BMA submission to the independent review of the physician associate and anaesthesia associate professions

About the BMA and this submission

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

This response has been submitted to the independent review of the physician associate (PA) and anaesthesia associate (AA) professions. The review, commissioned by the Secretary of State for Health and Care in England and chaired by Professor Gillian Leng CBE, is considering the safety of these roles and their contribution to multidisciplinary healthcare teams. The conclusion of the review is intended to inform the revised NHS England workforce plan, which in turn will seek to deliver the 10 Year Health Plan for England.

The BMA response has been developed collaboratively through its dedicated PA and AA Steering Group. Membership of the Steering Group encompasses doctors from across the medical specialties and throughout the UK and has representation from the BMA's Patient Liaison Group.

The response is based on the views and experiences of the medical profession, obtained through dedicated surveys, and through individual submissions to our data collection portal. It covers the key areas of the review's terms of reference - selection and recruitment, training, day to day work and scope of practice, oversight and supervision, and addresses the role and views of the General Medical Council (GMC) throughout. It also addresses the international experience of assistant/associate roles, and importantly, provides a comprehensive list of recommendations to assist the review team.

The following BMA documents are central to this submission and should be read in full by the review team:

1. BMA resident doctors committee and GP registrar committee statement, October 2023
2. BMA commissioned public omnibus survey results, November 2023
3. Medical Associate Professions (MAPs) survey report, February 2024
4. BMA member survey on PAs, AAs and safety, February 2025
5. Response to draft NHS England MAPs Career Development Framework, February 2024
6. Safe scope of practice for Medical Associate Professionals (MAPs), March 2024
7. Guidance for the supervision of Medical Associate Professions (MAPs), May 2024
8. Physician associates in general practice: making it safe for patients and GPs, August 2024

Terminology

1. Physician associates and anaesthesia associates are healthcare workers who work as part of multidisciplinary teams**.** However, to widen the appeal of these occupational groups, DHSC, NHS England (and devolved nations health services), and the GMC have repeatedly used terminology that inappropriately blurs the lines between these roles and those of uniquely qualified medical practitioners. This is particularly apparent in descriptions of physician associates. Physician associates are not medical practitioners. They are not medically trained, are not members of the medical profession, and therefore cannot be described as medical professionals. Claims by DHSC and NHS England that physician associates are *'trained to the medical model'* seek to draw misleading comparisons to the practice of medicine, when medical students who have trained as a PA in the past have reported to us the training bears no comparison.

2. In a BMA survey of doctors and medical students in November 2023 (report published February 2024), which generated over 18,000 responses, only 2.3% of respondents disagreed with the view that physician associates and anaesthesia associates should revert to their previous titles of physician assistants and physician assistants (anaesthesia). Over 90% felt PAs and AAs should not be described as having undertaken medical training. 86% of respondents felt the public had no understanding of the difference between PAs/AAs and doctors. In February 2025, a further BMA member survey showed that 86% of over 14,000 respondents disagreed (17.1%) or strongly disagreed (68.1%) with the view that PAs, AAs, and doctors should collectively be known as 'medical professionals' – only 8% agreed (5.8%) or strongly agreed (2.3%).

3. As part of an omnibus survey of 2,009 members of the public held in November 2023, one in four believed physician associates were doctors. Only 46% of respondents felt that when receiving care in the NHS, is it always clear when they were being treated or cared for by a doctor. In a randomised ranking of professionals by seniority, physician associate scored higher in perceived seniority than junior doctors (now known as resident doctors). Importantly, one in five respondents felt that the title 'physician assistant' also referred to doctors. This shows that additional efforts beyond a name change will need to be made by employers and stakeholders to ensure the public are aware that PAs are not doctors.

4. The review team will be aware of the tragic case of Emily Chesterton who died aged 30 after two appointments with a physician associate whom she believed was a GP. Regarding terminology, Emily's mother Marion previously told the BBC that her daughter *'didn't know she hadn't seen a doctor'* and that '*Physician associate sounds grander than a GP'*. The review team will also be aware of the Pamela Marking: Prevention of Future Deaths Report from the Coroner (Surrey) from 24th February 2025, which listed the first concern as '*The term 'Physician Associate' is misleading to the public'*. The Susan Pollitt: Prevention of Future Deaths Report from Coroner (Manchester North) dated 31st July 2024 also stated, *'The lack of a distinct uniform and the title "Physician" gives rise to confusion as to whether the practitioner is a doctor.'*

5. While the Faculty of PAs and other institutions have provided guidance on titles and introductions to help with the understanding of the physician associate role, this approach attempts to manage a problem associated with an inappropriate title, rather than looking at the role the title itself has played in creating the confusion.

6. There is even evidence of a lack of understanding within the NHS, as illustrated by a marketing campaign (later withdrawn) *"It's a GP Practice Thing"* by one NHS Integrated Care Board apparently designed to help the public understand PAs, which advanced "*Your Physician will see you now*" in reference to and containing a picture of a Physician Associate (see below). The use of the professional title "Physician" is amongst those protected by section 49(1) of the Medical Act 1983 (the 1983 Act), and its misuse can constitute a criminal offence (per s. 49A).

7. A related poster referred to a "Cancer Specialist" (above) and another (see Appendix 1) misleadingly portrayed health professionals supporting GP practices as part of a "specialist team" including a "Physician", dressed in a white coat and stethoscope and described as carrying out examination and diagnosis associated with the work of a qualified doctor, and referred to consultation, treatment and referral by "mental health experts".

