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BMA

Dr Hilary Williams
Chair, PA Oversight Group
Royal College of Physicians, London

via Email

12th September 2024

Dear Dr Williams,

**Stakeholder consultation: Physician Associates – Guidance for safe and effective practice**

Thank you for giving us the opportunity to respond to the Royal College of Physicians' consultation on physician associate guidance for safe and effective practice, which you have developed in consultation with the Faculty of Physician Associates. As you will know, the BMA has called for a pause in the recruitment of physician associates and the other MAPs professions until our serious concerns about their current deployment are addressed. We have produced a comprehensive Safe Scope of Practice guidance for MAPs and supervision guidance, while we also provide a reporting portal for doctors and medical students to raise any safety concerns about MAPs working arrangements in their place of work or training.

Unfortunately, despite strongly voicing our members' concerns with system leaders for some time, we continue to hear of examples across the NHS of the blatant disregard for patient safety by NHS employing organisations. It is therefore disappointing that this draft RCP guidance does not sufficiently tackle the clear patient safety concerns of doctors regarding the ways that PAs are currently employed in the NHS, or adequately address the loss of training opportunities for both medical students and doctors. These concerns have been shared in every recent survey of doctors about PAs, including the BMA's landmark survey of more than 18,000 doctors and medical students, as well as the RCP's own survey published following the Extraordinary General Meeting. Notably, it is inconsistent to maintain a position that, on the one hand, states quite clearly that "PAs are not doctors" while on the other, does not call for any limits to MAPs' scope of practice.

The College's response to the failings identified by the recent King's Fund learning review acknowledged that the RCP had neither listened, nor responded quickly enough, to the questions and concerns being raised by its fellows and members. We hope that the College will therefore take time to reflect on our feedback and that of the wider medical profession and strengthen this guidance accordingly. To assist with this, we have set out below our detailed response. This has been informed by our dedicated MAPs Steering Group, which is made up of elected representatives of the profession from across the medical specialties and throughout the UK.

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We would be happy to discuss our response with you and your PA working group should it be helpful.

Yours sincerely,

Professor Phil Banfield
Chair, UK Council

BMA

# BMA response to RCP London stakeholder consultation, Sept 2024:

## Physician Associates – Guidance for safe and effective practice.

### 1. Patient Safety

*To what extent do you agree or disagree that this draft guidance for employers and supervisors will support doctors and physician associates to deliver safe and effective patient care?*

DISAGREE

This draft guidance allows the employer and supervisors to set the scope limits for PAs. This is the status quo and has led to significant patient harm, including deaths. The guidance fails to specify nationally agreed limits to scope. Patient safety should not be compromised by the employment of less qualified healthcare professionals to roles traditionally held by doctors. The medical profession must not be asked to compromise on safety to cover the wider system's failure to recruit and retrain enough doctors.

PAs have only 1600 hours of formal training. This does not equip them to independently manage patients safely. A recent coroner's report from a death arising from treatment given by a PA included a regulation 28 notification to prevent future deaths arising from there being *'no national framework as to how physician associates should be trained, supervised, and deemed competent'*. It is incumbent on the RCP to acknowledge this failing and act quickly to remedy it by working with the BMA and other stakeholders to set nationally agreed scope limits for PAs.

We note that patient safety concerns have also been raised by patient groups and other organisations such as the Fire Bridges Union (FBU).

### 2. Impact of medical training

*To what extent do you agree or disagree that this draft guidance for employers and supervisors will support the career and educational development of doctors?*

DISAGREE

The way the guidance is currently phrased will not help to protect doctors' training opportunities. With doctors' training being based on hyper-rotations, there is very real risk (supported by surveys of doctors in training and submissions to our MAPs reporting portal) that departments will prioritise training permanent members of staff in various skills or procedures, over those who will soon rotate. To support doctors' training (and therefore ensure that the consultants and GPs of the future remain highly skilled), there needs to be consistent and firm messaging that their medical training must be prioritised. This is why we introduced the concept of 'first right of refusal' for doctors in our safe parameters of working for MAPs document. For any training opportunity, doctors must have the first opportunity to take it up over non-medical staff. The current draft guidance must be amended, and the language tightened up to prioritise the training of doctors.

