American Academy of Physician Associates

Response to:

“The Leng review: an independent review into the physician associate and anaesthesia associate professions”

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American Academy of Physician Associates

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Executive Summary

Background

As part of American Academy of Physician Associates (AAPA) ongoing commitment to representing the U.S. profession, we actively monitor how our international colleagues are progressing. As part of our close relationship with our UK PA colleagues, we have observed the challenges they faced establishing the profession until the present. When AAPA read the results of the Leng Review, we were concerned with possible bias within the methodology and what was used to underpin the recommendations put forth in the final report.

This response is the result of a closer look at the methodology of the Leng Review. The Leng Review was evaluated by members of AAPA's research division, including doctoral-prepared research scholars with more than 50 years of combined research experience.

Overview

The Leng Review found no substantive differences in the incidence of safety or "Never Events" between Physician Associates (PA) and comparator groups. However, recommendations to limit the practice of United Kingdom (UK) PAs, including professional name change, were still put forth. Additionally, the review had limited focus on regulatory structures within the National Health Service (NHS), namely the new regulatory oversight of the Associate roles by the GMC, overseeing clinical governance but rather emphasized a disproportionate amount of focus on opinion surveys and public feedback.

Furthermore, we have concerns regarding the methodological robustness of the literature review, focus groups, and surveys underpinning several of the report's recommendations. As such, we believe proposed recommendations to restrict UK PA scope of practice - such as prohibiting PAs from seeing undifferentiated patients or renaming the profession - are not sufficiently supported by the evidence presented within the Leng Review. However, we do see a rationale in recommended initiatives aimed at enhancing UK PA career progression, establishing clear roles within NHS multidisciplinary teams (MDTs), and ensuring that PAs are appropriately credentialed and prepared to deliver patient care through the General Medical Council (GMC).[1] These efforts can address legitimate concerns around process and communication without imposing unnecessary limitations on the profession's ability to provide safe, effective patient care. For purposes of this report, we will focus solely on the PA profession.

Concerns: Literature Review

The report's systematic review identified 47 relevant articles, but 24 were excluded based on subjective, inconsistent criteria such as small sample sizes, low quality, or outdated data. The remaining 23 studies were graded as medium or high quality, yet many were later dismissed without consistent rationale. For example, the Drennan, et al. (2015) study, which found PAs' clinical records were more appropriately

[1] The GMC is the UK's independent regulator for doctors, PAs, and AAs, and is dedicated to safeguarding public health by upholding high standards in medical practice and education.

documented than those of general practitioners (GPs; 81.6% vs. 50.8%) and showed no significant differences in clinical outcomes or patient satisfaction, was criticized for using narrow outcome metrics despite its robust sample sizes. Similarly, Halter, et al., (2020) was dismissed for being underpowered though its design followed accepted standards for clinical trial comparisons. The Senft, et. al (2019) study, which analyzed over 861,000 patient records, was questioned for case mix adjustment despite showing negligible differences in patient complexity. The report lacks a systematic framework for evaluating bias, sample size adequacy, or statistical power, raising concerns about ad hoc decision-making.

Concerns: Focus Groups and Interviews

Patient focus groups conducted by the Patients Association were limited by sampling bias, lack of methodological transparency, and unclear representation of participant views. They used a convenience sample recruited from a patients' rights newsletter with 23 of the 31 patients having been treated by PAs. This strategy resulted in comments about PAs that were not based on experience, potentially skewing perceptions. The report does not clarify whether data saturation was achieved or how themes were identified. Quotations lack context, and vague generalizations of patient perceptions such as "some" or "most" are used frequently, without providing the specific proportions of patients expressing those views. This weakens the reliability of findings and their applicability to broader policy decisions.

Concerns: Survey Data

The survey distributed as part of the evidence collection suffers from potential authenticity and representativeness issues. No verification was conducted to confirm respondents' NHS affiliation, and while duplicate and bot responses were screened, the lack of weighting or margin of error calculations limits the generalizability of findings. Non-response bias is evident, with only 32% of UK PAs responding and lower participation rates among doctors and resident doctors (2.6% responding[2]). The absence of statistical adjustments to correct for subgroup imbalances further compromises the validity of the results.