8. The BMA has legally challenged the GMC's decision to apply its core guidance document for doctors – Good Medical Practice – to associates / its failure to produce distinct and appropriately tailored guidance for associates, and the GMC's decision to characterise doctors and associates alike as "*medical professionals*", both in Good Medical Practice and more generally. We believe that the GMC's approach is unlawful because it is inconsistent with the applicable statutory framework, unlawful for want of appropriate regard being given to patient safety and confidence in the professions, as required by the GMC's statutory objectives, and irrational.

9. The GMC's approach poses significant concerns for public understanding of, and confidence in, the medical profession and the associate professions, and give rise to real patient safety concerns. These become particularly acute when considered in combination with the lack of any nationally agreed standards or guidance as to the ambit of the work that associates may undertake. The skeleton argument providing further details of the BMA's legal challenge of the GMC's approach to Good Medical Practice and its use of the term 'medical professionals' is available in Appendix 2. We await the outcome of our legal challenge, conscious that the role and remit of the court in determining unlawfulness is not the same as the safe and effective practice test that has been set by the Leng review, which includes looking '*at concerns that have been raised about potential confusion caused by regulation of the roles being*

undertaken by the GMC rather than another regulator, and consider any actions that could be taken to avoid confusion for those providing and receiving care.'

10. The BMA's February 2025 survey found that 78.7% of respondents agreed (13.2%) or strongly agreed (65.5%) that the GMC's Good Medical Practice guidance document should only set out the principles, values, and standards of professional behaviour expected of doctors and not any other profession. It also found that 93.8% of over 14,000 respondents agreed (15.1%) or strongly agreed (78.7%) that as the GMC is now regulating PAs and AAs, it should publish separate, standalone guidance that sets out the principles, values, and standards of professional behaviour expected of PAs and AAs.

11. An additional concern is that associates registered by the GMC that breach professional standards may face an associate tribunal panel run by *'The Medical Practitioners Tribunal Service'* (MPTS). Given the passing of The AA and PA Order, the MPTS needs to be renamed to accurately describe its expanded role. It is possible that future associate cases may become high-profile and generate significant media and public interest, it is therefore important that the pubic don't assume an associate is a qualified medical practitioner because their tribunal case is being managed the 'medical practitioners' tribunal service.

12. In 2014, Health Education England (now incorporated within NHS England) created the single umbrella term 'Medical Associate Professions' with the intention to work *'towards a common education and training programme to support a route to statutory regulation'*. This originally applied to PAs, AAs, and Surgical Care Practitioners (SCPs), with Advanced Critical Care Practitioners (ACCPs) added later (and since being withdrawn). In the BMA's legal case mentioned above, the GMC sought to argue that the widespread use of the term 'MAPs' was evidence that PAs and AAs were members of the 'medical profession'. With AAs and PAs now being subject to statutory regulation, there is no logical reason for NHS bodies, employers or regulators to retain this misleading umbrella terminology to discuss three distinct professions, with its retention only serving to further confuse between doctors and non-doctors. It is notable that the 'MAPs' term is not contained in any part of The AA and PA Order 2024. Confusion within the GMC itself regarding existing terminology has been demonstrated in its response to a FOI request dated 11th March 2025 (see Appendix 3), where, following a complaint about a PA, the GMC stated *'We have carefully considered the concerns that you have raised but unfortunately, these do not appear to be issues we can assist you with. This is because we can only consider concerns about individual doctors and physician associates on our list of registered medical practitioners'*. Physician associates cannot legally be included in the statutory list of registered medical practitioners held by the GMC. For clarity, this submission now refers to PAs and AAs as Associate Professionals (APs), in line with the Parliamentary defined AA and PA Order.

13. Scope of practice and the day-to-day work of associate roles is discussed in detail later, but there are many examples of highly inappropriate associate job descriptions and role profiles that effectively blur the lines between associate and medical practitioner roles. The review team should commission a comprehensive review of all job adverts, job descriptions, and role profiles issued by the NHS across the UK in recent years to better understand this problem and recommend solutions. Job descriptions, such as this example where PAs are described as clinically supervising resident doctors, and expected to *'lead medical and nursing staff in all clinical emergencies'* should never be issued. Nor should descriptions such as this recent example, state that PAs '*will provide expert evidence-based advice and clinical expertise within the ED'*.

Terminology recommendations

a. The AA and PA Order must be amended to change the regulated titles of PAs and AAs to physician's assistant and physician's assistant (anaesthesia) / anaesthesia assistant[1].

b. The Medical Practitioners Tribunal Service must be renamed 'The Medical Practitioners and Associate Professions Tribunal Service' – with this name amended further to reflect future changes to the protected titles of the currently named 'associate professions', for example, 'The Medical Practitioners and Physician's Assistants Tribunal Service'.

c. UK government departments, NHS bodies, statutory education bodies, higher education institutions, the GMC, and NHS (and private healthcare) employing organisations must not describe PAs and AAs (or any future legal definition) as:

    - medical practitioners
    - medical professionals
    - being medically trained
    - being trained in/to the medical model
    - having undertaken aspects of medical training
    - having more focused training than doctors in any aspect of their training

d. The GMC must retain Good Medical Practice solely for the medical profession, publishing separate professional standards for associates (with the title of these standards changed to reflect future title changes discussed above).

e. UK government departments, NHS bodies, statutory education bodies, higher education institutions, the GMC, and NHS (and private healthcare) employing organisations must discontinue the use of the umbrella term 'Medical Associate Professions' and 'Medical Associate Professionals' to describe separate and distinct non-doctor occupational groups.

