Safe scope of practice for Medical Associate Professionals (MAPs)

BMA

Introduction

Medical associate professionals (MAPs), including physician associates (PAs), anaesthesia associates (AAs), and surgical care practitioners (SCPs) are currently working in the NHS in a variety of roles across primary and secondary care.[1] The government in England plans to increase the number of PAs by 2036/37 from approximately 3,250 to 10,000 (an increase of over 300%); and AAs from approximately 180 to 2,000 as part of their NHS Long Term Workforce Plan.[2] We have always been clear that in well-defined limited roles, MAPs can play an important part in NHS teams, and that doctors will continue to value, respect and support the staff they work with. However, MAPs are not yet regulated and complete only a two-year postgraduate course (1,600 hours of clinical experience and teaching)[3,*] but are increasingly being employed in the NHS in roles that had previously been reserved for doctors. There have been several recent high-profile cases of harm occurring to patients following consultation by PAs, sadly including three deaths.[4] 87% of more than 18,000 doctors in a recent survey expressed concerns that PAs and AAs were currently employed in the NHS in ways that were 'sometimes' or 'always' a risk to patient safety.[5] The BMA has called for a halt in recruitment to these roles while their regulation and scope of practice can be reconsidered.[6]

The government intends PAs and AAs to be regulated by the General Medical Council (GMC, the doctors' regulator) and is pushing this regulation through Parliament. The BMA opposes the GMC as the regulator of PAs and AAs as it will further blur the lines between doctors and these roles, and we believe the regulator should instead be the Health and Care Professions Council.[7] We are very concerned by the fact that the GMC has no plans to set safe parameters on PA and AA scope of practice after regulation, and they have instead proposed that employers and the Royal Colleges should be setting these boundaries.[8] The BMA believes that it is inappropriate for individual employers to set the scope of practice for PAs and AAs, as this will likely lead to further unsafe practices occurring. As the medical profession has the greatest level of medical knowledge and will be supervising MAPs, we have produced this scope document with the aim of protecting patients and safeguarding medical training for the doctors of the future.

This document sets out a safe scope of practice for MAPs, which NHS employing organisations should adopt to help doctors and other staff to provide safe, high-quality care. These safe practice parameters reflect the notion that MAPs' 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. We recommend that that these safe parameters are regularly reviewed (at least every 5 years) to ensure they remain appropriate and that no additional definitions are needed.

Key concepts that are covered in this document include the following:

1. MAPs follow, and do not give, medical directives. That is, a PA, AA, or SCP acts upon the medical decisions of a doctor. A PA, AA, or SCP does not make independent treatment decisions.
2. MAPs must not see undifferentiated patients.
3. National standards for supervision of MAPs must be set and adhered to, including that supervision is voluntary and must be consented to by consultants and GPs in writing. Employers must not discriminate in any way against those who choose not to supervise.

* PAs have completed a previous undergraduate degree in the majority of cases, but this is not specific medical training. A limited number of PA courses are a combined undergraduate degree (2 years) with the PA masters (2 years), which is also not equivalent to a primary medical qualification.

Doctors must have '*first right of refusal*' for all clinical and training opportunities. This means that within a department, any procedure, senior doctor teaching (even bedside), clinic opportunity, or other learning event, such as managing patients in resus or ALS/APLS scenarios where it is possible to determine in advance who will do the task/attend the clinic/manage the resus scenario must be offered to doctors before being made available to other staff. This does not mean that a senior doctor is required to consult all doctors before imparting *ad hoc* knowledge or instruction to a MAP, but that the training of PAs/AAs/SCPs must not come at the expense of the education and training of doctors. In departments where the 'first right of refusal' is not being adhered to, we expect there to be mechanisms in place to allow doctors to report this and for swift remediation to occur. Where applicable, this 'first right of refusal' should be given to medical students over MAPs trainees.

This document is set out in the following sections:

1. General principles about the scope and safe scope parameters for MAPs
2. General principles regarding the supervision requirements for MAPs with some specialty-specific notes
3. The scope and safe parameters of scope in a traffic light system in two tables:
   a. General scope of practice applying to all MAPs in all NHS settings
   b. Specialty specific additions of safe scope parameters that also must be adhered to in addition to the general scope for MAPs working in that specialty.

The tables outline the work of the PAs, AAs, and SCPs in terms of what they are expected to do, what they may do under the direct supervision of a doctor, and what they must not do.

These safe scope parameters are primarily written in relation to PAs but where they are also applicable for AAs and SCPs, we have made note with the ● symbol.

It is important to note that these safe scope parameters refer to fully qualified MAPs. It is expected that trainee PAs/AAs/SCPs will not be working independently in any capacity. In addition, the placement of MAP trainees must not be to the detriment of doctors or medical students; the training of the latter should be prioritised.

SECTION 1. General Principles of scope for MAPs

This section outlines the overarching principles for an appropriate scope of practice for MAPs given their two-year formal qualification.

Principles •

1. This is an assistant role to doctors helping with simple practical procedures, administrative tasks, and working with patients in a supportive and specified role.
2. This does not extend to seeing undifferentiated patients in any situation.
3. When seeing differentiated patients (those already triaged by a doctor as appropriate, or already assessed, diagnosed, and on a treatment plan by a doctor), MAPs must be directly and closely supervised.
4. PAs/AAs/SCPs must not make independent management decisions for patients nor be responsible for initial assessments of patients and diagnosis.
5. MAPs must make it clear in all communication to patients and to other staff members that they are not doctors and be clear about their specific role.
6. Statements such as 'I am one of the medical team' must not be used unless also stating their own title.

What PAs are permitted to do

All of these points are equally important and must be adhered to, regardless of the years of experience in the role. On-the-job learning is not recognized as a substitute for a formal medical qualification.