### 3. Supervision

*To what extent do you agree or disagree that this draft guidance for employers and supervisors will support the safe and effective supervision of PAs by doctors?*

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NEITHER AGREE NOR DISAGREE

It is undeniable that PAs, as a dependent profession, will need a high level of supervision to ensure that they are working safely. We have sadly already seen the tragic consequences that can occur if PAs are placed in a position where they are working beyond their competencies. This draft guidance does little to reassure that PAs will be safely supervised. While it states that PAs starting in a new department should be directly supervised, it does not clarify for how long. Nor does it recognise the fact that PAs do not complete any further formal qualifications and will always remain dependent practitioners. As such, they will always need a very close level of supervision to ensure they work safely.

*To what extent do you agree or disagree that PAs should have both a developmental and a clinical supervisor? Is the distinction between the two roles clear? Do you agree with the definitions and duties of each? Do you agree with the role title of developmental supervisor?*

We agree with the need to differentiate between supervision regarding general job /career concerns (developmental supervisor) and that of direct clinical supervision. However, this draft guidance fails to ensure that the clinical supervision on the job is sufficient to prevent the risk to patients from PAs working beyond their competences. There should always be direct supervision available from the supervising consultant or senior doctor with delegated responsibilities. Placing resident doctors in a situation to provide *de facto* supervision in the absence of the supervising consultant is unsafe and inappropriately adds to their workload.

The titles of the two roles are less important than ensuring that the description of the role and the appropriateness of such role limits are clear. Developmental supervisor is adequate as the title. We would like it to be made explicitly clear that all supervisors of PAs in secondary care must be GMC registered consultants or autonomously practising SAS doctors. We also note that the number of GMC recognised trainer doctors with the appropriate skills and qualifications to be an educational/developmental supervisor is limited and therefore we must be certain that resident doctors are prioritised over any non-medical employee when considering this limited capacity.

We are very concerned to see that PAs are only "recommended" to seek further advice (it is recommended that PAs seek advice and guidance from the most senior available doctor page 11). It should be mandatory as a dependent practitioner for them to seek and ensure regular supervision regarding all patient care. Remote supervision should never be appropriate for dependent practitioners with only 1600 hours of formal training. If the clinical supervisor will not be present to review patients, they should delegate their responsibility to another consenting consultant or autonomously practising SAS doctor available onsite to supervise.

*To what extent do you agree or disagree that any specialty advice given by a PA should remain the responsibility of their clinical supervisor?*

PAs as dependent practitioners should not be giving any specialty advice. They do not have the formal qualifications that would permit them to do so. In our scope of practice, we state that a PA may only repeat the advice of a consultant/autonomously practising SAS doctor and make it clear where this advice came from. In such cases, the advice remains the responsibility of the supervising doctor who provided it.

In the case that a PA gave advice without consulting their supervisor first, and such advice caused harm to the patient, there is reason to believe that the supervising doctor may remain responsible for the patient care. This is based on medical defence union (MDU) assertions that

while a PA may have some accountability for their work, the responsibility for the patient outcomes remains with the supervising doctor. Similarly, the GMC makes it clear that doctors should only delegate tasks to people that are competent to perform them. If a PA is allowed to provide specialty advice as a delegated duty from their supervisor, the responsibility for patient care stays with the doctor who delegated that task to the PA. The draft guidance should be amended to ensure that supervisors are aware of the additional risk they take when agreeing to supervise PAs.

