Principles for effective working
Doctors and the Medical Associate Professions working together
Introduction

This document outlines a range of principles that can help to improve the ways that doctors and MAPs work together and identifies possible solutions to some of the common problems that have arisen with the introduction of MAPs.

The four roles which fall within the Medical Associate Profession (MAP) bracket are; PAs (Physician Associates), AAs (Anaesthesia Associates), SCPs (Surgical Care Practitioners) and ACCPs (Advanced Critical Care Practitioners). While there are significant differences between the roles, they are alike in the way that they work to the medical model; setting them apart from other clinical professionals working in the MDT (multi-disciplinary team). Over the past 15 years, MAPs have been introduced into the NHS without a formal national programme and little central co-ordination. These roles were entirely new to the NHS and at time of publication are unregulated\(^1\), leading to inevitable local variation in how they work and how they are supervised.

Consequently, a great deal of concern has been generated throughout the medical profession as to what MAPs mean for the future of the role of the doctor and about the way their introduction has influenced day-to-day working life in the NHS. Some of these concerns have centred on practical matters such as impact on training and lines of accountability, while we have also heard broader concerns about what MAPs mean for patients and that MAPs are being brought in as a quicker and cheaper alternative to training doctors. At the root of these concerns is a general lack of clarity, at local and national levels, about what MAPs are for, how they should work within MDTs and how they fit with established clinical roles.

Many doctors support and understand the benefits of working in a more multi-disciplinary workforce. When asked to what extent they approved of the current focus on expanding the non-medical clinical workforce, nearly twice as many doctors approved as disapproved\(^2\). However, a survey of BMA members\(^3\) showed that 74% of respondents were worried about new clinical roles lacking accountability for their actions, whereas 62% were concerned that they are seen as a cheaper alternative to doctors and will undermine medical recruitment.

Despite this, most doctors who have experience of working with MAPs report having positive experiences, with two-thirds rating their experience as highly positive or somewhat positive, with only one in seven saying it was 'highly negative' or 'somewhat negative'\(^4\). This general positivity was reflected in research we conducted with the profession while developing this principles document.

If managed well, MAPs and other new clinical roles have the potential to free up trainees for training, help reduce workload pressures and allow doctors to focus on tasks where their expertise is essential; all of which ultimately mean providing a better service for patients. However, more work must be done to ensure they fulfil this aspiration and do not fragment systems of medical training.

With the number of MAPs set to increase significantly in the coming years, it is essential that the NHS acts in response to doctors’ and other health care professionals’ experiences and the problems that have arisen from some of the ways that MAPs have been introduced. Sharing good practice must become the norm.

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1 The GMC has been approved as regulator for PAs and AAs, although it will be 2021 at the earliest until regulation is in place. See the BMA’s Medical Associate Professions in the UK briefing paper for more on this.
2 Ibid, 48% of respondents to our 2018 survey stated approval, with 25% disapproving
3 Future Vision for the NHS, BMA all member survey (2018)
4 19.11% of those with experience of working with MAPs stated that their experience was neither positive or negative. 45.36% of the total survey sample (816) had experience of working with MAPs.
About this principles document

The principles in this document are drawn from the experiences of a cross-section of doctors and medical students, which were captured by the BMA in a series of semi-structured telephone interviews. Additionally, experience and opinion of BMA members was gathered through its quarterly survey in which a series of questions about MAPs were included, and members were further consulted using the network of BMA committees. In our interviews, we spoke only to doctors and medical students who stated that they had direct experience of working with MAPs. The interviewees were self-selecting via an expression of interest form which was sent out through a range of BMA communication channels. A total of 20 interviews were conducted.

The BMA's Quarterly Survey (Quarter 3, 2019), was sent to a research panel of members including doctors from across the profession. We received a total of 816 responses to a wide range of questions, four of which related to doctors' experience of working with MAPs. The experience of doctors outlined here will provide employers, doctors and MAPs with ideas which can be mutually beneficial to their working lives, whilst helping to ensure positive patient experience and safe care.

This document can be read in conjunction with the BMA's Medical Associate Professions in the UK briefing paper.

Principles

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Doctors and MAPs are distinct professions with distinct roles and must be treated as such

When we asked doctors about MAPs’ scope of practice, it was common to hear that MAPs were treated like ‘any other junior doctor’. The description implies that in many care settings, the distinction between doctors and MAPs is unclear. Over half of survey respondents (56%) who had experience of working with MAPs described MAPs’ scope of practice as ‘poorly defined’.

‘For us the scope of practice for the PAs was to be exactly the same as the junior doctors on our intensive care rota, both night and day. Junior doctors had difficulty with knowing who was in charge…. the problem for us was over the eight years they did not improve at all…I think some of that may be our fault…

...PAs fall between medical and nursing...the PAs felt they didn’t need to be as protocolised as nurses, but they weren’t doctors and protected by that, so they did need to be protocolised...