Concerns: Secondary Data Analysis

The report draws on national datasets including coroners' reports, whistleblower files, and the Learn from Patient Safety Events (LFPSE) system. However, it characterizes these sources as "inconclusive and largely unhelpful," despite evidence suggesting PAs provide safe care. For instance, there was no pattern of findings related the Prevention of future deaths report (PFD) reports[3] for the care attributed to PAs between July 2013 and February 2025. Furthermore, the comparator search was for May 2023 to February 2025, a much shorter time frame and the number of reports related to doctors or resident

[2] According to Key Facts and Figures About the NHS, as of January 1, 2025, there were 147,000 doctors in the NHS. The survey included responses from 888 GPs, 289 specialist doctors, and 2,586 resident doctors.

[3] Prevention of Future Deaths (PFD) reports, sometimes referred to as Regulation 28 reports, are issued by coroners in England and Wales when an inquest reveals concerns that, if addressed, could prevent future deaths. These reports must be responded to within 56 days by the named individuals or organizations, detailing actions taken or planned, and are publicly published to ensure accountability and transparency.

doctors was not provided. A comparative analysis of Never Events[4] found no significant differences in rates per full time equivalent (FTE) between PAs and resident doctors or nurses. While Audit 2025[5] data showed reduced wait times in hospitals employing PAs, the source data is unpublished and lacks transparency. The report also fails to standardize search periods across professions, limiting the validity of comparisons.

Concerns: Influence of External Commentary

The report references public comments from the British Medical Association (BMA) but does not clarify if these influenced policy recommendations or perceptions of the climate within the NHS. The BMA has historically opposed the PA profession. They may also be expressing broader discontent with systemic issues related to the training of doctors, which is well documented within the UK. Furthermore, it is unclear whether PA-supporting organizations were given equal opportunity to contribute to the expert testimony.

Response to Recommendations: Title and Profession Positioning

The recommendation to rename the PA profession from "Physician Associate" to "Physician Assistant" lacks evidence of impact on patient understanding. Communication and education strategies, rather than title changes, are more likely to improve role clarity. Survey data shows most PAs feel confident in their supervision and ability to report safety incidents. Blocking PAs from treating undifferentiated patients could exacerbate workforce shortages, especially given that many GPs and resident doctors support expanding PA responsibilities. Continuing GMC regulation, that had been worked towards for over half a decade and has only just been put into effect, is expected to improve safety and public perception – questioning the rationality of changing the roles prior to the effect of the regulation is seen.

Methodological Concerns

Literature review

The systematic review of literature located 47 relevant articles determined to be relevant by the reviewers (Page 30, Leng Review).

Among these 47 articles:

- 12 articles were removed because the sample size of PAs or AAs was less than 3.
- 8 were removed because they were determined to be of "very low quality" for unstated reasons.
- 2 were removed for a risk of bias.
- 2 were removed for using "primarily pre-2010 date."

[4] According to the NHS, "Never Events are incidents that require investigation under the Serious Incident framework."

[5] Audit 2025 broadly refers to the evolving landscape of clinical audit and quality improvement across the NHS.

The reviewers judged the remaining 23 articles to be "evidence graded medium or high" and included in the outcome tables within the report.

Having already been screened for quality at the beginning of the process, the Leng Review authors appear to dismiss the results of these studies based on subjective, ad hoc rationales. The review of literature on the "safety of physician associates in primary care" includes the article, "Physician associates and GPs in primary care: a comparison" by Drennan et. al. (2015). This article includes the finding that PA clinical records are more likely to be assessed as appropriate by independent reviewers (81.6% appropriate for PAs and 50.8% appropriate for GPs). This is a substantial and significant difference. The sample size for the clinical records analysis was 475 patient records.

From this same article, an analysis of 2,086 patient records showed no significant difference between PAs and GPs on three clinical outcome metrics. An analysis of 1,010 patient satisfaction surveys also showed no significant difference across 7 satisfaction domains. The Leng Review authors argue studies like these, "...used narrow outcome metrics, focused on a small number of participants." The report does not provide a threshold for what should be considered a "large enough" sample size. Nor does it systematically grade the articles included within the review on sample size adequacy.