This guidance also does not recognise the practicalities of service provision as currently experienced by doctors in the workplace. The NHS is seriously understaffed and there is immense pressure to insert PAs into jobs that are intended to be filled by doctors but do not have doctors in them. In that situation the supervising doctor is forced to supervise a PA working beyond their role's limits, and yet they personally remain professionally responsible for errors and harm that may occur. The doctor may claim at the inquest, medical tribunal or court hearing that they were put in this situation by systemic problems, but history has shown us that tribunals often disregard these underlying problems and hold the doctor individually responsible for things outside their control, such as being made to supervise someone working beyond their defined competence due to understaffing.

This is not sustainable as a regulatory framework, and indicates why local, employer-defined scope of practice is not safe because there is always immense pressure on employers to provide more care with limited resources, incentivising PA substitution on doctors' rotas.

*To what extent do you agree or disagree that specialist and associate specialist doctors should be able to act as supervising doctors?*

AGREE

If they are on the GMC register of recognised trainers, it is entirely appropriate for Specialist or Associate Specialist doctors to be allowed to supervise PAs if they consent to taking on that responsibility

## 4. Working in a team with a PA

*To what extent do you agree or disagree that this draft guidance for employers and supervisors will support safe and effective team working, especially around medicines management?*

DISAGREE

PAs do not have formal training in pharmacology nor physiology in enough detail to be able to recommend any medications for patients. They must not alter medications nor prescribe them. It is our opinion that PAs should not be directing any doctor to prescribe or alter medications given their lack of qualifications. We would like to see this section tightened to ensure that PAs do not act outside their remit and alter medications or offer advice on medication management. In line with this, the last sentence should be changed to *'Unless it is a life-threatening situation, which has clear PGDs for PAs or others to follow, PAs must refer any prescribing matter to their supervising doctor'.*

Guidance must be designed to account for human behaviour, known pressures, and incentives. Doctors working in a busy department who are approached by a PA recommending a drug be prescribed are under significant pressure to accept the PA's recommendation – both practical (they often don't have time to see every patient themselves again to verify the PA's findings) and

sociological (it is often difficult to refuse a colleague's well-intentioned and seemingly-reasonable request). This guidance does not protect patients, doctors, or PAs from those pressures by setting the clear boundaries necessary: PAs should not be making prescribing recommendations.

## 5. Career development, evidence-based practice and CPD

*To what extent do you agree or disagree that this draft guidance for employers and supervisors will support PAs to develop their careers in a safe and effective way that adheres to national standards and guidance?*

DISAGREE

A PA has only a two-year postgraduate qualification with 1600 hours of clinical skills and education. They sit no further nationally set postgraduate exams to demonstrate any additional competencies gained; the *"defined training pathway"* mentioned in the guidance does not exist. It is unsafe and inappropriate for their scope to be expanded based on local assessment of their skills. This is why we have largely international and recognised standards for medical training to ensure that quality is maintained. Allowing subjective local judgement for whether a PA is competent or not will increase the risk of patient harm. As noted in other responses, failure to ensure that PAs are working within their competences has allowed several tragic and preventable cases of patient harm to occur.

Furthermore, being competent in an isolated skill (to remove a chest drain, for example) does not mean that you have the understanding and ability to recognise and manage complications that may arise. 1600 hours is not sufficient to learn how to recognise and manage complications and therefore is insufficient to allow scope expansion, especially if the PA has merely learnt on the job and has no formal further qualifications. To keep patients safe, there should be clear limits to what someone with only a two-year postgraduate course. These limits should be set nationally and not locally due to the inevitable local incentives and pressures that act counter to maintaining safe clinical standards.

## 6. Governance structures for PAs, employing a PA and revalidation

*To what extent do you agree or disagree that this draft guidance for employers and supervisors will support employers to put in place clear governance processes when employing a PA, particularly around accountability and oversight?*

DISAGREE

PAs are dependent healthcare workers but are also on the Agenda for Change contract. While they should have clear supervision rules and oversight from consultants/ autonomously practising SAS for the clinical work done in the doctor's name, the rest of the governance could sit appropriately within other Agenda for Change frameworks.