Appendices

Appendix 1 Survey questions

Category	No	Question	Selection options
Demographic	1.	What region do you work in?	East Midlands, Eastern. Kent Sussex and Surrey, London. Mersey. North Western. Northern, Northern Ireland, Oxford, Peninsula, Republic of Ireland, Scotland South East, Scotland East, Scotland North, Scotland West, Severn, Wales, Wessex, West Midlands, Yorkshire
	2.	What is your current grade?	F1 or Intern / equivalent, F2, ST1/CT1, ST2/CT2, CT3, ST3, ST4, ST5, ST6, ST7, ST8, Post CCT Fellow, Junior Clinical Fellow, Senior Clinical Fellow, Non training/locum work, OOPR/OOPT/OOPR - junior level, OOPR/OOPT/OOPR - higher surgical trainees, Other (please specify)
	3.	What is your current or declared surgical specialty?	General Surgery, Cardiothoracic Surgery, Neurosurgery, Trauma and Orthopaedic Surgery, Vascular Surgery, Paediatric Surgery, Plastic Surgery, Urology, Ear, Nose, and Throat (ENT) Surgery, Oral and

			Maxillofacial Surgery, Core surgery, Not applicable
Exposure and understanding	4.	How familiar are you with the role and scope of practice of Physician Associates (PAs) in healthcare (please select the statement that best describes your understanding of the physician associate role)	➢ Yes, I am very familiar and understand their role. ➢ Yes, I am somewhat familiar and have some understanding of their role. ➢ Yes, I am somewhat familiar but do not understand the role ➢ No, I'm not familiar with their role
	5.	Have you worked alongside Physician Associates (PAs) in a surgical setting?	➢ Yes ➢ No
Experiences working with the PAs	6.	In which specialties have you collaborated with Physician Associates (PAs)? *you can select multiple specialties	General Surgery, Cardiothoracic Surgery, Neurosurgery, Trauma and Orthopaedic Surgery, Vascular Surgery, Paediatric Surgery, Plastic Surgery, Urology, Ear, Nose, and Throat (ENT) Surgery, Oral and Maxillofacial Surgery,
	7.	What impact do you think Physicians Associates (PAs) have on your surgical training?	➢ PAs have had a strongly positive impact on my training opportunities ➢ PAs have had some positive impact on my training opportunities ➢ I do not feel PAs have had any positive or negative impact on my training opportunities ➢ PAs have had some negative impact on my training opportunities ➢ PAs have had a strongly negative impact on my training opportunities

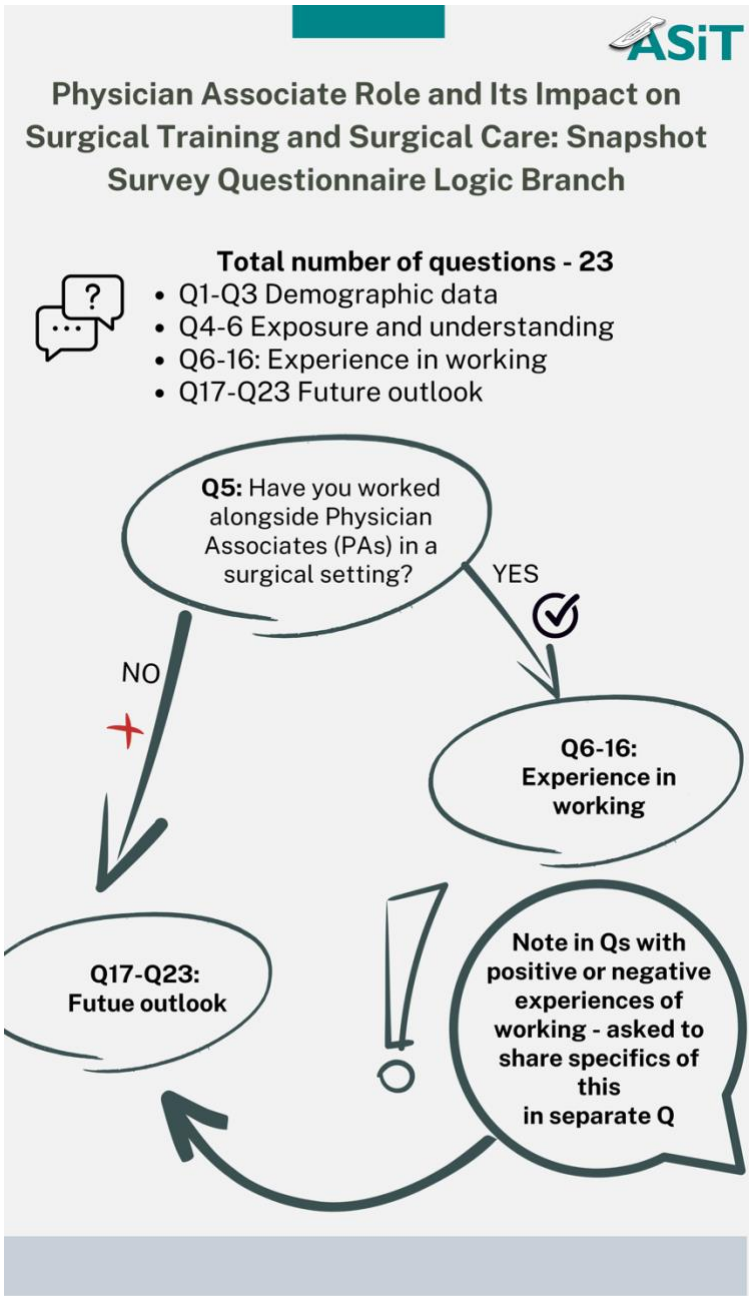
			➢ I am not sure or unable to comment
	8.	Please select the statements that best explain why you believe Physician Associates (PAs) have a positive impact (select all that apply):	➢ Theatre: increased my training opportunities in theatre ➢ Ward: Supported ward work efficiency ➢ Clinic: Increased efficiency and training opportunities ➢ On call/emergency commitments: Supported on call service efficiency ➢ Ensure continuity of patient care ➢ Other (please specify)
	9.	Please select the statement(s) that best explain why you believe Physician Associates (PAs) have a negative impact	➢ Theatre: Reduced case volume/logbook numbers for my training ➢ Theatre: Decreased my training opportunities in theatre ➢ Ward: Increased workload ➢ Clinic: Reduced training opportunities and exposure ➢ On call/emergency commitments: Increased workload ➢ Other (please specify)
	10.	What impact do you think Physicians Associates (PAs) have on surgical care?	➢ PAs have had a strongly positive impact on surgical care ➢ PAs have had some positive impact on surgical care ➢ I do not feel PAs have had any positive or negative impact on surgical care ➢ PAs have had some negative impact on surgical care ➢ PAs have had a strongly negative impact on surgical care

			➢ I am not sure or unable to comment
	11.	Please select the statements that best explain why you believe Physician Associates (PAs) have a positive impact on surgical care (select all that apply)	➢ Appropriate clinical decision-making with clinical supervision ➢ Improved patient care ➢ Performing procedures/interventions in theatre with clinician supervision ➢ Requesting appropriate investigations ➢ Other (please specify)
	12.	From your experience – has good or outstanding practice of PAs been acknowledged (e.g. GREAT-ix)?	➢ Yes ➢ No
	13.	Please select all the statements that best explain why you believe Physician Associates (PAs) have a negative impact on surgical care:	➢ Concerns regarding patient safety: clinical decisions without appropriate clinician supervision ➢ Concerns regarding patient safety: procedures/interventions without appropriate clinician supervision ➢ Asked to prescribe on behalf of PAs ➢ Asked to request investigations on behalf of PAs ➢ Unclear role within the medical team ➢ Misrepresentation of role to the patients ➢ Other (please specify)
	14.	If there were patient safety concerns relating to PAs, has this been reported locally:	➢ Yes ➢ No ➢ Other (please specify)
	15.	Have you ever been supervised by a PA?	➢ Yes ➢ No ➢ Other (please specify)

	16.	Have you ever supervised PA?	➢ Yes ➢ No ➢ Other (please specify)
Future outlook	17.	Do you think the term Physicians Associate (PA) is misleading)?	➢ Yes ➢ No ➢ Not sure
	18.	Do you think the public have a good understanding about the difference between a doctor and a Physicians Associate (PA)?	➢ Yes ➢ No ➢ Not sure
	19.	Where can Physicians Associates (PAs) best contribute to delivery of surgical care (select all that apply):	➢ Daily ward jobs ➢ Performing procedures/interventions on the ward ➢ Performing procedures/interventions in theatre ➢ Seeing referrals ➢ Holding the on call bleep/taking referrals ➢ Providing out of hours care/on call services in a medical rota

			➢ I do not believe PAs have a role within surgical care Other (please specify)
	20.	In your opinion, what is the role of Physicians Associates (PAs) within surgical procedures (e.g. theatre operations/interventions)	➢ Full autonomous practice ➢ Supervised practice ➢ Assisting ➢ I do not believe PAs have a role within surgical procedures ➢ Other (please specify)
	21.	Do you believe Physicians Associates (PAs) should be regulated by a professional body (e.g. GMC/NMC)?	➢ Yes ➢ No ➢ Not sure
	22.	Should further expansion of Physicians Associates (PAs) be paused until there is clarification on regulation and scopes of practice?	➢ Yes ➢ No ➢ Not sure
	23.	Do you believe trainees should be involved in defining the scope of practice of Physicians Associates (PAs)?	➢ Yes ➢ No ➢ Not sure

