BMA

# BMA Medical Associate Professions (MAPs) survey

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British Medical Association
bma.org.uk

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# Background

The UK has a severe shortage of healthcare professionals, amounting to more than 110,000[1] in England alone. This is coupled with a growing, ageing population with an ever-increasing need for a strong and responsive health service. To address this shortage, the government in England introduced the NHS Long Term Workforce Plan,[2] with proposals also being set out in the devolved nations. NHS England's plan sets out a wide range of mostly unfunded workforce measures, including doubling the current number of medical student places to potentially add 60,000 doctors to the workforce by 2036/37. Controversially, it also includes plans to increase the number of physician associates (PAs) from approximately 3,250 to 10,000 (an increase of over 300%); and anaesthesia associates (AAs) from approximately 180 to 2,000 during this time. These professions, a long with Surgical Care Practitioners, are collectively known as the medical associate professions (MAPs). PAs and AAs complete a two-year postgraduate course and are currently employed in a variety of settings in the NHS, including GP surgeries, the emergency department, medical and surgical settings, and have been introduced into mental health settings.[3]

PAs and AAs are not currently regulated. There have been a number of recent high-profile cases of patient harm as a result of being seen by MAPs, sadly with some associated deaths. In one notable case, the patient was unaware that she had not been seen by a doctor.[4] The BMA has been resolute in its stance that the word 'associate' in MAPs titles is confusing to patients and that MAPs should not be regulated by the General Medical Council (GMC), as this will create a false equivalence between MAPs and doctors[5].

In November 2023, due to severe concerns around patient safety, the BMA called for a halt to the recruitment of MAPs,[6] allowing time for the extent of patient safety claims to be investigated and the role reconsidered.

The aim of this survey was to collate the opinions and experiences of, doctors and medical students from around the UK, including those who routinely work with MAPs, to assist the BMA's positioning and better inform the respective relevant bodies involved in the roll out and planned expansion of MAPs roles.

When the PA role was introduced, it was notably sold as part of the solution to a doctor shortage (currently at more than 8,500)[7] by freeing up doctors from administrative tasks and minor clinical roles to allow them to see more complex patients and get the training required to become excellent consultants or GPs.[8] Unfortunately, PAs and AAs have been employed in the NHS in roles which stretch far beyond this original remit and, in many cases that have been reported to us, they appear to be working beyond their competence. This has raised serious patient safety concerns and led to calls to review the role, limit the scope, and protect training for the doctors that the NHS desperately needs. In addition, the government has provided funding to GP practices (ARRS) that can be used to pay for PAs and other clinical staff but not for hiring additional doctors. As a result, we are now receiving reports of practices making GPs redundant.[9]

The results of this survey are summarised below. Questions were included with care to cover the key concerns: patient safety, day-to-day job role, and professional issues including regulation. Recommendations for the next steps to reconsider the MAP roles based on the 18,000 plus responses received are also included.

# Main take home points

Almost 80% of respondents work or train with MAPs, meaning that contact with MAPs is widespread throughout the NHS.

## Patient care and safety concerns

MAPs are currently unregulated and with a poorly defined scope of practice. They have been employed in the NHS in a variety of roles, well beyond that originally envisioned as an 'assistant' role. Recent patient safety concerns have been raised due to well-publicised patient harm arising from MAPs in both primary and secondary care. This survey confirms those patient safety concerns:

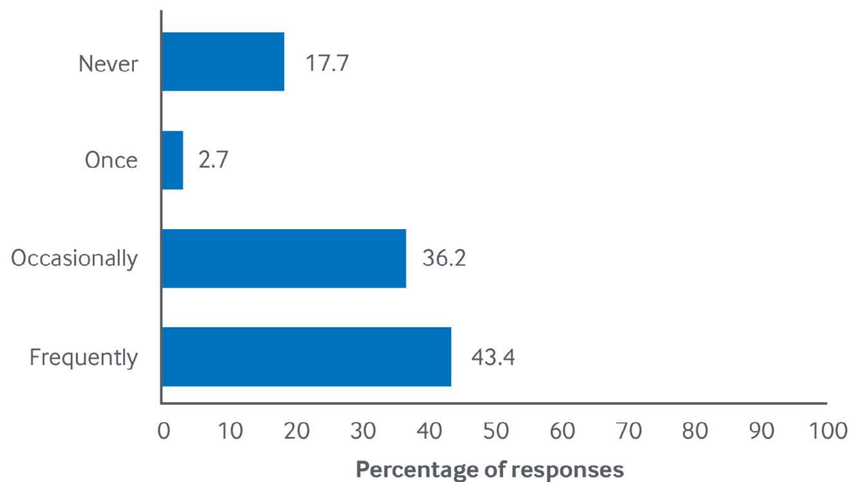


**Figure. 1** Concerns that a PA or AA was undertaking work beyond their competence.

– **Around 80% of the respondents were concerned that MAPs were occasionally or frequently working beyond their competence (Fig. 1)**. Only a minority of respondents were never concerned about PAs or AAs undertaking work beyond their competence.

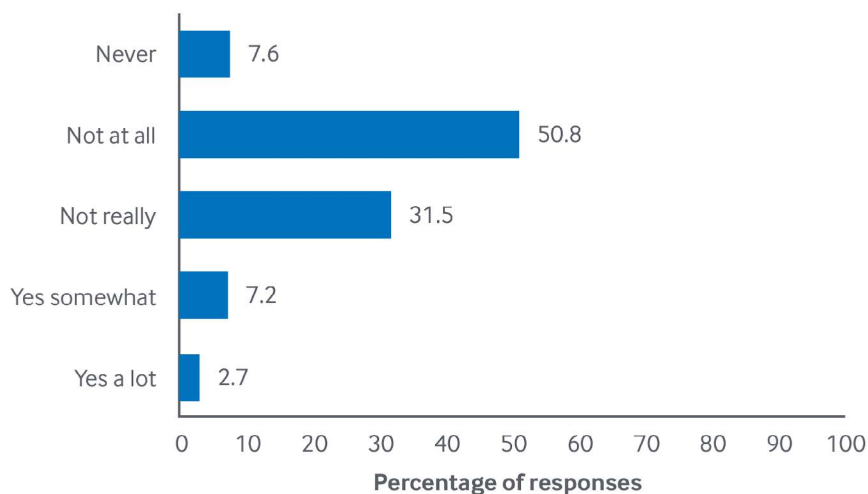


**Figure 2.** Has the introduction of PAs and AAs improved patient care?

– Fewer than 10% of doctors reported that MAPs improved patient care (Fig.2).

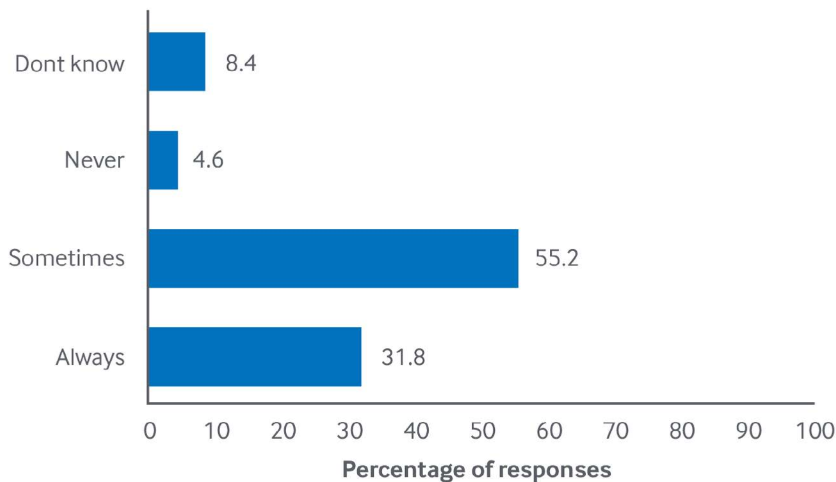


**Figure 3.** Is the way that PAs and AAs currently work in the NHS a risk to patient safety?

- **87% of doctors believe the way MAPs currently work in the NHS is a risk to patient safety (Fig. 3). Fewer than 5% respondents think MAPs are never a risk to patient safety as they are currently employed in the NHS.**

- The most pressing concerns included: the quality of MAPs training (75% of respondents), the quality of their supervision (84%), that they work outside their competence (91%), and that the public would confuse them with doctors (86%). In fact, less than 1% of doctors think patients fully understand the MAP role (with only 11.3% thinking patients fully or to some extent understand the role).

