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December 11, 2023

An open letter to MPs on Behalf of Medical Associate Professionals across the UK,

Subject: Support for “The Anaesthesia Associates and Physician Associates Order 2023”

I hope this letter finds you well. My name is Stephen Nash, and I am writing to you on behalf of your constituent, a Medical Associate Professional (MAP) and a member of United Medical Associate Professionals (UMAPs). As a healthcare professional, I believe it is crucial to address certain challenges facing our profession, and I am seeking your support on these matters. If you have received this letter it has likely been forwarded to you by the constituent themselves.

I would not be surprised to hear that your awareness of MAPs over the last 2 decades has been limited. It is not until recently that we have become a topic of debate within the NHS workforce. It was in 2003 that Physician Associates were adopted into the NHS workforce to produce a new tier of medical professional that can help remove some of the burdens from our junior and middle-grade medical doctor colleagues to allow them to spend more time training and reduce the NHS dependence on them for the actual day to day service provision. We work under the supervision of a consultant or GP and we have worked within this model successfully for the last 20 years.

During this time, we have voluntarily registered on the Managed Voluntary Register with the Faculty of Physician Associates, or the Royal College of Anaesthetists if an Anaesthesia Associate, and we have been held to account by the Fitness to Practice Standards of these bodies.

You will be aware that recent controversy has surrounded the profession due to a campaign by the BMA to try and roll back the workforce of MAPs across the NHS. It has made several claims to attempt to lead you to oppose the roles not limited to:

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- PAs and AAs are not medically qualified.
 - Patients cannot recognise a Physician Associate or AA versus a Doctor.
 - Returning the title to Physician Assistant or Anaesthesia Assistant will suddenly right the public's ability to discern between a MAP and a Doctor.
 - MAPs should be regulated by the Health and Care Professions Council.
 - That we are substituting the role of doctors.
 - That we are reducing patient safety.

I will attempt to address these issues and explain to you not only that MAPs remain a safe and highly effective part of the medical team, but that you should openly support the regulation of the PA role by the GMC.

Arguments for recognising MAPs as medically qualified.

There is a plethora of studies related to the efficacy of MAPs in the UK in the NHS workforce. Only recently the BMA questioned the availability of such studies but a search of PUBMED reveals a great study examining the role expansion of PAs across the world [1]. This study explains that in recent surveys of doctors, even as close as 2014[2] in the UK, our doctor colleagues were generally satisfied with the role of the PA in practice and the majority of the problems faced were due to lack of recognition and regulation within UK law. This prevented the profession from being able to carry out requests for ionising radiation and prescribe medications – limiting our ability to reduce the workload.

Whilst the BMA has recently tried to state there is a lack of clarity around the role, Malone[1] also encapsulates the world-recognised role of the PA as follows: “PAs function under the supervision of a doctor and practice as semi-autonomous clinicians with roles that complement those of the doctor. PA tasks include taking patient’s medical histories, performing examinations, making a diagnosis, requesting tests, analysing results and initiation of treatment” [2,3,4].

Although there seems to be an unwilling desire to discuss this in recent times, this is the definition of the role that we were trained for in a 2-year post-graduate degree after the 3 years of our health science-related degree. This amounts to a total of 5 years of training to be able to practice and provide an entry-level of service within our chosen specialities or general practice. This does not encompass the additional 3.5 hours per week of training we get whilst in service; leading to a total of 182 hours a year or just under 5 weeks per year of on-the-job training.



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This also does not consider the 50 hours a year of additional continued professional development we have to carry out per year to remain registered on the PAMVR.

Most importantly, it has been established since 2003 that we have been trained in the medical model [1] and have operated as members of the medical team [1,2,3,4].

It is therefore disingenuous to argue that there are no synergistic tiers of medicine being practised in this country and that, whilst junior doctors are specifically on an extended training program to become consultants, MAPs are practising to a standard of an entry to middle-grade level of medicine which they were specifically designed to provide.

Patients can identify MAPs from Doctors and changing their name to Assistant will not aid this.

Unfortunately, the UK healthcare system is full of acronyms and varying levels of healthcare providers. There is much history of patients not understanding who they are speaking to even from within the grades of nurses and doctors. The argument that patients cannot understand that Physician Associates are different from a doctor is no less true than a patient not being able to discern that they are talking to a foundation year doctor, registrar, or consultant. The difference between these grades is exponentially more than that between a PA to a Junior or middle-grade doctor. In this specific regard the General Medical Council noted that in the studies highlighted in its report on communication failures leading to patient harm, 55% of studies showed failure to communicate was reported to occur during doctor-patient consultations causing moderate harm [5]. There is currently no evidence to suggest that MAPs have a higher percentage of failing to communicate with patients than this benchmark and there is no evidence to suggest that we have harmed patients through our communication.