f. NHS bodies and private healthcare providers must ensure that PA and AA job descriptions, role profiles, and job adverts accurately describe the PA and AA roles, clearly distinguishing them from doctors.

g. Based on nationally agreed scopes of practice, nationally agreed role descriptions, role profiles, and recruitment material must be adopted within the NHS and by private healthcare providers

Selection, recruitment, and training

14. When describing the qualifications of physician associates, it has long been claimed that they benefit from an undergraduate bioscience degree. DHSC has stated that *'PAs usually undergo a three-year undergraduate degree, in a health, biomedical science or life-sciences subject followed by two years postgraduate training, gaining significant clinical experience.'* And that *'The course curriculums overlap with undergraduate medical degrees in certain areas but offers a more focused and less extensive training compared to what medical students receive'.*

[1] This is current BMA policy, but another term may be appropriate if consulted upon.

15. However, an investigation by The Telegraph in March 2024 noted undergraduate degrees in homoeopathy, computer science, banking, English literature, anthropology, geography, management and global health, and human resources have all been being accepted as entry qualifications to train to become a physician associate. Freedom of information request responses from 14 PA course providers found that 456 undergraduate degrees were accepted over a three-year period, which were neither biomedical science related degrees nor linked to past allied healthcare qualifications. Claims by DHSC that any PA course provide *'more focussed'* training in any aspect compared to medical student training is unhelpful and misleading.

16. The BMA and RCGP has made it clear that there is no role in general practice for physician associates. Government health departments, NHS England, and devolved nation health bodies must take note of this clear patient safety and care quality position when undertaking essential workforce planning. Higher education institutions must highlight to all future applicants to PA courses that a career in general practice must not be assumed.

17. In 2022, the GMC published its overarching generic and shared professional capabilities and outcomes that newly qualified PAs and AAs must meet to be registered. The outcomes in this framework have been embedded in the respective curricula. The GMC's medical development team has been working with the Physician Associate Schools Council (PASC) to prepare for final approval of both the AA and PA curricula. This follows a change of submitting body for the PA curricula from the Faculty of PAs (under the auspices of the RCP) to the PASC in late 2024. Both curricula were subject to a review against a draft set of curricula standards in 2022. The GMC finalised AA and PA curricula standards in 2024, and the RCoA and PASC have been invited to make a formal application for approval following legislative changes in December 2024. Formal decisions regarding approval of PA and AA courses will be made by GMC Council in Spring 2025. Our medical student BMA members who have been trained as PAs within UK universities report a wide variation in the standard, quality and experience of teaching they received in their PA courses.

18. The BMA's safe scope of practice for the associate professions sets out parameters that NHS employing organisations and private providers should adopt to help doctors and other staff to provide safe, high-quality care. These safe practice parameters reflect the notion that associate qualifications are appropriate for working in an assistant role under the direct supervision of a doctor and at no stage should any MAP work beyond the parameters of this scope document. Currently, the GMC's generic and shared professional capabilities and outcomes document, its 'PA registration assessment content map' its 'AA registration assessment content map and guidance' and other curricula documents aspire to competencies way beyond the level that is safe for those undertaking a two-year non-medical course. The GMC's documentation has led to the publication of dangerously unsafe guidance issued by UMAPs and CMAPs on scope and supervision, which promotes self-assessment and sign-off of competencies by associates. Rather than progressing with curricula approval, the GMC should take stock of the outcome of the Leng review and re-assess (engaging fully with the medical profession) its AA and PA capabilities and outcomes expectations, content maps, and curricula applications (or any approvals) to ensure patient safety.

19. In our November 2023 survey of over 18,000 doctors and medical students, 78% of respondents included concerns regarding the quality of PA and AA training as one of the reasons they felt PAs and AAs presented a risk to patient safety. 68% of respondents (who have worked or trained with PAs or AAs) reported that the training of PAs and AAs had a *somewhat negative* or *very negative* impact on the training of doctors. Our reporting portal

also collected 236 separate incidents of medical education and training being directly impacted by the PA and AA roles. Appendix 4 shows the geographically widespread impact on medical education and training. It has also been reported that past decisions to expand associate training has directly impacted the funding made available to train doctors.

20. As we have stated above, several PAs have decided to pursue a career in medicine. The review team would benefit from hearing directly from those who have completed, or are currently part-way through, their medical education, as they will have a helpful understanding of the ability of PA course providers to meet current curricula requirements and of the overall quality of PA training. There are worrying reports of occasions where the pass rate was 100% over a three year period, raising questions about the robustness of the exams being set. The review team should explore the data held by the Royal College of Physicians (host of the now closed Faculty of PAs) of all Physician Associate National Examination pass rates from PA schools.

21. The current ownership of the PA and AA curricula is also a concern. The curricula for dependent healthcare workers assisting doctors should be set by the medical profession, and while members of the PASC should of course contribute, an independent body of doctors, without links to course providers, should determine proportionate and safe expectations of what can be covered in curricula for assistant roles within a two-year training period. The GMC has stated that '*each profession will define their scope of learning and practice in their specific curriculum*' – this must not be the case and is inappropriate for dependent, assisting occupational groups.

