BMA Reporting Portal Submissions

Physician Associates and Anaesthesia Associates

BMA

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1. Introduction

In November 2023 the BMA established a reporting portal for doctors and medical students to share concerns regarding the deployment of physician and anaesthesia associates in both primary and secondary care. When submitting a concern, the BMA was clear that incidents should additionally be reported through formal mechanisms.

This report includes all submissions received by February 2025 that concern patient safety. In addition, we have submitted a wider report to the Independent Review of Physician Associates and Anaesthesia Associates, chaired by Professor Gillian Leng (the "Leng Review"), which includes submissions relating to the impact these roles have on the training and education of medical students and doctors.

We have submitted this report to relevant regulators across England, Wales, Scotland and Northern Ireland, as well as those responsible for the delivery of healthcare services across all 4 nations.

We expect the Leng Review to take the themes reported here seriously when making its final recommendations. This report presents unequivocal evidence of doctor substitution, doctors being coerced or pressured into signing prescriptions or ionising radiation requests for patients of whom they have no knowledge, examples of doctors losing out on basic skills training and multiple situations where neither the public nor other healthcare staff know the role or competencies of physician and anaesthesia associates. Of greater concern are the many examples where harm has come to patients or has thankfully been narrowly avoided only by subsequent intervention from a doctor.

Doctors consistently tell us that formal patient safety reporting mechanisms are complex and insufficient. Many doctors continue to be afraid of raising safety concerns in the workplace for fear of reprisal. This represents a problem across the health service which must be tackled by Government, healthcare providers and healthcare regulators. The BMA will work with all relevant organisations to change this dangerous culture, but it will require substantial efforts on behalf of all parties. Rather than ignoring problems, safety concerns must be responded to with openness and a genuine curiosity to learn from and correct errors. The current situation is unfair on staff, including physician and anaesthesia associates, but most importantly unfair for patients and their families.

Healthcare system leaders must take responsibility for patient safety, take note of this large body of evidence and act now ensure that unsafe practice is not happening in their own organisations. Doctors are instructed by their regulator to act promptly when patient safety or dignity is, or may be, seriously compromised. It is high time that the leaders of regulators and providers are held to the same standard.

Professor Phil Banfield MBBS (Lond) MD DA(UK) FAcadMEd FRCOG
BMA Chair of Council

2. Physician associates and anaesthesia associates working on doctors' rotas

**The NP and OP codes and numbers on each submission are for internal BMA reference.*

NP 127 – The IT access for a PA allowing them to order ionising radiation under our consultants name, as junior doctors on our team do after any scans post ward round. The access was taken away after a radiologist complained that a PA had ordered the scans, not a doctor.
Resident Doctor, Wessex.

NP 148 – A PA in GP surgery saw a woman with post menopausal bleeding and documented a normal cervical examination. She came to clinic and had a 6cm cervical cancer.
Resident Doctor, Peninsula

NP 433 – PA working on surgical SHO rota and stating they are a surgical SHO. This is impersonating a doctor.
Unspecified, Northern Ireland

NP 450 – I was on placement last year in vascular surgery and while on rounds a person who didn't identify themselves to me wearing plain clothes and coverings over their badge (and who I assumed was a junior doctor) was making clinical decisions and prescribing for patients on rounds, they turned out to be a PA.
Medical Student, Scotland

NP 760 – AA not following guidance/instructions of consultant when performing IJV CVC access – resulted in carotid puncture prior to cardiac surgery with cardiopulmonary bypass. Could have been avoided had the AA followed the instructions of the consultant supervising.
Consultant, Northern

NP 899 – PA asked me to order a CT TAP to look for peritonitis and chest infection and said the consultant said so. When I read through the patients notes the consultant had documented that the abdomen was soft non tender and that he wanted a CT AP. When I formed the PA of this she was adamant that they were looking for peritonitis and a chest infection and then asked me to speak to the nurse. The nurse said they were actually looking for ischaemic bowel and pulmonary oedema as the patient had non proportional pain.
Resident Doctor, Wales

NP 936 – Witnessed directly the PA ordering high dose radiation CT scan via telephone to a radiologist. It was heavily implied on the phone that they were a doctor and could request radiation I.e. radiologist was not aware the PA could not request radiation as their identify was obscured. Also witnessed the PA illegally using pre-signed radiation request forms (forms completed in a separate clinical time/setting with another doctor's signature on it). The PA in question has also been funded by cutting a non-training doctor position. The PA also operates independently in the hospital without direct consultant oversight, against RCP guidance as far as I am aware.
Resident Doctor, Wales

OP 243 – This PA holds the speciality referral bleep for Gastro registrar. We sought advice from another team. The PA went and reviewed our patient independently, made recommendations for management plans independently. We believed that the PA misdiagnosed our patient. We had to call the consultant on call who apologised and took over the care. This is a dangerous practice.

This PA apparently was also on the consultant on call rota.

This PA does his own clinics and being trained to do independent scopes.
Unspecified, West Midlands

NP 167 – XXX has 2 newly hired PAs currently working in A&E on the SHO rota, as well as 4 ACPs and 2 new trainee ACPs.

One PA came up to me on more than one occasion, literally asking "can I have some drugs?" for patients. I was an F2.

I always went to review the patient and re-clerk them myself.