Likewise in the review of "effectiveness of physician assistants" in secondary care, the report criticizes studies for being "underpowered" to assess the outcomes considered related to PA effectiveness. The article, "Comparing physician associates and foundation year two doctors-in-training undertaking emergency medicine consultations in England: a mixed-methods study of processes and outcomes" (Halter et. al., 2020) is criticized for having a sample size "powered to detect a 50% change in its primary outcome which would represent an improbably large and troubling difference in performance between PAs and FY2s."[6] Again, the Leng authors do not specify what the appropriate minimum detectable difference should be, and do not systematically evaluate each article based on a sample size power criterion, making the criticism seem *ad hoc*. Calibrating sample size based on a 50% relative minimum difference is based on common practice in clinical drug trials to define noninferiority margin (See Althunian, et al., 2017). If the Leng authors believe this is an "improbably large and troubling difference" they should provide a plausible alternative and then consistently evaluate studies based on their proposed minimum detectable difference.

The review of "effectiveness of physician associates in primary care," includes an article using data from 861,223 patients (Senft, 2019). For this article, sample size is not a plausible concern. The Leng Review author raise concerns about "inconsistent or partial adjustment" for case mix, leaving open the possibility that PAs could see patients with less complexity of need. There is always risk of bias from heterogenous treatment groups in observational studies. However, it is important to note the listed articles were already screened for bias risk and were not excluded in that process. It is reasonable to

[6] Following graduation, new doctors in the UK go through a two-year training program. In Foundation Year (FY) 1, they rotate through hospital departments under close supervision. In FY2, they gain more responsibility while still being supervised.

treat observational studies as lower in quality than randomized trials (Dijkers, 2013). However, this report makes no effort to systematically categorize articles by bias risk or patient heterogeneity.

While the Leng Review claims to apply a systematic approach to its literature review, its process for study inclusion, exclusion, and appraisal lacks transparency and methodological rigor. The report excludes a substantial proportion of initially relevant studies based on poorly documented criteria and then applies inconsistent standards to the remaining evidence - often dismissing robust studies for "narrow outcome metrics" or being "underpowered" without defining objective thresholds for sample size or effect size. Notably, large, well-conducted observational studies demonstrating comparable safety and effectiveness between PAs and other providers are discounted due to concerns about case mix or study design, even when these concerns were already addressed in initial bias screening. The absence of a systematic, pre-specified framework for evaluating study quality, sample size adequacy, and risk of bias undermines the reliability of the synthesis. Best practice in systematic reviews requires clear, consistently applied criteria and transparent reporting of how each study is assessed.

Focus groups/Interviews

Participants to the focus group were recruited from a patients' rights newsletter with 23 of the 31 patients having been treated by PAs. All of the participants had long-term conditions and 23 had disabilities. In sum, the patients within the focus group represent a spectrum of more complex cases; no other patients were included such as those with no need for ongoing medical care. Some bias may be present in the convenience sample used for the focus groups . Cumulative interactions with the healthcare system while managing a complex health condition may influence perception of the NHS's effectiveness. Additionally, recruitment via the Patients Association newsletter and partner publications can over-represent individuals with polarized views actively involved in patient advocacy - as opposed to the general patient population encountering PAs within the NHS. Moreover, there is no clarification on the context of the respondent's history of interaction with PAs within their attributed responses.

It is also unclear whether achieving theoretical saturation was a goal of the research team conducting the focus groups. The analytical approach of the research team, their reflexivity and background related to the project, and the codebooks/discussion guides utilized as part of the interview and analysis process are not included within the documentation. There is a gap in our understanding of how the researchers identified themes as "significant" within the report. Without this information, or insights on the process of achieving data saturation, it is impossible to extrapolate the findings of this focus group to a broader policy context.

In no point of their analysis of the findings from the discussions do the researchers clarify the proportion of their participants who had a particular viewpoint related to the UK PA profession; instead, the Patients Association report relies on grouping terms such as "some" or "most." Additionally, the quotations are not provided with any descriptive context to allow an external audience to determine if the responses reflect multiple participants or a sub-group of respondents. This becomes problematic for two reasons. First, without providing clear insights into the proportion of a focus group who held these

views it is difficult to ascertain how much weight should be given to these perspectives. Second, without greater contextualization the words of participants could be misinterpreted – especially if the respondent had limited to no interaction with PAs.