1. PAs in secondary care settings can only be employed for inpatient work in a ward setting. PAs should not staff EDs because the patients are undifferentiated. In any emergency department setting, they must work under direct supervision, with a senior doctor reviewing each patient in person and not work as part of a specialty referral service. This applies to all hospital settings, both public and private, within the UK.

2. PAs in secondary care settings must be employed and work in a specified department within a Trust/Hospital Board/Private hospital setting.

3. PAs must have a named consultant supervisor within their responsible department who •

    a. Is indemnified appropriately for supervising MAPs.
    b. Has a clear understanding of the scope, competencies, and level of supervision required.
    c. Has agreed to include supervisory responsibilities in their job plan and is given an appropriate number of programmed activities for this work.
    d. Prioritises the supervision of doctors over PAs/AAs/SCPs and if there is a limited time for supervision, understands that doctors' needs must come before any commitment to PA/AA/SCP supervision.

4. PAs should be able to undertake ward based tasks to enable basic patient care limited to:

    a. Bedside observations •
    b. Venepuncture and peripheral IV cannula placement •
    c. Insertion of urinary catheters or nasogastric tubes in adults (but not CXR interpretation for the correct placement in the stomach)
    d. Electrocardiography (take ECGs but not interpret them) •

e. Obtaining point of care tests such as capillary blood sugars, urinalysis, or venous blood gases ●
f. Assist with ward round documentation ●
g. Preparing discharge letters for later review and signature by a doctor ●
h. Medication administration: call pharmacy to check if a script was collected or confirm when it was last supplied ●
i. Administrative tasks such as arranging outpatient follow up, arrange transfer of patient down to CT and back, and scheduling timing of investigations ●
j. Updating relatives regarding the condition of patients (if medical staff assess this to be appropriate) ●
k. Routine daily reviews of stable inpatients who are medically optimised for discharge, if the patient's consultant assess this to be appropriate, provided that any adverse change in clinical status prompts medical review by a doctor ●
l. Acknowledging, sourcing and filing urgent radiology and laboratory results provided that systems are in place to ensure that they communicate these results promptly to the appropriate doctor on the team ●

5. All entries in clinical documentation including medical notes and letters require ●

   a. Documented name of the supervising consultant/GP
   b. Absolute clarity regarding role including registration status, being explicit that such registration is not equivalent or interchangeable with the status of a doctor.
   c. Avoidance of prefixes such as "Dr", "Miss/Ms." or "Mr" that might imply status as a medical practitioner, including surgeons, in a health care setting.

6. MAPs can contribute to research, audit, and quality improvement work in a clinical setting, provided they are adequately supervised by doctors or the Trust's/Board's research team. They must not publish research about the effectiveness of MAPs work/role without identifying the MAP as a PA/AA/SCP and declaring this as a conflict of interest if the research relates to the MAP role/effectiveness. ●

7. MAPs can help direct doctors to local hospital policies appropriate to the condition of the patient. Additionally, they can help the Foundation/Specialty doctor new to the department learn how to find local policies and learn local processes for particular conditions, for example. ●

What PAs are not permitted to do

All of these points are equally important and must be adhered to, regardless of the years of experience in the role.

1. Use the title 'consultant'. ●
2. Refer to themselves as a medical student/doctor/SHO/resident/specialist/associate specialist/registrar/GP or imply to be equivalent. ●
3. Undertake outpatient work on clinic patients unless this is in a predictable, pathway-led role within their department (such as a surgical-operative assessment service) where no diagnosis or medical decision-making is expected and where there is a clear pathway for escalation of unwell or unstable patients. ●
4. Assess, diagnose, or manage undifferentiated patients in ANY setting, including emergency departments, acute medical take, general practice, primary care, home visits, or companies providing primary care services.
5. Independently make any decisions regarding initial management or ongoing care of patients, including discharging patients; their role is to confirm that a medical plan has been documented and acted upon, with the only exception being an acute situation where they have called for help and are initiating Basic Life Support. ●
6. Cover, share or participate in a rota designed for, or populated by, doctors; or be referred to as medical staff. ●

7. Direct/instruct/advise a doctor or other professional to prescribe a medication, alter or cancel an existing prescription, or request ionising radiation imaging ●
8. Undertake a medications review or discuss ionising radiation imaging requests with radiologists, even if the imaging is requested by a doctor. In line with recent RCR recommendations,[9] MAPs should not be requesting non-ionising radiation imaging either. ●
9. Direct/instruct a doctor or other professional to request an investigation or procedure ●
10. Be consulted for, or provide, specialty-specific advice, unless documenting on behalf of a consultant/senior registrar in that specialty with caveats as defined above ●
11. Perform, train in, or consent others for invasive or life-threatening procedures including: ●

    a. Any procedure under general anaesthesia (GA) or regional anaesthesia (including spinal anaesthesia, Bier, or nerve blocks)
    b. Administering a GA, spinal anaesthesia or epidural, nerve blocks or Bier anaesthesia
    c. Endoscopy (any)
    d. Surgical procedures under local anaesthetic, including administering the local anaesthetic, wound closure, debridement, incision, angiography, echocardiography, pacemaker insertion or valvular intervention
    e. Pleural procedures