> "Several PAs in my trust work in the AMU, taking acutely unwell patients from ED, prior to being transferred onto ward level care - I have witnessed these PAs and PAs up on the wards independently reviewing patients on WRs without supervision and no documentation that they have discussed management and treatment plans with a doctor – working outside scope, as well as incidents where some of the plans have been seen to cause more harm than benefit."
> **Foundation doctor, Northern Ireland**

> "Risk is increased when PAs are working with critical patients or suddenly deteriorating patients, as they do not start treatment quickly so it affects pt outcomes as well along with safety issues."
> **Consultant, England**

> "I have witnessed PAs prescribing and requesting imaging on other people's accounts. They are aware that this has multiple layers of inappropriateness but did it regardless."
> **Locally employed doctor, England**

> "Do not know their limitations. Aggressively come to radiology requesting multiple unnecessary tests, say they don't know what is wrong with (the) patient but refuse to seek senior clinical help."
> **Radiologist, England**

> "Used by medical & management staff to work in high risk medical roles, such as seeing undifferentiated general practice where supervision is extremely difficult".
> **GP, England**

"My non-medical family has had personal experience of PAs on more than one occasion pretending to be doctors and working outside their competence and giving inappropriate care or making decisions beyond their competence. In one example when queried what their job title meant and if they were a doctor or not, their explanation was "it's like a doctor."
**Consultant, England**

"I have personal experience of poor care from a PA when I was a patient and they did not make it clear to me they were a PA - I only found out after-the-fact. Also, my Aunt was misdiagnosed by a PA at GP (reviewed 3+ times, never saw a Dr). They said she had 'asthma' and just gave her an inhaler. Instead she had a bilateral pulmonary embolism with right heart strain."
**Doctor in training, Scotland**

"There have been real life patient harms caused due to PAs unable to identify clinical concerns/signs especially in undifferentiated patients. I have seen PAs misdiagnosing emergencies such as when a PA missed an acute bowel ischaemia (writing it off as acute gastroenteritis) & it was only picked when the doctor who received the handover reassessed the patient. A patient also had delayed treatment of a fracture as it was dismissed by the PA & was picked up when the doctor examined the patient on their own."
**Doctor in training, England**

"I have only worked with excellent PAs. They have always been brilliant members of the team. The problem is that because the NHS is so stretched, PAs are put in the position of working as doctors with minimal supervision. I think many are trained well but they are not exposed to enough in their clinical training or afterwards to treat undifferentiated patients. It's not the fault of the PAs, rather it's poor supervision due to limited resources and the NHS management thinking the same care can be provided by doctors and PAs. It's not fair on PAs or patients".
**GP England**

"Any qualified PAs I've worked with have extremely limited medical knowledge, barely equivalent to a 2nd or 3rd year medical student at best. They appear to have limited insight into the consequences of the extent of unsupervised clinical and procedural practice they undertake. I think they must be limited to scribing and taking direct instruction from clinicians i.e. look up blood results and discuss directly. Those that become embedded within clinical teams often mistake unit and procedural familiarity with genuine medical knowledge, which to me is dangerous. I'm not sure what function they are supposed to provide and certainly they should not be providing any unsupervised clinical care."
**Consultant, Northern Ireland**

"PAs seeing unselected take in GP or A&E concerns me as a specialist who takes referrals. The quality of referral can be poor, and they have limited training in assessing patients who present with symptoms related to my specialty. They are often calling without discussion with a senior in their own team. I worry about the patients they review in unselected take, which are not discussed appropriately."
**Higher specialty trainee, Scotland**

"My main concern is the vast variability in capabilities/competence between different individual PAs/PA trainees: some are clearly excellent and highly dependable and make significant contributions to their departments (and would in fact make excellent doctors if undertook full medical training), others from my experience are significantly less competent (mainly relating to lack of insight regarding 'unknown unknowns'): I think this marked variability leads to difficulties in determining optimal roles for PAs. You just wonder whether broadening accessibility to postgraduate medical degrees (while retaining the rigours of full medical training) would help".
**Doctor, Scotland**

"I've worked quite a lot with a PA. Absolutely no understanding of his limitations. Was seeing patients independently, taking people to resus. Prescribing inotropes etc despite having almost no understanding of what he was doing."
**Emergency medicine Consultant, England**

## Daily job role

MAP roles were reportedly introduced to free up doctors from minor administrative and clinical tasks, allowing them to focus on more complex clinical work and training. The results of this survey shows that the opposite is occurring in the experience of doctors in their day-to-day work with MAPs in their team:

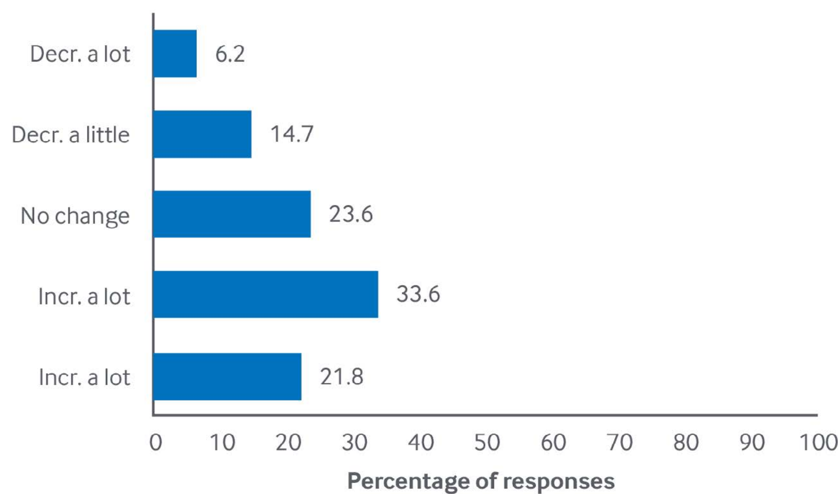


**Figure 4.** Has the employment of PAs or AAs in places you have worked reduced or increased your workload?

- Only around 21% of respondents reported a decreased workload since the employment of MAPs (Fig. 4). In fact, more than half reported that their workload had increased instead.

- Fewer than 15% of doctors reported the presence of MAPs improved their working day.

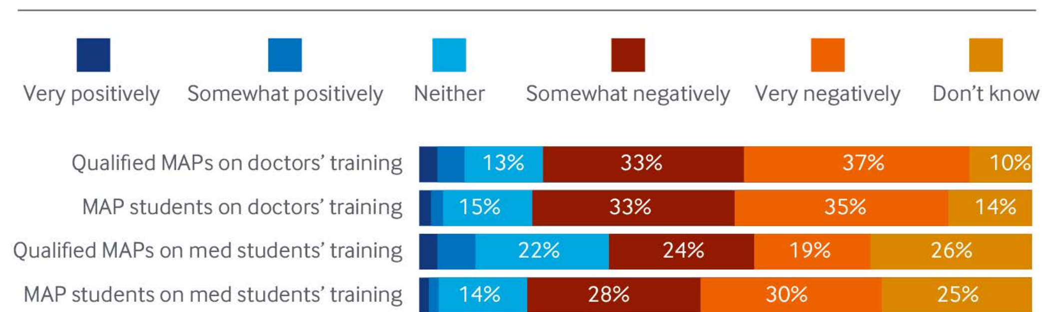


**Figure 5.** Impact of qualified and trainee MAPs on doctors and medical students' training

- Fewer than 10% of respondents believe that the training of MAPs positively impacted doctors' or medical students' training. Almost 70% believed that training MAPs somewhat or very negatively impacted doctors' training (Fig. 5).

- **96% of doctors believe it is unfair that newly qualified MAPs are paid 35% more than a first year (FY1) doctor for fewer hours per week and no on-call shifts (nights, 13 hour long days)**.