Selection, recruitment and training recommendations

h. UK government departments, NHS bodies, statutory education bodies, higher education institutions, statutory regulators, and NHS (and private healthcare) employing organisations must provide accurate information on the qualifications needed to train as an AA or PA.

i. Ownership of PA / AA curricula must be held by an independent medical practitioner body.

j. Exam setting arrangements and the pass rates for PA schools must be reviewed to assess the robustness of the PA National Examination (PANE).

k. Following the outcome of the Leng review, and the establishment of national scopes of practice, the GMC must revise its PA and AA generic and shared learning outcomes document and related content maps, and review existing approved or submitted curricula to ensure their contents match the agreed level of care that can safely be delivered by dependent assisting roles.

l. The training opportunities of medical students, foundation doctors, and resident doctors must be prioritised over the training opportunities of those who assist doctors. This will ensure that doctors are suitably equipped with knowledge, skills, and competencies for developing the expertise they must acquire to practice medicine.

m. The funding and provision of medical student, foundation doctor, and resident doctor training places must be prioritised over the funding and provision of training for doctor's assistants.

Scope of practice

22. There is no nationally agreed scope of practice for AAs or PAs. The absence of agreed scopes of practice is a fundamental failing that lies at the heart of today's patient safety concerns. In our November 2023 survey, 87% of respondents felt the way that PAs and AAs currently work in the NHS is a risk to patient safety. 91% of respondents felt there is a risk of PAs and AAs working outside of their competence. Our reporting portal contains 622 separate entries of patient safety concerns, 287 of which were directly linked to associates working beyond a safe scope of practice by replacing doctors on medical rotas. Appendix 4 shows the geographical spread of patient safety incidents. This has been described to us as a scandal that has been facilitated by an absence of a national ceiling of safe practice. Doctor substitution in this way should never take place. It is clear that if nationally agreed safe scopes of practice were implemented it would be more difficult for employers to place associates directly on medical rotas.

23. An extensive range of patient safety concerns regarding scope have been submitted to the BMA's reporting portal (Appendix 5); however, the nature of the concerns can be seen from the examples below:

'A physician associate refers to themselves as doctor/junior doctor to other staff and to patients, resulting in confusion within the workforce. This same PA assessed a patient independently on a ward round. This patient had had an iatrogenic opioid overdose due to her poor renal and hepatic function. Her oxycodone and buprenorphine patch were stopped by the on-call doctor who was alerted of this. During the PAs ward round, they restarted the buprenorphine patch and Oxycodone, asked their colleague to prescribe it, without any documentation of discussion with the consultant. This resulted in another opioid overdose in this patient.'

'Physician associate on AMU. Patient spiking temps with CRp >400. CXR looked like effusion so I asked resp to see for chest drain ?empyema. The PA said "I can do chest drains". I said "are you signed off for pleural USS?" He said "I can do ultrasound and chest drains". I said "I'll call respiratory". The PA got the ultrasound and said "there's loads of fluid, come on let me tap it" I said "no we will wait for respiratory as you are not pleural ultrasound trained" he was very insistent but I stood my ground. respiratory came and scanned the patient. The lung was collapsed and the PA was scanning the spleen, he was very close to sticking a needle into the patients spleen.

'A PA I worked with runs the ascitic drain clinic and trains IMT trainees and signs off their DOPs for ascitic drains, and yet when one of the IMTs asked them about calculating the dose of lidocaine they responded "I don't know I just give them Xmls". Same PA is then looking at a coronal CT scan of a patient who has had a huge intrabdominal haematoma following ascitic drainage, when myself and the registrar look at the scan and comment on the size of the collection, the PA agrees that it appears huge whilst pointing to the patient's pelvic bone. So we have a scenario where the PA can complete ascitic drains to a good practical standard, but they cannot appreciate any variation from the norm, and they haven't the knowledge to understand the pre-procedure checks or the post procedure complications. The same PA also works on the Acute Unselected Take but cannot recognise a pelvis on a coronal CT.'

'A respiratory PA at my hospital recently inserted a chest drain in a patient unsupervised. This patient was a haematology patient who had platelet levels of 8. Normal platelet levels are >150. Therefore, this patient was at extremely high risk of having uncontrolled bleeds.

Chest drains are an invasive procedure which involves cutting through all the layers of the skin to enter the pleural cavity. The chest drain, as expected, caused the patient to have a significant bleed and deteriorate over night. The PA told no doctors from either the respiratory team nor the haematology team that they were inserting the chest drain. Luckily the night doctors transfused the patient and gave medication to control the bleeding. However, this could have easily resulted in a catastrophic outcome.'

'PAs working as 'SHO's on the on-call rota for orthopaedics in a major trauma centre. This means the on-call registrar only has a PA to help with the on-call in one of the busiest trauma centres in the country, as the admitting specialty for all major trauma in the region. This is dangerous.'

'Today I came across A DNACPR form that had been completed by a PA. It had been signed by a PA who used the countersigning consultant's GMC number under their own name (the electronic form does not allow the form to be completed without a GMC number).'

'PA is leading ward rounds for the paediatric neurosurgical team. The SHO is used as a scribe instead.'

'Anaesthesia associate running gynae list. He was only anaesthetic representative present during the brief. He is the only anaesthetic representative on the operating note. Consultant anaesthetist was present for 5 minutes of the operating list when associate was not present. Anaesthetic associate was not directly supervised at any point during operation. In addition, anaesthetic associate was giving medications during gynae operation, no one directly supervising him.'