That being said, we have all received instructions on how to educate patients at the beginning of our consultations and have become even more passionate about making sure we are identified clearly.

MAPs Should be regulated by the GMC

The FPA, DHSC, HEE and NHS have been lobbying and working together for the best part of 20 years to achieve regulation for MAPs. We are part of the long-term plan for the NHS [6] and have been providing medical care since 2003 as previously evidenced.

The HCPC regulates allied health care professionals who provide specialist care separate from that of the medical team. The GMC regulates medical practitioners. Therefore, as associate medical professionals, it is most appropriate, by definition, that we are regulated by the body most experienced in the nuances of regulating medical professionals.

In doing so, the pathway to prescribing and requesting scans will be open to us quickly and efficiently, drawing on the knowledge the GMC possesses on regulating these elements of the medical profession. In doing this we can then further reduce the burden on our junior and middle-grade colleagues thereby allowing them to be able to take advantage of more training opportunities instead of service provision and becoming responsible for our requests and prescriptions.

We are not substituting the role of junior doctors.

It is our position that a junior doctor's primary objective should be to train to become a consultant. At present, they are locked in a dispute with the government regarding their quality of life and their access to training. At a time when the BMA should be supporting its members on this focus, they have instead been misdirected and distracted from this challenge largely due to rhetoric like this. NHSE and HEE recently made clear that even with the expansion of the PA workforce it is dwarfed by the recruitment of doctors in the UK by around 5-1 [7].

This makes this argument disingenuous and facile at best. Whilst this dispute goes on, we will continue to support the medical team and patients, alongside the wider medical, health and nursing team and will look forward, with the utmost joy, to their return in the new year.

We are not reducing patient safety.

Rather distastefully, there has been great use of a tragic case in which a patient lost their life, to discredit the greater MAP body across the UK. However, there is no evidence currently to suggest that patient safety has been reduced by our presence. Whilst the heartbreaking case of a patient managed in a primary care setting led to the death of a patient with a PE, it also needs to be acknowledged that a comprehensive study taking into consideration 2053 patients in the UK made the following conclusion:

“in ED settings 27.5% of patients with PE are misdiagnosed initially and half of all patients in inpatient settings are misdiagnosed (53.6%). Among patients that die in intensive care who undergo autopsy 37.9% were found to have PE that was missed. The commonly diagnosed conditions instead of PE were respiratory infection, heart failure and acute coronary syndrome (ACS). Misdiagnosis in patients with an eventual diagnosis of PE is common.”[8]

It was stated in parliament that there were 400 missed pulmonary emboli leading to mortality across England from April 2021 to March 2022 [9]. These excess deaths were a result of missed diagnoses. Whilst we are aware of 1 case involving a PE misdiagnosed by a PA, to what profession do we attribute the other 99.75% of cases? Is there any doubt about the efficacy of the other professions missing this diagnosis?

Equally, in this case, the brand new PA was removed from the register and is now unable to practice. This means that, as a profession, we have patient safety as our highest priority despite only being “Voluntarily” regulated by the FPA.

Our request to you.

I hope that I have been able to convey upon you both the self-defeating and hypocritical nature of the current stance of the BMA around MAPs and the fact that by denying us this regulation you cause the things they are supposedly worried about.

For 20 years we have worked diligently alongside our medical colleagues to deliver advanced patient care and be recognised for the benefit we bring to the team.



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3 years ago, we mobilised alongside all doctors and health professionals in the UK where even our students were called in to help, and deemed worthy, to assist in the fight against the pandemic.

We have been fighting for 20 years for appropriate legal recognition and regulation to establish ourselves as a profession and allow us to fully fulfill our potential. If you stand against this bill when it comes to parliament, then you will jeopardise patient safety by allowing us to continue working without the full powers required to do the role - that we have awaited for over a decade.

You will also be allowing people not qualified or registered to use our titles that we have earned (and are proud to wear) as we look after the nation's health alongside our medical colleagues and allied health professionals.

We believe that with your support, we can address these challenges, contribute to the improvement of healthcare, and ensure that MAPs receive the recognition and support they deserve. We would be honoured to have you as an advocate for our cause.

Thank you for your time and consideration. We appreciate your dedication to representing our community, and we look forward to the possibility of working together to address the needs of Medical Associate Professionals.

Yours Sincerely,

**Stephen Nash (PA-R)
Founder of UMAPs**