> "Doctors in training facing increased competition for learning opportunities will result in less well-trained doctors, ultimately affecting patient safety."
> **Doctor, Medical Specialty, Northern Ireland**

> They make your day extremely stressful by constantly coming to you asking you to prescribe drugs and request scans that could potentially harm a patient. It is your GMC number at risk not theirs. In reality junior doctors therefore end up supervising them, not consultants. You end up spending large amounts of time checking if these requests are appropriate. This is an inefficient and dangerous way of working. It increases the workload of doctors."
> **Doctor in training, Scotland**

> "As a GP I note (I) have the added burden of supervising associated staff at a time when GP workload is increasing. This is the perfect storm that will lead to burnout and the loss of more GPs."
> **GP, England**

> "Increasing risk and management required by existing clinicians (doctors) who end up responsible for someone they haven't employed or trained".
> **GP, Scotland**

> "They examine/assess patients and ask juniors to sign off prescriptions but all the weight of responsibility then goes on the shoulders of that junior so they either have to re-examine/assess or just sign it, so it's either a waste of time and delay in patient treatment or unsafe as the PA has limited (2yrs) training to make the diagnosis. Overall a recipe for disaster which we've seen several times on a national scale."
> **SAS Doctor, Wales**

> "Trainees report to me that they have to order tests and sign scripts for PAs. And they are unhappy with the governance and safety of this, which is understandable".
> **GP, Scotland**

> "Concern about a lack of depth of medical knowledge. Not knowing what they don't know. Placing more strain on junior and senior doctors to supervise and take medical risks based on their assessment."
> **GP, Wales**

"PAs are frequently asked to fill the role of doctors, or counted in the number of doctor staff on shift. This puts additional pressures on doctors, essentially understaffing the shift due to the restrictions necessary on PA work (eg prescribing)."
**Doctor in training, Wales**

"PAs taking training opportunities from doctors, leaving SHOs to prescribe on wards while they doing interventions" SAS doctor,
**Northern Ireland**

"When I was working with trainee and qualified PAs as a foundation doctor I found I spent most of my time re-reviewing their work, having to prescribe for them or carry out their tasks. I think this impacted the safety of the patients as I would have to rush through my own reviews in order to review double of the patients I should have been. Also, there were multiple occasions where the jobs allocated to training and qualified PAs were not completed, such as ordering blood products or taking important time-limited blood tests and the medical team was not informed this hadn't been done. On the occasions I am thinking about, there seemed to be no appreciation on the PAs part of how important it was to have completed these tasks in a timely way, or to tell someone if they couldn't do it. This significantly impacted on patient care and delayed discharges frequently."
**Doctor in training, England**

"On an individual level I have worked with competent PAs, but they are paid more than FYs and can do a fraction of the work."
**Doctor, Scotland**

## Professional issues

The NHS long-term workforce plan intends to roll out more of the MAP roles across the NHS, including increasing the number of PAs to 10,000 by 2036/37. Respondents to this survey expressed grave concerns about this and key decisions around who should regulate MAPs and what responsibilities they should have, including:

- Fewer than 5% of respondents think that MAPs should retain their current titles instead of reverting back to what they were originally called (physician assistant and physician assistant (anaesthesia)).

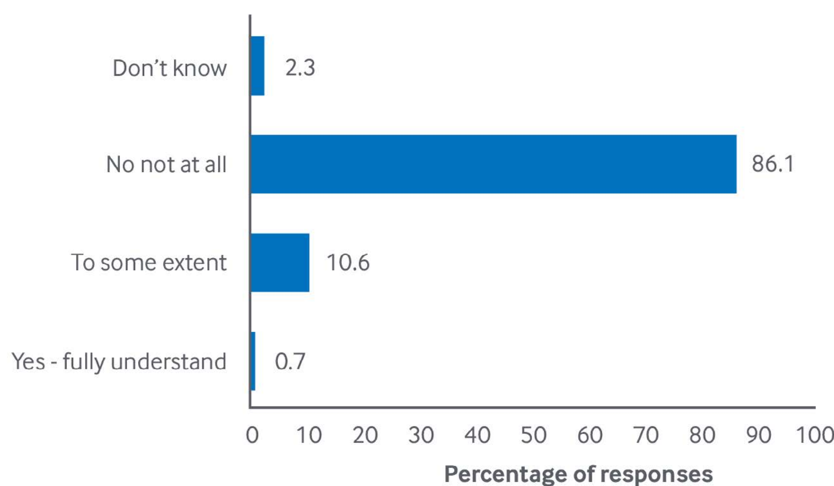


**Figure 6.** Does the public understand the difference between PAs/AAs and doctors?

- **86% believe that the public confuses MAPs with doctors (Fig. 6) and 98% believe that it is important that the public know who is treating them**.

- Fewer than 20% of doctors believe that the General Medical Council (GMC) should regulate MAP**s**, likely related to the fact that this choice to use the doctors' regulator will give MAPs a false equivalence to doctors.

- Similarly, in order to reduce confusion over the role, fewer than 5% of respondents think that MAPs should claim to have undertaken medical training and fewer than 10% think MAPs should refer to themselves as medical practitioners.

- Fewer than 5% of respondents think that MAPs should get the same prescribing rights as doctors after regulation. Some support limited and defined scope (42%) while almost half (49%) do not think that MAPs should be granted prescribing rights at all.

> "They have introduced themselves as doctors/surgeons to other health professionals so also knowingly confused their colleagues".
> **Senior doctor in training, England**

> "Our SCP gets mistaken (for a doctor) all the time and he doesn't do anything to change their misconception."
> **Surgical consultant, Wales**

> "I was an examiner for the Physician Associate National Exam and asked the qualified PA examiners how they introduce themselves and describe the role of the PA - answers varied from 'I don't know' to 'I say I'm like a doctor'."
> **Core trainee, England**

> "I have been involved in training AAs through their university. The course … lacks anything like the rigour, educational governance or standard setting that is involved in undergraduate or postgraduate medical education. From my initial curiosity of being involved in their training I've become more and more concerned about how little oversight there is."
> **Anaesthetist, Scotland**

> "(I have) concerns regarding PAs having their own independent clinics and patients not knowing they are not seeing a doctor."
> **Locum doctor, Wales**

> "Inappropriate role extension. I have direct experience of PAs trying to illegally request imaging and also other consultants allowing their login details to be used in this way. Patients must be clear about who is delivering their care. Employers must be clear that PAs are not a substitute for doctors. Training bodies must be firm in protecting medical training opportunities."
> **Consultant, Northern Ireland**

> "As a medical student, I have had teaching sessions delivered by PAs and they have been unable to answer our questions relating to disease mechanisms and self-admit that they only know how to manage conditions and can't fully explain the conditions themselves. Additionally, when I was doing some cannula/ECG practice on patients, the PA + ACP that were in the room did not fully explain their job role and when they were referred to as Dr by the HCAs in the room (who figured they were Drs due to them supervising medical students), the individuals did not correct them – there were patients present in the room."
> **Medical student, England**

"Patients think they are being seen by a doctor and that is not right because it's not true. They are not doctors."
**Emergency medicine Consultant, England**

"I have witnessed a PA request a CT out of hours saying she was a senior house officer. They don't clearly explain what their role is. They take away learning opportunities. They take away clinics – I did not undertake a single clinic during the foundation programme, which is a travesty."
**Core trainee, England**

"Concerns they deliberately mislead patients as to their role. I heard a PA student tell a patient that with his undergrad degree he'd had the same training as a doctor."
**Senior doctor, England**

"PA leading medical school teaching, multiple times, at two different trusts I work at, on one occasion presented self as 'one of the facilitators' while all other staff said 'I'm an f1/2 from so and so', in another one introduced self as 'I work on cardiac icu and in teaching' and not told in what capacity. Happened multiple times on multiple occasions, not an accident."
**Medical student, England**

# Specialty breakdown

In June 2023 in England there were 73 FTE anaesthesia associates, 1,508 FTE physician associates working in NHS trusts and 1,707 PAs in GP practices and primary care networks.[10] MAPs have been introduced into various specialties at different rates.

An informal census was conducted by the Faculty of Physician Associates on October 1st 2022. 3,208 PAs responded and reported to be working in the following specialties: 37% in primary care, 31% in medical specialties, 12% in emergency medicine, 10% in surgical specialties, 4% in psychiatry, and 2% in paediatrics.[11]

We have broken down the survey results by broad specialty groups. .