24. The GMC has argued that once registered, it simply requires AAs and PAs to work within their competence and that this requirement can be enforced without the need for any universal limit/restriction on what (outside legal restrictions such as prescribing) an AA or PA may do. The GMC has stated it can take a case-by-case approach to regulating the competence of AAs and PAs, and that it can assess whether a particular AA or PA has worked beyond their competence by having regard to guidance from employers, the Royal Colleges, and if necessary, an expert. It has stated *'we don't set a defined post-qualification scope of practice that determines what tasks registrants can safely carry out, as this depends on their individual skills and competence which develop over time.'*

25. This liberal approach to scope of practice has been adopted in the NHS since the associate roles were first introduced to the UK. By allowing a free-for-all within the NHS on what PAs can and can't do, hospitals have become a postcode lottery in which local decisions on basic competence, and if/when this can expand, has resulted in unsafe variation. The BMA's February 2025 survey found that 75.2% of respondents were fearful of being unfairly blamed for errors involving associate roles in their workplace, with over half of all respondents practising defensively when engaging with associate roles because they believe they are working in a blame culture. Only 10.4% of respondents believe that senior NHS leaders can ensure that PA and AA roles are used safely in the NHS. The medical profession's faith in the leadership of the NHS has been further eroded following the publication of a rapid systematic review of recent UK based research of PAs and AAs in the UK. The findings of this review are in start contrast to the claims by NHS England on 22nd November 2023 that *'[Physician associates and anaesthesia associates] perform specific aspects of patient care and, based on case studies, clinical and professional engagement and literature reviews, are proven to increase the effectiveness of multidisciplinary teams.'* And that *'This evidence tells us MAPs*

are safe, increase the breadth of skill, capacity and flexibility of teams, positively contribute to patient experience and flow, and reduce workload pressure on other clinicians.' A letter from the BMA to NHS England addressing the research and calling for action has been published.

26. In contrast to the GMC, the General Dental Council (GDC) first developed a scope of practice guidance document in 2008-09 to support dental professionals through the legislative change to registration. All dental professionals working in the UK now had to be registered with the GDC. Following the transition to registration of dental nurses, dental technicians, clinical dental technicians, and orthodontic therapists, there were calls for more guidance to distinguish roles and responsibilities within the dental team. The GDC felt that the guidance would help to protect and promote patient safety and wellbeing, as it would support new dental professionals to practise safely and legally, and it would help patients to understand the roles within the dental team.

27. The GDC published its current scope of practice guidance in 2013 and commissioned a review of its approach to scope of practice, the conclusions of which were published in June 2020. The report found that dental professional awareness and understanding of their own scope was high and had mainly come from their education before they qualified. It also found that dental professionals and stakeholders were keen for the scope of practice guidance document to continue to exist and when the scenario of the guidance document no longer existing was aired, they were generally fearful of what would happen in its absence. There were concerns that this could lead to dental professionals acting out of scope. A few stakeholders and dental professionals were less concerned, but they still felt that the scope of practice guidance document needed to continue to exist.

28. Anaesthetists United, a grass-roots medical campaigning organisation, has issued judicial review proceedings against the GMC, stating it has '*failed to fulfil its duties and lawfully exercise its powers under the Medical Act 1983 and the Anaesthesia Associates and Physician Associates Order 2024, by failing to introduce the safe and lawful practise measures'*. In response, Mr Justice Chamberlain allowed the challenge to proceed and advised that *'the claim raises serious issues of importance to the relevant professions and to patients which should be determined on a reasonably expedited basis'*.

29. Although the GMC has refused to set scopes of practice for AAs and PAs, it did respond to Royal College consultations on draft scopes and supervision guidance. In response to the RCP London, it stated that *'We are also concerned that the guidance on PA supervision and scope of practice appear in places to be somewhat burdensome and restrictive, to the extent that, if adopted as drafted, it could have the effect of dissuading employers from employing PAs'*.

30. In response to the RCGP, it stated that *'we are concerned that the draft guidance on PA supervision and scope of practice appear in places to be somewhat burdensome and restrictive, to the extent that, if adopted as drafted, it could have the effect of dissuading GP practices from employing PAs'*. Given the GMC's statutory overarching objective to protect the public, it is highly irresponsible for it to essentially encourage royal colleges to set laxer standards for associates in order to make them more appealing to employ. Patient safety should be the only priority when defining what PAs can do, not their employment prospects. Keeping patients safe is not burdensome, it is essential. It is the duty of doctors under paragraph 75 of Good Medical Practice to raise patient safety concerns promptly, but both the GMC and NHSE have ignored thousands of doctors raising such concerns: "*You must act*

promptly if you think that patient safety or dignity is, or may be, seriously compromised". This has led to doctors losing confidence in the GMC as a regulator, because the GMC continues to ignore their safety concerns.

31. In February 2025, a further survey of BMA members found that 95% of nearly 14,000 respondents agreed (18.1%) or strongly agreed (76.9%) that there should be nationally determined scopes of practice for PAs and AAs. Only 2.4% of respondents disagreed or disagreed strongly. In order to avoid asking leading questions, the survey asked questions using different emphases. 87.3% of respondents disagreed (22.3%) or strongly disagreed (65%) that restricting the range of tasks PAs and AAs can perform and designating them as 'assistants' would negatively impact patient care. The survey also found that 82.6% of respondents disagreed (16.7%) or strongly disagreed (65.9%) that PAs should be able to provide initial care to undifferentiated, untriaged patients in general practice and the emergency department.