Appendix 2 Questionnaire logic branch



Appendix 3 Respondent comment answers

➢ **Question**	➢ **Comments**
➢ **Please select the statements that best explain why you believe Physician Associates (PAs) have a positive impact on surgical**	➢ Bridge the gaps in a service transient junior doctors cannot fill. Thereby improving patient care and contributing towards a service, not just a surgeon that does operations within a surgical unit - an outcome and upgrade from the traditional model of care that is positive for patients. To be a part of a service that provides optimum care is in and of itself training for a junior doctor

training (select all that apply): ➢ **Other (comments):**	➢ Knew how the speciality worked very well and so able to guide me in gaining knowledge, advise me how the department worked, worked efficiently to split workload ➢ Taught me key procedures on ITU
➢ **Please select the statement(s) that best explain why you believe Physician Associates (PAs) have a negative impact on surgical training:** ➢ **Other (comments):**	➢ I have also been asked to train PAs at the expense of training my junior trainees. ➢ Teaching commitment, been instructed to take PA into clinic to observe over medical students. Increased workload in clinics reviewing patients and requesting ionising rafiation, ultrasound and reviewinf patients for prescriptions. Managing results of investigations ordered by PAs. ➢ PA students often get in the way ➢ Taking good learning opportunities from doctor positions on ward and oncall ➢ Hostile attitude ?bullying towards trainees - they did not wish the consultant to be teaching me but rather get on with the operation ➢ They attend theaters and clerk in patients from A&E whilst junior doctors are left to do discharge letters, bloods (because there are no phlebotomists). And we as junior doctors have to answer to the PAs when surgical patients deteriorate and so they dictate the management plan of said patient. ➢ They were given the priority for theatre and clinics, we were left alone on the wards as F1 to run the wards and help with the on-call. Even when asked for their help and support, they didn't show up. ➢ Dreadfull referrals from ED. They do not understand surgery or surgical pathology. ➢ Clinic errors, misdiagnoses, arrogance, misrepresentation of role, use of physician or doctor ➢ They don't know exactly what they are doing which creates more work for me to do to explain everything to them or examine yhe patient my self or get the job done ➢ Can't prescribe, in accurate ward round documenting, false presentation of role to public ➢ Dangerously incompetent- out of hours work at X hospital is covered by a PA who can't prescribe/request imaging. Patient had a STEMI which was missed ➢ Training courses provided for free for PAs while doctors need to pay ➢ Do not prescribe and need a doctor to finish the task ➢ ACP used synonymously with PA as both having hugely detrimental effect ➢ Had to explain basic medicine

	➢ Clinic increased time when asking for advice ➢ Poor delineation of role within the team. Poor understanding of my role and prioritisation ➢ Reduced opportunity in all areas ➢ Took a doctor's place on BSS, fully funded, whereas we had to pay for ourselves ➢ As an SHO, being on with a PA meant increased workload (ordering scans CT/XR and prescribing meds, which they could not do). Also if on with an SHO, we could alternate holding bleeps and going to theatre - not possible with PAs as they can't be without a prescriber. As an SpR, consultants give preference in training and advancing PAs as they remain in unit so can get their own clinics, publish papers etc - doctors (in training and trust grade alike) not given same opportunities because primary role is often service provision. Being on call Neurosurgery SpR with just a PA as a junior (when it used to be an SHO) means you have to be both the SHO and SpRs as they can't prescribe, can't order scans that have ionising radiation (in a speciality very heavily reliant on CTs) and because they are unregulated they cannot be left to do procedures that SHOs can do such as insertion of ICP bolts. ➢ they are listed for elective duties like clinic and theatre. they do not help with oncall workload or long colorectl ward rounds. ➢ We have to spend time double checking everything they do. That is a time we could spend finding training opportunities ➢ Core trainees are now expected to stay on the wards while PAs are allocated clinic and theatre lists resulting in training opportunities being significantly reduced. ➢ PAs were not wardbased and took all appropriate opportunities that a CT previously would have done wg. Flexi, biopsies ➢ Dedicated lists for PA’s in endoscopy - no lists available AT ALL for trainees ➢ PAs are competing with SHOs to get operating opportunities. SHOs are left to do ward work in Plastic surgery department, whilst PA helped out in plastics emergency theatre. ➢ Called away from training for patient reviews and medications - adding to workload ➢ They bring no benefits ➢ Increased workload on wards as I have to double check their work before prescribing on their behalf. An additional Doctor would cost the department less but reduce workload. Additonally, they get more

	scheduled theatre and clinic time, which reduces my training opportunities given the limited theatre lists as is. This is an existential crisis for surgical training. ➢ Most I've met do very little work and so the rest of the team has to fill in anyway, but the consultants think the PA is helping ➢ Take experience from FY1 which leaves them I'll prepared for responsibilities of FY2 ➢ minor op/ surgical procedures under local anaesthetic in SDEC ➢ Bully SHOs to prescribe for them, increasing my workload as I then had to support them. ➢ Dangerous. Poor knowledge. I was expected to cut corners by prescribing and requesting radiology for them without reviewing patients myself ➢ Giving prescribing to trainees. Trainees who have no clue about the patient need to then go through the whole patient and then prescribe. Because of the same reason they can't do discharge summary. Because consultants have a long term person to assist in theatre they don't need to get core trainees to theatre and they actively ask the core trainee to manage the wards. Also if a sick patient is in the wards the consultants send the registrar to the ward to manage the patient in the meantime they continue operating with the PAs ➢ Less opportunities to perform ward based procedures e.g bolts ➢ Prioritised for procedures, as couldn't prescribe often put in uncomfortable positions where expected to pick this up for patients they had reviewed or stuck doing discharge meds everyday ➢ There are instances where PAs are getting priority over trainees in endoscopy training ➢ Their inability to work at the same grade as foundations doctors meaning their jobs have to be done by others ➢ My main concern is PAs in my line of work are used on the oncall in order to help with workload. Instead I am left to supervise them reviewing patients. And will often have to review them myself after already being seen by the PA in order to make a management plan. It doesn't actually help the process, in fact makes patients more frustrated that they are being seen multiple times. It would honestly be easier for me to clerk someone from scratch and make a decision, than have them clerked, discussed, reviewed by me then further investigations and management decided. ➢ Having to redo work done by PA, not being able to trust their judgement on patients

	➢ ED PA's who introduce themselves as SHO then give an incorrect referral ➢ not only taking such positions but even PA students to occupy such training slots ➢ Gatekeeping of opportunities for research, QI, etc within a dept ➢ They bully others ➢ Even ones who were able to prescribe would ask us to do all their prescribing, would act more entitled as have been around the consultants for longer and had a relationship, took away teaching opportunities ➢ Competition for learning opportunities and being asked to do extra admin tasks to support the PAs rather than being able to complete jobs and try to attend training opportunities eg clinic and theatre ➢ Even when placed on some lists the PAs have been prioritised. ➢ Reduced access to endoscopy ➢ Toxic attitudes, undertrained but not aware of that fact, value their opinion more than anybody else's. They are treated better than trainees by consultants. Additionally, they are overdo unnecessary diagnostic testing OR they underestimate patient problems, especially in the outpatient setting, where a lot of consultants do not directly oversee their patient care. Going back to toxic attitudes - PAs constantly talk poorly about trainees, some introduce themselves as doctors, they refer to juniors as 'our interns' instead of junior doctors on the team. They also influence consultant decisions. They help tremendously in managing social situations and discharge planning but have no role in theatre or trainee assessment. Their different training makes their assessment of trainees more subjective; and yet they significantly influence consultant assessments and attitudes. ➢ Generally increased the workload and were ineffective. A doctor would have been more useful and suitable. ➢ The PA was in charge of the junior rota and made it very clear that she did not want to see junior trainees (especially female ones) get training opportunities/ achieve portfolio point requirements and has been actively calling me out of theatre, pulling me out of clinic, denying leave requests, etc. ➢ They are integrated into rota as surrogate founds doctors who cannot prescribe and do not have the same clinical knowledge, so it doubles the work load because even if you split the pt numbers per se in the morning, the doctor will has to double back and see all of the PAs pts too in order to prescribe and ensure

	appropriate management. Which you wouldn't have to do if it was another foundation Dr. Issues around regulation and oversight, between myself and the PA only one of us has a regulatory body with clear guidance and oversight, and it often feels like two people are practicing on my GMC number (myself) and the PA ➢ Organised rota and prioritised themselves ➢ PAs attend clinics but we don't. They attend ACE day but we don't because we are on the ward doing the jobs. They have a day a week of admin and self development. They have their own office and desk. We get less opportunities and they are not seen much on the wards. Occasionally see them for the morning and then they disappear leaving us with all the jobs. We have to do the mundane prescriptions and TTOs whilst they go to clinic or see patients and do other hands on things ➢ They require ongoing supervision. They can't prescribe and can't make clinical decisions but they are rostered for covering oncalls. So I have to do my job and go through everything they do as part of their job and do their prescription workload ➢ I was moved to clinic so a PA could assist in theatre on a list for my subspecialty. I have been in clinic with PA as a junior registrar where I have been expected to supervise them, this includes reviewing all patients they have seen, this in no way benefits my training and results in increased work load. Currently I do not understand how they provide value for money in the training system.I have also had clinics with Extended scope physios who in a fracture clinic of 60 patients will see in a morning will the training regsirstrar is expected to see 20 and supervise the ESP. ➢ Undermining of doctors. Able to locum on F1 rota OOH, without being able to prescribe so increased workload for doctors ➢ They are absolutely pointless and add on to our workload ➢ I have to spend more time helping them and educating than I would other juniors and it takes opportunities away from my F1/SHO colleagues ➢ Unnecessary referrals from other specialties. ➢ No training opportunities for theatre as only PAs went to theatre ➢ Priority given to PAs for procedure training (endoscopy in this case) ➢ Taking up research opportunities