One example was a request for morphine for an elderly patient with severe dementia. I asked what the morphine was for. "Pain" replied the PA. I asked what was causing the pain. "I don't know but she's distressed and only had paracetamol". I asked what the patient came in with. "A fall but the hip x-ray is normal".

I went to see the patient, who was distressed. I did a full A-E and secondary survey, stood the patient and walked them with a HCA assisting, and elicited no pain.

The patient calmed down with some verbal reassurance. She was able to go home.

Another SHO may have prescribed the morphine and caused a delirium that could have led to serious injury and/or unnecessary admission. The patient was on a number of medications including PRN Lorazepam.

The PA had several years of A&E experience and was regarded by consultants as independent/above F2 grade.
Resident Doctor, East of England

NP 199 – Frailty Medicine has a PA working in ostensibly an SpR role – taking referrals from ED with no oversight and mostly with no Consultant input. Several referrals refused which were unsafe, with tests requested which make no sense in view of the referring condition. These patients are often kept under ED, and then referred to the Medical Team once Frailty stop accepting patients (approx 1530)
Resident Doctor, South East

NP 235 – Referrals during on call shifts received from an PA introducing themselves as 'doctor', and appears in nursing documentation as 'Dr ------'. Clearly misleading to patients, colleagues and doctors, and a safety issue.
Resident Doctor, Wessex

NP 252 – AA filling role of ACCP on ITU in the doctors' rota. Works unsupervised and autonomously including night shifts. Able to prescribe (but makes odd prescribing decisions such as 'day team to decide if regular meds required' or omitting insulin) and request ionising radiation despite not appearing on NMC or HCPC registers, just the RCoA AA register.
Resident Doctor, East of England

NP 263 – In ED PA's work on the same rota as the doctors. The PA was working in CYP (Paeds) whilst I was on a Paediatric shift. They independently say a male child with fever and abdominal pain. The nurses had a positive urine dip (Leuk & Nitrites) but the PA was discharging them home. I overheard and asked the nurses to raise the results with the PA, they had. I was concerned and asked them to speak to them again. After seeing my own patient the nurse told me the PA had been rude to them and told them it didn't need treating with antibiotics. They'd sent them home. I needed up raising it with my SpR who had to follow up and give antibiotics themselves to this child, arranging follow up due to age and gender.
Resident Doctor, Severn

NP 268 – Physician Associate in XXX running the oncology ward and acute oncology services. He requests scans using doctor's accounts, vets scan by pretending to be a registrar, he is the rota coordinator as well so he is always on-call. He also misleads others by introducing himself as the registrar. When patients mistaken him as the doctor, he does not attempt to correct the patients.
Resident Doctor, East Midlands

NP 416 – Very unsafe, don't know basic anatomy and physiology, one day Bradycardia patient – started beta blocker and made it more bradycardic- later I noticed and stopped.
Resident Doctor, West Midlands

NP 473 – At XXX Hospital in the Maternity unit, the "Gynaecology PA" is given a weekly elective Caesarean Section list – they are being trained by the consultant to perform CS independently on "straightforward" low-risk patients (i.e. no surgical history, normal BMI, term pregnancy). The college tutor openly states that the aim is for the PA to supervise ST1s in the future to teach them how to perform CS. Women who have their CS by the PA are at no stage informed that their operation is being performed by someone who is not a doctor. The PA in question also cannot answer basic questions on pelvic anatomy (i.e. location of the broad ligament, significance of a broad ligament tear). The PA also has multiple hysteroscopy clinics every week, and prioritised for these lists over any and all O&G trainees (regardless of grade).

NP 494 – A patient had been intubated in "Isolation" (high acuity area not dissimilar to resus) in A&E awaiting transfer to ICU. After being tubed, the patient desaturated. A PA on shift, on the SHO rota, was asked to review the patient as the doctors were otherwise tied up elsewhere, and the PA removed the tube. The PA did not consider how or why the patient was desaturating, did not auscultate the chest or consider suctioning, but decided that removal of the tube (which constituted the patients patent airway) was necessary. No harm befell the patient as one of the consultants noticed what was going on and promptly bag & mask ventilated the patient until another tube was inserted. This could have been catastrophic.
Locally Employed Doctor, North West

NP 536 – I work in a hospital dermatology clinic. I received an advice and guidance letter from a physician associate who assessed a 14 year old child independently with an acute vesicular rash. This was the child's first presentation.

The physician associate independently diagnosed pemphigus (an extremely rare disease) and independently prescribed high dose oral steroids. The physician associate then called the on call dermatology registrar once and when there was no answer sent an advice and guidance request.

This patient clinically had varicella zoster or herpes simplex infection. This is a straightforward diagnosis that most GPs could confidently make. High dose oral steroids was very inappropriate and can cause significant morbidity and even mortality in the context of varicella zoster.