## 1. General Practice

More than one third of PAs are working in primary care.[11] 3,482 respondents to the BMA survey identified as being from primary practice. 793 were GP registrars and 161 were FY2 doctors on placement. 73.1% of all respondents had worked with PAs or AAs.

- 89.6% of respondents working in primary care thought that PAs were a risk to patient safety in how they were currently being employed by the NHS.
- Fewer than 15% of respondents never had concerns about PAs undertaking work beyond their competence.
- 82% thought that PAs frequently or often worked beyond their competence. Only 12% of respondents thought that PAs improved patient care.

> "PA working in our practice failed to examine a patient on 2 occasions, failed to escalate or discuss with [a] supervisor despite there being very clear supervision protocols in place. PA missed a fatal DVT."
> **Salaried GP**

> "I've observed PA's making risky/poor/ inappropriate and sometimes dangerous decisions regarding the care of their patients because they don't know what they don't know. They often don't know when to ask for help. As a supervisor I am not given enough time to go through every patient with them, so (I) rely on them knowing when to ask for help but my experience is that they often don't and we have already seen a number of patient safety incidents as a result."
> **GP contractor/principal**

> "I personally train and supervise a fantastic PA one day a week in a GP practice. They are motivated to learn. Unfortunately, their management plans are shocking. They have no fundamental understanding of pathophysiology or anatomy so are making grave errors with even basic MSK consultations. I have witnessed first hand a vast amount of excessive referrals, investigations including x-rays. bloods and MRI scans being requested. I do not believe PAs should work in General Practice because of the risk."
> **GP contractor/principal**

> "There have been times when locum PAs have not discussed doubts they had in a consultation in a timely manner. I think this demonstrates a potential blindness to the degree of risk they are taking on at times. It also puts a supervisor in a difficult position if, for example, they disagree with a PA's decision once a pt has left the building. I am unsure whether they are working in some environments where they are encouraged to be as autonomous as possible and so this is where this behaviour comes from, or if it is a feature of their training that means they just don't recognise the value of admitting doubt and seeking a second opinion on the spot."
> **Salaried GP**

- More than 60% reported increased workload since MAPs were employed in primary care.
- Only 12% of respondents said that their job role or working day was improved by the addition of MAPs.

> "As a GP, when I am supervising or overseeing PAs, I don't have the time to see my own patients."
> **Salaried GP**

> "We have a PA through AARS. Because we oversee her, we ensure there is no risk to patients but her capabilities currently are less than our own minor injury practice paramedic. She requires a lot of GP time to support and train her. Even simple ear checks were outside her skill set when she first started. She is lovely and keen to learn but not value for money and takes valuable GP time away from patients."
> **Salaried GP**

> "I work in a busy GP surgery. The only way we can make PAs work safely is for all of their appointments to be selected by a senior triage doctor - to ensure they aren't seeing patients outside their safe scope of practice. This, combined with the speed at which PAs can see patients makes them the most expensive member of staff (per consultation), but who only treats the most straightforward patients. All of their work has to be reviewed, and the tasks generated for the supervising doctor outweigh any possible benefit."
> **Locum GP**

More than half of respondents thought that doctor's training was somewhat or very negatively affected by the presence of MAPs (Fig. 7).

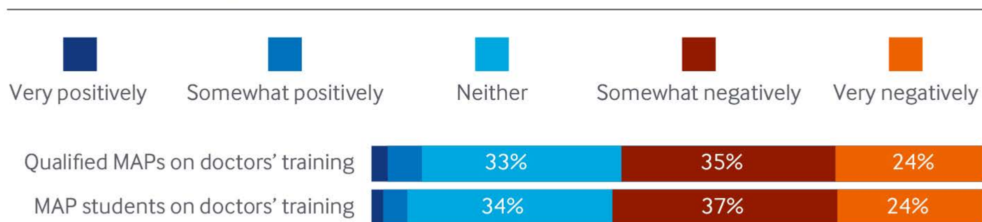


**Figure 7.** Impact of qualified and trainee MAPs on doctors' training

> "They reduce training opportunities for junior doctors which affects their ability to rapidly learn how to be safe senior doctors."
> **GP contractor /principal**

> "I had almost no training in my ST2 GP placement because my trainer spent all the time teaching PAs."
> **GP registrar**

> "Because they are negatively affecting the training of a cohort of doctors. I cannot recommend medicine as a career any longer. Why do 5 years at medical school when you could do 2 years and be paid more with less responsibility and fewer hours?"
> **Salaried GP**

> "As a GP trainee I have experienced PAs being prioritised over myself and other trainee doctors for teaching skills/ gaining experience and was told it was more important to train the PA than myself or colleagues as we are moving on from the service in question at the end of our 6 month placement. This directly negatively impacted on my and other GP colleagues in training."
> **GP registrar**

> "They also affect the quality of training of medical students/doctors. As a 4th year medical student, I have to have GP placements. My placements often involve sitting in with the GP while they carry out their telephone consultations. However, the PA students get to have their own clinics. This is nonsensical, and is only taking away crucial clinical experience from medical students with whom roughly 50% will end up working as actual GPs."
> **Medical student**

## 2. Medical Specialities

PAs are reported to be working in cardiology, medical oncology, rehabilitation medicine, respiratory medicine, care of the elderly, general internal medicine, acute medicine, and stroke medicine [11]. 5,021 respondents of this survey stated they were working in medical specialties in the UK. 1,004 were consultants, 148 SAS doctors, 2,564 were trainees, 865 locum or LED doctors, and the rest made up of medical students and GP registrars on hospital placements. 86.2% had worked with a PA or AA.

- 81.5% of medical respondents had concerns about PAs working beyond their scope of practice.
- **86.4% thought that the ways that MAPs were working in the NHS sometimes or always was a risk to patient safety.**
- Fewer than 12% of respondents thought that MAPs had improved patient care.

> "Often seen PAs making decisions or diagnosis beyond capacity, and inappropriate referrals to specialists."
> **Consultant**

> "Personal experience of PA missing serious conditions and discharging from ambulatory care with no senior review."
> **Doctor**

> "I have intervened on several occasions with a PA who called himself a doctor or allowed himself to be referred to as a doctor. Some others when they were asking junior members of the team to prescribe drugs or do investigations, which would cause undue harm to the patient."
> **SAS doctor**

> "I have seen countless consultants give their smart card to the PA to prescribe with little to no supervision as it speeds up the ward round and prevents interruptions. I have been called quite a few times to fix prescribing errors such as incorrect date for warfarin dose, incorrect dose of antibiotics (gave paeds dose to an adult) and incorrect VTE prophylaxis dosage."
> **Doctor**

MAPs were reportedly introduced to help with administrative tasks and free doctors up for their clinical work and for training opportunities. However,

- Only 24.3% reported that their workload had reduced since the introduction of MAPs.
- Only 14.9% reported that their job role or working day had improved since the introduction of MAPs.

"I have worked with a brilliant PA who improved my life and my patient's care immeasurably but the majority are overconfident and work beyond their scope of competence, endangering patients and creating hours of work for me."
**Consultant**

"Puts enormous pressure on the doctors as they need to constantly supervise the work of the PAs."
**SAS doctor**

"PAs are often used as a role to cover up understaffing issues on wards when there are not enough Junior Doctors to provide care. PAs in my experience increase my workload as I am often required to oversee or redo work that they have completed."
**Foundation Doctor**

Fewer than 10% reported that doctors in training had improved training opportunities with MAPs employed in the NHS (Fig. 8).