For example, participants within the report expressed that often they did not know they were seen by a PA until after their visits and, according to the report, "where participants had a positive experience of seeing PAs in general practice, advance knowledge of this played a big role." (Patients Association report, pg. 4). These interactions are then extrapolated into larger policy implications later in the report. On page 13 of the Patients Association report the authors claim: "The way PAs interact with patients can be inconsistent. Some offered little to no introduction, others introduced themselves by name and / or job title, others explained the role and its limitations." At no point in this section of the report did the authors clarify that this finding is based off a limited sample of patient interactions. Given that public awareness is extremely low. as reported on page 15 of the focus group report, recommendations about the profession and their qualifications based on lived experiences could be biased by several factors – including negative media coverage of the PA profession. It is important to understand the context of reported negative experiences before highlighting the transferability of the research findings.

Survey

On page 23 of the Leng Review, the authors write, "By the autumn of 2024, the debate around PAs and AAs was regularly being described as 'toxic', with reports of bullying and harassment in the day-to-day working environment and leaders being unwilling to speak up." This anecdote speaks to the degree of bias that may have existed in the background of the report's data collection efforts. In this specific case, distributing a survey through public channels without any clear implementation of processes to validate the identity of respondents as members of the NHS workforce introduces questions related to the authenticity of the response data. While the authors did check for obvious duplicates and bots, there was no way to identify if the practitioners sharing their thoughts about the role and performance of PAs had worked with PAs or within the NHS. This means at best that the representativeness of the survey data can be called into question.

The survey distributed as part of the evidence collection suffers from potential authenticity and representativeness issues. No verification was conducted to confirm respondents' NHS affiliation, and while duplicate and bot responses were screened, the lack of weighting or margin of error calculations limits the generalizability of findings. Non-response bias is evident,

The findings of the survey may not accurately reflect the opinions of healthcare professionals within the NHS. At best, the authors utilization of a network-based recruiting strategy (i.e., convenience snowball sampling) could have restricted survey participation to engaged subgroups rather than the general NHS workforce. At worst, a coordinated campaign could have influenced the responses – impacting the potential generalizability of the survey data. It is difficult to identify from the results presented the likelihood of specific views being under, or over, represented. An effective way for the authors to

provide greater context for their survey findings would have been to include margins of error or confidence intervals in the tables. Without this information, it is difficult to evaluate the estimated range of responses within the overall populations of practitioner subgroups who participated in the survey.

The impact of the lack of margin of error is further compounded when considering the effect of non-response bias on the survey. Using the numbers provided in the survey report, approximately 32% of the UK PA profession responded and shared their insights (1,141/3,555). While the survey received more overall responses from GPs, specialty and associate specialist doctors and resident doctors, the response rate for these groups is much lower (2.5%) compared to their make-up of the NHS workforce (147,000). It is then important to consider the impact of non-response bias on the responses shared by these practitioners. There is a risk that the views expressed by the doctors and resident doctors are not aligned with the broader – less engaged – NHS workforce. Further, no action was taken to specifically target underrepresented provider groups and improve response rates.

Within survey and public opinion research, some of these biases can be resolved through weighting the data to bring the proportions of responses more in line with the overall population. For example, researchers could have applied statistical adjustments to ensure the proportion of primary and secondary PAs in the sample were relatively similar to the regional distribution patterns of PAs within the NHS to mitigate imbalances in the data and make findings more representative. This can be especially important when response rates vary across key subgroups. Without weighting, it is more likely decisions makers could be making decisions based on skewed data. While these adjustments do not wholly make up for the impact of nonresponse, they are a part of a statistical toolkit used by researchers to better extrapolate the responses of a sample to make judgements about the opinions held by the overall population.

Secondary Data

Despite a breath of extant secondary data illustrating the safe and effective care of PAs within the NHS, the authors of the Leng Review claim results are mixed on the safety and effectiveness of the UK PA profession. However, the data utilized within the report simultaneously features references to how PAs provide care that is as safe as comparable practitioner groups.