I spoke with the physician associate and he confirmed that he never discussed the patient with a supervising GP.
Resident Doctor, East of England

NP 557 – Independently working, caused a tracheal tear on intubation, failed to recognise seriousness, discharged patient from day-case surgery. Patient re-presented peri-arrest with surgical emphysema requiring ICU and transfer to cardiothoracics.
Resident Doctor, Mersey

NP 778 – PAs at XXX doing VP shunts, including paediatric cases, and introducing themselves to patients and family as "the surgeon". Meanwhile Neurology JCFs have to do ward cover.
Medical Student, South Thames

NP 823 – Booked and confirmed on 2 anaesthetic long day locum shifts on Allocate booking system, then subsequently informed that the shifts had already been given to an anaesthetic associate and couldn't be given back because the AAD was cheaper and the trust need to save money.
Resident Doctor, East of England

NP 874 – Patient was waiting to be taken down to CT by the porters. PAs job was to cannula the patient before the contrast which she failed to do before the time slot that we knew about. PA didn't tell anyone.

Then when porters came to collect the patient, the PA blocked them from doing so and loudly said in the corridor "the patient isn't well enough to go down to CT right now, tell radiology that a DOCTOR says so".

She had intentionally misrepresented herself as a Dr and falsely claimed that the patient was not well enough to be transferred.

The patient missed her CT and we had to reorganise it for the next day.
Resident Doctor, North West

OP 62 – I am concerned that at XXX Hospital there is a PA on the registrar rota. This PA makes references to SHOs now being "beneath me" and passing on all the "rubbish jobs".

Doctors on the SHO rota are supervised by this PA in theatre with no consultant or senior doctor present.

My concern is that if there was a problem the SHO is at risk of being held accountable for acting outside of their competencies with no recognisable supervision.
Resident Doctor, Peninsula

OP 70 – PAs authorised by hospitals to act as doctors, remaining indistinguishable from doctors (other than in the unnecessary harm and suffering they cause), and on each occasion I have been unable to stop them, despite reporting this harmful unconsented travesty.

I normally only realise that a doctor is not a doctor when I see them inexplicably harming patients. I have then questioned them and found out that they were not actually a doctor, even though they had previously been indistinguishable from one – in their location, dress, title, job role, and rota. I have been unable to prevent this ongoing harm, as when I report it to more senior doctors, I have been told that these members of the public are unregulated (not registered) but are working as doctors (they are on the medical rota carrying out the same roles and tasks), therefore we are unable to stop them.

Whenever I realise that one of these doctors is actually a PA, I always ask them what a PA is. Their uniform reply is 'I am the same as a doctor, except I can't prescribe or request ionising radiation yet'. It therefore appears that this is what they are being told during their training and in-post by the hospitals or their supervisors/trainers. On questioning, they are absolutely clear that when they are soon allowed to prescribe and request X-rays, they will be doctors. Medical school is irrelevant, as they have undertaken a shortened medical school. Most appear to be lovely, well-intentioned individuals, but unfortunately this has not diminished the harm that these well-

intentioned members of the public cause when they erroneously believe they are doctors.

For example, at XXX Hospital, I was called to a cardiac arrest; as the cardiac arrest team leader, I noticed one of the doctors repeatedly stabbing the groin of the unconscious patient in a strange way (no-one had asked them to do anything to the patient). I asked them who they were, as they were dressed like a doctor, but acting like someone who had wandered in from the street, and were harming the patient. The doctor smiled, and explained that they were a PA, and this was the first day that PAs were now on the cardiac arrest team.

I asked the PA to stop stabbing the patient's groin, and asked if they were competent to take an arterial blood gas from the patient's wrist. They said they were fully trained to do so, and would be glad to help. I then watched with horror as they started doing strange things to the patient's wrist with a needle. I therefore asked them if they had done the procedure before, and they said they had done so many times.

It appeared to me that they were lying, as there was no other explanation for the strange things they were doing to the patient – they were harming an unconsenting, critically ill patient that desperately needed resuscitation from competent doctors, but were only making the patient worse – it did not appear that they had even seen these procedures done before (even on YouTube or television), and I have no idea why such a person would assault a vulnerable patient in the way that I saw them do.

I stopped them harming that patient, but when I later asked other (real) senior doctors whether anything could be done, I was told that as PAs were not registered, they were able to continue in this way – nothing could be done. I was also told that this was a political issue, as XXX was one of the first and keenest proponents of PAs and their training, therefore we should expect this situation to increase exponentially.
Resident Doctor, South Thames

NP 73 – A PA holding the OPALS bleep which is usually held by a consultant. Offering advice to other specialties who often refer cases involving frail, elderly patients. Decisions which may greatly impact their care. This PA has <5 years experience. Feel free to contact me for further information.
Resident Doctor, South East

NP 74 – A PA carries the cardiology registrar bleep, meaning that both IMTs on Cardiology miss out on learning opportunities to see cardiology referrals from ED/Acute Med but also that a PA sees acute cardiology patients prior to a doctor seeing them.
Resident Doctor, Peninsula

NP 82 – Gastro PA does advice and guidance for GP, has solo endoscopy lists, holds the reg phone for on call gastro advice from other specialities.
Resident Doctor, North West

NP 112 – PA acting as a cardiology registrar – seeing cardio referrals from the ED/ medical take/wards.
Resident Doctor, East of England

NP 350 – As an FY2 and a budding surgeon, I was made to unscrub to allow the Physician's associate to scrub into a robotic TAH BSO, as they are being trained to be a permanent robotic surgery assistant- removing the possibility for doctors to get off the ward and gain experience as well as confidence in theatres.

Worst of all I was then contacted back to theatre to fill in the discharge letter because the physician associate could not prescribe the essential VTE prophylaxis (a slap in the face).