### Effects on training

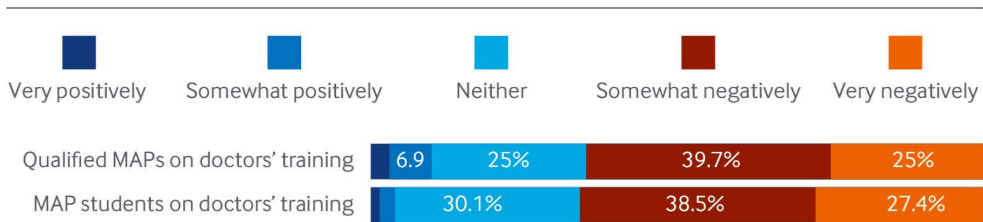


**Figure 8.** Impact of qualified and trainee MAPs on doctors' training

"It is also having a negative impact on the mentality of our present students and junior doctors, who spend 5 years training. It is already causing rifts in the junior workforce. The training of these PAs is increasing the workload of an already stretched Consultant workforce The additional workload covered by the PAs is being over-viewed by an already stretched Consultant workforce. I am concerned that errors will occur and that patient safety will become an issue. The responsibility for this will not lie with the PAs, but instead will lie with the Consultant responsible for the PAs."
**Consultant**

"Department's focus on PA training means that doctor's training (including my own) is often neglected and I get fewer opportunities to practise procedures."
**Foundation doctor**

"How detrimental it is to junior doctor training."
**Consultant**

"I'm also hugely concerned specifically about PAs persistently removing procedural training opportunities for medical doctors. As a result the new generation of medical registrars coming through are in-experienced (and sometimes incompetent) at emergency procedures such as chest drains. This is largely due to a lack of training, and in some hospitals all procedures have been removed from SHOs and given to PAs. Interestingly, I don't see the PA being asked to do an emergency chest drain for a pneumothorax at 3am. This is just one example of how I believe PAs are affecting patient safety."
**Doctor**

## 3. Emergency Medicine

Around 12% of PAs are reportedly working in emergency departments in the UK [11]. 1,514 respondents identified as working in emergency medicine. 234 were consultants, 113 were SAS, 710 were doctors in training, and 363 locum/LED doctors, and the remainder were medical students. 89.7% had worked with PAs or AAs.

- 82.7% had concerns that MAPs were working beyond their competence at least once.
- 82.5% did not think that MAPs had improved patient care.
- **86.9% reported that the way that MAPs are currently working in the NHS is sometimes or always a risk to patient care.**

> "They don't have the training. I wouldn't want any family member or friend being treated by a PA."
> **Consultant**

> "As a registrar, my workload is increased by having to see patients myself regularly after they are seen by a PA. There are also numerous tasks that come with this such as prescribing. I don't want this increased workload - it is inefficient and not good for patients. I'm taken away from my job. In my first week working with a PA they made a huge error and so I need to review every patient closely now."
> **Higher Specialty trainee**

> "I think this is all dependent on the situations in which PAs are placed - which is very much determined by factors out of their control. The model is a dependent practitioner - I have worked closely with PAs for 10+ years and my experience is overwhelmingly positive in the environment in which I work, where they are in very close proximity to the senior medical staff."
> **Consultant Emergency med Scotland**

- More than half of respondents working in emergency medicine said their workload had increased since the introduction of MAPs.
- Fewer than 12% said that MAPs had improved their working day or job role.

> "The clinical teams (are) expected to train and supervise doctors in training, ACPs in training, and now PAs but without any extra supervision time with consultant PAs at max allowance for SPA of 0.5 and already go beyond this allocation supervising. PA teaching slots advertised by medical schools to clinicians without any pay for the hours to provide lectures and sessions."
> **Consultant**

> "My worry is mainly the push to get PAs and AA to do nerve blocks , procedures and sedations and other procedures in ED without the background knowledge of the effects and complications and the ability to manage complications when they arise. The increased effect of the supervision of PAs and AAs is on the senior doctors."
> **Consultant**

> "Our trust has employed PAs to help with seeing patients. It doubles my workload as they don't have the understanding of medical complexity and are unable to make decisions."
> **Consultant**

"Greatly increase the workload of middle-grades/consultants supervising them, having to answer queries / prescribe for the MAPs etc, inevitably leading to dilution of our bandwidth. They're far from being independent in terms of actual training and abilities, despite overly loud claims that they're "equivalent to ST3s at least."
**SAS doctor**

"Being asked to prescribe on behalf of PAs when you do not know the patient is unsafe and often adds to workload as you have to review the patient yourself."
**Doctor**

Fewer than 10% of respondents thought that doctors' training was improved by the presence of MAPs in the team (Fig. 9).

## Effects on training

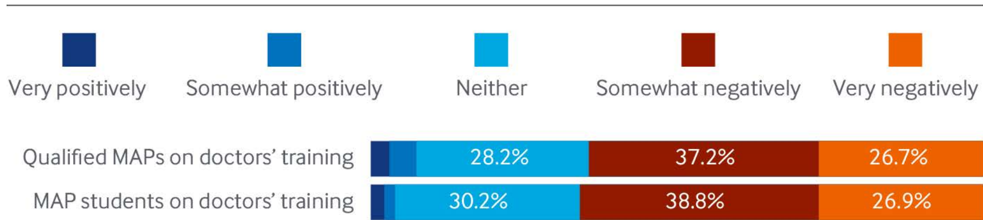


**Figure 9.** Impact of qualified and trainee MAPs on doctors' training

"Medical students and doctors-in-training miss out on valuable teaching and training as preference is given to PAs as they are 'permanent'. We already have permanent staff in most departments and they're called SAS doctors."
**SAS doctor**

"My head of department (in A&E) explicitly told me that the long term PAs would be prioritised for training opportunities above us rotating F2s and that I couldn't be angry about it because it was logical."
**Foundation doctor**

"My training is severely affected. PAs have a much better rota. They take more resus time and more minor time. I am just doing service provision."
**Higher Specialty trainee**

## 4. Surgical Specialties

Approximately 10% of PAs are working in surgical specialties including general surgery, colorectal surgery, vascular surgery, orthopaedic surgery, and neurosurgery [11]. 2,788 respondents stated that they worked in surgical specialties. 736 consultants, 160 SAS, 1,375 doctors in training, and 327 locum or LED doctors. The rest accounted for medical students or GP registrars on a surgical placement. 78.2% had worked with PAs or AAs.

- 89.6% of surgical respondents had concerns about MAPs working beyond their competence.
- Fewer than 10% thought that MAPs had improved patient care.
- **86.8% believed that MAPs were sometimes or always a risk to patient safety. Only 5.1% stated that MAPs were never a risk to patient safety**.

> "I am retired and I work doing diagnostic and therapeutic endoscopy. Almost all of the patients referred for these investigations have been assessed as needing these tests by PAs. The quality of the referrals is extremely poor. Vast sums of money are being wasted requesting unnecessary tests to cover their backs. Few of these tests (CT scans excluded) will harm the patients but they are unpleasant and unnecessary and there are risks of complications."
> **Consultant**

> "As a consultant I have received referrals for patients from PAs which are not safe (e.g. routine referral for a man in retention with renal failure) and inappropriate (e.g. a scrotal mass which was the patient's epididymis). Not safe!"
> **Consultant**

> "PAs consistently work outside of their competence in my trust. One PA reviewed an ECG and said it was normal but did not show a doctor: the patient was in fast AF. They are not regulated enough within the clinical environment and are given too much responsibility for their limited training time. They do not have appropriate medical training like doctors do."
> **Foundation doctor**

– More than half of the surgical respondents reported that their workload has increased since the introduction of MAPs.

– Fewer than 12% reported that MAPs improved their working day or job role.

> "With their lack of prescribing and often leaving wards to go to clinics/theatre etc they leave junior doctors with more work and unsafe staffing levels."
> **Doctor**

> "Unknown unknowns are vast. Make mistakes they don't even know are mistakes. Only picked up frequently because a junior doctor has to effectively check all their work anyway in order to order scans and rx on their behalf. Once regulated this safety net will be removed and it will be a greater risk to patient safety. With 3x more PAs , who will supervise them closely?"
> **Foundation doctor**

MAPs were said to be introduced to free up doctors in training from administrative tasks and to allow them training opportunities. However surgical respondents stated that:

## Effects on training

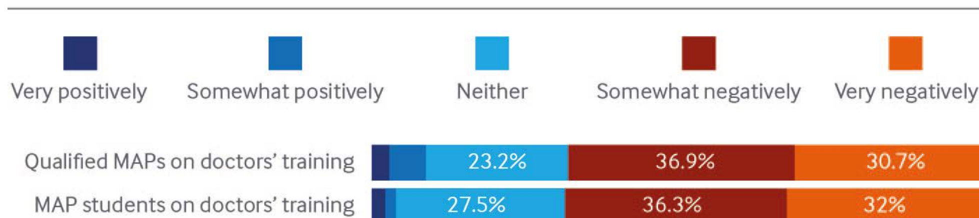


**Figure 10.** Impact of qualified and trainee MAPs on doctors' training

– Fewer than 10% thought that MAPs improved doctors' training (Fig . 10).