To assess the safety and effectiveness of UK PAs and Aneasthesia Associates (AA), national bodies, including the Care Quality Commission (CQC), were tasked by the Leng Commission with examining multiple secondary datasets. These included coroners' Prevention of Future Deaths reports, whistleblower files, and the LFPSE system. NHS trusts contributed to a five-year breakdown of 'Never Events' by professional group, while effectiveness was gauged through primary care performance metrics, hospital throughput, and references in Getting It Right First Time[7] (GIRFT) reviews. The report

[7] The NHS program, Getting It Right First Time (GIRFT), is "designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change."

states a two-sample, two-tailed T-test was conducted to determine whether trusts employing PAs and AAs had significantly different rates of Never Events per clinical FTE compared to those that did not. This analysis used publicly available workforce data from December 2024 and Never Event data spanning 2013 to 2025. Statistical checks were designed to assess whether the sample used was representative of broader NHS reporting trends.

Analysis of Department of Health and Social Care (DHSC) data found no statistically significant difference in the number of appointments per GP at practices or Primary Care Networks (PCNs) employing PAs versus those that do not (Pg. 42, Leng Review). Additionally, there were no statistically significant differences in the rate of Never Events per FTE when comparing PAs to resident doctors and nurses (Pg. 44, Leng Review). These data points highlight an important lack of difference between PAs and other NHS providers; however, the underlying data supporting these analyses is not included in the final report or made available online. To ensure transparency and facilitate informed decision-making, it is recommended that this data be summarized and appended to the report. This is especially important as LFPSE data is not publicly available.

Figure 1: Excerpt Tables from the Leng Review

No. 10 analysis, 2025[28]	2013 to 2025	Regression analysis from an internal request made to NHS trusts to provide FTE and never event rates per year for a range of medical professionals in secondary care	52 respondent trusts, 40 employing PAs and resident doctors, 37 employing PAs and nurses, over a range of time periods from FY 2013 to 2014 to 2024 to 2025	Involvement of PAs in never events compared with resident doctors by FTE; involvement of PAs in never events compared with nurses by FTE
				rather than a PA
FOI: Significant and Never Events Involving Medical Associate Professionals, 2025[30]	Financial years 2019/20 to 2024/25	Analysis of responses from an external freedom of information request made to trusts of never events and significant events against headcount in each role	39 respondent trusts, 23 recording details of staff involved in events. No trusts reported employing AAs. Number employing PAs unclear due to partial data	Involvement of PA in significant event compared with composition in sample; involvement of PA in never event compared with composition in sample

The analysis of coroners' PFD reports revealed a notably low incidence rate for PAs of 1.43 cases per 1,000 PAs between January 1, 2019, and August 19, 2025. There was no pattern of findings related to the care attributed to PAs between July 2013 and February 2025. Despite this, the report's authors characterized the national datasets as "inconclusive and largely unhelpful" (pg. 79), a framing that risks misrepresenting the data's implications. In fact, the absence of significant safety concerns in these reports should be interpreted as evidence supporting the safety of PA-provided care. To strengthen the evidence base, it is recommended that the existing coroners' data be acknowledged as a valid and informative component of the safety profile for PAs.

The current PA search period (May 2023 - February 2025) differs from that used for comparator professions (July 2013 - February 2025), and notably, the PA timeframe includes the post-2019 era when reporting standards changed. To ensure methodological consistency and enable valid comparisons, it is recommended that the search period be standardized to span 2019 - 2025 for both PAs and their comparators. Data should be categorized by attribution (whether to a single profession, multiple

professions, or systemic error) and subjected to statistical analysis to assess relative incidence rates. Although statistical analysis was considered, it was ultimately not conducted due to concerns about data volume, potential double counting, and time constraints (pg. 104). However, manual deduplication of reports is feasible and would allow for meaningful comparisons.

National benchmarking data was also used to evaluate the performance of UK PAs. Audit, 2025 (p. 47, Leng review) found mean wait times to (a) doctor review, (b) consultant review, and (c) doctor/NP/PA review all decreased in hospitals with PAs compared to national benchmarks. However, the source data related to this citation is unpublished and adds to the problem of limited available data related to the effectiveness of PAs or the professions impact on patient outcomes. Additional context is needed to better understand the source of this data, its inclusion in the report, and the availability of these findings for other researchers aiming to illustrate the effectiveness of PAs.