12. Issue a formal radiology report or undertake any interventional radiology procedure.
13. Deliver a baby or cause a baby to be delivered, in a midwifery role or that of a doctor in obstetrics. ●
14. Undertake any Mental Health Act assessment, diagnose or manage any mental health condition for which inpatient care is required or accept devolved responsibility for the physical health of patients under the care of a psychiatrist.
15. Complete or sign a DNACPR/respect form or equivalent or have discussions with patients and family members about this. ●
16. Sign a death certificate or cremation form. ●
17. Be asked to complete workplace-based assessments (WBA) for doctors or to examine any level of doctors such as for OSCEs or postgraduate clinical exams. WBA and OSCEs for medical students can be completed if the skill is within the safe parameters and scope of practice for MAPs. ●
18. Offer any clinical teaching to training doctors or Locally Employed Doctors (LEDs). Similarly, offer teaching to medical students unless it falls within the safe parameters of working for MAPs. ●
19. Attend routine medical teaching sessions on topics or skills outside the scope of practice of MAPS unless the session is inclusive of other healthcare professionals such as physios or nurses. This is also true for MAP trainees/students. ●
20. Act as Clinical Director of a department nor Medical Director of a Trust/Board, or be a direct line manager for doctors in any way. ●

● also applies to anaesthesia associates (AAs) and surgical care practitioners (SCPs) working in anaesthetics or other surgical departments/roles

SECTION 2. SUPERVISION.

Given that MAPs are dependent practitioners, close and frequent supervision is necessary to keep patients safe. Nationally agreed supervision standards must be set. The principles of appropriate levels of supervision are noted below with some specific details for primary care settings and for AAs in anaesthetic departments and SCPs in surgical settings. This holds true for both public and private healthcare settings.

Overarching principles

1. There must be national standards of supervision and all MAPs must have a named supervisor. They should introduce themselves in the following way: "I am Joe Bloggs, one of the physician associates/anaesthesia associates/surgical care practitioners but I am not a doctor myself. My supervisor is Dr Jane Smith". If MAPs titles are changed to make it clear that their role is to assist doctors, the need for them to state in their introduction that they are not a doctor can be reviewed.
2. Supervision of PAs/AAs/SCPs should be voluntary for medical staff. Employers must not discriminate against doctors in any way who choose not to supervise MAPs.
3. Named supervisors for MAPs must consent in writing to supervision, be properly indemnified, and be immediately available for supervision whenever the MAP is on duty.
4. Has a clear understanding of the scope, competencies and level of supervision required.
5. Doctors must not be put in a position where they are obliged to supervise the work of a MAP unless they have expressly consented in writing to do so. This applies also for cross-specialty purposes, e.g. a surgeon should be free to refrain from working with a MAP without repercussions.
6. MAPs must only be supervised by:
   a. Consultants
   b. GPs
   c. SAS doctors equivalent to the level of consultants

   No other level of doctor should supervise MAPs, nor should MAPs receive supervision from other health professionals, including other MAPs.
7. MAPs must not supervise doctors or medical students.
8. MAPs should not offer postgraduate teaching to doctors. They should not hold general teaching responsibilities for medical students. However, it may be appropriate for MAPs to demonstrate particular tasks, in which they are skilled.
9. Supervision must not be off-site or via telephone (unless the supervisor is present in another room in the same hospital/practice/place of work). It must always be possible for patients to be reviewed by the named senior clinician. If the named supervisor will not be present on a shift where the MAP is working, they must nominate someone else to be their substitute. This doctor must also consent to supervise MAPs in writing and be appropriately indemnified for this type of supervision. Contact details of the supervisor and who they are supervising should be available in the setting where the MAP is working and updated with substitutes as appropriate.

Possible supervision scenarios include:

a. directly supervising a MAP in the same room/ward for a task or procedure in person,
b. directly supervising a MAP during a ward round where the MAP might scribe or perform a limited clinical examination,
c. more indirectly supervising a MAP by being present in the same room/department while they are working and being available for help/review of patients as needed,
d. being present in the same GP practice but not the same room and discussing all patients with the PA.

e. with experienced MAPs, being available by telephone still in the same building and able to quickly review patients. As above, it is expected that the supervisor can attend in person to review patients quickly if needed, so remote supervision while performing surgery or otherwise involved in clinic duties, for example, is not appropriate. In such cases, a named delegate supervisor, who volunteers and consents in writing, must be available to supervise in their absence. In such cases, it is expected that all patients are discussed with the supervisor at least once a shift or they are in contact that frequently to ensure that delegated tasks have been completed in a timely manner.

10. Supervisors must have appropriate training in supervising MAPs. Appropriate guidance and checks must be in place to ensure that MAPs continue to meet the minimum standards in competence in order to keep patients safe, with pathways developed to ensure any necessary remediation if necessary.
11. MAPs must receive regular and frequent feedback, formal assessments, and annual appraisal with input from the named supervisor and wider clinical team.
12. Supervisors must prioritise the training of medical students and doctors over that of MAPs and MAP students, adhering to the principle of '*first right of refusal'* for training and teaching opportunities (see introduction, page 2 for further details).

Specialty-specific details

PAs in a GP setting
After appropriate triage, PAs may see selected patients, such as for annual health checks. If the patient requires any changes to management, the patient must be reviewed by a GP in person, unless this change is part of a pre-existing written management plan authorised by the patient's GP. All changes to management suggested by a PA must be reviewed appropriately and approved by the patient's GP in advance of changes being made.

AAs
a. should be supervised on a 1:1 basis.
b. A 1:1 supervision ratio must occur, except where the supervising consultant is supervising a senior (post-FRCA) anaesthetic trainee or SAS doctor in an immediately adjacent operating theatre and the AA is experienced enough to have allow this particular circumstance.
c. More than 1:2 supervision ratio in the explicit circumstances above must not occur under any circumstances.
d. AAs must be supervised by a named consultant supervisor who consents in writing and is appropriately indemnified.

SCPs
SCPs must be closely supervised by a named consultant supervisor who consents in writing and is appropriately indemnified. In the theatre setting, they must have direct supervision while performing their secondary assistant role. In the ward setting, they must adhere to close supervision, such as described above for PAs.