I spent the day then back on the wards doing more discharge letters and sat at the edge of the theatre space like a piece of furniture.
Resident Doctor, Peninsula

NP 380 – I witnessed a Physician Associate deprescribe a medication when asked about it by a nurse. He did not consult with a doctor or pharmacist and did not make an attempt to ask a doctor even though one on his team was just a few metres away.
Medical Student, Wales

NP 586 – The senior decision maker in resus was a PA. She was supervising me (F1) and a trainee ACP. When I went to discuss a patient with the consultant (EPIC), I was advised that I should have run the patient past the PA first.
Resident Doctor, Severn.

NP 630 – PA is conducting ward rounds unsupervised, signing DNARs and covering doctors' rotas, diagnosing undifferentiated patients, prescribing medication.
Consultant, Wales

NP 718 – Bleeped anaesthetic registrar number at my hospital. Bleep being held and answered by a PA.
Resident Doctor, Wales

NP 731 – Urgent radiologically guided biopsy of suspected high grade malignancy in an unwell inpatient was arranged by discussion between a medical consultant and radiology consultant. Mildly abnormal clotting parameters noted at this time; these were discussed and mutually agreed to be safe to proceed by referring consultant and radiologist.

Biopsy cancelled unilaterally by radiology physician associate without discussion with medical team or, seemingly, radiology team. PA in question deemed the clotting parameters to be unsafe. PA in question documented that they discussed this with the "medical team" but no member of the 3 person medical team spoke with this PA.

Patient was able to have their biopsy only after rediscussing with radiology consultant and urgent rearrangement of procedure list for the day. Radiology doctors appeared unaware of cancellation by PA or the clinical justification for this. Overall patient was delayed in having a critical diagnostic procedure, time was wasted and patient lost a degree of trust in medical team due to poor communication.

My concern in this case is that a PA appears to be making medical decisions outwith their scope of practice without oversight of a supervising consultant and with insufficient medical knowledge to justify their actions. Additionally I have concerns about the accuracy of the events and clinical discussions they have documented.
Resident Doctor, Mersey

NP 746 – Phoned referring a patient for a CT scan. Did not introduce themselves as a PA (who are not allowed to request CTs). Were unaware of patient history, indication for scan and contraindications to iodinated contrast (which would have been unsuitable in this patient).
Resident Doctor, Northern

NP 753 – Colleague of mine is on Urology as an SHO. He was telling me there is a PA who has their own lists for cystoscopy and uss guided biopsies. Meanwhile he struggles to get any procedures done or supervised as he is overwhelmed with ward work/referrals. The PA is listed as an Associate Specialist on their rota and the consultants back this. The PA often has to ask around for someone to prescribe prophylactic ABx for her if the pt has a positive urine dip. She is 5 years post-pa school and already has her own list when he doesn't even get a chance to procedures which count towards CST.
Resident Doctor, South East

NP 761 – AAs being trained to perform regional techniques eg popliteal nerve block- not in keeping with RCOA draft scope of practice, therefore potential for risk to patient safety & resulting in reduced opportunities for resident doctors to train these techniques.
Resident Doctor, Scotland

NP 827 – PA is signing off blood gases of critically ill patients and ECGs, under the form which says "doctor name and signature". They are signing with PA next to their name, however I do not believe they are qualified to sign off these tasks. I have raised this with their consultant directly who have promised to look into this further but wish to flag to the BMA also.
Resident Doctor, Wessex

NP 829 – In Paediatrics at XXX. PAs are counted in the staffing numbers for ward doctors. If there is a limited number of doctors, PAs can be left on wards by themselves without senior input to manage patients.

Nurse are not aware that the PAs are different to the resident doctors.
Resident Doctor, East Midlands

NP 844 – In our trust PA's are put onto the SHO rota for xxx.

I previously completed one of my 4 months foundation posts in xxx (in XXX) and throughout my whole rotation I was unaware that a particular PA was not a doctor. I would discuss cases with him assuming he was a registrar because he was dressed in the same colour scrubs and I was told he'd been in the department for many years. He would occasionally ask me "can you just prescribe some paracetamol for patient X and order a chest XR" and I would oblige thinking he was my senior and just needed help because of time/convenience/not being logged in to a computer. I was shocked to find out that he was a PA. If I, as a fellow colleague, was unaware he wasn't a doctor then how are patients expected to know?
Resident Doctor, West Midlands

NP 853 – There was a PA on my respiratory ward. On days that were not consultant led ward rounds (at least twice a week), the doctors would split up patients: fys/imts/gps seeing majority of patients and reg seeing the few acutely unwell. A PA used to be there every day and she would see patients in same way as fys/imts/gps (ie independently, only clinician to review that patient that day, only asking reg if any problems). She would examine patients independently and decide the day management plan. Often she would decide to prescribe for these patients. In this hospital notes and prescriptions were handwritten. She used to write the whole prescription except a signature and expect the doctor to just sign without seeing the patient. I used to refuse out of principle, often she would write antibiotics incorrectly and directly against MicroGuide, and would often mistake heart failure for pneumonia (both obviously common on the resp ward!) it became a very hostile environment if junior doctors refused to sign her prescription, especially as she was a long term fixture on the ward.
Resident Doctor, Thames Valley