	➢ Counted as minimum staffing of FYs however are not very useful at managing the workload so effectively working consistently understaffed ➢ PA's are able to attend all of the extracurricular opportunities because they do not have the same clinical responsibilities but offload them onto the juniors and give the ward juniors increased workload ➢ Reduced research opportunities as PAs are preferred than trainees who move elsewhere after few months! ➢ High rate and low quality of referrals. AA slows lists so less time for me to operate. ➢ Workforce in my trust have hired PAs to act as support for junior doctor admin roles. However, PAs cannot pr scribe and as they have now reduced the number of doctors locally employed and the number of trainees in the department, most of the admin/prescribing/irradiating jobs fall to the junior doctors, whilst the PAs is taken as a spare pair of hands to assist the consultant/registrar in theatre. This is not the PAs' fault by any means, but I believe more a symptom of one of the many things that are wrong with our surgical training structure and wider healthcare workforce. ➢ They can be undermining and can hold quite a lot of (what can be) unjustified privilege because they are permanent members of staff. My understanding of the role is that it should ease the workload of doctors, specifically admin and ward work that does not require a medical degree. In my experience some PAs pick and choose what they do and can abuse their power over rotational medics. However, they can be adept at showing themselves in the best light, this is always easier for stable, familiar staff. They can also unjustifiably take theatre time without any of the work up, and most certainly without a medical degree or MRCS. They can make a total mockery of all of the hoops we get made to jump through, all the sacrificed time, exams, financial expense, lack of stability and lost time with loved ones - for what? Shouldn't we all have just been PAs? ➢ reduced endoscopy opportunity ➢ As a foundation doctor in London , not as a CT. ➢ Having to check their work for unsafe practice to protect patients. Having to field their constant requests for prescribing. It is unsafe to expect a trainee to take liability for an unqualified person "treating" patients. ➢ Responsibility for prescribing / signing off things for PAs who are treated as being extra numbers but aren't actually able to sign for themselves. PA students

	having had their training requirements made expressedly clear and making very sure they get these done sometimes to the detriment of medical students. PAs providing “junior doctor level cover” in hours (but without responsibility), but not covering any out of hours thus increasing pressures on F1s / F2s. All whilst being paid more. ➢ On call / emergency commitments: took over on call so no workload for me ➢ Decreased training opportunities in flexible cystoscopy and LATP. Also WBAs must be signed by consultant - impossible when these diagnostics are all done be PAs ➢ Don’t affect on call because they don’t actually do any. Endoscopy training. Some sites they think they are leading the ward round. ➢ PA has been prioritised despite being a doctor hoping to apply for surgical training ➢ I've mostly worked with junior PAs so they double my workload having to check. They take longer to learn skills so remove more training than just one other trainee. Most seem to want to use the pa qualification to become a Dr so there will keep being more PAs needing to be trained. Often a difficult attitude to work with so not good for team work, training. , In terms of pay I'd rather it went to a ward nurses that could cannulate, do bloods,ore pharmacy time to help with discharges, systems that allowed Dr to be more efficient. ➢ PAs who had been employed for some time had priority over those trainees who rotate ➢ They dump their work on us and expect us to complete their clerking ➢ endoscopy less training ➢ Additional workload and clinical risk resulting from having to prescribe for, order radiological investigations for, and otherwise supervise PAs. ➢ Give suboptimal and incomplete referrals when working in other departments ➢ Didn't get to theatre a single time during 4 month rotation because PA got to go instead of me and I had to cover ward jobs e.g. discharges and referrals. PA would only half complete tasks and leave without handing over leaving more stress and workload to tidy up ➢ They get dedicated theatre and clinic time and the cTs do not. They are firm based so have a better relationship with the consultants. They will often ‘review’ patients but then you have to prescribe for

	them and this can be unsafe when you do not know the patients you are prescribing for ➢ PA (1 year post qualification) acted as trauma coordinator 1 day a week and used to ring on call team to do inappropriate jobs and add to workload. ➢ Endoscopy lists lost to PA being on university scheme to obtain JAG certification in extremely short time ➢ Reduced exposure to the breadth of speciality ➢ They take up more clinical apportunities, they leave some of the work unfinished and you end up the one responsible for completion. ➢ Reduced opportunities to get involved in departmental leadership positions ➢ PAs being trained to do procedures and getting clinic time in preference to surgical trainees as they did not rotate ➢ Taking on prescribing and ordering scan tasks on behalf of someone else adds to the workload. Many position them as more senior than you and ask you to do tasks for them which means you are more ward based and they are going to theatres / clinics ➢ PA running SAU (and soon will be doing minor procedures such as abscess I+D) while juniors are purely ward monkeys with little to no educational opportunities ➢ Referrals from community without clear medical assessment or knowledge that increases the work again of both local doctors and specialists. No clear scope of practice and misrepresentation of position to patients such that they think they are treated by doctors. Unclesr responsibilities where there is assumed equivalence to registrars in clinic opportunities to clinics, theatre acces and MDT clinical input.
➢ **Please select the statements that best explain why you believe Physician Associates (PAs) have a positive impact on surgical care (select all that apply)** ➢ **Other (comments):**	➢ When they support ward work which allows trainee to attend theatre. Being ward based & knowing the patients to ensure flow/continuity on ward round ➢ PAs who work in a department for an extended period (more than six months) provide a level of continuity in patient care - and their familiarity of the local departmental processes and consultant prof wrenches can be useful given trainees often come and go every six months. ➢ I have only worked with PAs who help with ward work during the day (normal or long days) and in this situation have found them to benefit the smooth working of the ward team and are a good way of providing continuity ➢ Additional support in sdu

	➢ If only ward based, can be useful as they understand the system, hospital structure and teams in a unit ➢ can be useful on the ward round, usually non rotational so know the ward patients well, writing notes and doing discharge summaries etc ➢ PA dependent - have seen both positive impact from excellent individuals with improved continuity of care but also negative impact from poor decision making and lack of insight to the scope of their role. ➢ Helping with discharge letters, speeds up ward jobs ➢ Improved continuity of care ➢ Increased number of people on the ward, would be better filled with increasing f1/2, and ct posts in all ways ➢ Support doctors for ward based and SAU patient care ➢ Performing tasks competently to progress patient care ➢ Improved staffing levels ➢ Quicker assessment and helpful to have additional members on team to help ➢ Permanent staff aware of local procedures and structures ➢ The positive impact is mainly felt by having a larger workforce, not because of their specific skill set. The benefit would be enhanced with F1s rather than PAs ➢ Extra pairs of hands on the ward ➢ Improved efficiency esp with discharges ➢ Surgical assisting for robotic procedures ➢ Ultimately do the service provision jobs we don't want to do (ie cystoscopies) following appropriate training. Allowing us to go to theatre to be trained. Furthermore provide great continuity of care on the ward and support the on call service. Clerking patients. Sorting catheters. Etc ➢ Assisting in an operation. Same team=same unit. Improved outcomes. ➢ Bloods, cannulae, Ward documents ➢ They add continuity of care with the junior doctors on a shift pattern, the PA can be the only junior who knows the patients. They are also useful to help new juniors settle in and remind them of speciality specific things such as 28 days clexane after a cancer bowel resection ➢ Ward round documentation ➢ Supporting other clinicians ➢ Continuity of care and continuity of skills within a team (when trainees rotate) ➢ They provide continuity in a complex specialty and guidance for the new F1s freeing up senior trainees for theatre. The department I worked in had a very defined role for the PAs in an assistant role

	➢ Sharing bureaucracy with the juniors. Assisting (not performing) in theatre to improve training opportunities for training doctors. I.e. in hip arthroplasty the registrar can be on the same side as the consultant and perform under supervision ➢ My experience has been that often the PA training is inadequate/ unclear boundaries which meaning work is often duplicated by junior doctors due to it not being completed correctly/worry that a job has not been done correctly ➢ Improved continuity of care as they do not rotate. Gives additional mentoring to FY1s as the PAs usually understand the system and how to get things done e.g. order tests ➢ Running OPD injection clinics ➢ First/junior clerking in acute areas; however severely impeded by inability to request more than CXR and unable to prescribe. ➢ Provide continuity to rotating junior doctors and helps to induct them into their new job role ➢ ward role reviewing investigations in timely manner ➢ supplement workforce ➢ Reduction in some work load I.e fluid prescribing, ordering scans ➢ Assistance with ward workload ➢ Supporting daily medical works on the wards with junior doctor's and maintaining a regular team presence while a constant changeover of doctors occurs due to their shift pattern (on-calls/days off post-on calls etc) and specialty changeovers ➢ Relieving some ward work and being a constant so knowing how to order various investigations and how local procedures work ➢ More staffing to care for patients ➢ Support of junior doctors on the ward - continuity as always with parent team ➢ Supporting the junior doctors on the ward ➢ Able to be the continuity if care ➢ Institutional memory in the context of transient junior doctors. Invariably stabilises an unstable service, which more and more rely upon junior staff ➢ Consistent care, different skills mix ➢ I believe physician associates can provide excellent care for selected patients within a narrow scope of practice. This can be in helping junior doctors with inpatient workload or in an outpatient minor procedures or clinic setting. ➢ Allow for senior clinicians eg registrars to spend time as decision makers rather than admin-type work ➢ Scribing on ward round, notes, referrals, EDNs/EDLs