SECTION 3. TRAFFIC LIGHT TABLES

This section sets out more specific examples of expected behaviour and builds on the principles in section 1.

Table one contains all expected tasks and behaviours for all PAs in all settings. The vast majority also apply to AAs and SCPs as signalled with the ● symbol.

Table two contains specialty-specific expectations and constraints on practice. PAs, AAs, and SCPs are expected to adhere to the principles of both tables equally. If something is a *must not* in the general scope but not mentioned in the specialty details where a PA/AA/SCP is working, the general scope still applies, and that task/procedure/behaviour remains a *must not*.

The columns of both tables take a traffic light format:

- **Green**: activities, behaviours, and tasks that PAs, AAs, and SCPs are competent to perform and expected to do,
- **Amber**: additional activities that may be completed at the request of a doctor and with an appropriate level of supervision, provided the *first right of refusal* principle is applied in all circumstances to all activity,
- **Red**: activities, behaviours, or tasks that must not be done in any circumstance.

Table 1. GENERAL SCOPE FOR PAs

DOMAIN	IS EXPECTED TO	MAY DO (Under direct supervision and with agreement of named consultant /GP). ******First right of refusal* for doctors must be upheld	MUST NOT
PROCEDURES •	– Take observations – Venepuncture/cannula insertion – Urinary catheter insertion in adults – Nasogastric tube insertion in adults but NOT interpreting the CXR and taking responsibility for ensuring correct placement in the stomach – Take ECGs (not interpret them) – Point of care tests: blood glucose, urinalysis, venous blood gas incl. capillary blood gas – To be BLS trained and able to initiate basic life support manoeuvres	– Flushing chest drains – Help with neonatal lumbar punctures by 'catching' or holding the infant – Neonatal urinary 'clean catch' – e-ILS if it would be helpful for the department/ setting that they are employed	Perform, train in, or consent others for invasive or life-threatening procedures including: a. Any procedure under a general anaesthetic (GA), under sedation, or regional anaesthesia (including spinal, nerve, Bier) b. Giving a GA except in the case of an AA giving it under the direct and immediate supervision of an anaesthetic consultant c. Endoscopy (any) d. Surgical procedures under GA, spinal anaesthesia, or local anaesthesia (LA), including caesarean section. e. Diagnostic and therapeutic abdominal paracentesis f. Angiography, echocardiography, pacemaker insertion or valvular intervention g. Pleural procedures h. Interventional radiology procedures i. Vaginal delivery of a baby, including instrumental delivery of a baby j. Lumbar punctures k. ABGs with lidocaine (therefore, excluding most ABGs)

ASSESSMENT ●	– Smoking assessments – AMT score – WHO performance status – Assessments of stable patients while on a ward round with doctors if requested to do a limited exam	– Routine daily reviews of stable inpatients (should there be any adverse change in clinical status a clinical review by a doctor is required) at any time with adequate supervision by a doctor and discussion of all patients seen – VTE assessments: can do the initial assessment according to a prescribed protocol, but if pharmacological prophylaxis is required, this must be flagged to the named supervisor for follow-up	– Undertake outpatient work in clinics unless this is within a predictable, protocol-led role within the department (e.g. surgical pre-op assessment) where no diagnosis or medical decision making is expected and there is a clear pathway for escalation of unwell or unstable patients – Assess, diagnose, or manage undifferentiated patients (this includes areas such as ED, the acute medical take, and general practice) – Make independent decisions regarding initial management or ongoing care of patients – Have input into DNACPR decisions/ ceiling of care/or escalation decisions (other than as a supportive role) nor sign DNACPR/RESPECT forms – Perform medication reviews – Be consulted for, or provide, specialty specific advice unless documenting on behalf of a consultant/senior registrar in that specialty (it must be clearly stated/ documented as such) – Triage or vet referrals received to the specialty/department/practice in which they are employed – Issue a formal radiology report – Undertake Mental Health Act assessments, diagnose or manage any mental health condition for which inpatient care is required – Accept devolved responsibility for the physical health of patients under the inpatient care of a psychiatrist – Use any 'workarounds' to get access to credentials for prescribing or requesting ionising radiation

COMMUNICATION with PATIENTS and COLLEAGUES ●	– All clinical documentation (ward round documentation, other patient notes or updates, letters, discharge summaries) undertaken by a PA must include: – Their job role – The name of the supervising consultant – Registration status And must be validated by a doctor as a true and correct record if concerning any correspondence going to a third party. – Clearly explain their role to all patients, clearly explain that they are not a doctor if misidentified as one – When communicating with other staff, PAs must state their role clearly as a PA and not as part of the ______ team or indirectly refer to themselves as a doctor, a medic, or any other vague term that will cause confusion. – Update relatives regarding the condition of patients (provided medical staff believe it is appropriate, have directed the PA/ AA/ SCP to do so, and given instructions on what to say) the condition of patients (provided medical staff believe it is appropri-ate, have directed the PA/ AA/SCP to do so, and given instructions on what to say)		– Clinical documentation must not include prefixes such as 'Dr' or 'Mr/Miss/ Ms' that could imply status as a medical practitioner (or surgeon) – Direct/instruct a doctor or other professional to prescribe a medication or to alter an existing prescription – Direct/instruct a doctor or other professional to request an investigation or procedure – Direct/instruct a doctor to perform any task based on the PA's sole assessment – Be involved in end-of-life discussions, except as a source of information or in a supportive role. The decision-making and related paperwork must be completed by doctors – Be involved in giving specialty advice (unless repeating a consultant/senior registrar's advice and making it clear who the advice has come from) – Take consent for procedures that they themselves do not perform – Notify public health in cases of notifiable infectious diseases nor make any public health decisions regarding infectious disease unless specifically instructed to by a doctor or public health specialist working in health protection