NP 870 – PA working as stroke responder, belief resolved symptoms could not be a TIA. Lack of understanding of pathophysiology.
Resident Doctor, Yorkshire

NP 890 – PA ward rounding independently. Their plans included changes to medications. They did not action these nor discuss with a colleague or part of normal day team. They ward rounded in the morning. Then the same PA places tasks on the out of hours doctor list to prescribe as per their ward round plan. No documentation of why they have not discussed it in the day. Nurses also bleep throughout the night to action their plan. This is very inappropriate as it means patients are not properly seen in the day. If they need this prescription (including VTE and antibiotics) there is a delay of many hours, some were ward rounded at 9 am and I was given the task during night shift. It increases work load for night team who are managing very unwell patients and increase work load, the job of ward round should be by a doctor or at least all jobs reviewed by the day team and actioned. This has happened on multiple occasions when I have been on nights and evening ward cover from 2 specialties – largely cardiology and sometimes respiratory. There are resident doctors on these wards but jobs previously taken by trust grade doctors are now being replaced by PA and so there are less doctors on the rota to cover the work load.
Resident Doctor, Peninsula

NP 925 – When working in paeds I would regularly take Gp referrals. There was one PA who would refer 3 to 4 children per day. They would usually have normal obs but the PA would say 'but they don't look right'. They were invariably discharged with no observation but clogged the system and wasted the time of the team. The PA was clearly out of her depth and unsupported and was causing an increased secondary care workload for her shortcomings.
Resident Doctor, Wales

OP 274 – There is a PA who works in the xxx team. On occasion she has been the only xxx clinician on call overnight. She has been named on the online rota for the hospital as "xxx consultant" or "xxx physician". Since the online scrutiny I note she has been removed from said shifts probably to avoid a leak. She is still routinely listed as "middle grade" which is a role commonly occupied by IMT2+ grades. During these shifts she attends ED for thrombolysis calls yet she is unable to prescribe the thrombolysis.
Resident Doctor, Scotland

NP 70 – I am doing a rotation in the stroke unit. I was surprised to see 4 physician associates on our SHO/FY1 rota. Additionally the rota is managed by a PA- all leave requests go through them. This is a very large and busy stroke unit which takes thrombectomy patients from XXX and the XXX. The minimum "juniors" ward staffing on a weekday is 6 (including SHO, F1 and PA's) and there must be a minimum of "2 prescribers". 2 prescribers is not enough for the volume of patients and work. The doctors are frequently leaving late to prescribe and add medications onto discharge summaries because PA's are included in the ward numbers.

The ward is split into two teams- Hyper acute stroke unit- 20 patients who are the most unwell who have a daily consultant led ward round. Acute stroke unit- around 30 "step down patients". Both doctors and PAs are allocated to both sides of the ward. The acute stroke unit side has a consultant ward round once or twice a week, otherwise the expectation is to split the patients amongst ourselves and review independently with consultant support if needed. PAs frequently see patients independently who are not medically fit, some liaise appropriately with the doctors for support with these patients, others do not. I do not feel like it is their fault- they are encouraged from the senior team to act in a role the same as the doctors- but ask to prescribe for them.

If we want to experience "front door" stroke assessments/decision making and be part of the on-call stroke team we have to have enough "juniors" on the ward to be allowed this learning opportunity. Unfortunately this is never the case and I have only been able to join the on-call team once in the 4month rotation. (The on-call team consists of stroke specialist nurses, a SpR and a consultant). The PA's have recently been allocated to night and evening shifts where they are part of this on-call team (instead of a specialist nurse). The doctors out of hours shifts are all ward cover.

I feel like all of the above would be improved and I would have a better learning experience as a GP trainee if we had more doctors which made up the "juniors" rota and the PA's were not included in this!
Resident Doctor, Severn.

NP 89 – PAs are on the medical SHO rota. There is no documented minimum safe staffing ratio of doctors to PAs in place.
Resident Doctor, Yorkshire

NP 93 – PAs are not "officially" counted in minimum staffing. However, in reality, on a ward with a minimum requirement of 4 Jr Drs, no locum/cross cover is sought when there are 3 Jr's and a PA.

From a patient safety perspective, we have consultant/SpR led ward rounds in the morning. And in the afternoon, the SHOs/F1s do the requested prescribing and radiology requests etc and can step in if patients allocated to the PAs deteriorate.

However, this means a significantly increased workload for the 3 Jr Drs. In addition, in areas like CCU, we cannot leave a PA or F1 alone to attend teaching/SPA time, as this is required to be SHO or above.

This means no clinic time, no time in cath lab etc, no attending teaching or SPA time. The response from the IMT programme organisers is that this time is not "protected" so no action is taken. Despite this, the PAs teaching and SPA time remains protected (1 whole day each week), adding to our workload.
Resident Doctor, North West

NP 105 – AA s undertaking sedation door burns dressings with absolutely no monitoring. No direct supervision (consultant in theatre five min walk away is officially responsible for them but run burns theatre lost). They also have anaesthetic reges rotate to spend time with them which I did. Never have I had training that suggests that anaesthesia is ok to be undertaken without monitoring! That have absolutely no idea of the aagbi guidelines etc. totally unsafe and a huge wider safety and training issue.
Resident Doctor, West Midlands

