faced with these shortages, the various EU Member States have been trying to find solutions....

But no one seems to have found the right one.

- How can we make the profession more attractive?
- How can we combat rural desertification?

Addressing the growing shortage of family doctors requires strategic planning, which is harder to achieve without formal recognition

Proposals from different countries to remedy the shortage situation

Shortage of doctors in different European countries

- **Increase in the numerus clausus**
  - France, Suisse
    - (no effect expected before **2035**)
    - **This system is not magic**, it trains more doctors, but they will not automatically choose general medicine, many will choose another speciality, some will go and practise in another country.
    - So we need to make the profession more attractive.
    - *What about the quality of training when the numerus clausus is reduced?*

* (a system that limited the number of students admitted to the second year of medical school)

Shortage of doctors in different European countries

- **Financial incentives for doctors who choose general practice**:
  - Greece
    - The Deputy Health Minister Irini Agapidaki say :

« The aim is to strengthen the pool of pathologists and general practitioners in our country, to meet citizens'personal doctor needs and to transform Greece into the country of choice for a career among young doctors."

(but financial incentives alone are not enough)

Shortage of doctors in different European countries

- **Regulation by the health authorities.**
  - Spain, UK, Italy, Germany**.** The example of Germany **:**

With a few exceptions, doctors are only registered with the social security system in areas where the number of doctors per inhabitant is below a threshold set by the authorities.

In concrete terms, doctors are not allowed to set up practice in areas where the density of doctors is 10% higher than the national average.

This system seems to be fairly effective (In the United Kingdom, Spain and Italy, where the installation of doctors is also regulated by the health authorities, the problem of medical deserts is less acute than in France)

Shortage of doctors in different European countries

- **Installation subsidies** to make it easier for family doctors to set up practice in areas where there is a shortage of doctors :
  - Belgium, Romania, France

The example of France :

Contract to help doctors set up (CAIM)

This contract is linked to financial assistance for doctors setting up in ‘under-serviced’ areas, whether for the first time or for a new liberal practice.

Financial assistance :

- 50,000 € for a 4-day week
- 43,750 € for working 3 and a half days a week
- 37,500 for working 3 days a week
- 31,250 for working 2 days a week

Shortage of doctors in different European countries

- **Hiring a medical assistant :** the example of France
  - This recruitment support is applies to all doctors.
    - To qualify, they must practise in sector 1 or sector 2
  - The contract is for 5 years and may be renewed.
  - **If you are over 65 :**
    - with an active file of 1000 patients
    - you benefit from :
      - 19,000 € in the first year for a part-time assistant
      - 14,000 € in the second year for a half-time assistant
      - 11,000 € from the 3rd year onwards for a half-time assistant

    (these amounts are doubled for a full-time assistant)

in the next presentation Dr Peter HOLDEN (UK)
will present :

Role of medical assistants and task shifting

If we want young doctors to go into general practice,

we have to stop complaining

and saying that we're doing badly.

On the contrary, we have to promote our profession

on its richness, its importance for patients health

and the happiness that practising it gives us.

Role of medical assistants and task shifting

Peter HOLDEN (UEMO Vice President) UK

10 minutes

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Role of medical assistants and task shifting

Dr Peter Holden – General Practitioner & Consultant in Pre-Hospital Emergency Medicine

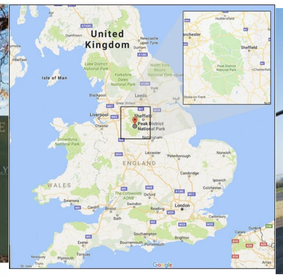
esident UEMO, Head of UK delegation

l Member, British Medical Association

Doctor – Senior Partner The Matlock & Ashover Practice 1985-2023,

Locum Eyam Surgery 2023 □ date

CIC 1996□ date



Matlock and Ashover Practices

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH
1505
The Faculty of Pre Hospital Care

BMA

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Declaration of interest - Dr Peter Holden

I DECLARE that I do not have any conflict of interest that could compromise my impartiality and independence with respect to my participation in this congress beyond the fact that I am a voting member of the Council of the BMA and thus involved in the current legal action in the UK High Court concerning this topic