DAILY WORK ●	– Assist with ward round documentation, including preparation of the notes in advance of the round and updating any relevant blood work in the appropriate place and sign these with title – Prepare discharge summaries and add in clinical codes for diagnoses as appropriate for later review and signature by a doctor – Arrange outpatient follow up appointments – Chase appointments such as CT scans already requested by a doctor or clinic appointments	– Act on treatment decisions made during ward round by the doctor/ Consultant	– Cover, share, or participate in a rota designed for doctors at any level – Sign a death certificate or cremation form – Make any independent treatment decisions – Attend, prepare, or give any teaching or seminars to doctors as part of their specialty or foundation teaching. PAs or AAs are not eligible to attend doctor teaching of any specialty unless offered to the wider MDT – Be the sole person taking PICU/ICU step-down or transport handovers without a doctor present – Discharge patients independently
CLINICAL GOVERNANCE ●	– Contribute to audit and quality improvement practices in their department under supervision the appropriate Trust/Board research team or an appropriate medical doctor	– Publish research arising from audits completed with doctor supervision or by the appropriate Trust/Board research team, provided that they have clearly stated that they are a PA/AA/SCP in their author credentials	– Publish or be involved in publishing research about the effectiveness of the PA/AA/SCP role without declaring this as a conflict of interest – Operate in any supervisory or leadership role in which oversight is given over medical staff (e.g. clinical or medical director, clinical or educational supervisor, responsible officer) – Be involved in revalidation of medical staff except as a colleague giving feedback – Be involved in disciplinary or fitness to practice investigations at departmental, Trust, Board or MPTS level other than as a witness – Prepare reports for coronial inquests/ procuratorial inquests or act as an expert witness in a civil or criminal trial (though it is permissible to act as a material witness like any other member of the public)

● also applies to anaesthesia associates (AAs) and surgical care practitioners (SCPs) working in anaesthetic or other surgical departments/roles

Table 2. SPECIALTY-SPECIFIC SCOPE OF PRACTICE

DOMAIN	IS EXPECTED TO	MAY DO (Under direct supervision and with agreement of named consultant /GP). *First right of refusal for doctors must be upheld	MUST NOT
Anaesthetics/ ITU ●	– Undertake AAGBI anaesthetic machine check and two-bag test – Assist in, with direct supervision at all times, the conduct of anaesthesia for ASA 1-2 adult (>18 years) patients presenting for minor elective surgery (excluding obstetrics, cardiothoracics, neurosurgery, transplant surgery) – Preparations for anaesthetic pre-operative visit i.e. relevant notes, bloods, investigation reports, anaesthetic patient information sheets – Perform and record patient observations accurately – Perform 12-lead ECG (not interpret) – Venepuncture (including for cross-matching blood for transfusion) – Perform point of care tests for venous blood gas, glucose, ketones and coagulation studies – Prepare syringes, needles, and drugs for the anaesthetist to draw up – Set-up and apply AAGBI monitoring – Priming of IV, arterial and central venous giving and transduction sets, respectively – Assist operating department practitioners with checking in patients/WHO checklist	– Undertake anaesthetic pre-operative visit assessment for ASA 1 or 2 patients presenting for minor elective surgery (an anaesthetist must complete consent) – Assist in, with direct supervision at all times, the conduct of anaesthesia for ASA 3+ adult (>18 years) patients presenting for minor elective surgery (excluding obstetrics, cardiothoracics, neurosurgery, transplant surgery) – Assist in, with direct supervision at all times, the conduct of anaesthesia for ASA 1-2 adult (>18 years) patients presenting for major elective surgery (excluding obstetrics, cardiothoracics, neurosurgery, transplant surgery) – Be able to insert 1st and 2nd generation supraglottic airways under direct supervision of an anaesthetist – Interpret standard investigations e.g. bloods, ECG under the direct supervision of a doctor	– Formulate anaesthetic management plans or lead the brief for the anaesthetic team – Assist in any paediatric anaesthesia (<18 years) – Assist in any emergency or trauma anaesthesia – Assist in anaesthetising any patients in remote environments (i.e. outside of main operating theatre suites) – Assist in anaesthetising any patients outside of normal working day hours (0800-1800) Monday to Friday – Administer any medicines by any route to patients – Induce anaesthesia – Undertake laryngoscopy or endotracheal intubation – Undertake any advanced airway procedure – Conduct emergence of a patient from anaesthesia without direct supervision by a consultant anaesthetist – Undertake Rapid Sequence Induction, or advanced airway procedures – Anaesthetise any patients with a known or predicted difficult airway such as previous grade 3 or grade 4 Cormack-Lehane view – Anaesthetise patients for any high-risk elective surgery, including any cardiac, thoracic, neuro-surgical, and obstetric surgery – Perform total intravenous anaesthesia – Undertake neuraxial or regional anaesthesia – Perform conscious sedation – Perform central venous or arterial cannulation