– More than 60% reported that MAPs somewhat or very negatively affected doctors' training (Fig. 10).

"Taking training opportunities away from doctors as they are more permanent staff. Difficult establishing a hierarchy- especially in emergency situations."
**Foundation doctor**

"Trained in preference to Drs i.e. senior Drs being under experienced in procedures, under exposed to clinical experience (as doing imaging requesting and prescribing for PAs (we have become their assistants)."
**Higher Specialty trainee**

"PAs I've worked with do not tell patients they are not doctors. I frequently had to do their work in addition to mine. They are used in place of well trained SHOs and my training was affected. I frequently had to share operating experience with PAs."
**Higher Specialty trainee**

"(PAs have) Taken training opportunities from trainees during work, participated in courses with royal college of surgeons and took spots from trainees for courses."
**LED doctor**

## 5. Anaesthetics

There are reported to be approximately 300 AAs working in the NHS with plans to increase them to 2,000 by 2036/37 [2]. There were 1,697 respondents from anaesthetics with 666 consultants, 123 SAS doctors, 808 doctors in training, 77 locum or LED doctors, and 23 medical students. 80% have worked with PAs or AAs: 31.4% with AAs alone, 31.9% with PAs alone, and 36.7% with both AAs and PAs.

- 80% of anaesthetic respondents had concerns about MAPs competence, at least once.
- Fewer than 10% thought that MAPs improved patient care.
- **85.8% reported that the way that MAPs were working in the NHS currently was sometimes or always a risk to patient safety**.

"They have limited breadth of knowledge, may miss important things. They will not be able to link symptoms and signs. I worry they will treat parameters and the numbers on the monitors, but without knowledge and experience, they will not be treating the patients safely."
**Consultant**

"In my experience, the best AAs are those with extensive clinical experience e.g. former ODPs. AA training takes great people from this shortage role. Those with no clinical background have been universally (in my experience) appalling and lacking in insight/awareness of what they don't know. Some are frighteningly over confident with very superficial understanding of what they are doing and no understanding of their limitations."
**Consultant**

"They are giving unprescribed unlimited anaesthetic drugs without these being prescribed and without being supervised. This is normal practice yet obviously illegal."
**Consultant**

"The AAs I work with currently are very difficult to supervise... constantly work outside their scope and have no insight into their limitations. One is happy to have his name written on the theatre board as Dr and does not correct this. Some consultants are happy to go along with the unagreed local scope creep. The AAs are given their own lists, which further encourages scope creep... they are never supervised for induction, emergence or spinals including not liaising re: complex multimorbid frail patients with decision to convert to GA."
**Consultant**

As noted in previous sections, the introduction of MAPs was supposed to free doctors up from administrative tasks and minor clinical work in order to focus on their clinical work and training. However:

- More than half of the anaesthetic respondents said that their workload had increased since the introduction of MAPs.

- Fewer than 10% said that MAPs improved their working day or job role.

> "Shortage of doctors provides opportunities for managers to push PAs into new roles and if nothing goes wrong on one occasion then it becomes proof of competency. Its creeping increasing responsibility. When something does go wrong it's the Doctor's fault. I refused to cover two theatres each with a PA in a day case unit and for this my own sessions in day case anaesthesia were revoked."
> **Consultant**

> "Increased workload for both junior and senior staff with regards to supervision of PA/AA, often have to re-review patients that PAs have seen."
> **Doctor**

> "Extra burden on existing consultants who are already at full bandwidth".
> **Consultant**

> "AAs were tried in our department. The cost was actually greater than medical staff due to the significant need to supervise them. In the end, they were most useful for letting medical staff out of theatre to see patients preoperatively and for lunch breaks. It is naive to think that this will sort the problem with staffing. We tried out the AAs as the government was keen to use them. They did not save money, in fact, it was more expensive than using medical staff they needed to be supervised all the time and could not induce or recover a patient (quite rightly) without a Consultant being present, hence the speed of the list did not increase, it just added another layer of staffing. If you want to spend more money on the service, fine, if you want increased turnover and cost efficiency, forget this solution."
> **Consultant**

Fewer than 10% of anaesthetic respondents stated that the introduction of MAPs improved doctors' training. In fact, around 65% thought that MAPs somewhat or very negatively affected doctors' training (Fig. 11).

**Effects on training**

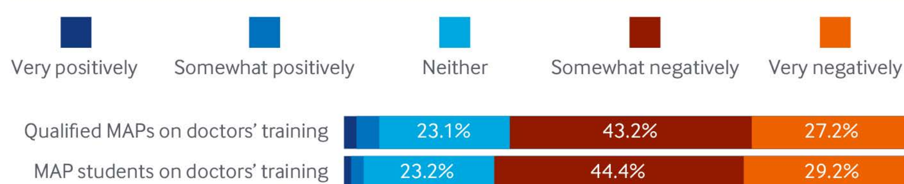


**Figure 11.** Impact of qualified and trainee MAPs on doctors' training

> "Impact of AA training on the availability of training opportunities for anaesthetists in training. And effect on morale for Anaesthetists in training."
> **Consultant**

> "Dilution and diversion of limited resources away from doctors in training. Adds to existing high pressure on doctors in training to purely act as service provision to try and ensure patient safety."
> **Doctor**

"Found PAs have not taken out of hours slots on rota, but are still considered within overall numbers. This pushes training doctors into doing more out of hours cover, further reducing training opportunities. Very little senior supervisor or ownership of PAs, falling to the job of new doctors on the ward to help them and prescribe for them. Frequently found they were prioritised for clinical skills and teaching over training doctors. When raised as an issue, we were told their training is a departmental priority as they are permanent members of the team. Likewise when raising the issue that they don't work out of hours, the head of department told us it was important to keep them happy as they are permanent members of the team."
Doctor

## 6. Psychiatry

PAs have only recently been introduced to psychiatry. In 2022, some 4% of PAs identified as working in the field.[11] 1,016 respondents to this survey reported working in psychiatry. This included 270 consultants, 86 SAS doctors, 576 doctors in training, 61 locum or LED doctors, and 23 medical students. 67.3% had worked with a PA or AA or both.

- 82.9% of psychiatry respondents had concerns regarding MAPs competence at least once.

- 79.2% did not think that MAPs improved patient care.

- **85.1% thought that the way that MAPs are currently working in the NHS is sometimes or always a risk to patient safety**. Less than 4% thought MAPs were never a risk to patient safety.

  "PAs and AAs are not trained to consider differential diagnosis or treat complex cases. I worry that eventually they will be practising independently and I work about delays in providing treatment."
  **Consultant**

  "I have trained PAs and am shocked that they are now expected to work independently as they just do not know enough. I thought that was never meant to be the case and that they were to work under direct supervision only."
  **Consultant**

  "Risk of a gradual shift whereby it becomes acceptable to operate healthcare with a lower level of medical expertise – with Drs steadily replaced by PAs and other roles such as ACPs – and safety standards gradually drop."
  **Consultant**

  "I have seen patients and staff be confused by PAs. I have seen that PAs are sometimes given opportunities in preference of training doctors. I do believe that PAs are incredibly useful and they generally have good knowledge of the administrative side of the department (due to lack of rotation). However, I believe that the lack of regulation and guidance on the scope of PAs is causing a lot of confusion and misuse of the role. I have seen good PAs and I do not wish to put down my own colleagues, who have done nothing wrong. Additionally, I have seen bad doctors. However, even with bad doctors, the exams they must undergo are rigorous and therefore, there is quality assurance."
  **Doctor**

  "I find the experience of PAs around mental health and illness is very poor, and either too quick to diagnose mental illness and unable to manage any complexity, or when faced with complexity, to appropriately seek the support of seniors."
  **LED doctor**

- More than half of the psychiatry respondents reported that the introduction of MAPs has increased their workloads.

- Only 12% thought that MAPs improved their working day or job role.