NP 110 – ED. They have reduced the number of SHOs on the rota and put in LOTS of PAs. The locum shifts are open to PA's and ACPs. The PAs get priority for Locum shifts. The PAs are put in Resus. ACPs in Recus. ACCS ST3 often sent to SDEC.
Resident Doctor, South East

NP 111 – 2 PAs on the gastro ward on the doctors rota. Each take the same share of patients as the doctors after the ward round but then come to the foundation doctors to action a lot of their tasks and do their prescribing. They also then give a lot of work to the foundation doctors when they leave to run their clinics and endoscopies. They see patients being referred in from GP. Supervision for their clinics is minimal from the consultants, probably similar to a reg clinic. They do pleural taps and drains on the ward so foundation doctors struggle to get opportunities.
Medical Student, North West

NP 113 – PAs undertaking ward rounds unsupervised.
Resident Doctor, Wales

NP 114 – Previously worked in this vascular department. Heard reports from other FY1s that a PA is encouraged to carry the surgical sho bleep. The PA has been doing multiple shifts like this and has been advising doctors and other hcps who refer to vascular surgery. I have a screenshot of PAs/ ANPs being offered to work on the SHO shift at locum rates if required.
Resident Doctor, North West.

NP 125 – physician's assistants in the ED. Unsafe practice – no clinical acumen when referring and unaware of their limitations. Exponentially increase the workload of specialty teams as a result. PAs also in urology – have their own clinics, flexi lists, theatre time, admin time and have a better timetable than training SpRs.
Resident Doctor, Thames Valley

NP 128 – PA is leading ward rounds for the paediatric neurosurgical team. The SHO is used as a scribe instead.
Resident Doctor, South Thames

NP 137 – PA working on SHO rota and counting toward minimum staffing requirement.
Resident Doctor, Peninsula

NP 139 – I worked with 3 PAs between 2018 and 2020 at XXX and XXX hospitals in the XXX. One was a great asset to the team – completing discharge summaries, bloods and helping junior doctors to get to training. The other two however were different. I heard one repeatedly introducing herself to patients as a doctor. When challenged informally she responded that as PAs complete medical training in only 2 years rather than 5 she was more qualified than the F1s or F2s. The other PA asserted himself within his department in order to practice effectively independently as a middle grade doctor. This was achieved because his department was very understaffed. He would complete lots of procedures, taking opportunities away from training doctors, and also at times acting beyond the competence of a PA.
Resident Doctor, Peninsula.

NP 149 – Physician associate placed in Paeds ED as sole clinician.
Resident Doctor, North West

NP 152 – PA carrying respiratory FY1 bleep. Did volunteer that they were a PA when I asked whether this was the SHO bleep.
Resident Doctor, North Thames

NP 153 – PAs clerking undifferentiated patients in ED on the SHO rota, able to discuss with registrars but the information they gained from their clerking may be insufficient/incomplete and they may not have ascertained an accurate picture of what the patient needs. Depending on the registrar the discussion may be brief and so the patient is essentially relying on the history and examination of the PA without a doctor having seen them. This is dangerous. PAs covering entire areas of ED e.g. the clinical decision making unit, which may initially have a senior doctor doing the ward round, after which they leave to attend other duties (continuing to supervise remotely) but the PA is essentially the only person in that area and needs to be able to complete all the jobs safely (which is not possible as this includes prescribing etc) meaning the supervising doctor is having to cover two doctors worth of duties. This would be entirely avoided if this was an SHO covering that area. (The date I entered is an estimate, this occurred throughout my F2 ED rotation at the start of this year).
Resident Doctor, North Thames

NP 155 – PAs seeing paediatric patients in A&E. I am surprised that they are allowed to do this, given that the ACPs in the department are either Paeds ACPs or Adult ACPs. I am concerned that PAs do not have the relevant training to be seeing paediatric patients in A&E, given that ED trainees have specific training periods to do this safely.
Resident Doctor, Yorkshire

NP 157 – There is a PA in our emergency department who is being put into SHO rota gaps for the brand new Ambulatory Majors Unit (new government initiative to try and cut ED wait times.) He is being paid locum SHO wages, currently £45 per hour.
Resident Doctor, West Midlands

NP 160 – PAs doing solo ward rounds on medical wards specifically Endocrinology XXX with many complex patients and patients having consultant review only once a week. Patients only being seen by PAs for a whole week at a time.
Resident Doctor, South Thames

NP 161 – In the Emergency Department locum shift chat PAs are able to pick SHO shifts.
Resident Doctor, Yorkshire

NP 162 – PA doing independent ward round on inpatient medical (geriatrics) ward. No evidence of supervision by a doctor. Identified blood results abnormalities including hypokalaemia & hypophosphataemia and left a message on electronic bleep system for the on call team to prescribe replacement (not directly verbally handed over, therefore not actioned for 12+ hours). No evidence of attempts to find a doctor to prescribe necessary medications during normal working hours – therefore clearly not adequately supervised.
Resident Doctor, North West

NP 164 – They've started training PAs in the XXX emergency department. The consultants force the juniors to train them – and when I'm taking a history from a patient, the PAs keep trying to overrule me in front of the patient with incorrect knowledge. I've had PA students introduce themselves as medical students and student doctors to myself and patients. When I've let them clerk in a patient, the history I got from them was wildly different to what the patient told me a few minutes later. The consultants have said we have to let them shadow us and train them so I have just made sure I give the worst possible teaching so none of the PAs pick me to work with.
Resident Doctor, West Midlands.

