Physician Associate story – Renni Johnson

British Thoracic Society

About this story

As a Society we are aware of the growing importance of Physician Associates within the NHS. We met Renni Johnson, based at the St James' University Hospital in Leeds and asked her about her experience as a Physician Associate.

You started your training to become a Physician Associate (PA) in 2015. Can you tell us a little more about what first attracted you to the role?

I am very familiar with PAs - I am originally from the US, where they have been an established part of the healthcare service for nearly 60 years.

I came to the UK to do my undergraduate degree and planned to return to the US to do my postgraduate PA training. The expansion of PA courses in the UK made me realise that training here, and contributing to a burgeoning profession could present exciting opportunities.

You now work with the respiratory team. How did this post come about?

I was fortunate to be offered a permanent position with the respiratory team after spending my intern year here in Leeds doing three separate clinical rotations, one being respiratory.

One advantage of the being a PA is, for the moment at least, there is no predetermined route for us to take once we have graduated.

This gives us the chance to enjoy varied roles and play an active part in the planning our jobs.

How have you settled in to your role?

I am really lucky to work with a very supportive team. Like all qualified PAs in Leeds, I have been allocated a consultant supervisor. I work very closely with all members of the ward staff and also attend MDT meetings.

I spend the majority of my time on the general respiratory ward and one of the things I love is that the patient group is so varied. With so many people with multiple co-morbidities there is also a good deal of general medicine involved in the care we deliver.

Can you outline what a typical week involves?

Inpatient work:
I am usually assigned 10 patients and each morning I review them on ward round, discussing the more complex patients with the consultants. I work closely with the trainees on the ward and over time we have adjusted to our roles and we have a great working relationship and complement each other's skills.

Outpatient clinics:
I contribute to the Monday afternoon Rapid Access COPD clinic. In this clinic, I do capillary blood gases (CBG) and review patients that required acute NIV (non-invasive ventilation) during a recent admission.

Teaching:
I like to get involved with teaching. I have delivered presentations at our PA teaching on Thursdays and our departmental teaching for the junior doctors. I also make it a priority to deliver teaching to PA students when they are on placement in Respiratory.

Training:
Here in Leeds we have a 2-hour PA specific training twice a month, which is protected teaching time. Consultants or PAs from the trust typically deliver the teaching sessions on various topics.

Quality Improvement:
Opportunities to work on audits have been really rewarding. I carried out an audit looking at the documentation of type 2 respiratory

failure and target saturations in discharge summaries. Now, I am collecting data about patients that recently required acute NIV and assessing whether or not they need to be established on domiciliary NIV.

Could tell us about your experience with a particular patient?

We had a man admitted to the Respiratory Care Unit (RCU) - this is the higher dependency unit in the respiratory department.

He had presented with shortness of breath and was found to be decompensated type 2 respiratory failure and required acute NIV. He had a background of end stage COPD, but this was his first admission requiring acute NIV.

He was brought up to RCU, was struggling to tolerate the mask. We kept monitoring the patient's status and considered putting him on the End of Life Care Plan.

Thankfully, the patient started to pick up a bit and we decided to try the mask again. He managed to tolerate the NIV better with the help of anxiolytics. His repeat ABGs showed his pH normalising and his CO2 coming down. A few days later, he was discharged.

A couple weeks later, he was booked in to see me in clinic. He walked into my room for a capillary blood gas and review. I was pleased to see that he was doing well since his hospital discharge. His CBG showed a normal CO2 and he was delighted that he wouldn't need domiciliary NIV.

This was a great case to learn from and reflect back on. It also highlights the value of seeing patients in outpatient clinics. I think if you only work on the wards, it can skew your perspective of the patient population because you are always seeing them at their worst, but when they walk into your clinic a few weeks later, its rewarding to see them well and know you had a part in their recovery.

How do you see the profession developing?

I think this is a really interesting time for PAs. When I first joined the Trust, there were 8 PAs, and now there will be 29 by the end of this month. There is a greater number of courses on offer, making it possible for people to choose one that suits their needs and way of learning.

There is certainly a growing awareness among healthcare professionals about the support we can offer.

I am really keen to expand my knowledge and experience of pleural procedures. Right now I am on the lookout for a suitable ultrasound course to facilitate this.

Although a few years away yet, GMC regulation will bring further benefits. At the moment, we are unable to prescribe or request imaging with ionising radiation, but PAs are optimistic this will change.

What advice would you give someone thinking of training as a PA?

Pick your course! Do your research and find a course that suits you. I was drawn to the University of Worcester because I was keen to study some pharmacology and my second year was almost entirely spent on placement. Other courses will spread the placements and lectures more evenly across the 2 years of study.

Once qualified, I do think PAs can have a significant influence on their career paths. This is still a relatively new role in the NHS and it is entirely possible that colleagues will not have worked with a PA before.

Sell yourself and your skills and be proactive to let people know what you are able to do to support their work. I found the rotational post offered in Leeds very beneficial. It gave me exposure to different specialties and opportunities to work with different patient groups.

Hopefully the word is spreading that BTS welcomes and encourages PAs as members of the Society. Is there anything we could offer on our website that would be helpful to PAs working in respiratory medicine?

That is a difficult one. I think access to the e-learning and BTS short courses at a discounted rate is a huge benefit to help PAs achieve their CPD credits. I will certainly be looking for upcoming ultrasound courses.

I think it would be great if the PAs that work in Respiratory could get together. It would be useful to get a feel for what other people are doing and discuss how to improve the role of PAs in the specialty.

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