Healthcare, supply, demand and cost

- Governments are feeling the heat from their electorates if healthcare cannot be procured at an **acceptable price, speed or, patient convenience.**
- Nations which have a state-based health service, or a state-backed health insurance system are seeking to solve these problems by encouraging healthcare systems to be more efficient through political and financial initiatives.
- Governments are politically sensitive to the **tax burden/healthcare cost dynamic** and constantly seek efficiencies in care delivery
- Efficiency measures are limited because **healthcare delivery is customised to each individual patient** and delivered by human beings who also have their own needs, failings and limitations.
- Governments and patients want **bespoke treatment at off the peg prices and is frequently incompatible with efficiencies.** Patients are not widgets

Ultimately clinical capacity can only be increased by increasing the number of personnel able to deliver healthcare.

Healthcare is a commodity

- For governments healthcare is **votes and tax costs**
- For insurers healthcare is **profit**
- For healthcare corporations, healthcare provision is **big business**
- For the patient healthcare has become **a "right", and a service to which they feel entitled**
- Unlike any other product in a marketplace the customer/patient does not always
  - Know what they need versus what they want
  - whether what they need or want is safe or appropriate for them at that time or at anytime
- Healthcare provision is labour intensive and **labour costs are the largest single cost factor**
- Big healthcare corporations from the USA are circling to get a slice of the action and **THEY KNOW HOW TO CUT COSTS**
- What starts in the US usually transitions to Europe often trailed and stage-posted via the British Isles
- **Suppression of the primacy of physicians is no exception to this rule**

The increasing clinical capacity gap

Physician supply

- **Doctors take 10-15+ years to train to European standards**
- Training is arduous challenging and costly
- Doctors are not cheap and nor should their personal expectations be low
- No longer prepared to or able to work crazy hours – and why should they?
- On call = AT WORK
- The gender shift
- Work-life balance
- Modern medicine requires constant physician inputs not occasional injects
- Long hours no longer possible on patient safely and physician health grounds
- **There are NO SHORTCUTS**

BMJ 04 October 2024

OPINION

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http://dx.doi.org/10.1136/bmj.q2163
Published: 03 October 2024

Medicine is difficult—there are no shortcuts

Delivering high quality, patient centred care requires medical training that is long enough, broad enough, and deep enough, writes Andrew Elder

Andrew Elder,

A senior medical leader recently gave me a piece of advice.

"Even when you are bored stiff saying the same thing again and again, say it again. Even when you think everybody will be fed up hearing it, say it again. Because the politicians may not yet have heard you."

So, I will say it again. Medicine is difficult.

Yes, we have fabulous imaging and more laboratory investigations than any of us can name. And yes, we can interrogate our patients' genomes, and the genomes of the organisms and cancers that infect and affect them. But, despite all this wonderful technology, diagnosis remains difficult. Every patient is a unique individual in a unique context, a product of both their biology and their biography. Making accurate and timely diagnoses requires more than just technology—it requires listening, observation, careful thought, judgment, and time. Uncertainty often prevails—and the ability to manage that is not learnt from any textbook.

The treatment, management, and care decisions that follow diagnosis are also difficult. Multiple minds, meeting in multiprofessional teams, seek consensus on the best that can be offered. Complex options lead to complex explanations and discussions with a patient and their family. What could be done may be

Medical knowledge, as measured by published research and guidelines, is now said to double every 60 days. One might think this would provoke calls for longer, even more intense teaching, training, and learning for those who aspire to be doctors. But it is now suggested that we can "make" our doctors in shorter timeframes—for example, in a four year undergraduate degree course. Even shorter training, with entirely different entry criteria, is also promoted. Medical associate professionals, with a pre-degree in a wide range of subjects, are judged ready for clinical practice after only two years of training in "the medical model."

But the "medical model" of education and training is defined by much more than a structured approach to history taking, physical examination, diagnostic reasoning, and care planning. It is defined by the breadth and depth of knowledge and skills that the doctor must acquire. It is defined by the intensity of mandatory assessments of knowledge and skills that the doctor must undergo in the workplace and examination hall. And the "medical model" is also defined by its duration. Clinical experience—by the bedside, in the consulting room, and in the operating theatre—and all that comes with it, is a time-based commodity. Competency based medical education may not see experience, or "time served," as of any

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Healthcare demand and capacity

Demand for medical services worldwide is rising rapidly driven by numerous pressures including

- patient demand arising from knowledge accessed from the Internet
- ageing populations
- professional and scientific ability to cope with (and imperfectly treat) multi-morbidity
- increasing technological capability within the medical sciences
- increasing personal and national wealth
- rising (and sometimes unrealistic) expectations of patients, their families and politicians in terms of scope and speed of treatment

Shortage of physicians is no longer a third world problem but a first world one too.