32. In January 2025, The Nuffield Trust published its research report *'In the balance - Lessons for changing the mix of professions in NHS services'*. This included the following clear recommendation *'Having a clear outline of new and emerging roles and what they can and cannot do, which everybody has access to and understands, has been identified as important, and this will likely require some national intervention NHS England and, where appropriate, professional regulators and counterparts in the other UK nations, must outline (openly) the governance arrangements for the roles and/or publish up-to-date guidance on the scope and ongoing development of these roles. This must include how the range of stakeholders are to be engaged'*.

Scope of practice recommendations

n. Establishment of nationally agreed scopes of practice led by medical royal colleges, specialist medical organisations, and the BMA, with input from associate representatives and patient organisations, that set ceilings of practice for these dependent non-medical roles.

o. Recognition of nationally agreed scopes of practice by the GMC, NHS bodies and NHS Employers, with individual scope setting to be facilitated only below agreed national scope ceilings.

p. Regular monitoring and enforcement of nationally agreed scopes by the CQC (and devolved nation alternatives)

q. Implementation of the BMA's safe scope of practice as an interim measure until nationally agreed scopes are in place.

r. Prior to setting nationally agreed scopes, each of the relevant specialist medical bodies and societies should determine whether there is a role for PAs or AAs in their multidisciplinary team. The views of these bodies should be respected.

Supervision and oversight

33. The BMA's November 2023 survey found that 84% of respondents had concerns with the quality (including capacity/availability) of PA/AA supervision. In May 2024, the BMA published the first guidance for doctors supervising medical associate professionals. This document sets out the BMA's formal position on the supervision of PAs and AAs and must be

reviewed and considered as a central part of this submission. PAs and AAs must always work under the supervision of senior doctors (GPs, consultants, and autonomous working associate specialist and specialty doctors), but until publication of this guidance the responsibilities of those doctors have not been made sufficiently clear, allowing unsafe situations to develop in which PAs and AAs could be seeing patients without clear supervision.

34. The guidance clearly sets out which doctors should be available throughout a PA or AA shift, as opposed to existing practices where in some cases the named supervisors have been unreachable. This represents a major change in practice for some but is seen as vital if the NHS is to ensure consistency in patient safety across all healthcare settings and end practices where AAs and PAs could work unsafely and effectively unsupervised. This guidance has been necessary because of extensive reports from resident and SAS doctors that they have been asked to supervise PAs inappropriately. Again, the GMC Good Medical Practice guidance throws up contradictory and confusing guidance: paragraphs 66 and 67. Paragraph 66: "*You must be confident that any person you delegate to has the necessary knowledge, skills and training to carry out the task you're delegating. You must give them clear instructions and encourage them to ask questions and seek support or supervision if they need it"*. Paragraph 67: "*If a task is delegated to you by a colleague but you're not confident you have the necessary knowledge, skills or training to carry it out safely, you must prioritise patient safety and seek help, even if you've already agreed to carry out the task independently"*. This has caused extensive friction in the workplace because most doctors have little idea of the competencies of individual PAs that they may work with infrequently and the consultants responsible for supervision of individual PAs may not always be in a position to undertake the close supervision required personally, whilst being unable to ensure that appropriate supervision for those PAs has been delegated safely.

35. The guidance includes specific recommendations for both supervising doctors and employers, emphasising the importance of supervising doctors having allotted time for discussions with PAs and to review patients, in accordance with the BMA's safe scope of practice. Practical recommendations are also included for non-supervising doctors who work with APs in their departments or primary care settings. The guidance clearly established that only doctors with sufficient seniority and training can safely supervise APs.

36. In a public letter to the President of the RCP, dated 7th February 2024, NHS England's National Medical Director, its Chief Workforce, Training and Education Officer, and its Director of Education and Training stated that *'Employers must ensure that the supervision of PAs is never to the detriment of doctors'*. Yet the BMA's November 2023 survey showed that over half (55.4%) of those doctors working with associates stated their employment had increased their workload.

37. The BMA's February 2025 survey of members found that 73.9% of nearly 14,000 respondents disagreed (18.7%) or strongly disagreed (55.2%) with the GMC's statement in relation to supervision of PAs and AAs that '*while there should be a named consultant with overall responsibility, we believe clinical supervision may be delivered by other members of the team including trainee doctors*.'

38. To ensure appropriate oversight and address concerns, NHS leaders need to ensure safety incidents are being recorded when they occur. However, the BMA's February 2025 survey shows that only 48.4% of nearly 14,000 respondents agreed that they feel content to report errors, near misses and incidents involving associate roles in their workplace, with over a third

of respondents (37.5%) worried that reporting errors, near misses and incidents involving associate roles would negatively impact their career/training progression, with 8.4% of respondents worryingly agreeing that it has been agreed locally that incidents should be reported directly to line managers rather than using an Incident Recording and Reporting System, such as Datix. Importantly, a FOI dated 13th March 2025 (Appendix 6) has also shown that the errors related to the death of Pamela Marking were not recorded on the NHS employer's incident reporting system.

Supervision and oversight recommendations

s. In each healthcare setting (private or public), PAs and AAs must have an immediately available, named supervisor. Consultants, GPs, and autonomously practising SAS doctors are all suitable as APs' supervisors. There should be a readily available register of supervisors.

t. Locally employed doctors, specialty doctors who do not practice autonomously, or resident doctors (doctors in GMC approved postgraduate training) are not suitable to provide supervision and must not be put into a position where they are asked to do so.

u. Consultants, GPs and autonomously practising SAS doctors who supervise APs delegate only the tasks described in the traffic light tables in the BMA's Safe Scope of Practice for MAPs[2] to those they are supervising in order to minimise risk to patient safety caused by the possibility of dependent practitioners working beyond their competence.

v. Employers must ensure that where AAs and PAs are employed there is adequate time allocated each working day for every patient to be fully discussed with the supervising doctor and reviewed in person by the supervising doctor if necessary.

w. The full list of recommendations set out in the BMA's 'Guidance for the supervision of Medical Associate Professions (MAPs)' May 2024, must be implemented in full by NHS employing organisations and private healthcare providers.