	– Basic airway skills, including head tilt chin-lift, jaw thrust, use of oral and nasal airway adjuncts, one- and two-handed bag mask ventilation – Recognise common anaesthetic emergencies, inform the theatre team, and call the anaesthetist to the patient immediately – Where required assist anaesthetists with quality improvement projects, research – Where required, act as scribe for anaesthetists undertaking patient assessments and clearly document their name and title in the notes, so it is clear who is writing them – Where required, assist in the drafting of professional letters pertaining to patients as well as referrals	– Monitor patients under maintenance of inhalational anaesthesia for minor surgery in ASA1 and 2 patients with immediate access to supervisor (i.e. supervisor in relevant theatre or anaesthetic room), and recognise when immediate intervention by an anaesthetist is required in such patients (e.g. low BP, anaesthesia too light)	– Percutaneous drainage or needle aspiration of contents of any body cavity – Undertake any anaesthetic work with less than a 1:1 supervision ratio, except where the supervising consultant is supervising a senior (post-FRCA) anaesthetic trainee or SAS doctor in an immediately adjacent operating theatre and 1:1 recommended for all but the most experienced (10 years plus) – Undertake any anaesthetic work with less than a 1:2 supervision ratio under any circumstances – Cover any vacancy on an anaesthetic or intensive care doctors' rota – Hold a specialty bleep, take specialist referrals of any kind, nor be involved in vetting referrals – Discharge patients independently – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

Clinical Radiology	– Insert intravenous cannulas – Take observations – Liaise with referring teams to ensure patient preparation is followed (full bladder, NBM for 6 hours) – Act as chaperone for intimate procedures	– Administer intravenous contrast – Complete audits/ research under the supervision of the appropriate doctor/ research team	Formally report imaging in any modality including: – Plain film – Computed tomography (CT) – Magnetic resonance imaging (MRI) – Nuclear medicine – Ultrasound Approve, vet, or protocol imaging in any modality including: – Plain film – CT – MRI – Nuclear medicine – Ultrasound Perform, train in, or consent for invasive of life-threatening procedures including: – Fluoroscopic procedures – CT-guided procedures – Ultrasound guided procedures – Any endovascular intervention Lead or coordinate MDT meetings Interpret imaging for MDT meetings. – Hold a radiology referral bleep or mobile device – Take specialist referrals of any kind or give specialist advice – Be on the radiologist rota at any level or be used interchangeably with radiologists in any way Auxiliary roles within an intervention theatre: – Diagnostic radiography – Radiation planning – Radiotherapy delivery – MDT coordination – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

General Practice	– Undertake and present audits – Take observations – Take POC tests, take bloods/ECGs (if practice is funded for it, but not interpret ECGs) – See differentiated patients with known conditions who have been triaged as appropriate by a GP – Provide lifestyle support, according to protocolised pathways – Provide flu clinic support and other vaccination-based clinics	For selected patients who have been triaged by the named supervising GP and for whom there is an appropriate protocol the PA may do: – Annual LD Health Checks – Annual LTC reviews – Annual dementia, CVD, asthma/COPD/diabetes reviews* – Contraception review* – HRT review* – Smears – IM injections e.g. depo, B12 – Spirometry – Safeguarding referrals (where there is a safeguarding concern around a patient, this must be escalated to a doctor although should not prevent timely referral) **Unless part of a pre-existing written management plan authorised by the patient's GP, all changes to management suggested by a PA must be reviewed appropriately and approved by the patient's GP in advance of changes being made*	– See undifferentiated patients* – See any paediatric (<16) patients – Be sole practitioner on call or duty clinician – Be sole practitioner in the premises – Be responsible for clinical triage – Undertake direct supervision of GP registrars, FY2s or medical students – Undertake teaching of doctors – Undertake debriefs for GPRs/FYs/medical students – Undertake EoLC discussions and documentation (DNACPR or RESPECT forms) – Complete cremation forms – Do home visits involving undifferentiated patients – Do minor surgery, IUS/IUD/Nexplanon insertion – Do 6/8-week baby checks – Steroid injections or any intra-articular injection – Do referrals to secondary care (scheduled) or advice & guidance, unless reviewed by a GP – See any patient that has not a) been clearly informed at the point of booking that the appointment is with a PA rather than a GP b) subsequently consented to the appointment with a PA – Use the titles 'generalist practitioner' or 'registrar' or other titles that imply equivalence to a doctor **Unless the patient is also reviewed by a GP, immediately and in person*

Medicine	– "Clerk" elective patients e.g. being admitted for colonoscopy – Take observations – Venepuncture – IV cannulation – Urinary catheter insertion – Perform ECGs (not interpret) – Point of care tests: blood glucose, urinalysis, VBGs – Carry out urinary bladder scanning – Assist with ward round documentation, clearly documenting their name and title, and complete basic ward jobs in the assistant role (e.g. bloods, ECGs (take ECG and not interpret) – Prepare discharge summaries for later review by a doctor – Chaperone intimate examinations – Be BLS certified and initiate airway management and CPR until the crash team arrives	– Contribute to, but not lead, a cardiac arrest team if they hold a valid ALS certificate – See "medically fit" inpatients to confirm stability (should there be any change in clinical status a clinical review by a doctor is required) – Prepare cases for discussions at MDTs – VTE assessments: can do the initial assessment according to a prescribed protocol, but if prophylaxis is required, this must be flagged to the named supervisor for follow-up Gastroenterology: NGT insertion, GI physiology procedures e.g. breath test or oesophageal manometry (if appropriately trained and directly supervised by a doctor) Respiratory: PEFR, spirometry, provide advice on inhaler technique and assess compliance provided they are trained to do so, provide routine asthma/COPD reviews using established monitoring pathways under direction and close on-site supervision of a doctor where a patient is stable and maintained on current therapy	– Lead a ward round – Provide specialty advice other than when documenting or communicating advice from a consultant or registrar in that specialty – Hold a med reg bleep or equivalent – Clerk, triage or accept referrals for acute medical take, unless relating to protocolised assessment on a defined pathway under direct supervision Perform, train in, or consent for: – Endoscopy – Cathlabs – Pacing – DCCV even protocolised Respiratory: – Change NIV settings – Undertake pleural procedures including pleurodesis, drain insertion, or pleural aspiration – Perform and interpret thoracic ultrasound imaging – Perform thoracoscopy Clinical oncology: Auxiliary roles within an intervention theatre: – Diagnostic radiography – Radiation planning – Radiotherapy delivery – MDT coordination – Be on the doctor rota at any level or used interchangeably with doctors in any way – Hold referral bleeps, be involved in vetting referrals, or be acting in a way where they need to give specialist advice – Discharge patients independently – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