...we used them to teach the junior doctors how things worked on the ward and I don’t think they liked that...in our unit we no longer employ any PAs.’

Consultant

MAPs can be extremely useful if the benefits and limitations of their roles are properly understood. Currently, PAs and AAs cannot prescribe, and MAPs are not on a pathway of postgraduate education and development in the same way way as a junior doctor who is working towards a Certificate of Completion of Training (CCT). Crucially, the absence of statutory regulation for the roles has restricted the development of universally accepted standards.
Deployed properly, MAPs can reduce workload burden for doctors by picking up appropriate work and providing valuable continuity, but concerns arise if they are placed onto rotas with an expectation, implicit or explicit, that they will work equivalently to a junior doctor. This could put patient safety and the accountable clinician at risk. Treating MAPs as junior doctors may also unfairly raise their expectations about their levels of responsibility and opportunities for development, which can lead to frustration within teams.

Clarity about roles is important to ensure that teams integrate well, to help patients understand who is responsible for their treatment and to ensure junior doctors receive the training they need to become the high-quality senior doctors of the future. It is also essential that there is clarity across the NHS as to why MAPs are being introduced.

### Employers and senior doctors must ensure there are clear mechanisms in place for junior doctors to raise concerns about lost training opportunities and take appropriate measures to ensure that they get the experience they need

In our telephone interviews, senior doctors often spoke of the benefits that MAPs provide in freeing up time for junior doctor training while many juniors raised concerns about the way in which the presence of MAPs has hindered their informal learning opportunities. This disconnect may be a product of the inconsistency in the way that MAPs have been introduced across the UK; there will indeed be care settings where MAPs have freed up time for juniors to train, just as there will be others where the opposite is the case. It also highlights the importance of sharing good practice and ensuring there is greater understanding across the medical profession about MAPs’ roles.

‘...during winter pressures it really helped to have more hands on the ground, and it allowed me to carry out procedures that might not have been possible otherwise’. Junior Doctor (ST1)

In a 2018 BMA member survey, 39% of respondents stated that they were concerned that the training of non-medical practitioners was interfering with junior doctor training. Permanent members within any team will often, over time, build stronger working relationships and develop a level of trust that goes beyond what is possible with doctors who are on rotation. The permanent status of MAPs within teams is one of their great strengths, and senior doctors have told us just how important this has been in improving the way that their department functions.

‘(PAs) have enhanced patient experience by achieving things quicker... by writing discharge notices, transferring care...(and) they can provide the organisational memory that is often missing by being the continuity within the team.’ Consultant

Less experienced junior doctors recognised that MAPs could often perform certain tasks better than the junior doctor. Within busier, more reactive or critical care settings, a senior clinician may automatically seek assistance from a permanent, trusted member of their team in preference to a junior doctor on rotation. While this instinctively makes sense and may work from a service provision perspective, the future of the medical workforce relies upon junior doctors gaining a good range of experiences on their rotations and not missing out on regular or ad hoc training opportunities.

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5 Future Vision for the NHS, BMA all member survey (2018)
‘ACCPs are doing things like rapid sequence inductions (instead of junior doctors)...all of us (junior doctors) want to be doing it so that when we have to do it solo in a few years’ time, we’ve done it before...I feel woefully underprepared to be the ITU registrar and next time I am on ITU it will be as the registrar.’ Junior Doctor (CT2)

‘(The PA) got priority above the doctors for some things like teaching a new skill, for example, introducing fibrinolytic drugs...because she was a long-term investment to the ward’. Junior Doctor (FY1)

While MAPs can be useful in allowing doctors to concentrate on more complex tasks, it is still important that doctors learn how to do the more routine aspects of the role.

‘Often the AAs were taking all of the quick turnover, high-volume stuff and that can leave trainees, who actually need to learn to do things from the start, a little bit high and dry... In critical care they (ACCPs) do a lot of the practical procedures (and) almost all of the patient transport between hospitals... and now having completed this part of my training I have still never done a transport.’ ACCS Academic Clinical Fellow

The challenge of balancing service provision and training opportunities for junior doctors is not new. Employers, local education providers and senior clinicians must engage with their junior doctors continually to ensure that opportunities are not being missed. All junior doctors need to be assured that the importance of their training is understood at managerial and senior clinician level and that there are clear mechanisms to raise concerns should they feel that they are being overlooked. Departments where trainee doctors are placed should carry out an impact assessment to establish how doctors’ training and development could be affected by the introduction of new roles.