Influence of Public Comments/Concerns from the BMA

The authors cite submissions provided by the BMA from resident doctors, consultants, GPs, and students as a factor that was viewed as part of the broader narrative about the concerns present within the NHS workforce about the safety and effectiveness of PAs (pg. 55, Leng Review). It is unclear whether the recommendations presented in the report stem in part from the concerns expressed in these submissions. However, the authors do clarify that these views were not considered as part of the verified core evidence set.

It is also unclear whether similar trade associations supporting other professions (e.g., AAs and PAs) were afforded the same opportunity to provide feedback on their profession and have it similarly considered by the Leng Commission as expert testimony. Therefore, this end impact is the amplification of voices who have historically opposed the development of the UK PA profession as opposed to the experiences of patients. Allowing additional stakeholders the opportunity to provide sources of secondary data and literature highlighting the role of PAs in the UK and comparator countries would have given the authors of the report additional insights on the safety and effectiveness of the profession.

Response to the Recommendations for Physician Associates

Recommendation 1: Positioning of the Role

The Leng Review argues the role of physician associate should be renamed as ‘physician assistant’ to better position the role as a supportive, complementary member of MDTs within the NHS. However, there is no evidence provided that changing the title to “assistant” would make a difference in the ability of patients to identify clear role differences between PAs, GPs, and other members of the MDT. Further, other - more purposeful - avenues for role delineation are provided by the authors of the Leng Review (see recommendation 7). It is unclear how other proposed changes cannot be implemented with the existing title.

Education of the public and healthcare workers on the role of PAs in the UK could be used to further delineate the distinctions of the role of GPs and PAs. Recommendations provided to NHS England on providing “standard patient-facing information about the role of the PA” are not predicated on a change in title for this workforce. Effective training for line managers of PAs can also help ensure PAs are effectively positioned and supported in their patient care.

From the review and accompanying documents, it appears the positioning of the PA profession within the NHS is less of an issue of role confusion and more an issue of communication. The term “physician assistant" and “physician associate” are both synonymous with the abbreviation with “PA”, and it is unclear how a change in title will impact the general view of PAs as “confident and capable” providers “with positive attitudes and communication skills” (Leng Review, pg. 51 – systematic review of UK PAs). Overall, patients who directly interact with PAs report a positive or neutral experience and those who have not interacted with a PA have a more negative view of the profession, further illustrating the likely impact of biased communication on patient perceptions of the profession (Leng Review, pg. 51).

Recommendation 4: Undifferentiated Patients

The authors of the Leng Review propose limiting the scope of PA practice to undifferentiated patients - except within clearly defined national clinical protocols. However, the analysis of the secondary data on patient safety included within this report does not appear to support this recommendation. Specifically there was no pattern of findings related the Prevention of future deaths report (PFD) reports for the care attributed to PAs between July 2013 and February 2025. Most of the PFD reports highlighted broader issues in the NHS – where the PA was providing care under the direction of, or in consultation with, doctors – as well as failure of the provider to diagnose and provide care and failure of the patient to pursue recommended follow-up. Importantly, these isolated incidents should not outweigh the millions of patient interactions PAs have had within the NHS.

Moreover, there are 1,752 preventable deaths reported in this data period. The authors do not provide either 1) the number of deaths related to the care of other providers or 2) the rates of occurrence by provider for these deaths. Presenting this information is informative as it illustrates the safety and effectiveness of patient care for each arm of an NHS MDT. References within Table 3: Effectiveness of physician associates in primary care demonstrate few statistically significant differences between PAs and primary care comparators. Similarly, Table 4: Safety of physician associates in secondary care presents few differences in safety between PAs and their comparators. Decisions regarding the practice of a segment of the NHS should be consistent with longitudinal trend data and root cause analysis demonstrating a causal link between the actions of PAs, their training, and the safety/effectiveness of their patient interactions.