	➢ Permits doctors to attend training opportunities without detriment to patients having routine clinical tasks performed ➢ Continuity of care as they don't rotate and are not on call. ➢ Familiarity with systems and service leading to improved patient care ➢ Filling a gap on the rota to allow surgical trainees to get to theatre instead of completing ward work ➢ Ward jobs ➢ Completion of T ➢ Performing routine ward work ➢ patient continuity ➢ providing increased ward cover to allow protected clinic and theatre time ➢ pre-op clinics and investigations run smoothly ➢ More people to cover ward rounds ➢ Ward management of patients including clerical tasks, post op review, organisation of patients on the ward and paperwork ➢ Supporting doctors on ward rounds and F1s and F2s with ward jobs etc. ➢ Perform generic time consuming tasks ➢ Continuity of care ➢ Can be helpful in knowing the system well (E.g. how to complete certain referrals), documenting on ward rounds and can be helpful in organising the list. ➢ Had independent injection lists after minimal supervision - an opportunity not provided to STs or trust grade junior doctors. ➢ Continuity of care ➢ I feel the positive impact their work is the same as a junior doctor, NOT better than the care of a junior doctor ➢ improve the efficiency of the team ➢ Reliable when it comes to clerikal work- documenting, discharges, requesting. Role compromised due to not being able to request all investigations or prescribe. ➢ more bodies on rotas and more team members to share burden of emergency and ward care ➢ Assisted so I can perform operation with consultant on my side, assisted me so consultant can be unscrubbed to improve operative autonomy, seen patients referred to clinic before onward referral to surgeon if indicated, assisted in ED with MUAs ➢ Assisting with ward jobs ➢ Helped with ward work and administration ➢ Assisting with documentation and PTWR jobs, admin etc

	➢ Their main advantage is in a ward setting in which they offer continuity where other juniors do on-calls. This helps seniors to better look after patients. ➢ Ward jobs ➢ Increase manpower for ward tasks ➢ Continuity of care for ward patients (if not on an on-call rota) ➢ Added manpower on the ward to improve timeliness of patient care ➢ Doing the service provision and logistics side of the job. I.e typing up notes, doing basic bloods, cannulas. They should be used to do the scut work that F1/SHO do to let F1 and SHO have better training experiences. ➢ Efficient at producing discharge summaries and referring patients ➢ Stability in a department where junior doctors change every 4 and 6 months ➢ support junior colleagues with ward jobs - really depends on the individual PA though ➢ Increased overall staff numbers ➢ Chasing investigations, doing admin work ➢ Helped on ward round with surgical patients ➢ Support ward teams ➢ Orientating new juniors to department work flows ➢ Do not rotate between teams as frequently as JDs therefore have a good understanding of logistical pathways and treatment algorithms. ➢ They are able to help out with ward jobs. Their role should be ward-based only, freeing surgical trainees to go to theatre and attend outpatient clinics and MDT. ➢ Ward based care for patients to allow trainees to go to clinic and theatre. Limited role in clinic (if no trainee) and very limited role in theatres (assistant only if no trainee) ➢ Scribing on ward round. Helping new fys understand referral pathways ➢ Doing ward work and other dross tasks that we currently get doctors to do that you don't need a medical degree for, I don't think they should be used in theatre much, best used on the wards to support freeing up trainees to be in theatre. ➢ Doing minor procedures eg venepuncture, cannulas, chasing results ➢ Continuity of ward care ➢ Continuity of care ➢ They often provide continuity in a department where many of the doctors rotate regularly. They understand the hospital/department/system and are able to advise on system queries.

	➢ Able to delegate ward based tasks to complete with sho support ➢ Can reduce the workload within surgical work force at a time when junior doctor numbers are being curtailed despite increasing healthcare system demand. They can improve patient safety and general care by ensuring the extended surgical team covering the ward is not over stretched. ➢ Covering clinics and lists where doctors not available, chasing scans and bloods and referrals alawing us todo our job without all the bureaucratic demands ➢ More PAs on the surgical ward allows for administrative jobs eg discharge summaries to be done quicker thus improving patient flow and allowing surgical trainees time away from ward admin. ➢ Provide continuity of care to ward patients and help with ward rounds and on calls ➢ Ward work as not on call and present everyday. But they get bored after a year and look to expand their scope ➢ Continuity of care during rotation periods; prevent understaffing on wards ➢ They are generally keen to help and motivated, however this can be to the detriment of junior doctor training I believe. ➢ Sharing ward jobs in the ward ➢ Continuity of care for the ward patients ➢ I feel they could free up trainees (CT1s and CT2s) so they can have time to be trained in theatre. They could do this by doing ward jobs or holding the bleep and doing ward jobs ➢ Very thorough clerking of patients however I have had occasions where I've had to double check prescribed medications with patients as PAs had written them down incorrectly ➢ Long term, permanent staff so know individual unit's working policies better than rotational trainees ➢ They are usually part of a team for a longer period of time compared to a rotational trainee, therefore they know how things “run” in the hospital, not necessarily relating to making medical decision but facilitating them (e.g. they know who to contact to refer for an MDT, how to arrange an OP investigation etc.) ➢ Completing ward work to facilitate freeing trainees for other clinical activity ➢ Clerking patients ➢ Continuity of care

	➢ They work well in a ward setting, reviewing patients, doing examinations and requesting initial investigations ➢ Undertaking administrative and organisational duties. Keeping new foundation doctors right and there on the ward for their support ➢ Can help with ward jobs so trainees can go to theatre ➢ Freeing up doctors to focus on higher level decision making and operating ➢ Useful as a point of contact for patients who are in the community - our PA used to triage telephone calls from recent postoperative patients and discuss with the team, our PA used to arrange OR schedules and list patients we selected for MDT. I have also worked with PAs who do robotic assisting - this is helpful where there is a dual console as it allows the trainee to get console time, but needs to be managed carefully when there is a single console and/or the trainee wants to gain tableside experience. ➢ Support of foundation and SHO doctors on wards and continuity ➢ Preparing notes/ward rounds, taking bloods etc allowing surgical trainee to spend more time being trained ➢ Ward work
➢ **Please select all the statements that best explain why you believe Physician Associates (PAs) have a negative impact on surgical care:** ➢ **Other (comments):**	➢ Inappropriately respond to doctor and do not correct patients who mistake them for doctors. Limited knowledge of surgical care or patients. ➢ Especially at a very junior lever, from FY1 to SHO, role in the team appears to be the same, hence demoralising junior doctors who have worked through medical school as role and responsibilities within the team appear to be the same. ➢ Taking opportunities away from foundation doctors ➢ PAs would always introduce themselves to patients and document in the notes as “Mr” or “Ms” - which can be very misleading to patients and colleagues who have assumed that they are surgeons with their MRCS qualification or higher. ➢ Some PAs misinterpreting their roles - think they work at level of registrars and 'bossing' SHOs/F1s... ➢ Lack of training and experience in managing an unwell patient or identifying complications. ➢ They often reply to doctor and are not clear to patients about who they are/ what their role is ➢ Reduced training opportunities ➢ Patients being left for hours without prescribed meds or scans. ➢ Lack of clarity regarding scope of practice. No post graduate examinations to qualify their level of

	competency yet often anecdotally described as “CT equivalent” ➢ In settings where PAs are poorly supervised or poorly integrated, supervision can be more burdensome than their absence ➢ I have not seen any of these problems but have heard of such issues esp. in the UK. I think it is the responsibility of the surgical leadership to ensure that PAs work within their scope of training and practice. PAs can be extremely helpful when given appropriate responsibilities and supervision. I see no problem with PAs as a concept - the issue is with the oversight and governance of PAs working, and that is the responsibility of clinical leadership. ➢ My biggest concern is that I believe they often preferentially take the better training opportunities within junior roles and thus inhibit proper development for junior colleagues ➢ Doing procedures without doing any of the pre requisites that I had to do. How is it remotely fair that I need audits, publications MRCS just to enter surgical training but someone with none of that gets their own lists and clinics? Either all the stuff we have to do is necessary for surgery or none of it is
If there were patient safety concerns relating to PAs, has this been reported locally: ➢ **Other comments**	➢ Have not seen ➢ No patient safety concern ➢ Don't know ➢ Small issues are often dealt with within the team. There is no purpose datixing a clinic eith too many patients to handle within an afternoon. Or a Pa being assigned to a clinic with only distant consultant supervision. Lack of depth and breadth of knowledge can be raised eith a supervising consultant but is hard to demonstrate as an ongoing issue. ➢ Unsure ➢ No concerns raised over patient safety ➢ unsure ➢ I don’t know of any ➢ No concerns ➢ You aren't allowed to criticse them without an ED consultant jumping on you ➢ Don’t know ➢ Nothing was done internally about it at X hospital ➢ The consultant team supported the PA over the SHO body ➢ Don't know ➢ No explivit patient safety concerns ➢ Well supervised and roles clearly defined ➢ there is none