‘Every single one of us complained that we weren’t getting the training we needed because training opportunities were being taken away from us due to the ACCPs...the entire cohort sat in a room with the college tutor and highlighted the problem...nothing changed. I appreciate it takes time to affect change and we were only on the unit for three months, but this still had a huge impact on my training’. Junior Doctor (CT2)

‘There are more people to compete with to go to theatre. Cutting a trainee’s time in surgery in half because there is a very inexperienced PA who wants to learn new skills, is not appropriate because the PA is not on a surgical training path.’ Junior Doctor (SHO)
MAPs roles should be carefully designed and their impact on the team properly assessed and reviewed on a regular basis

MAPs offer the possibility of freeing-up doctors to train and to do the work where their expertise is most valuable. These aims should be central to the way that MAP roles are designed. Many of the more senior doctors we interviewed spoke encouragingly of how MAPs have improved their working experience.

‘She (the PA) allowed me to do a ward round properly. She knew the patients inside out and wasn’t called away to do on-calls or other activities.’ Junior Doctor (ST8)

‘They offer continuity. They know the institution they work in much better than junior doctors normally do and they should be able to do the stuff we (junior doctors) really dislike more quickly... all the administration and wading through processes’. Academic Clinical Fellow

Given that MAPs work to a medical model, it can be tempting for managers who are struggling with staffing numbers to try to use them in ways which exceed their capabilities and their scope of practice.

One clinical manager we spoke to had felt that newly employed MAPs should be able to do the same work as junior doctors which led to the creation of an out of hours rota consisting only of PAs. The fact that PAs are dependant practitioners who cannot prescribe or order ionising radiation meant that they felt out of their depth and required frequent contact with a remote supervisor. The all-PA rota did not last long, and the doctor recognised that the experiment had been a failure

‘Having PAs in the rota has meant that we’ve saved money on locums... probably if you asked them, particularly given that 3 of them have resigned, what we were asking them to do was too difficult. Unlike most PAs I was asking them to work at night...I think they would say “he’s made my life hell”’ Consultant

Replacing junior doctors with MAPs on a rota which is likely to exceed their scope of practice and competence may cause more problems than it solves; and treating MAPs as if they are doctors will undermine the potential for them to free up time for doctors to train and to concentrate on the areas where their expertise is needed. As MAPs are dependant practitioners, putting them into situations where they work beyond their scope of practice and level of competence could lead to doctors being held accountable for any mistakes made. It is also important to consider whether the new roles could create tension with the existing staff. We have heard from MAPs representatives that their roles glean their effectiveness from the fact that they are not doctors, what the Head of Kent, Surrey & Sussex School of Physician Associates has called “the DNA of a PA”.

‘Initially integration was very very difficult...the mistake we made was that the PAs came in on a band 7, the nursing staff knew this...band 7 for nursing staff is a very high grade...and clearly these were people with no experience in the workplace at all, and that was detrimental to them and detrimental to our team’. Consultant

https://twitter.com/s_vigor81/status/1186646561352329637?s=19
Inductions for new team members should include clear explanations of the roles that each of the team members play and their responsibilities

When new staff of any kind join a Multi-Disciplinary Team, it is possible that they will not have worked alongside MAPs before. We know that the way MAPs work around the UK and in different care settings varies significantly. So even if new staff have worked with MAPs before, there may be important differences. Ensuring that all new team members have a comprehensive understanding of roles within the team can have a positive impact on team integration and help to prevent confusion about where responsibilities lie. This will give new staff members the best chance of being received positively by their new colleagues; helping them to settle in to the team.

One junior doctor we interviewed spoke very highly of the PAs they had worked with and felt that their presence had helped free up time for themselves and other junior doctors to concentrate on training. The way that this department was organised, with clear explanations about roles and responsibilities, was seen as a crucial factor:

’My clinical supervisor was also the lead for physician associate integration... he talked to us about their roles and what they could and couldn’t do...he did a grand round where he explained to the rest of the hospital the roles of PAs and what they were able to do’ Junior Doctor (ST1)

On the other hand, where there is a lack of clarity about roles and supervisory responsibilities it can lead to confusion and can lead team members to doubt that they are working in the best way:

’No-one has ever made us (junior doctors) aware of what the PAs are supposed to be doing...nobody has ever said you need to supervise them (PAs), but I look over their discharge summaries sometimes, whereas some other juniors won’t do that because they say it isn’t their job...I have no idea how they are formally supervised’ Junior Doctor (SHO)

Results from the BMA quarterly survey suggested that consultants were more likely than junior doctors to believe that the supervision of MAPs is well defined, with a significant majority of consultants describing supervision as ‘mostly clear’ while junior doctors were more likely to say they thought supervision was ‘neither clear nor unclear’ and ‘mostly unclear’.

It must be made clear to MAPs and junior doctors what is expected in terms of sign-off and oversight. Patient safety relies on clinicians getting this right. With PAs and AAs currently unable to prescribe, it is often the case that a relatively inexperienced junior doctor is asked to sign off a prescription or a course of action for a more experienced MAP. This can lead to a problematic dynamic with the doctors torn between micro-managing MAPs’ work and trusting a new colleague.