Responses from PAs in the survey conducted to gather information for the Leng Review also indicate that PAs are extremely/very confident in the adequacy of their supervision (90%, Table 40, pg.74; Leng Review survey findings) and are very/extremely confident in their ability to report safety incidents (90%, Table 46, p.81; Leng Review survey findings). Importantly, a majority of PAs were confident they would

be supported after a patient safety incident (Table 47, pgs. 81-82) - highlighting the success of previous initiatives designed to mitigate unsafe patient conditions within the NHS.

Blocking PAs from seeing undifferentiated patients has the potential impact of exacerbating existing shortages within the NHS. Based on the responses to the survey conducted as part of the Leng Review, approximately two in five (43%) participants felt there were additional activities within their service that could be assigned to PAs. Only a slim majority of GPs (53%) and resident doctors (50%) who had recently worked with PAs were opposed to providing them with additional activities (Table 16, pg. 32; Leng Review survey findings). Open–ended questions within the survey also highlight how including and expanding the role of PAs can increase available appointments, improve access to services, and reduce wait times in primary care settings (pg. 71; Leng Review survey findings).

Three in five surveyed PAs believe GMC regulation will have a positive impact on safety, support, and public perceptions of the profession. There are areas to improve the conditions for these providers, but it is unclear how the perspectives shared by the survey respondents about the practice of NHS PAs compare to the weight the authors of the Leng Review gave to unverified reports of adverse events collected through BMA impact statement comments. While these comments indicate opposition to the PA profession and concerns related to their safety, a vast majority of surveyed PAs indicate never being involved in a patient safety incident (Table 48, pg. 83; Leng Review survey findings).

Conclusion

The Leng Review acknowledges no significant differences in safety, effectiveness, or “Never Events” between PAs and comparator groups within the NHS, yet recommends restrictive measures, such as prohibiting PAs from managing undifferentiated patients and renaming the role, which are not strongly supported by its own evidence. Methodological weaknesses in the literature review, patient focus groups, and survey design undermine the robustness of findings used to justify perceived confusion on the role of UK PAs and their ability to provide safe and effective patient care. Secondary data, including national safety metrics and Never Event analyses, indicate PAs deliver care comparable to other NHS professionals, while the introduction of GMC regulation, after 6 years of planning and development, is expected to further strengthen governance and public confidence.

The Leng Review’s recommendations would benefit from a more explicit consideration of feasibility and potential unintended consequences. Including said consequences to not only providers and health systems, but the potential serious consequences on patients, families, and communities given Leng’s recommended sweeping changes. Implementation science best practice calls for a formal assessment of how recommendations will be operationalized, what resources are required, and how potential negative effects will be mitigated. These impacts are not provided in the review. However, we do acknowledge the difficulties involved in assessing the impact of the proposed changes at this stage within the constraints of the available data.

Figure 2: Overview of Leng Review Methodological Concerns

	Lit. Review	Focus Groups	Survey	Secondary Data
Sound Design	Structured PRISMA Method Initial Screening	Captures Direct Insights of NHS Patients for Exploratory Work	Broad Outreach with Some Integrity Checks	Use of National Datasets and Inferential Tests
Caution	Limited Rationale for "Low Quality" Article Classification	Convenience Sample via Advocacy Channels	No Weighting to Workforce Benchmarks Snowball Sampling	Transparency of Underlying, Non-Public Data Sources
Concern	Post-hoc Downgrades Without Clear Thresholds Inconsistent Appraisal of Observational Work	Lack of Transparency in Thematic Analysis Policy Generalization from Anecdotes	No NHS Affiliation Verification Non-response Bias	Non-standardized timeframes (e.g., PAs 23–25 vs. others 13–25) No Comparators for Reg-28 Data

Rather than imposing constraints and potentially exacerbating workforce shortages, policy should prioritize evidence-based strategies: clear role definition within multidisciplinary teams, structured credentialing, and enhanced career development pathways for UK PAs. To this end, we recognize the benefits of the proposed recommendations aimed at enhancing UK PA career progression, establishing clear roles within NHS MDTs, and ensuring that PAs are appropriately credentialed and prepared to deliver patient care through the GMC. These measures address opportunities for additional collaboration and communication without unnecessarily curtailing the profession's capacity to provide safe, effective care.