	➢ There weren't any ➢ N/a ➢ Not experienced that ➢ Na ➢ Not come across any major safety concerns ➢ Don't know ➢ Difficult culture on trying to. ➢ Not sure ➢ No because senior people usually prefer PAs to us junior doctors so it is intimidating to report them ➢ I dont know. I have personally escalated my concerns with my current rotation to the TPDs ➢ N/a ➢ Not aware of any ➢ Don't know ➢ No personal experience, but have had from other doctors ➢ N/A ➢ Not personally but aware of this happening elsewhere. ➢ Unsure ➢ Not aware ➢ Protected class ➢ No concerned about consultant bullying ➢ Haven't had any ➢ Attempted to raise, but has been minimised due to political powers in hospital. ➢ NA ➢ Unknown of patient safety concerns specifically - have to redo their work to prescribe meds or requests to ensure patient safety issues don't occur ➢ I don't know ➢ This Pa has not done anything affecting patient safety. only delay in prescribing as they had to find a doctor to prescribe fluids/meds ➢ N/A ➢ Unsure ➢ Unsure, reported issues in other trusts/departments ➢ No concerns were raised when I worked with PAs ➢ As permanent members of the team they are well protected and backed up by consultants who deny any patient safety concerns and will retrospectively sign off on any decisions made by the PA and deny there was ever any issue or let the rotating doctors on a training pathway take the slack. ➢ I have not seen serious patient safety concerns yet ➢ N/a no issues ➢ No concerns ➢ Only informally, but it's dismissed by seniors ➢ Don't know ➢ No concerns

	➢ I have none ➢ N/a ➢ unknown ➢ N/A ➢ None noted ➢ Not happened yet in my experience ➢ Don’t know ➢ Unknown ➢ No specific concerns ➢ N/A ➢ NA ➢ N/a ➢ Not sure ➢ Not sure ➢ None noted ➢ I spoke to the consultant and the registrar although I was not supported as PA worked in the department for three years. ➢ I don't know ➢ Complex answer. ➢ N/a ➢ Raised and brushed off ➢ No specific patient safety concerns in my experience ➢ N/a ➢ n/a ➢ Not reported as afraid of consequences ➢ seniors not receptive/ were very protective of their pas. They are used in roles not suitable in my opinion. ➢ N/a ➢ Not sure ➢ Not witnessed or aware of any locally. ➢ N/A ➢ Concerns RE patient safety were around prescribing for the PAs. When raised locally it was felt normal for us to prescribe for them. ➢ Not Applicable ➢ N/a ➢ Not sure. Haven't witnessed anything like this ➢ There were none ➢ Na ➢ N/a ➢ N/A ➢ unclear ➢ Unsure ➢ N/A ➢ Concerns are not listened to ➢ Unknown ➢ Don’t know ➢ Managers use them as excuse to failed recruitment and staff management. They always put clinicians in

	situation (would you rather have a PA in your shift or have to work both SHO and registrar shift together?) ➢ Culture discouraged identifying PA issues ➢ N/A ➢ Unknown ➢ All potential safety concerns were subsequently managed by the doctors on the team. ➢ N/a ➢ This has been reported several times and then ignored ➢ Risk but never seen ➢ Not observed but concern re potential ➢ Sometimes ➢ Not sure if it was reported ➢ i am honestly to nervous to raise my concerns. i don't want to be part of a witch hunt ➢ Yes by others but not by me ➢ N/a ➢ PA ended up quitting as was not allowed enough independence in their eyes and now works in GP ➢ Unsure ➢ Na ➢ N/A ➢ Unsure ➢ N/a ➢ N/A ➢ N/A ➢ I haven't had patient safety concerns ➢ N/A ➢ Unsure ➢ There have been no concerns ➢ No concerns ➢ N/A ➢ Not applicable ➢ NA ➢ Not acted upon due to the fact that the PAs are permanent team members and have made friends with all in the department. ➢ Not seen it happen personally ➢ No significant patient safety issues identified, concerned about potential problems ➢ Not aware ➢ No experience ➢ Unsure ➢ Never experienced ➢ Unsure of any ➢ Consultants are defensive of PAs (who are long term colleagues) working under them when concerns are raised by rotational trainees. ➢ I am not aware ➢ Not aware

	➢ Not directly observed specific harm to patients but aware of situations ➢ None arisen within surgical dept ➢ No clear pathway to escalate concerns. Tried the consultants but they report they are not the responsible officers. Scary and dangerous. ➢ NA ➢ No concerns ➢ Unknown ➢ Unaware of this personally ➢ Not applicable ➢ Na
Have you ever been supervised by a PA? ➢ **Other (comments)**	➢ I have recently joined the trust where there are PA's ➢ Yes - on induction to department - and still asked to prescribe for them!! ➢ I have been but not in surgery. In Geriatrics medicine and the PAs were very supportive and encouraging to reach our training objectives, unlike surgical PAs ➢ No, but it has felt like they perceived higher ranking than an SHO ➢ I think it's insulting to highly educated colleagues who have completed medical school to be supervised by such a group who are less able in every aspect ➢ N/A ➢ unclear statement - ?supervision officially ➢ Not personally but f1 colleagues being asked to scribe on ward rounds for PAs ➢ No, and I would not need someone at a lower grade to supervise me? ➢ They've tried! I've clearly said that they're neither my supervisor nor my equal. ➢ Only as a medical student in London ➢ As a medical student (final year) ➢ No, I wouldn't allow for that. It's entirely inappropriate for someone below the level of a foundation doctor with minimal training, no postgraduate exams or any reasonable qualifications to be supervising a doctor. It should be supervision ONLY by a trained doctor.

	➢ Not directly supervised, but the PA was in charge of the junior rota and leave requests and was actively obstructive to providing opportunities ➢ NEVER SHOULD BE HAPPENING ➢ No, however they believed they were supervising ➢ Not me, but others have. Blind leading the blind. ➢ At start of local rotation, PAs we're the longest permanent employees in our team due to the nature of hyper rotational training amongst junior doctors. They therefore had a supervising/induction role at that point. Now several PAs have been promoted to managerial roles and whilst not directly supervising me, they do supervise some of the ward activities involving doctors. ➢ I have worked with PAs before but not supervised ➢ As a FY1 ➢ But there was a plan for juniors in the department to be taught by PAs. ➢ PAs cannot supervise a doctor ➢ No, it would be an insult to us if we were being supervised by someone who can't event prescribe paracetamol
Have you ever supervised PA? ➢ **Other (comments)**	➢ Have supervised PA students ➢ Supervised PA students ➢ taught mixed PA and medical students ➢ Although I've worked with PAs, no distinct hierarchy has been established ➢ Not sure, as it is not clear that they should be supervised. If they are independent. ➢ Asked to by consultant ➢ Required to when having to do ward jobs for all patients, including ones not seen myself - as patient allocated to a PA colleague. ➢ Not officially ➢ Asked to supervise a PA who was assigned to ED, didn't agree to this and then found them clerking the surgical patients on my behalf. Dangerous. ➢ Same "grade" i.e. SHO ➢ Not supervised but worked alongside. ➢ Yes, except I do not feel this is our role. We do not know their curriculum and extent of their knowledge. Their supervision should be solely their named consultant. They are not equivalent to our juniors and should not be treated as such. ➢ We don't have the same job role or responsibilities therefore it's not my job to supervise or train them. ➢ PA student ➢ I have told them what to order and what to write in the notes. ➢ Depends on your definition

	➢ I have years ago, but now refuse to if I feel they lack the knowledge or r ➢ PA student ➢ Not formally, but asked to prescribe/request Ix due to inadequate supervision from their named consultant ➢ Not formally, but when on-call, I had to check their work for patient safety reasons ➢ Work alongside them ➢ Have been asked to but refused ➢ Worked "alongside" ➢ Student PAs ➢ If you lead a ward round with a PA on it presumably you're deemed to be supervising them ➢ Not supervised but asked to prescribe almost daily, this means having to actually do double my work as I often had to see patients whom the PA had already seen to ensure I was prescribing correctly ➢ Refuse to ➢ They tell me that they are working at ST4 level so I am their junior. ➢ Worked alongside. Did the prescribing and majority of jobs. They scribed ➢ I was never formally asked to by a senior or advised that this would be part of my job role, so have declined to prescribe or order investigations on behalf of a PA as I did not wish to resume the responsibility without formal recognition that this may be expected of me ➢ It is not my responsibility to train PAs, we have different training backgrounds and different roles ➢ Indirectly ➢ I refused to supervise them as they have dedicated clinical supervisor, i.e. a consultant. Therefore, I was in no position to provide any supervision to non-medically trained professional ➢ PA (and ANPs) in SAU used to ask on-call SHO to sign prescriptions and request scans.
Where can Physicians Associates (PAs) best contribute to delivery of surgical care (select all that apply): ➢ **Other (comments)**	➢ Assisting nursing staff with duties such as wound care, drain removal and liaising with nursing staff in surgical specialties ➢ They should be ward based to allow doctors to achieve training requirements ➢ Administrative jobs ➢ PAs do well with learning referrals processes and local structures, they could be useful for directing junior doctors to these, or for example the admin side of arranging an ercp list, and checking that investigations and instructions have happened ahead of this. This could free up time for trainees to be training on those lists, instead trusts are pushing for

