Physician Associate story – Sophia Crasto

About this story

As a Society we are aware of the growing importance of Physician Associates (PA) within the NHS. We met Sophia Crasto, A PA based at the Royal Brompton & Harefield NHS Foundation Trust.
Ms Crasto trained as a PA in 2013 and has been a Physician Associate since.

What first attracted you to the role?

I knew I wanted a medical career, but initially I was not aware of the variety of professions that exist in the NHS. I was studying for a biomedical science degree at St George's and a career symposium introduced me to the role of PA.

I was instantly attracted to the variation and flexibility within a "normal working day" and the positive impact that PAs can have within a department. As cliché as it sounds, it was one of those lightbulb moments you only see in cartoons.

That was my epiphany moment; I had found the career that I never knew I was looking for.

As soon as I graduated I did my Post Graduate Diploma. At that time, there were only 2 courses available, but many more courses are available now.

I understand you now work in transplant medicine?

My first role after graduating consisted of three years in the Acute Medical Unit of Northampton General Hospital. In this post I gained a huge amount of experience and it was a steep but amazing learning curve.

Patients presented with a large variety of medical conditions and it allowed me to upskill clinically and procedurally. We grew from a team of 2 to a team of 8 during this time.

When Harefield advertised the role and made clear they wanted to integrate PAs into their multi-disciplinary team, I knew it was a great time for me to take on a new challenge.

PA training is centred on general medicine. Did you need to undertake any specific training for your position?

I was fortunate that my previous job meant my Consultants were happy that I had a stable foundation of medical knowledge to build upon, and I had completed additional training, for example Advanced Life Support.

Most importantly, my training was to spend the first couple of weeks shadowing as many of my multi-disciplinary colleagues as possible to learn about how everyone's specialist roles integrate to provide high quality post-transplant care.

Working in a department looking after patients with chronic illness has presented different opportunities for me. I have trained in ultrasound guided vascular access, and I am now competent to insert peripherally inserted central catheters (PICC) and midlines lines independently.

What are your key tasks and responsibilities in this role?

The key task is support. I work closely with the specialist registrars on the wards and in outpatient clinic. I also work closely with the specialist nurses to action outcomes of our MDT meetings.

Inpatient work:

- Preparing ward round notes
- Attending and documenting the Registrar-led ward round
- Implementing the management plans
- Ultrasound guided vascular access [cannula/PICC/midline]

Outpatient clinics:

- Review stable patients

service improvement e.g. video call consultations

Teaching

- I help teach on certain courses, for example vascular access and Med Reg Ready simulation.

Quality Improvement

This is a valuable and enjoyable part of my job. I am working with colleagues on multiple projects:

- Video call consultations for stable patients – some of our patients have to travel hundreds of miles to get to our hospital for their routine clinic reviews
- Developing an antibody mediated rejection MDT, so we now have a structured pathway to monitor and investigate these patients.
- Developing an impedance MDT, to create a similar structured pathway to monitor and intervene in chronic reflux to preserve lung function
- Improving quality and efficiency of electronic ward round documentation

Is there a particular patient experience you would like to highlight?

I reviewed a patient in clinic, their lung function had reduced slightly so I escalated them to the Consultant in clinic. I liaised with the Outpatient Nurse to have viral nose/throat swab and sputum sent to the laboratory and arranged for the Outpatient Pharmacist to provide an acute 14 day course of oral antibiotics. I then discussed safety net advice and organised follow-up with the patient, which included reserving a day case bed in two weeks' time.

Two weeks later, the patient came back to clinic for repeat lung function which had still declined despite oral antibiotics. The Consultant confirmed they wished to perform a bronchoscopy the next day. The day case bed had already reserved. I liaised with the Registrar who requested the CT and discussed with the Radiologist on-call so the patient could have the HRCT chest performed before bronchoscopy.

After bronchoscopy the decision was to admit the patient to the ward for intravenous antibiotics and chest physiotherapy. I clerked in the patient, liaised with the Doctor on the ward for the drug chart and the Physiotherapy team for intervention.

As the patient needed a long course of antibiotics, a longline was indicated. Later in the week I consented the patient and inserted a peripherally central catheter under ultrasound guidance, so that they could have daily blood monitoring and intravenous medications administered without the need for recurrent venepuncture/cannulation.

Once they had completed their course of intravenous antibiotics and were medically stable for discharge I was able to complete the clinical information section of the discharge summary for the Doctor on the ward.

Are you offered specific training and CPD?

As with other medical professions, CPD is vital. We are required to complete 50 CPD credits per year; 25 of these have to be certified so 5 study days per year is a standard minimum requirement.

PAs must keep their portfolios/CPD diary up to date. We are also required to take the national revalidation exam every 6 years to ensure we have kept up our standard of general medical knowledge, this is currently run by the Faculty of PAs in the RCP and will be taken over by the GMC going forward.

British Thoracic Society

Is there anything that BTS could offer to PAs working in respiratory medicine?
Any help to signpost courses would be very welcome. PAs are involved in, and looking to learn more about respiratory medicine. The things that immediately spring to mind are:

- Respiratory ultrasound at the point of care
- Pleural procedures
- NIV study days
- Invasive ventilation study days
- Tracheostomy care study days
- Understand more about chest physiotherapy study day

How do you see the role of PA developing in the coming years?

This is an exciting time to be a PA. Careers in the NHS often follow a hierarchal model and PAs challenge that. We are a flexible member of the MDT that can be utilised by departments where the clinical need is, be that primary, secondary or tertiary services.

As the role is still in its infancy in the UK it is still currently an ambassadorial role. I am more than happy to discuss recruitment with departments considering it. It is important that everyone understands the impact a PA can have, and appropriate planning before recruitment is key.

The Royal College of Physicians has a PA Faculty and there are good documents that outline our curriculum, core values, training and the matrix of conditions we work with.

At present there is a managed voluntary register, but there has now been agreement from the GMC that they will take on the regulation and re-validation of PAs. This will ensure there are strong and appropriate patient safety checks in place, along with clear education and training.

Once this is in place and we are 5-10 years down the line I imagine we will see more PAs looking to develop management skills e.g. aiming to improving patient journey / flow / experience / pathways.

What advice would you offer to someone thinking about training as a PA?

I would thoroughly recommend that people who want to work in healthcare consider being a PA. The best way of explaining advice I would offer is a metaphor from my former Course Director. This role is for people that "want to be part of the crew and are happy not to captain the ship".