Improving Physician supply is a government priority all over the world

So What is happening?

The governmental temptation is to shorten medical training and/or Physician substitution

- Improve physician supply by
  - Reducing the length of undergraduate entry training
  - Alternative routes to a primary registrable physician qualification such as apprenticeship rather than a traditional university-based education
  - Physicians supervising non physicians to do physician type tasks
- **Task re-assignation to other healthcare professionals**
- **Introduction of Physician Associates/Assistants**

LIKELY RESULTS

- DUMBING DOWN of our learned self-governing profession
- Where this happens physicians will become qualification prisoners in their own country
- Loss of free movement of labour
- (Why else do EU member nations NOT apply for specialist recognition?
  – to prevent easy movement of labour and keep YOU captive!)

Substitution with MAPS working at the "Top of their License to practise"

Governments are **pushing the boundaries** with non physicians encouraging **Medical Associate Practitioners**

THEY ARE TECHNICIANS of limited safe scope of practice and NEED SUPERVISION OF EACH CASE
THEY CANNOT SAFELY SEE UNDIFFERENTIATED PATIENT PRESENTATIONS UNSUPERVISED

- **Top of their license = perilously close to limits of knowledge skill and attitudes on a regular and routine basis**
- **Dunning-Kruger Effect – Confidence >>>> Competence**
- Recruiting persons into 2 year MAP courses after (any) university degree many therefore lack
  - Basic Maturity
  - Clinical judgement skills
  - Clinical acumen

And don't know what they don't know

NB MAPs are NOT the same as for example Advanced Care Practitioners which are drawn from the ranks of

Turning GP/FM/MG from professionals to technicians 1

Physicians

- **Possess a powerful knowledge and skill base permitting us to**
  - Challenge situations, ask appropriate questions, seek answers, and test our own practice
  - Make bespoke decisions for individual patients based on our knowledge and skill base
  - Base our work on a full understanding of how the human body operates
  - Respond with interventions born out of a deep understanding resulting from a **comprehensive and lengthy undergraduate medical education**
  - Continuously update their skills and understanding through initiating and evaluating new research

- **And we reflect on the impact of our practise and adapt as new knowledge and procedures emerge**

Turning GP/FM/MG from professionals to technicians 2

Technicians after training (rather than education)

- Work from assumptions that tell them what to do
- Follow a script

- Identify problems or a situation and then
  - Either search for someone who knows what to do or how to proceed.
  - Or follow protocols with accuracy and precision, SOPs or procedures requiring specific steps which rarely vary

- Rarely make complex decisions requiring a broad base of knowledge and experience.

- Work is practical and proficient without requiring fundamental comprehension and ability to synthesis from basic knowledge

- do as instructed and supervised

Professional or technician, where next?

- No time for being squeamish for fear we might offend others
- MUST (politely but forcibly and repeatedly) say it how it is
- This is about US.
- This is about OUR survival
- This is about US as a profession
- Other valuable team colleague interests come SECOND to OUR OWN as physicians
- **We are threatened with an existential crisis as a liberal self-governing senior profession**
- **We risk downgrading to medically qualified technicians employed as civil servants owing allegiance to the government of the day**

Definitions matter!

Any European discussion on any topic needs tight definition

- **EXAMPLE a Physician Assistant (PA) in NL is what in UK and IRL would be termed an Advanced Clinical Practitioner (ACP)**
  - **They have a registered health care practitioner background of several years standing**
  - **Can prescribe**
  - **Are educated to Masters level**
  - **Know their own limitations of practice and are on a professional register with a sanction imposing regulator**

- **In other countries they possess**
  - **(Any) university degree plus 2 years “clinical” training**
  - **And cannot prescribe**
  - **Too often DON’T know their own limitations and are not yet on a register**

GP/FM/MG job description

GPs Job description (Holden 2014)

- GPs manage clinical risk
- With an incomplete dataset
- From an unreliable witness
- In a resource poor environment
- Against and ever shifting backdrop
- Every 10 minutes!