Day-to-day working

39. As noted previously, our data collection portal contains 363 separate reports of associates inappropriately replacing doctors on medical rotas. In addition, in March 2024, The Telegraph reported the widespread misuse of associates on medical rotas. Its investigation found that 31 NHS hospitals in England allowed this doctor substitution to take place, with one advising that '*new junior doctors and PAs can all swap together'* and 10 placing associates on medical rotas when doctors were unwell. Other findings included one hospital roster where the '*on-call cover anaesthetist'* would be filled by an anaesthesia associate, and 10 hospitals where associates were counted as part of the *'minimum safe number of medics on shift'*.

40. While NHS England responded by issuing a letter, advising employers that PAs should not be used as replacements for doctors on a rota. The BMA's calls for an urgent investigation into the unsafe substitution of doctors went unanswered. However, in October 2024, revelations from Channel 4 News showed that over 109 doctors' shifts in 11 hospital trusts had been covered by associates between April and September that year (after the instruction from NHS England in March that this must not happen).

[2] This guidance was issued prior to the AA/PA order that removed the word 'medical' when referring to Associate Professionals. The BMA will be updating this guidance in due course.

41. In addition to substituting doctors, numerous responses to freedom of information requests, often circulated on social media, have shown that many PAs and their NHS employing organisations have breached prescribing regulations and ionising radiation regulations that have been put in place to ensure patient safety. For example, this has occurred in Leeds where reports show 1,168 ionising radiation requests were made by PAs.

42. We strongly believe that assisting, dependent roles should not have prescribing rights, nor should they direct/instruct/advise a doctor or other professional to prescribe a medication, alter or cancel an existing prescription, or request ionising radiation imaging. Despite being legally prevented from doing so, a FOI response has provided one example of an employer enabling associates to issue medicines via Patient Group Directions.

Day to day working recommendations

x. An investigation into the unsafe substitution of doctors by associates must be instigated to examine the full extent of the problem across the NHS.

y. Staff rostering systems must ensure the complete separation of doctor and non-doctor roles with dedicated doctor-only rosters, which prevent non-doctors being assigned to duties that can only be undertaken by doctors

z. The Care Quality Commission in England (and devolved nation systems regulators) must ensure that a review of hospital staffing rotas is built into its monitoring and inspection protocols

aa. All NHS hospitals and trusts must undertake an urgent review of all electronic prescribing systems, and ionising radiation requesting systems, to ensure associates are prevented from accessing them.

bb. Any instances of non-doctors on medical rotas, inappropriate prescribing requests, and breaches in ionising radiation protocols, must be reported at Board level, with a senior leader accountable to ensure safe practice.

General practice

43. The number of PAs working in general practice settings has increased significantly in the last decade. This has been driven by contractual arrangements in England which, since 2019, have resulted in practices (via Primary Care Networks) receiving direct funds from NHS England to cover the costs of employing PAs. The conditions attached to this funding arrangement have been set out in the various annual '*Network Contract DES – Contract specifications – PCN requirements and entitlements'*. From April 2020 until April 2024 the requirements were as follows:

'Where a PCN employs or engages one or more Physician Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Physician Associate has the following key responsibilities, in delivering health services:

a. provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable);

b. support the management of patient's conditions through offering specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes, and anticoagulation;
c. provide health/disease promotion and prevention advice, alongside analysing and actioning diagnostic test results;
d. develop integrated patient-centred care through appropriate wording with the wider primary care multi-disciplinary team and social care networks;
e. utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks;
f. participate in duty rotas; undertaking face-to-face, telephone, and online consultations for emergency or routine problems as determined by the PCN, including management of patients with long-term conditions;
g. undertake home visits when required; and h. develop and agree a personal development plan (PDP) utilising a reflective approach to practice, operating under appropriate clinical supervision'.

44. Between April 2020 and April 2024, the GP contract in England perversely financially incentivised GP practices (via PCNs) to employ PAs, only to dictate exactly the range of clinical work PAs should undertake. Once PAs were in place, this put practices in the invidious position of trying to meet their contractual requirements and provide safe and effective care at the same time. Given the Network DES required PAs to provide first point of contact care to patients presenting with undifferentiated, undiagnosed problems, this was virtually impossible.

45. In April 2024, the *'Network Contract DES – Contract specifications – PCN requirements and entitlements'* was updated to state the following:

'B6.2. Where a PCN employs or engages one or more Physician Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Physician Associate has the following key responsibilities, in delivering health services:
where their named GP supervisor is satisfied that adequate supervision, supporting governance and systems are in place, provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable). The GP supervisor must take into account a Physician Associate's knowledge, skills and experience gained through their training and development.'