’There was no formal “this is what they do and this is what we do” induction, it was just finding out as you go, mostly by them (the MAPs) telling you “I can or can’t do that”’. Academic Clinical Fellow
'They had very little autonomy in acute medicine...in Anaesthesia they were always under supervision, but it was quite loose supervision...and in Critical Care I felt that they had a lot of autonomy, even more than the ITU SHOs.'
Academic Clinical Fellow, Acute Care

It is therefore important, alongside good quality inductions, to ensure that a set of broad principles around accountability, teaching levels, scope of practice and supervision are shared across the NHS. While MAPs, like doctors, should be treated as individuals and responsibilities allocated commensurate with their experience and educational need, it is essential that a degree of commonality is achieved across the service.

5 Terminology and uniforms (where in use) should make it easy for patients and other staff to differentiate between doctors and MAPs

It is essential in any care setting that patients and staff are able to discern a clinician’s level of experience or their roles within the team. Uniforms and terminology should be chosen that help to provide clarity about distinctions. This is particularly important given the number of new roles that are being introduced and the ongoing development of MDTs.

In some parts of the country employers have made changes which have led to confusion:

'(The trust) re-branded the role (PAs) so that their uniforms were the same as doctors', albeit with “practitioner” in indiscernible writing, and they would introduce themselves as “practitioner” which I think just means “doctor” to the lay person’. Junior Doctor (ST3)

In care settings where staff wear uniforms, employers should review their policy ensuring that patients are not unintentionally being confused and that staff can easily identify different types of clinician, particularly in fast-paced, high-pressure environments such as A&E and acute settings.

Titles such as ‘Consultant PA’ should be avoided, particularly because, unlike Consultant Nurses, MAPs work to a medical model. Patients may misunderstand the experience of a ‘Consultant PA’ who uses the term ‘Consultant Practitioner’. It is imperative that all patients are clear about who they are speaking to and who is responsible for their care.
Conclusion

Most of the doctors we have consulted are positive about their experiences of working with MAPs and about multi-disciplinary working in general. Doctors understand that, where introduced properly, MAPs can improve patient experience and have a positive impact on their experience of working and training.

When new roles are introduced into the NHS without preparation, co-ordination, or regulation, it is inevitable that there will be some mistakes and unintended consequences. It is vital to learn and take measures to minimise the chances of those mistakes being repeated.

While doctors understand the benefits that MAPs may bring, and are bringing, in care settings where their introduction has been well managed, many are still cautious and concerned about what the changes mean for their own careers and departments. By working together, employers, education providers, doctors and MAPs can ensure that patients benefit from expanding multi-disciplinary working, ensuring that the role of the doctor is enhanced and can continue to evolve to lead the changing shape of healthcare.
Checklist for doctors

– Have you missed training opportunities due to MAPs being preferred for particular tasks?
– Do you understand the role of the MAPs within your team?
– Do you know who is responsible for supervising the MAPs within your team?
– Is there a consistent team approach to MAPs level of autonomy?
– Are systems in place to make sure that patients understand MAPs roles and responsibilities? Have patients expressed confusion?

Checklist for clinical managers

– Does everyone in the MDT know who is responsible for supervising the MAPs?
– Which jobs/tasks within the MDT could be appropriately assigned to MAPs to free up doctors to concentrate on tasks that they are best qualified to perform/learn from?
– Have problems arisen within the MDT that could have been avoided if staff had a better understanding of roles and responsibilities within the team?

Checklist for employers

– Are senior clinicians taking measures to ensure that junior doctors obtain the experience they need?
– Are there clear mechanisms for raising concerns about lost training opportunities? Are junior doctors encouraged and supported in raising and recording their concerns?
– In which ways could the presence of a MAP potentially challenge team cohesion and how can this be avoided?
– Are you regularly reviewing whether MAPs’ roles reduce pressures on doctors?
– Has the presence of MAPs increased opportunities for junior doctors to attend teaching?
– Are senior clinicians within the team alert to and monitoring how MAPs’ duties are/ could be negatively impacting on training opportunities that are made available to junior doctors.
– Does the care setting include clear patient information on the range of roles within the MDT?
– Are staff roles, levels of seniority and responsibilities fully outlined during new starter inductions for all staff?
– Does the team (including MAPs) ever get chance to get to know each other? What spaces do you provide for the team to make connections?
– Do uniforms and name badges help patients and other staff to understand roles and responsibilities, and to avoid confusion?

If in doubt about any of these considerations for more effective team working, you should discuss them with your manager / employer or contact the BMA on 0300 123 1233 or support@bma.org.uk