	PAs to start scoping, where trainees are slready struggling to qualify with scope accreditation. ➢ May have a role assisting doctors with admin (updating and printing lists, carrying computer) ➢ Not sure ➢ I think PAs' scope of practice should be limited to basic ward skills such as referrals, venipunctures/ cannulations/ catheterisation, scribing during ward rounds and discharge letters ➢ The jobs that F1s do should be handed to PAs. Discharge letters, bloods, cannulas should be their job. F1s have very little training as it is especially within a surgical rotation with multiple publications proving this as well as personal anecdotes. We should strive for doctors to do jobs that we are trained for and not for these second tier roles to replace us and have doctors do the jobs they were supposed to relieve in the first place. ➢ Bloods, cannulas and discharge letters. And Also do ward jobs and allow doctors to attend theaters. Procedures should be taught to doctors not noctors. ➢ Discharges and bloods ➢ PA should be working in the wards but should not be allowed to obtain surgical opportunities above doctors ➢ Routine post op - wound check etc. USA PA style ➢ Useful to have PAs for bloods / cannulas etc but I don't believe they should have any further role unless they are registered with the HCPC (NOT THE GMC!) ➢ Supporting juniors in ward based and SAU care ➢ prepping ward notes, performing procedures with no training value, completing proforma based referrals ➢ They could do ward work but gwt bored, threaten leaving unless they increase their responsibility. ➢ Not holding the bleep ➢ No role within theatre or in clinics. PAs should only hold service provision and admin roles. ➢ Discharge summaries, taking bloods, doing cannula, assisting on call sho ➢ clerical duties ➢ Admin/Clerking/Liasing/Chasing ➢ Admin ➢ Help with Clerking (NOt seeing patients individually), scribing, cannulas, discharge summaries, update lists and documentation (all validated by a doctor) ➢ Audit/M&M ➢ Assistant in theatre so that trainees can have console time/ better training ➢ Basic diagnostics - prostate biopsy/ flexible cystoscope

	➢ Performing outpatient procedures ➢ Depends on experience, e.g. if at specialist ACP level, on-call roles could be suitable ➢ They should be able to form basic outpatient investigations which have no bearing on training. Ie prostate biopsies and flexis ➢ I've no idea what their training is, I gather it's not a 5 year medical degree so I doubt that any medical jobs would be appropriate. ➢ Documenting, bloods, doing jobs that free up doctors ➢ Supporting the junior doctors ➢ At the most, as a physician assistant role - doing ward jobs to free up surgical trainees to attend theatre and training opportunities ➢ The inability to prescribe medication, make referrals, and request imaging hinders the ward process also. clinics , straightforward referrals. Follow up patients need to see routine /simple referrals ➢ Helping with unselected on call take ➢ Going through check lists, doing cannulas, doing the post op surgical notes ➢ Supporting junior doctors in achieving training objectives by taking on administrative responsibilities ➢ Administration tasks ➢ Updating lists and helping with ward administration and electronic referrals ➢ I feel positions associates would have a role in seeing follow-up fracture clinic patients to reduce commitment from registrar body. Rather than being focused on theatre. ➢ Assisting in theatres ➢ Assisting Physicians… ➢ Admin related tasks only, eg scribe etc ➢ PAs should be able to prescribe and order investigations and then be employed as an SHO including covering the on call out of hours; given that they earn in line with an ST4 to work 09-1700 Mon-Fri. ➢ Completion of Discharge Summaries ➢ Wound clinics, Hot clinics ➢ Basic administrative jobs that could free up doctors to attend learning opportunities ➢ If they are doing only ward jobs it would work but in practice from what I hear from colleagues who face worked with them in a surgical setting they instead get trained whilst the ‘trainees’ are oncall. ➢ General administrative work ➢ Assisting doctors wherever the service is short - there is no point training the most able for 15yrs and the

	least able for 2 or 3yrs and then again put all the responsibilities on the most burdened and able people ➢ They can help with the day to day jobs on the wards to take the pressure off the doctors to allow doctors to be trained. E.g. a PA should help with ward round whilst a core trainee goes to a day case list and not visa verse. ➢ No role for them ➢ Developing PA specific service roles that allow surgical trainees to improve the efficiency of their training and patient care ➢ The PA role should free up trainees to train. It should be a service provision role only. ➢ I am not sure that they play a role in emergency surgical care. I think there may be more of a place in elective settings either to assist in clinics with documentation or running their own clinics in specific high number low complexity conditions that they are specifically trained for. If they were able to prescribe they would have a role in undertaking ward jobs, freeing more junior trainees up to go to more elective activity but as they are limited in this role they cannot provide this support currently. ➢ Clinical administration (can be outpatient/MDT/spoke services) ➢ I think PAs can fill a lot of the functions above and will get better at these in time, but crucially should not be at the expense of a medically qualified doctor doing these. ➢ Requesting routine investigations, all non clinical clerical duties that surgical trainees perform ➢ Everything they can and should do already has a pre-existing speciality with the skills to handle it, who know the remit of their role. A cohesive team of skilled nurses abd phlebotimists, well Supervised junior doctors, skilled HCAs and proper ward clerks or scribes could handle any of the roles supposedly covered by a PA and a junior doctor can do all of them. ➢ bloods, catheters, cannulation and discharges. This is where the demand is, and they could be extremely helpful if they could assist in this regard. ➢ I dont think physician associates should be anywhere near an operating theatre. They have no qualification or formal training to assist / operate on patients. They're scope should be limited to ward jobs, ward rounds, and seeing ward referrals. They could also see low complexity patients in follow up clinic after surgery before discussing with consultant / registrar.

	➢ Assisting the surgical team with ward work / delivery of care, not in delivery the equivalent of medical care ➢ Ward rounds, ambulatory care under supervision ➢ Scribing, discharge letters, bloods, cannulas etc ➢ Admin tasks such as requesting tests after authorisation from doctors, chasing tests and results, scribing ward rounds, updating lists and such admin duties, putting out blood forms, ➢ at most they should be on simple wards doing tasks like taking bloods, scribing and writing discharge letters. They should NOT be clerking patients or be in theatre ever ➢ Outpatient clinics, administrative role eg junior doctor rota, MDT coordination, maintaining patient banks/databases for research, departmental induction of junior doctors ➢ all with appropriate supervision and as long as junior training is not compromised ➢ PAs should only be assiting with adminstrative tasks and assiting doctors in the management of patients ➢ Paperwork and ttas etc. ➢ They have a role in aiding with the ward care of surgical patients, which can including performing minor procedures on the ward (cannula, catheter, ABG), but they should not take training opportunities (ie. chest drain insertion, wound suturing) if these can otherwise be of any educational value to a trainee doctor/surgeon. ➢ Routine assisting in theatre that has no training value e.g. robotic assistance (i.e. similar to roles that can be performed by surgical care practitioner) ➢ As with the origins of the role, to assist physicians / surgeons with clinical duties. I.e ward jobs and to free up surgical trainees to address the clear deficit in surgical training opportunities ➢ Strongly believe that PAs do not have the appropriate training to stratify referrals and prioritise cases accordingly. These skills are honed during a surgical training and predicated upon the medical degree. ➢ Chasing bloods, taking scan requests to radiology, taking referral letters to different wards, documenting during rounds, writing discharge letters (except treatment plans) ➢ chasing results ➢ Assisting in theate (but this role should really be done by junior surgical trainees who are regularly rota'd into dedicated theatre sessions) ➢ Perfomring simple ward procedures such as venepuncture, cannulation, taking ABGs. ➢ Do night shift covering wards

	➢ Admin type role - scribing on ward rounds with supervision, not seeing undifferentiated patients, possibly prepping for MDT ➢ They may have a role in helping to provide continuity of care of the ward if the regular surgical team is rotating between on call and elective commitments, and also across different hospital sites ➢ Only certain ward jobs - paperwork and administrative work. ➢ Being the physician assistant role they were designed for to provide support for basic ward jobs such as bloods cannulas scribing ➢ ward based clinical and administrative tasks - should not be independent. we don't allow CT2 to be independent with 8 years of medical training, why should we give that privilege to someone with 2 years of substandard training ➢ Doing clerical bits of typing discharge summary. Documentation etc administrative where a level of knowledge is advantageous. ➢ Minor clinic jobs, such as bloods, paper work and administration should be the limits of their role. They should not have any role in theatre or in assessing unwell patients ➢ Pre op assessment clinics, assistance in follow up clinics (always with a doctor), telephone follow ups, ➢ Assisting junior doctors on ward rounds and doing jobs ➢ Any role suitable for an associate ➢ Keeping tally of longterm tasks such as MDT referral liaison ➢ can be supportive in on call work, to allow medically trained clinicians to spend more time assessing patients and less time chasing investigations or documenting. ➢ Writing discharge summaries, scribing on the ward round, addressing simple questions from relatives and patients, manning ward phone for clinical queries ➢ In gynaecology onc in our department the PA will hopefully help with triaging referrals to clinics which saves time and money instead of consultants triaging which seems very helpful ➢ providing continuity of care and institutional knowledge when junior doctors rotate ➢ 5th yr medical student / FY1 level jobs and more complex only under direct supervision with supervisor physically present ➢ audit, note taking, assisting doctors on the wards. ➢ Helping with some ward tasks such as bloods/cannulas would be helpful. Often though they

	are places on doctor rotas which only adds to workload of doctors working with them. ➢ Bloods and EDDs ➢ Only in assisting juniors and never replacing them ➢ Clinics ➢ Assisting with manipulations in ED ➢ Scribing on ward rounds, teaching about PA specific things like drains etc ➢ PAs should support doctors to complete routine ward jobs that require a level of clinical knowledge but are mostly admin related , thus freeing up doctors to see more patients making clinical decisions and performing procedures ➢ They should be limited to basic reviews and administrative tasks, bloods, cannulas but their utility is limited by their lack of license/accountability to perform these things without a supervising doctor. ➢ Specifically the ward level and interventions such as NG tubes and urinary catheters ➢ Admin tasks ➢ administrative duties. documenting a ward round. keeping lists up to date. TTAs. MDTs ➢ Scribing/performing general tasks which take F1s away from training opportunities. And NOT being given priority over medically qualified staff ➢ Acting as assistants to doctors helping with admin tasks ➢ Study the role of PAs in europe/USA they have a valuable role in reducing the admin burden on registrars e.g. prepping patients to present at MDT, enacting plans from MDT, E.g. dictation, calling patients to arrange attendance for scans/clinic etc. Administration roles. ➢ The role of a PA should be for organisation and daily ward jobs. There could be some scope for acute assessment. However I generally believe that they provide a good continuity for team organisation and integration. By having someone continuously remaining on the surgical team, when the doctors change over, you have a person who knows how they system works and how to request and get things done. This brings the team up to speed quickly and doesn't delay patient treatment whilst juniors scramble to get something routine sorted (e.g. picc lines are requested differently and performed by different people in each hospital, by having someone who knows how to get these sorted promptly, it just makes the flow better). ➢ I think their continuity in a department helps when foundation doctors rotate ➢ Assist in procedures in theatres