		(and escalated to the supervising consultant if patient is not stable or needs therapy modifications) Endocrine: perform a short synacthen or overnight dexamethasone test if requested by a doctor Care of the elderly: take a social history; complete DOLS paperwork if there already is a documented capacity assessment and plan for restraint Acute medicine: protocol driven assessment for "rule out" conditions on a defined pathway e.g. PE, DVT, with a named consultant supervision on-site and with the minimum level of discussion of cases to be no less frequent than that expected of FY1 doctors	

Ophthalmology	– Clearly explain their role to all patients, clearly explain that they are not a doctor before any patient interaction – Take physical observations – Venepuncture – IV cannulation – Perform ECGs (not interpret) – Point of care tests: blood glucose, urinalysis – Assist with ward round and clinic documentation for patient notes only when dictated by a doctor – Prepare discharge summaries, which will later be checked by a doctor – Check intraocular pressures using iCare machine (not GAT) – Test visual acuity – Visual fields testing	Outpatient Clinic Scope: – "Work-up" (take basic medical, ophthalmic, medication, allergy history using protocol/proforma) patients in "high-volume" and "one-stop" medical retina, glaucoma, and cataract outpatient clinics under consultant supervision only (cannot be supervised by registrar/SAS doctor/ANP/optometrist/orthoptist) – Telephone follow up clinics for low-risk post-op or eye casualty patients – Post-op oculoplastics video consultation clinic (e.g. post ectropion/entropion/ptosis repairs) – Pre-op assessment clinics Scope in other settings: – Low vision counselling after appropriate training – Low vision aid dispensing after appropriate training – Diabetic retinopathy screening and grading after appropriate training – Intravitreal injections after appropriate training in a non-emergency outpatient setting (must not perform	– Consent patients for surgery – Perform any intraocular or extraocular surgery under any circumstances (not including non-emergency intravitreal injections) – Consent patients for or perform any laser procedure – Triage, review or examine any undifferentiated patients in eye casualty – Review or examine any undifferentiated patients in outpatient clinics – Independently request investigations or ionising radiation imaging – Cover any trainee/registrar shifts during absence/sickness of doctors – Review patients independently on ward rounds – Discharge inpatients independently – Be on the doctor rota at any level or used interchangeably with doctors in any way – Hold referral bleeps, be involved in vetting referrals, or be acting in a way where they need to give specialist advice – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

		in an emergency setting e.g. for endophthalmitis) – Perform imaging and investigations such as Macula/ Optic Disc OCT scans, photography, pentacam, biometry, pachymetry only after appropriate training and when requested to do so by a doctor	

Paediatrics	– Take observations – Venepuncture/cannulation – Perform ECGs (not interpret) – Point of care tests: blood glucose, urinalysis, capillary or VBGs – Update daily records on Badgernet (or equivalent system) in their own name with title – Update blood results in appropriate section of the notes prior to ward rounds and clearly sign that they completed this – Scribe during consultant-led ward rounds and document their name and title so it is clear who took the notes – Prepare discharge paperwork for later review by a doctor – Call to find time for imaging appointments or to find time for another specialty review – Undertake basic airway manoeuvres such as head tilt chin lift, jaw thrust, one- and two-handed bag mask ventilation, placement of airway adjuncts such as LMAs if trained in paediatric BLS as a minimum – Perform physical examination of patients, including cardiac and respiratory systems examination in stable inpatients as part of the ward round with doctors present	– Flushing chest drains if appropriately trained – Assist with neonatal lumbar punctures by 'catching' or holding the infant – Assist with neonatal urinary 'clean catch' by holding the infant securely while the doctor performs the catheterisation – Perform baby checks if adequately supervised by a doctor onsite. – Interpret standard investigations e.g. bloods, ECG, x-rays, SBR results if adequately supervised by a doctor in person – Act on urgent situation such as give oral glucogel to hypoglycaemic infant under adequate supervision (as a nurse would do if taking a BS) – Wheeze reviews if accompanied by a doctor	– Hold a referral bleep for any specialty or be part of any referral triage or vetting role – Act as a registrar or senior doctor in any capacity – Take any PICU step-down or transport handovers as the sole receiver of the handover without a doctor present – Do the first post-operative review – Perform any UAC/UVC or long line insertion in an infant or any other central venous or arterial lines in any age – Carry the crash bleep on the NNU or children's wards – Attend deliveries as the SHO or registrar or as anything other than an observer/assistant role – Be on a transport rota in the role of a doctor – Intubate infants with endotracheal tubes, nasal endotracheal tubes, or apply NPA – Give any routine immunizations – Decide that a child is fit to undergo chemotherapy – Undertake an LP for ICP or sepsis, or any neonatal indication – Make any changes to any medications or direct any doctor to do so – Undertake any part of safeguarding reviews or NAI assessments – Be involved in any palliative care decisions or end of life conversations with parents, unless there in a supportive role only to parents – Attend any outpatient clinics or participate in any outpatient work in clinics, unless assisting under the direct supervision of doctors e.g. taking bloods – Lead any ward rounds – Be on the doctor rota at any level or used interchangeably with doctors in any way – Hold the referral bleep in any capacity nor be responsible for giving any specialty advice at any level. – Discharge patients independently – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