46. A further set of requirements is also listed; however, this update provides the same financial incentives while continuing to burden supervising GPs and practices with responsibility and accountability if they facilitate PAs to work in this way. As mentioned previously, the recent Nuffield Trust report has warned against the distortion in decision-making that comes with certain central funding mechanisms. It states:

'Central financial salary support, with its clear financial appeal to providers, has been cited as a driver for the expansion of new and emerging roles. But this may be distorting local decisions, as the salary costs that providers meet differ significantly from the total costs, including any central support, from a taxpayer perspective. Such central funding has taken different forms, including national funding to support the training of nursing associates, and various forms of salary reimbursement. In general practice, three-quarters (78%) of the growth in staff in general practice over the past five years has been through the Additional

Roles Reimbursement Scheme (ARRS), which covers the cost of salaries for additional roles for practices. This means that the effective average annual salary costs for practices to employ an existing salaried GP and a general practice nurse have been approximately £106,000 and £49,000, respectively, compared with £0 for a clinical pharmacist or physician associate (for example) and – due to a separate education and training tariff – £0 for a GP registrar.'

47. As noted previously, the BMA and RCGP have made it clear that there is no role in general practice for physician associates. The BMA view was made clear at a meeting of GPC UK on 17th October 2024, where an overwhelming majority of members voted in favour of the following motion:

    'This meeting believes that the role of physician associates in general practice is fundamentally unsafe and:
    1. *There should be no new appointments of physician associates in general practice*
    2. *The role of physician associates in general practice should be phased out*
    3. *The role of a physician associate is inadequately trained to manage undifferentiated patients, and there should be an immediate moratorium on such sessions*.

48. However, for those already in working in general practice, both the BMA and RCGP have separately produced safe scopes of practice and accompanying guidance that ensures patient safety. In relation to general practice funding, the BMA is also clear that the current Additional Roles Reimbursement Scheme (ARRS) funds linked to the Network Direct Enhanced Services Contract should instead be added to the core GP practice contract to enable practices to determine how best to provide for their patients.

General practice recommendations

cc. NHS England should redirect current ARRS funding into core general practice funds to enable practices to make their own decisions on how best to invest in its own medical practitioner and healthcare worker workforce.

dd. GP contract arrangements across the UK must exclude any binding directions on the utilisation of general practice healthcare staff.

ee. Workforce planning by government and NHS bodies must take account of the RCGP and BMA opposition to the role of PAs in general practice and modify current and future workforce plans to reflect this opposition.

ff. UK statutory education bodies, NHS bodies, and higher education institutions must highlight to all future applicants to PA courses that a career in general practice must not be assumed and may not be financially supported by central government or NHS body funds.

gg. Existing safe scope of practice guidance and supervision guidance issued by the BMA and RCGP must be recognised by NHS bodies, CQC and equivalent devolved nation systems regulators, and the GMC to assist practices to provide safe care.

The international experience

49. We note that the review will draw upon international evidence to produce a comprehensive picture of the physician associate and anaesthesia associate roles. It will be important for

the review team to listen to the views of national medical associations to ensure that a true picture of the international experience is understood. In January this year we wrote to key international medical associations where assistant roles have been introduced. The responses are provided in Appendix 7, however it is worth highlighting below the nature of feedback. The Australian Medical Association stated the following:

'The reality is that Australia has a highly skilled health workforce with the role of each health profession continuing to evolve in response to the changing health care needs of the community. While there are an estimated 40 physician assistants in Australia, it is an orphaned workforce that has not been integrated into the Australian health system and this reflects the fact that there is no demonstrated need for physician assistants in the Australian context.

There is strong opposition to the role in Australia from a broad cross section of health professions including the medical and nursing professions. While the role is promoted as a solution to workforce shortages, the root cause of these shortages is the chronic failure to invest properly in the existing medical workforce and the broader health system. It is disappointing that policy makers ignore this and look instead to simplistic solutions that fragment care, deliver poorer health care outcomes and result in higher costs in the longer term. There is also longstanding concern that physician assistants will cannibalise roles and training opportunities that would normally be available to doctors in training.'

50. The response from the American Medical Association (AMA) sets out its opposition to efforts by the American Academy of Physician Assistants to change the official title of the profession from 'physician assistant' to 'physician associate' and confirmation of its view that physician assistants have neither the didactic education nor clinical training to practice independently. It provides a warning for those seeking to enhance the role of associates, as it states that 'allowing non-physicians, including physician assistants, to have their own primary care panel of patients led to higher costs, more referrals, higher emergency department use, and lower patient satisfaction than care provided by physicians.'

51. Those seeking additional rights for associates should note the AMA view that *'multiple studies have found that physician assistants and other non-physicians order more diagnostic imaging in the emergency department compared to physicians.'* And that *'Other studies have also found that physician assistants tend to prescribe more frequently compared to physicians.'* Specifically, the AMA have highlighted *'a 2020 study published in the Journal of Internal Medicine found that 8.4 percent of physician assistants prescribed opioids to more than 50 percent of their patients, compared to just 1.3 percent of physicians. The study further found that in states that allow independent prescribing, physician assistants and nurse practitioners were 20 times more likely to overprescribe opioids than those in prescription-restricted states'* and that *'Physician assistants also tend to prescribe more antibiotics compared to physicians'*.

52. The review team should also be aware of widespread international concerns regarding *'task shifting'* away from the medical profession. The was the subject of a World Medical Association resolution in 2011 and reaffirmed in 2019 and contains 15 important recommendations. The European Union of General Practitioners (UEMO) also set out its concerns regarding associate/assistant roles in October 2024, calling upon *'all governments to legislate prohibiting the initial assessment, unverified diagnosis, treatment, and discharge of the undifferentiated patient by Physician assistants/Physician Associates'*.