"The time PA colleagues take from the working day of MDT staff for guidance/advice/ supervision needs. Reluctance to work with established protocols/ pathways and adverse impact on risk assessments and patient advice. They can get scared in clinical reality & need care themselves, which the system is not set up for."
**Consultant**

"Increasing workload for junior doctors (prescribing etc) when their workload is already vast."
**Foundation doctor**

"Actively misrepresent themselves to the public, provide a lower standard of care and often do not even know their own limitations and errors. Often have to fix their messes. They actively take away from training opportunities and usually increase my workload."
**Locum doctor**

### Effects on training

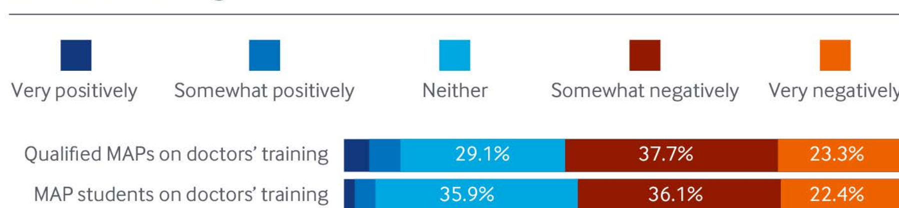


**Figure 12.** Impact of qualified and trainee MAPs on doctors' training

- Fewer than 10% of psychiatry respondents thought that MAPs had improved doctors' training (Fig 12.).
- Around 60% thought that MAPs somewhat or very negatively affected the training of doctors (Fig. 12).

"Medical students and junior doctors are missing out on training opportunities and thus having less clinical knowledge/expertise as a result."
**Consultant**

"I have seen training opportunities and clinic time frequently taken from core and speciality doctors in favour of PAs as they do not rotate departments therefore it is seen as more worthwhile to train them as the skills they develop will be retained within the department. I have seen workload increase for junior doctors with PAs in their team as they must undertake review/prescribing work following PA assessment. In my experience, most lay people do not know the difference between a doctor and a PA."
**Core trainee**

"In my trust PA gets more opportunities in research training rather than core trainees. They are offered to attend SAS doctor teaching sessions whereas Core and foundation trainees are not invited to these events at all."
**Doctor**

## 7. Paediatrics

Fewer PAs are reportedly working in paediatrics with approximately 2% reporting working in paediatrics in October 2022 [11]. 719 survey respondents reported working in paediatrics with 178 consultants, 36 SAS doctors, 412 doctors in training, 65 locum or LED doctors, and 28 medical students. 76.5% reported working with PAs or AAs.

- 77.8% of respondents working in paediatrics had concerns about MAPs working outside their competence.

- Only around 10% thought that MAPs improved patient care.

- **84.6% thought that the way MAPs were employed in the NHS was sometimes or always a risk to patient safety**.

> "I think they are ok when in acute Trusts and supervised and role clearly defined but in primary care, I have received some shocking referral letters."
> **Consultant**

> "We get poor quality referrals from PAs that we unfortunately have to take, lacking in basic paediatric history skills and understanding of paediatric normal observations. You end up getting worried and seeing the child due to poor referrals."
> **Higher specialty trainee**

> "Have seen newly qualified PAs (who are much less competent than F1s) undertake outrageous tasks such as take referrals from ED, hold the registrar phone for referrals etc."
> **Consultant**

- More than half of respondents working in paediatrics thought that MAPs had increased their workload.

- Fewer than 13% thought that the introduction of MAPs had improved their working day or job role.

> "Takes time off training future doctors and distracts from daily work because of the need for supervision."
> **Consultant**

> "They are not regulated and not independent practitioners. They will review a patient and ask you to prescribe a particular medication as per their management plan. This is concerning practice. To be safe, you would have to review the patient yourself prior to any empirical prescription. This doubles workload and renders their role defunct."
> **Doctor**

Fewer than 10% of respondents working in paediatrics thought that MAPs had improved doctors' training (Fig. 13).

### Effects on training

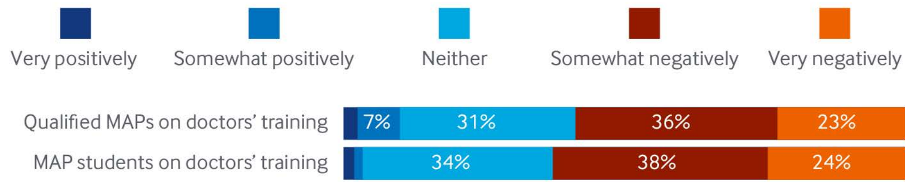


**Figure 13.** Impact of qualified and trainee MAPs on doctors' training

> "Their role is poorly defined. Also they impact on medical training meaning doctors get less experience of procedures and so are likely to be less experienced at the end of training."
> **Consultant**

> "Increasing workload on junior doctors who are expected to prescribe for them and taking away opportunities such as practical skills. as they are seen as a more long term useful asset to the trust they work in."
> **Foundation doctor**

> "Their training and presence takes away learning and development opportunities for paediatric SHOs, which becomes a patient safety issue when they become registrars at ST3, and have had less experience at procedures etc."
> **Core trainee**

## Response to the findings

In what is thought to be the first survey of its kind, with over 18,000 responses, UK doctors are reporting overwhelming concern about patient safety in the NHS due to the current ways of employing physician associates and anaesthesia associates. The majority of doctors who took part in this extensive survey believe that the way in which physician associates (PAs) or anaesthesia associates (AAs) work presents a significant risk to patient safety. The results of the survey is more evidence that the Government's plan to regulate PAs and AAs by the GMC – the doctors' regulator – are ill-thought-through and will likely further blur the lines between doctors and other roles in patients' minds.

The creeping expansion of these roles and their central part in the Government's workforce plan for the NHS has been undertaken against the advice and warnings of an entire profession. To change the nature of medical care in this country without the consent of the medical profession is utter folly and will be revealed as such. There is still time for the Government to reverse course and finally listen to the medical professionals who know what they are talking about. The BMA will continue to oppose this dangerous path every step of the way.

## Methodology and results

Medical associate professions (MAPs) in this survey refers to Physician Associates (PAs) and Anaesthesia Associates (AAs). The BMA ran the survey from the 10th of November to the 13th of December 2023. The request to complete the survey was emailed to members and shared on social media.

18,894 members responded. 712 responses were excluded due to not currently working in the UK at the time of responding or missing pertinent data regarding in what capacity they were working. This leaves 18,182 respondents across the UK.

Please note that the following summary data represent a self-selecting sample of members that responded to the request to complete the survey. The summary data is not weighted. While the robust sample size allows us to be relatively confident that the survey is representative of the wider membership's views, it must be understood that there will be some small margin of error. Missing data ranged from 0.1 to 0.5% per question.

# Demographic info

| GRADE | Number (n=18,182) | Percentage |
|---|---|---|
| Consultant | 3,705 | 20.4 |
| GP | 2,325 | 12.8 |
| SAS | 779 | 4.3 |
| Doctor in training | 8,480 | 46.6 |
| LED/Locum | 1,943 | 10.7 |
| Medical Student | 950 | 5.2 |

| SPECIALTY | Number | Percentage |
|---|---|---|
| Medical | 5,021 | 27.6 |
| Surgical | 2,788 | 15.3 |
| EM | 1,514 | 8.3 |
| Anaesthetics | 1,697 | 9.3 |
| Paediatrics | 719 | 4.0 |
| GP | 3,482 | 19.2 |
| Psychiatry | 1,016 | 5.6 |
| Other | 1,872 | 10.3 |
| Missing data | 73 | 0.4 |

| COUNTRY | Number | Percentage |
|---|---|---|
| England | 15,070 | 82.9 |
| Scotland | 1,644 | 9.0 |
| Wales | 905 | 5.0 |
| Northern Ireland | 563 | 3.1 |

# Question summary data

**Q5. Have you ever worked or trained with a physician associate or anaesthesia associate?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes | 14,279 | 78.5 |
| No | 3,501 | 19.3 |
| Unsure | 402 | 2.2 |

**Q6. When you have worked or trained with a PA or AA, to what extent was their role and remit clearly explained?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Fully explained | 1,705 | 11.8 |
| A vague explanation was offered but it remained unclear | 4,016 | 28.0 |
| Introduced only by their job title | 5,034 | 35.3 |
| No explanation offered | 3,555 | 24.9 |