	➢ Bloods, cannulas and helping out ➢ Monitoring medically well patients awaiting social discharge ➢ As assistant in theatre to spr. Allowing the consultant to be unscrubbed in theatre, ➢ bloods, cannulas, typing up notes on ward round, other simple jobs such as coordinating with nurses and other members of teams (PT, Pharmicists) they should act as assistants rather than independent clincians ➢ General admin generated by clinic, waiting list etc ➢ MDM organisation ➢ Chase investigations, discharge summaries, phlebotomy, cannulation ➢ As PAs are not able to review actually unwell patients, prescribe or order investigations, I do not feel that they are able to contribute to the majority of the workload that junior trainees encounter. Their role can be in supporting ward work such as cannulation/bloods, administrative work (writing referrals, discharges, letters), the problem is that PAs often ask doctors to sign off prescriptions for patients that the doctor has not reviewed and the medico-legal risk then lies with the doctor not the PA ➢ Cannulas, bloods, scribing ward rounds ➢ Assisting in theatre ➢ discharge letters and phlebotomy. however, they never seem to be confined to this role. As such, I believe they should not have a role within surgical care. ➢ They should do admin. ➢ I feel the role should be defined physicians assistant not associate, if they helped with the multile administrative tasks that fall to junior doctors this could dramatically improve training, i.e make the list, take bloods, put in cannulas, request scans, complete discharge summaries, all the tasks that don't require a medical degree. ➢ However they must be properly regulated like nurses and doctors with an accountable body to do daily ward work ➢ Coordinating MDT care, assisting with documentation ➢ PA remit should be the same as any non-qualified person. ➢ Discharge letter drafting to be approved by doctor ➢ Bloods/catheters/NG tubes and ward administrative tasks ➢ Should not be anywhere near operating theatre while trainees are doing ward rounds

	➢ Performing admin tasks such as documenting WR, holding Ward bleep, completing TTO transcribing ➢ service provision tasks. They should act as assistants to doctors. They are not doctors and not medically qualified. ➢ Administrative tasks such updating joint registries etc ➢ They are there to support junior doctors in their medical and surgical training and help with continuity when trainees rotate; not to take away training opportunities from surgical trainees ➢ Scribing on ward rounds, updating patient lists, helping in handover and with other routine / administrative tasks. Should not lead on patient care and/or delegate to a doctor- this was not the original scope of their practice or 'why' they were brought in to aid the NHS. ➢ Assisting with documentation, taking bloods, cannulating. Helping oncall with admin work. ➢ If PAs are to participate in surgical care, it should be to facilitate the training of surgeons to address long-term staff shortages. ➢ Paperwork ➢ Discharge summaries. Organising the list. Bloods and cannula. Scribing for the doctor. Carrying out doctors orders. Organising scans / chasing scans ordered by the doctor. ➢ Ward jobs including venepuncture, cannulas, catheters, NG tubes, wound checks, taking notes, initial review of ward patients only. ➢ Admin ➢ Limited role in clinic i.e follow ups etc ➢ In narrow scope non discharging roles eg deciding between colonoscopy and ctc in 2ww colorectal patients not suitable for stt ix. ➢ Other services like an ambulatory service. Helping coordinate but not reviewing patients without a doctor doing a brief review ➢ Pas should only ever have been used in the assistant role. However, in the last ten years the change from what was thought and what has happened has been truly frightening to us, to the public and even to lawmakers. It is human nature to want to increase one's scope and seniors have been feeding their own interests by having PAs perform outside their scope. They should be tightly regulated by a body other than the GMC and they should not be allowed to work outside their scope in any manner unless they go through the same hoops as every other medic. It is downright wrong that we have to ask for this. In surgery, they should simply be doing ward tasks at a

	foundation level. Continuity does not change one's qualifications. There has to be a differentiation. ➢ For question 16, yes for regulation, not with GMC or NMC. Also only simple bloods and cannula, maybe change dressings on ward. Not intervention. ➢ The role they were intended for which is reducing admin workload on doctors. ➢ Bloods, tto. ➢ Should be admin based, with phlebotomy roles etc ➢ General ward and clinic dogs body. Assistant to the physician/surgeon as was their original name. ➢ semi-urgent outpatient tasks, e.g. pre-op work ups, ward attender reviews/wound reviews ➢ I don't understand the role enough to answer this question but most of the options are roles that doctors do ➢ Essentially a role to facilitate surgical training and gaining of clinical experience for surgeons. Taking the administrative duties. ➢ Providing PAs are supervised by their dedicated supervising consultant and is competent in: daily ward jobs/ procedures/ interventions/ seeing referrals, there should be no problem with this. This should not come at the detriment of training opportunities for Doctors in surgical training. Furthermore PAs should recognise when there are training opportunities suited to surgical trainees and ensure they get exposure to this. This issues come when PAs work outside of their scope of practise, and without appropriate levels of supervision. It is unfortunate that their is so much negativity at the moment. It is understandable, however the vast majority of PAs just want to help deliver high quality care for patients. This can be achieve with their level of training and supervision as well as support from their supervisors ➢ surgical admin- eg booking follow ups, or looking at endoscopy guidelines for polypectomy and triaging referrals as per guidelines- their role should be to ASSIST doctors with administerial tasks and NOT perform procedures ➢ Robotic assisting ➢ I think certain ward jobs, such as bloods, cannulas, discharge letters are all feasible for PAs, maybe even gathering info for MDTs and recording outcomes, however I am uncertain that these tasks require a band 7 member of staff. I find it curious that this role has a higher starting salary than a FY1, they have stability, none of the responsibility, exams and they have subsidised courses!! How is this possible? ASiT have tried to estimate the cost of surgical training before, it

	is extortionate - what's the point when we can be PAs - less responsibility, all of the perks with none of the downsides. PAs make mugs of us all ➢ No more than what a medical student is allowed to do, but then we already have medical students. ➢ Procedural clinics and basic surveillance clinics with clear guidelines ➢ Administrative roles to free up surgeons to go to clinic & theatres ➢ Admin based ward jobs or basic practical skills (phlebotomy etc). Not decision making and not requesting tests that they cannot interpret or act on. Nothing to do with diagnosis due to the limitations of their training. ➢ Discharge letters, basic administrative tasks, writing notes ➢ Being an associate to the junior team rather than their senior who have way less years or training. ➢ Ward rounds; support with staffing; minor procedures eg phlebotomy; knowledge and experience in department not achieved by rotational basis of foundation training ➢ I believe their training should end with prescribing ability and being independent practitioners ie responsible for their own decisions. In the current setup they appear to do the nice hours and the nice jobs without having to rotate or do half the other assessment things that doctors do. ➢ Performing ward procedures like cannulation, bloods, maintaining the surgical list ➢ Bloods, Cannulas, Prepping discharge summaries, prepping ward notes, ➢ Discharge letters, cannulas, phlebotomy ➢ Ward based tasks that otherwise take a significant amount of physician time but low acuity e.g. cannulas/bloods/ABG/ECG/Simple catheters/ scribe for WR. Simple low acuity tasks to free junior doctors for training opportunities ➢ Scribing for ward rounds ➢ I think daily ward based work is the only setting with adequate supervision of PAs ➢ Discharge summaries, letter writing, examination request placing, liaising with other specialties or ED, chasing up referrals ➢ Low grade clinical work (eg: phlebotomy) ➢ Simple clinic duties - like within ENT (microsuctioning) ➢ They are unregulated and while unregulated they have no role. ➢ Scribing, discharge letters

	➢ Continuity of knowledge when Dr change over, knowing how the ward works. But nurses are often as good as this at most levels. Out of hours ward jobs or perhaps have a cannulation service. ➢ Very basic ward tasks such as venepuncture and NG tubes. Ensuring general 'housekeeping'- making sure list is maintained and correct, print lists and organise notes for ward round. And any other admin tasks that are particular to that department - for example if scans need a certain vetting procedure etc, or referrals to other teams need a particular online form - physician assistants would be the perfect person to do thus rather than have to teavh the rotating f1s the ins and outs (non clinical) of each department...this would make the dept run smoothly and free up opportunities for actually training the more junior team in surgery. ➢ Basic documenting of ward round/admin tasks and small ward based jobs (cannula, catheter, phlebotomy ONLY) ➢ Can do basic surgical procedure or intervention (i.e I+D). But they must teach a foundation doctor or surgical trainee as well. For example, to pass their appraisal, they must be signed off/supervise certain number of foundation doctor or surgical trainee (not PA trainee) if the want to pass appraisal or continue doing the procedure. ➢ Administrative tasks - keeping the ward list up to date, managing MDT paperwork, scribing on ward rounds. They should be doing the administrative parts of the foundation doctor role so that doctors can see patients. ➢ Assisting the doctors with their work in the ward. Doing the easier simpler tasks. ➢ the role was originally called physician assistant. roles should include TTOs, ward jobs, scribing ward round, phlebotomy ➢ Administrative duties ➢ Everything they provide an FY1 does for less money. ➢ Little role past daily ward jobs ➢ The role should be similar to a “static F1”. As they’re not medically trained reviewing patients, prescribing, investigations etc should not be part of their scope of practice ➢ Administrative tasks such as discharge summaries, basic ward jobs such as cannulas, perhaps triaging clinics at push (in terms of face to face VS telephone not actually making decisions) ➢ Perhaps in scribing tasks. I do not believe the team is enhanced by PAs in the same way other specialties may be