GPs compared to specialists (Marinker 1980)

- GPs EXCLUDE presence of serious disease
- Specialist CONFIRM the presence of serious disease
- GPs accept uncertainty, Explore Probability and Marginalise DANGER
- Specialists reduce uncertainty, explore possibility and marginalize ERROR

This is NOT safe territory for clinicians who are not "Registered Medical Practitioners" – PHYSICIANS!

IT REQUIRES MASSIVE REDUNDANCY OF KNOWLEDGE SKILLS ATTITUDES AND APTITUDES

Taking a stand

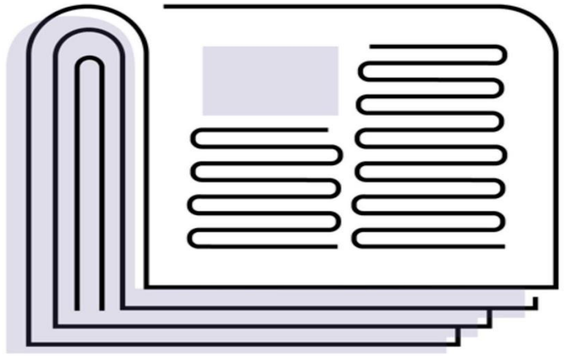
Home > BMA media centre >

BMA launches legal action against GMC over dangerous blurring of lines between doctors and physician associates

by BMA media team

BMA Press release

Location: UK Published: Monday 24 June 2024



The BMA is launching legal action against the doctors' regulator, the General Medical Council, over the way in which it plans to regulate physician and anaesthesia associates, in what the BMA says is the dangerous blurring of lines for patients between highly-skilled and experienced doctors, and assistant roles.

Following recent legislation, the GMC will become the regulator of physician associates (PAs) and anaesthesia associates (AAs) in December 2024.

The BMA has consistently made clear that physician and anaesthesia associates – who complete a two-year course rather than a five-year medical degree – need regulating, but that the GMC is not the right organisation to do this. By choosing the GMC as the regulator for PAs and AAs, the BMA says the Government is undermining and devaluing the medical profession, and confusing patients.

Emergency Guidance to the Profession

Safe scope of practice for Medical Associate Professionals (MAPs)

BMA

Table 1. GENERAL SCOPE FOR PAs

DOMAIN	IS EXPECTED TO	MAY DO (Under direct supervision and with agreement of named consultant /GP). *First right of refusal for doctors must be upheld	MUST NOT

Union Européenne Médecine Omnipraticienne

18E CONGRÈS MÉDECINE GÉNÉRALE FRANCE

CMGF 27 29 MARS 2025 PARIS

CMG collège de la médecine générale

Shortage of doctors in different European countries

French version

Union Européenne Médecine Omnipraticienne

UEMO

Medicine is international – YOUR country will be next

- Governments and big business will use market forces/physician underemployment to dictate
  - How and when physicians work
  - When physicians work
  - Where we work and the content of our work
  - That we supervise Medical Associate Professionals(Physician Associates, Physician Assistants, Anaesthetic Associate)

- WE LOSE CONTROL of
  - Our professionalism and autonomy
  - Our educational standards, our economic status and our societal standing

- Patients LOSE
  - the high quality professional PHYSICIAN LED service they are used to
  - The safe service arising BECAUSE physicians are operating well inside their very extensive boundaries of knowledge skills attitudes

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Work in 3 groups (with an expert as an observer per group)

15 mn

Groupe 1 : Impact of shortages on patients

Groupe 2 : Impact of the shortage on doctors

Groupe 3 : Repercussions of the shortage for the NHS.

Union Européenne Médecine Omnipraticienne

UEMO

You must design 1 rapporteur per group

Report Groupe 1

5’ Presentation
5’ Discussion

Impact of shortages on patients

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Report Groupe 2

5’ Presentation
5’ Discussion

Impact of the shortage on doctors

-

-

-

Report Groupe 3

5’ Presentation
5’ Discussion

Repercussions of the shortage for the NHS

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