NP 168 – ACCP's at the XXX ITU carry the emergency bleep when no doctor is able to. They have minimal training (a couple of elective theatre lists) with no paed training. The bleep covers the paed trauma and paed cardiac arrest team. It has been raised internally but has fallen on deaf ears. This happens about 3x/week.
Resident Doctor, East of England

NP 169 – Diabetes & Endocrine department at XXX has PAs on the doctors rota, counted in the minimum staffing numbers. Not only that, the rota is set out left-right from least to most senior (ie FY1 to IMT2). They have put the PAs between FY2 and IMT1/GPST. Additionally the PAs have *at least* once weekly scheduled clinics, which the IMTs do not. They also have blocked off time to attend the same teaching as the D&E SpRs, which none of the other doctors on this rota (FY1, FY2, IMT 1/2 and GPST1/2) have.
Resident Doctor, Yorkshire

NP 171 – PA would routinely "act as a registrar" and tell SHOs what to do. Would routinely cover the rota.
Resident Doctor, North West

NP 174 – Dodging discharge summaries piled up in the wards to be done and most of the time doing their own ward rounds.
Resident Doctor, West Midlands

NP 177 – General surgery PA – (upper GI firm) carries out ward rounds alone for acutely ill patients, has carried out shifts on the SHO on call rota in the past and has carried out consultant clinics unsupervised by a consultant**.**
Resident Doctor, West Midlands.

NP 188 – I am a 4th year medical student, but work as an HCA on the weekends at XXX Hospital. They have 2 PA on the ED rota. I have been alarmed to see that they can hold the SEPSIS bleep and the RESUS bleep. In both occasions they have told nurses to get drugs without a Dr present which without the ability to prescribe is a loophole. Additionally, they introduce themselves as a member of the medical team meaning that patients think they have seen a Dr, a few times they have done things that I know is incorrect such as D-dimer on a pregnant lady and no pre-reduction X-ray on a finger dislocation which when pointed out they say 'oh I didn't know'. I find the manner in which PAs are used in the EDs as alarming.
Medical Student, West Midlands

NP 192 – PA was holding orthopaedic SHO bleep. I bleeped ortho as we had a patient with a NOF that had been missed by ED and patient ended up under medics. PA reviewed the patient with the Registrar, but didn't prescribe anything on the NOF pathway**.**
Resident Doctor, North West

NP 193 – I did my neonatology rotation as an Fy2 in XXX . The physician associates were on Sho rota and there was one who was one who was on the reg rota (he was my senior when I did nights) . He was very good at procedures but lacked suitable clinical knowledge.
Resident Doctor, North West

NP 194 – Physician associate scrubbed in general surgery and urology theatres instead of doctors.
Resident Doctor, Thames Valley.

NP 196 – AA running a list independently (including giving medications which is illegal) with a named supervisor who is running their own list in a different theatre.
Resident Doctor, Thames Valley

NP 210 – PA was responsible for half of the ward and didn't alert a doctor when things needed prescribing. They didn't attend handover but instead used the online system to give the out of hours team time sensitive jobs such as warfarin prescribing, fluid prescribing and an NG which should have been escalated to seniors earlier in the day.
Resident Doctor, East of England

NP 211 – PAs are written into the paediatric rota and treated as SHOs, including covering night shifts on occasion with no other SHO and just 1 SpR.
Resident Doctor, East of England

NP 212 – Physician associates are counted in the rota minimum numbers for junior staffing in the respiratory department. This often leads to prescribers being thin on the ground and junior doctors having to move wards at last minute to ensure there's someone there on each ward to do the prescribing work or cover multiple wards.
Resident Doctor, North West

NP 228 – PA acting regularly as an ENT on call registrar, giving medication and management advice for junior doctors. Has happened for a number of years in the trust. Less so now, with heightened focus on PAs and their practice.
Resident Doctor, Peninsula

NP 239 – Seeing undifferentiated patients on same day emergency care without senior input. No in person consultant review of their patients unless requested. Ask other juniors to prescribe in their behalf every day and order ionising radiation.
Resident Doctor, Northern

NP 240 – Surgical consultant came to my busy clinic to ask me to supervise a PA to perform a procedure (I+D) under general anaesthesia. The consultant wanted to go home on their own list while the PA did the I+D.
Resident Doctor, North Thames

NP 244 – PA holding the thrombolysis bleep and listed as 'HASU registrar' on the rota. I have looked through the rota and in the last 10 working days the PA has been the thrombolysis reg for 7 of the days.
Resident Doctor, West Midlands

NP 245 – PAs picking up SHO locums regularly (given preference of shifts over doctors).

AMU assessment area now regularly staffed solely by PAs- post take jobs such as prescribing and imaging requests can't be done by PAs therefore they ask clerking doctors to these tasks for patients they have not seen.