	➢ I believe they should be doing ward jobs so that doctors can be freed up to attend clinics and theatres. If they have learnt to clerk patients in their PA training, why not apply it on wards and take, rather than doing a 1-day surgical course and going straight to theatres for suturing, assisting open or even robotic procedures. Surgical aspirants have years of training, exams and courses before they can do some assisting. Its unfair that a newly qualified PA is allowed to take on assisting even without basic knowledge of anatomy. They learn anatomy while operating which would not be welcome from doctors. ➢ Admin style jobs - chasing referrals/investigations/organising lists ➢ Seeing triaged pts within a limited scope of practice ➢ Paperwork, point of contact (phone line) for patients, outpatient clinic (e.g. follow-up/postop surveillance) with appropriate supervision, simple interventions like wound care or replacing a suture, removing a drain (where such interventions are not undertaking by nursing staff) ➢ Supporting busy on calls. Best deployed in a regular role, much like an ANP so that expertise and experience can drive up standards of care. ➢ They can be useful in chasing bloods and scans already requested by a doctor ➢ They should be limited to ward based tasks (scribing in WRs, bloods/cannulas/NGs/ECGs, TTO(IDLs) ➢ Depends what 'ward jobs' are envisaged ➢ Administrative ➢ Maintain training continuity for rotating FY1s/FY2. However, they should not take priority over FY or other doctor learning opportunities ➢ Administrative work, reducing doctors workload ➢ Scribing, IDLs, simple phlebotomy and cannulas ➢ PAs should be nowhere near a surgical theatre. Or clinic. If you must have them they must be relegated to the wards. If they want to assist then go to medical school, do foundation training, get an MRCS, get into CST. Otherwise enjoy the surgical wards ➢ Helping organise administration ➢ Doing admin tasks such as TTOs dc summaries, chasing results, basic tasks such as bloods cannulas etc ➢ Completing ward admin, paperwork and chasing jobs. Organising follow up appointments. Logistical organisation. Reducing doctors admin demands. ➢ To be free up time for doctors to be in clinics and theatres. Surgical trainees should still be on the wards

	during the mornings to learn how to deal with ward issues ➢ Perioperative planning clinics and ward continuity ➢ Clinic eg 2ww ➢ The only application for PA's should be to reduce administrative workload for doctors in order to allow doctors to focus on tasks that require medical training and higher levels of cognition
In your opinion, what is the role of Physicians Associates (PAs) within surgical procedures (e.g. theatre operations/interventions) ➢ **Other (Comments)**	➢ Assisting but not when trainees are present or instead of trainees. ➢ I believe they often get the opportunity to assist and trusted by seniors in a surgical department as they a more permanent that SHOs who by the nature of our training spend 4-6months in a job. I try think bosses are more likely to want PAs they know with them in theatre than an new SHO which does take away training opportunities. That can build resentment ➢ At most - assisting, but should not take opportunities from trainees. In my department & many others I have heard about, the PA is obviously not rotating so gains favour with consultants and are prioritised over lists and often do the rota and put themselves in better lists. ➢ Not sure ➢ They could have a role in assisting as they are the physician's ASSISTANTS after all but definitely AT NO COMPROMISE of trainees'/ students' learning opportunities ➢ I believe their role in theatre should money be to assist in situations where there is no surgical trainee or clinical fellow around to do so or where these doctors are happy to allow them to have these opportunities. Otherwise what unfortunately happens is that key opportunities are given to them I stead of trainees. ➢ May have a role if not impacting on training/opportunities for trainees ➢ Ability to assist if surgical trainee or junior doctor is not available interested in surgery ➢ Supporting training ➢ They can assist may be but not take part in the procedure ➢ Only have a role if surgical trainees not present and available ➢ Assisting only when no other trainee/doctor is available ➢ If PAs could free up junior doctors to get some time in theatre we may be able to inspire stone surgeons of the future. If PAs become the default assistant while

	junior doctors perform ward tasks, fewer junior doctors will consider a career in Surgery. ➢ Assisting only if no trainees available to assist ➢ Remotely supervised Injection lists ➢ We already have SCPs (surgical care practitioners) in theatre. I cannot see how there would be an additional theatre assistant role. ➢ I don't believe they should have a role as there aren't enough training oppportunites - however they believe they should assist over core trainees ➢ Don't know ➢ There are more than enough surgical trainees who want to be in theatre assisting. Unfair that PAs get all the theatre time ➢ Expert assistant only. No role for performing procedures at all. ➢ Assisting only if no other surgical trainees need/want experience/teaching ➢ While surgical trainees are struggling to access surgical procedures I do not believe PAs have a role, if there are adequate training numbers for doctors and they are getting adequate surgical procedure exposure then there absolutely is a role for PAs to help bridge that gap, but with the current gaps they should be filled by surgical trainees first. ➢ Assisting but not to be trained to perform procedure ➢ If they wish to complete the same training as the nurses to become surgical first assistants that could be appropriate ➢ Shouldn't interfer or detract from surgical training of junior doctors ➢ Administrative task for wards or Theatre assistant ➢ Assisting, but only within a private practice setting ➢ I think it very important their role is subject to the same training, portfolio requirements and exams as a surgical trainee and should only be in an area where this does not impact surgical training for junior doctors ➢ At best, assisting ONLY when it does not stop a doctor from gaining such experience. Otherwise they should be on the ward doing ward jobs ➢ Admin/ward jobs ➢ I do not believe PAs should be carrying out any procedures. They should not be used as theatre assistants nor as a cheap clinical endoscopist. Once we go down this route, trainers won't bother training, and trainees won't get trained. Also you will be left with PAs who won't commit to ward work anymore, and thus doctors will be purely left to ward stuff

	whilst and fight for what little training opportunities are available. ➢ Administrative tasks ➢ As a robotic assistant so that the trainee can be on a second console. Not if there is no second console. ➢ I would say assisting but that would take trainee positions away and secondly a trainee will assist with the aim of one day performing the procedure independently whereas a PA should be restricted to assisting ➢ Doing the non doctor critical tasks such as scribing on ward rounds, chasing results, liaising with radiology about scans etc requested, completing paperwork such as aki risk review etc. all this would free trainees to train. NOT to do technical tasks such as operating- their role should be entirely outside theatre ➢ Writing discharges. ➢ At most assisting if required, but not at the expense of surgical trainees ➢ Ward-based role only. Other aspects of surgical care- theatre, clinic, endoscopy, MDT should be for doctors only ➢ - ➢ Assisting if there are no surgical junior doctors available. I do not believe PAs should have any priority in surgical procedures over surgical junior doctors. ➢ Limited role in assisting only as a last resort (eg to assist a senior trainee, when no other junior is present). They should NOT be used as a replacement for junior trainees when assisting. Assisting remains a vital part of the surgical training, and surgical trainees should maintain priority. ➢ Our PA doesn't go to theatre but I'm aware some do and I would have a concern this would take training opportunities from surgeons in training ➢ Assisting only if no surgical trainee could be made available to assist ➢ they should stick to adminsterial jobs like discharge summaries, ensuring elective patients have the right pre op bloods, booking hdu beds, booking follow up appoinments after triaging the scenario etc ➢ In facilitating doctors to get to theatre to assist or train ➢ Assisting - priority needs to be given to surgical doctor trainees including foundation trainees. ➢ Specific roles eg bedside assistant during robotic cases ➢ Cannot comment as have not had experience ➢ Either fully autonomous (within limits) or as assistants to do more admin-type work.

	➢ I think PAs' role would take away trainees' opportunities ➢ Doing ward jobs alongside FY/SHO grade to free them up for learning. ➢ Assisting only if required and there is no trainee available ➢ Can do basic surgical procedure or intervention. But they must teach a foundation doctor or surgical trainee as well. For example, to pass their appraisal, they must be signed off/supervise certain number of foundation doctor or surgical trainee (not PA trainee) if the want to pass appraisal or continue doing the procedure. ➢ Assisting on the clear proviso there is no surgical trainee available. If wards need staffing this should be by the PAs and the Fy1's should be offered opportunities. ➢ Assisting when no other doctors are available (e.g. on annual/study leave) ➢ Perhaps assisting in some cases when there are not enough junior doctors available to help. ➢ Assisting when it ensures trainees can perform surgery with consultant unscrubbed and junior trainee or FYs are not impacted ➢ Helping with admin procedures and assisting with ward rounds when a consultant / reg is leading ➢ Assisting when no surgical trainee is available ➢ PAs could be used for assisting, however, this should only be the case if not enough trainees can be recruited due to location not being desirable enough to trainees. Junior doctors should be encouraged and prioritised when it comes to surgical procedures ➢ Assisting where there is no trainee to do so (ie not taking a training opportunity away from a trainee) ➢ Assisting only where doctor cover for the list is absent