*included only those who had worked with them (n=14,279)

**Q7. Have you ever been concerned that a PA or AA you have worked or trained alongside was undertaking work beyond their competence?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Frequently | 6,190 | 43.4 |
| Occasionally | 5,157 | 36.2 |
| Once | 388 | 2.7 |
| Never | 2,524 | 17.7 |

*included only those who had worked with them (n=14,279)

**Q8. In general, has the employment of PAs or AAs in places you have worked reduced or increased your workload?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Increased a lot | 2,909 | 21.8 |
| Increased a little | 4,488 | 33.6 |
| No change | 3,148 | 23.6 |
| Decreased a little | 1,967 | 14.7 |
| Decreased a lot | 832 | 6.2 |

* included only those who worked with them currently (n=13,355)

### Q9 How has the training of PAs/AAs affected your own training?

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Very positively | 50 | 0.8 |
| Somewhat positively | 91 | 1.5 |
| Neither positively or negatively | 1,641 | 27.4 |
| Somewhat negatively | 2,436 | 40.6 |
| Very negatively | 1,767 | 29.5 |

*only included those doctors currently in training posts (n=7,294)

### Q10 How has the presence of qualified PAs/AAs affected your own training?

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Very positively | 107 | 1.7 |
| Somewhat positively | 305 | 4.9 |
| Neither positively or negatively | 1,483 | 23.6 |
| Somewhat negatively | 2,574 | 41.0 |
| Very negatively | 1,794 | 28.6 |

*only included those doctors currently in training posts (n=7,294)

### Q11 In your experience, how has the training of PAs/AAs affected the training of medical students?

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Very positively | 200 | 1.4 |
| Somewhat positively | 256 | 1.8 |
| Neither positively or negatively | 2,058 | 14.4 |
| Somewhat negatively | 4,054 | 28.4 |
| Very negatively | 4,206 | 29.5 |
| Don't know | 3,496 | 24.5 |

*Only included those who currently work with MAPs (n=14,279)

**Q12 In your experience, how has the presence of qualified PAs/AAs affected the training of medical students?**

| ANSWER CHOICES | Number * | Percentage |
|---|---|---|
| Very positively | 430 | 3.0 |
| Somewhat positively | 877 | 6.1 |
| Neither positively or negatively | 3,113 | 21.8 |
| Somewhat negatively | 3,381 | 23.7 |
| Very negatively | 2,718 | 19.0 |
| Don't know | 3,734 | 26.2 |

*included only those who worked with MAPs currently (n=14,279)

**Q13 In your experience, how has the training of PAs/AAs affected the training of doctors?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Very positively | 236 | 1.7 |
| Somewhat positively | 290 | 2.0 |
| Neither positively or negatively | 2,101 | 14.7 |
| Somewhat negatively | 4,704 | 32.9 |
| Very negatively | 4,972 | 34.8 |
| Don't know | 19 35 | 13.6 |

*included only those who worked with MAPs currently (n=14,279)

**Q14 In your experience, how has the presence of qualified PAs/AAs affected the training of doctors?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Very positively | 401 | 2.8 |
| Somewhat positively | 656 | 4.6 |
| Neither positively or negatively | 1,799 | 12.6 |
| Somewhat negatively | 4,704 | 32.9 |
| Very negatively | 5,213 | 36.5 |
| Don't know | 1,474 | 10.3 |

*included only those who worked with MAPs currently (n=14,279)

**Q15 How has the presence of PAs/AAs changed your job role/your working day?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Improved sig. | 542 | 3.8 |
| Improved somewhat | 1,222 | 8.6 |
| No change | 4,887 | 34.2 |
| Deteriorated somewhat | 5,439 | 38.1 |
| Deteriorated sig. | 2,115 | 14.8 |

*included only those who worked with MAPs currently (n=14,279)

**Q16 In England, the Long Term Workforce Plan proposes increasing the PA workforce from approximately 3,000 to 10,000 by 2036/37, and the AA workforce from approximately 160 to 2,000 by the same date. To what extent do you approve of the expansion of physician associate and anaesthesia associate roles in the NHS workforce?**

| ANSWER CHOICES | Number* | Percentage |
|---|---|---|
| Strongly approve | 385 | 2.6 |
| Approve | 679 | 4.5 |
| Neither approve nor disapprove | 1,155 | 7.7 |
| Disapprove | 3,667 | 24.3 |
| Strongly disapprove | 9,157 | 60.8 |

*included only those current working in England (n=15,070)

**Q20 Do you believe the introduction and increase in PAs and AAs in the NHS has improved patient care?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes a lot | 491 | 2.7 |
| Yes somewhat | 1,303 | 7.2 |
| Not really | 5,722 | 31.5 |
| Not at all | 9,237 | 50.8 |
| Too soon to tell | 1,380 | 7.6 |

**Q21 Do you support the future regulation of PAs and AAs by the GMC?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes | 3,459 | 19.0 |
| No – the Health Care and Professions Council (HCPC) should be the regulator | 6,270 | 34.5 |
| No – a different regulator would be appropriate | 6,804 | 37.4 |
| No – I don't think PAs and AAs should be regulated | 524 | 2.9 |
| Don't know | 1,080 | 5.9 |

**Q22 To what extent do you agree with the following statement: 'Physician associates and anaesthesia associates should revert to their previous titles of physician assistants and physician assistants (anaesthesia)'**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Strongly agree | 11,077 | 60.9 |
| Agree | 3,391 | 18.7 |
| Neither agree or disagree | 2,923 | 16.1 |
| Disagree | 420 | 2.3 |

**Q23 Once they are regulated, should PAs and AAs be granted prescribing rights?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes – the same rights as doctors | 436 | 2.4 |
| Yes – but with a defined and limited scope | 7,659 | 42.1 |
| No | 8,901 | 49.0 |
| Unsure | 1,147 | 6.3 |

**Q24 Should PAs and AAs be described as medical practitioners?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| No | 15,061 | 82.8 |
| Yes | 1,112 | 6.1 |
| Don't mind either way | 1,948 | 10.7 |

### Q25 Should PAs and AAs be described as having undertaken medical training?

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| No | 16373 | 90.1 |
| Yes | 918 | 5.0 |
| Don't mind either way | 835 | 4.6 |

### Q26 Do you think the public understand the difference between PAs/AAs and doctors?

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes – fully understand | 130 | 0.7 |
| To some extent | 1,932 | 10.6 |
| No not at all | 15,660 | 86.1 |
| Don't know | 421 | 2.3 |

### Q27 How important is it that patients know which kind of healthcare professional is providing their care?

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Very important | 16,373 | 90.1 |
| Somewhat important | 1,420 | 7.8 |
| Somewhat unimportant | 180 | 1.0 |
| Very unimportant | 150 | 0.8 |

### Q28 Do you believe the way that PAs and AAs currently work in the NHS is a risk to patient safety?

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Always | 5,777 | 31.8 |
| Sometimes | 10,042 | 55.2 |
| Never | 839 | 4.6 |
| Don't know | 1,524 | 8.4 |

**Q29 What is it that makes you feel the way PAs and AAs currently work is a risk to patient safety? (tick all that apply)**

| ANSWER CHOICES | Number (n=15,755) | Percentage |
|---|---|---|
| Concerns with the quality of PA/AA training | 11,788 | 74.8 |
| Concerns with the quality (including capacity/availability) of PA/AA supervision | 13,236 | 84.0 |
| The risk of PAs/AAs working outside their competence | 14,344 | 91.0 |
| The risk that patients will confuse PAs/AAs with doctors | 13,516 | 85.8 |

**Q30 A newly qualified PA or AA may be paid 35% more than a F1 doctor for a 9am-5pm, 40-hour working week. Do you think this fair?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes | 423 | 2.3 |
| No | 17,395 | 95.7 |
| Don't know | 325 | 1.8 |

**Q31 Do you think this difference in basic pay may be justified by other factors, such as the potential for greater whole career earnings?**

| ANSWER CHOICES | Number (n=18,182) | Percentage |
|---|---|---|
| Yes | 1,068 | 5.9 |
| No | 16,212 | 89.2 |
| Don't know | 856 | 4.7 |

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