Psychiatry	– Take observations – Venepuncture – Perform ECGs (not interpret) – Perform screening physical examination – Assist with ward round documentation and document their name and title so it is clear who is taking the notes	– Perform follow up assessments to be reported to their supervising doctor – Help with social support (e.g. helping with benefit or housing applications) if appropriate training undertaken and with regular in-person supervision by a consultant with the appropriate indemnity and who agrees to this. Supervision level and frequency is never to be less than what would be expected of a FY doctor (regardless of additional clinical experience accrued) – Direct requests/ referrals to the most appropriate team after discussing each one with a doctor – Provide patient leaflets relating to particular types of therapy/treatments offered to the patient as part of their treatment plan (made by the psychiatrist)	– Undertake Mental Health Act assessments, diagnose or manage any mental health condition for which inpatient care is required – Accept devolved responsibility for the physical health of patients under the inpatient care of a psychiatrist – Be a substitute for doctors when a patient presents with physical symptoms – Consent for or initiate treatment – Make decisions that deprives a person of their liberties (MHA/MCA/DOLS/LPS) – Be involved in decision making or delivery of experimental (psychedelics, rTMS, etc.) or invasive treatments (ECT, or similar therapies) – Be on the doctor rota at any level or used interchangeably with doctors in any way – Hold referral bleeps, be involved in vetting referrals, or be acting in a way where they need to give specialist advice – Discharge patients independently – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

Surgery ●	– Take observations – Venepuncture – IV cannulation – Urinary catheter insertion in adults – Perform ECGs (not interpret) – Point of care tests: blood glucose, urinalysis, VBGs – Carry out urinary bladder scanning – Assist with ward round documentation and document their name and title whilst doing so, so it is clear who is taking the notes – Prepare discharge summaries for later review by a doctor – Chaperone intimate examinations – Change stoma bags	– Flushing chest drains – Routine daily reviews of stable inpatients (should there be any change in clinical status a clinical review by named supervisor is required) – Apply simple dressings under the instruction of a doctor and for appropriate patients only (not paediatric patients with facial/scalp injuries or anything else that would usually be seen by the Plastic surgery team) – Change VAC dressings under the instruction of a doctor – Review patients in outpatient settings (must have direct consultant supervision and discussion of all patients) – NELA/P-POSSUM operative risk assessments with discussion with a doctor for all – Removing drains if directed to do so by a doctor – VTE assessments: can do the initial assessment according to a prescribed protocol, but if prophylaxis is required, this must be flagged to the named supervisor for follow-up	– Perform, train in, or consent for invasive or life-threatening procedures including: 1. Endoscopy (any) 2. Surgical procedures under GA, spinal anaesthesia, or LA (local anaesthesia) 3. Chest drain insertions 4. Cystoscopy – Act as first assistant in the operating theatre – Have their own theatre list – Removing cholecystostomies – Removing or flushing neurosurgical drains including but not limited to external ventricular drains and post-operative drains following the evacuation of a subdural haematoma' from/in any space within the central nervous system – Lead ward rounds – Review or clerk new acute patients in the ED, Surgical triage units, surgical admissions units etc. – Be on the doctor rota at any level or used interchangeably with doctors in any way – Hold referral bleeps, be involved in vetting referrals, or be acting in a way where they need to give specialist advice – Discharge patients independently – Use the titles 'consultant', 'registrar', 'specialist', 'resident' or 'senior house officer'

Women's Health & Maternity Care ●	– Take observations – Venepuncture/cannula insertion – Urinary catheter insertion – Perform ECGs (not interpret) – Point of care tests: blood glucose, urinalysis, VBGs – Carry out urinary bladder scanning – Assist with ward round documentation and document their name and title whilst doing so, so it is clear who is taking the notes	– Standardised fundal height measurements – Continue oral contraception without changes (if requiring changes, to promptly flag to named supervisor for immediate review in person) – Refit or replace vaginal pessaries for those with long-term organ prolapse in keeping with established protocols – Inform VTE risk assessments in line with national antenatal, Intrapartum, and postpartum classifications but if requiring prophylaxis, this must be flagged to the named supervisor for prompt follow-up	– Undertake outpatient work in clinics unless in an assistant role (e.g. ANC, PMB clinic) – Assess women for labour, PPROM, SROM, APH, HTN/PET, or reduced foetal movements, or any acute presentation in pregnancy – Have any role in maternity triage – Be involved in surgical management of miscarriage, surgical termination of pregnancy, medical management of miscarriage, medical termination of pregnancy unless taking an assistant role under the direction of a doctor – Act as first assistant in the operating theatre Perform, train in, assist with, or consent for invasive or life-threatening procedures including: – Caesarean section – Instrumental delivery – Perineal repair – Cervical cerclage – Hysteroscopy – Hysterectomy – Laparoscopy – Salpingo-oophorectomy – Prolapse repair – Colposcopy – Vaginal examination including speculum and bimanual examination (in inpatient and outpatient settings) – Ultrasonography of the pelvis, either transabdominal or transvaginal – Insertion or counselling in long-acting contraceptive methods, including IUS, IUD, implants, and injectables – Administration or counselling in methods of hormone replacement therapy (HRT) – Initial fitting of vaginal pessaries for organ prolapse – Be on the doctor rota at any level or used interchangeably with doctors in any way

			– Hold referral bleeps, be involved in vetting referrals, or be acting in a way where they need to give specialist advice – Discharge patients independently – Use the titles ‘consultant’, ‘registrar’, ‘specialist’, ‘resident’ or ‘senior house officer’

● also applies to anaesthesia associates (AAs) and surgical care practitioners (SCPs) working in anaesthetic or other surgical departments/roles

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BMA 20240142