On a particularly busy SDEC weekend an SHO locum was put out to help ease the workload, this locum was picked up by a PA which further increased the work for the doctors on shift.
Resident Doctor, West Midlands

NP 251 – Physician associate working on liver SpR rota at tertiary paediatric hospital, when admitting (sometimes extremely unwell) patients they are unable to prescribe or request imaging. Means ED staff have to double workload and take on risk by doing this for them.
Resident Doctor, West Midlands

NP 254 – PAs work on acute medicine rota and count towards minimum staffing on the 'junior doctors rota'.
Resident Doctor, Yorkshire

NP 262 – ACPs/PAs regularly sit in SDEC and see patients as well OOH with little supervision and take over procedures unfortunately. I'm an SHO who has been trained well to do procedures but detrimental effects on FYs wanting to train in this.
Resident Doctor, Thames Valley

NP 264 – Junior doctors are replaced by PA on Rota, which has caused increased work load on doctors like prescribing medications, ABG. Sometimes below minimum staffing (doctors on the floor). Consultant expects sho and f1 to prescribe medications while working in hospital wards. (unsafe prescribing policy is being pushed onto juniors). In GP the named consultant is responsible for medication prescription for PA.
GP Registrar, South Thames

NP 265 – PA is seeing patients independently in A&E and ambulatory emergency care with acute abdomen and other undifferentiated presentations as a representative of general surgery e.g. appendicitis. PA is independently doing incision and drainage. PA does not identify themselves as a PA on the phone. PA is on the general surgery doctors rota in the SHO section. PA claims to have sat the MRCS part A which would be illegal as they do not have a medical degree. PA is putting prescriptions such as IVF in their "plan" in notes having reviewed patients independently which doctors then prescribe. PA's name is being written as Mr in surgical operation notes and is not being identified as an PA in these notes and therefore is representing themselves as a surgeon. PA is assisting in surgical operations – something that only postgraduate doctors should be doing such as surgical trainees. This is taking training opportunities away from junior doctors and surgical trainees and is unsafe. Patient does not wear clear identification to make patients realise they are not a doctor – they wear the same scrubs as surgeons and patients and staff assume PA is a doctor and surgeon. PA is admitting, referring and accepting general surgery patients. PA is inducting, "supervising" and overseeing doctors, "teaching them", telling them what to do and what to prescribe and document. PA does not assist at all with anything within their area of competency on the wards and this places additional stress and workload on doctors than would be there if they had an actual SHO or Registrar. Another PA is holding the respiratory medicine F1 bleep. **Resident Doctor, North Thames**

NP 266 – PA's working in the emergency department are doing both the work of a doctor as well as having a negative impact on training opportunities.

They are presently seeing undifferentiated patients independently in the department as the first person to see them following triage. Whilst patients are then discussed with doctors they do not appear to always be physically reviewed and on multiple occasions have been asking non-consultant/registrar/senior SAS doctors to prescribe medications on their behalf.

In addition to this they are frequently allocated shifts in resus working alongside the consultant or the registrar whereas this opportunity is not being offered to foundation doctors who instead are being forced to work shifts for 'medically lodged patients in A&E' where their whole shift involves reviewing results, prescribing medications and taking handovers rather than gaining experience seeing undifferentiated patients. **Resident Doctor, Northern**

NP 270 – Physicians associate prescribing on a consultant's e-prescribing login, with the consultants permission. Observed more than once in a ward with a high turnover rate admission to discharge, and the PA asked if they could complete discharge prescriptions, and the consultant said yes. The reported date is when I saw this happen on a separate occasion without overhearing an express permission from the consultant. **Consultant, Yorkshire**

NP 274 – PA diagnosing and treating patients in the resus area. Undifferentiated. **Resident Doctor, North West**

NP 280 – PA rostered into paediatric A+E, displacing a doctor in training. **Resident Doctor, North West**

NP 281 – PA based in Obs and Gynae very frequently (multiple sessions per week) conducting the 2 week wait clinic and 1st assistant in c-section. There are multiple O&G trainees who need clinic and theatre exposure. **Resident Doctor, Yorkshire**

NP 282 – The gastroenterology PA in our trust is on the gastro Reg rota, carrying the gastro Registrar phone. I myself have rang the gastro Reg phone for advice and it has been answered by the PA.

The same PA also carries out independent endoscopy lists at our trust- while some trainees have been told there is no funding for them to be trained in endoscopy.
Resident Doctor, Mersey

NP 285 – Physician associates have recently started in our O+G department. They are assisting in gynae theatres instead of SHOs. We have O+G career trainee SHOs in the unit. There is a well acknowledged major training issue within the (very broad!) specialty of O+G when it comes to gynae surgery: https://www.sciencedirect.com/science/article/abs/pii/S0301211523002968. Therefore this is a massive training issue .

It is also a patient safety issue – I have no idea what/if any training/preparation for surgery these PAs are given. I have also needed to attend to resolve issues with unknown medications post op because the PAs have no idea that a drug history needs to be taken at a pre-op clerking (would be second nature to SHOs) and supervising consultants don't do it, and so there is also an obvious patient safety issue!
Resident Doctor, Thames Valley

NP 290 – I worked with PAs in my previous department and I can tell that they are brilliant in admin work and skills and played an important role at teaching me many things on my first job but the way they are utilised, it makes my workload even worse as I have to do specific jobs for their patients including prescribing and requesting scans. The more senior some of the PAs are, the less clear is the line between them and a physician and the way other staff interact with them as I had the nurse in charge calling me with my first name and calling a senior PA doctor! That PA would not like the idea of me as an on call SHO dividing jobs and leading the team as he said to me once "are you trying to micromanage me?" When I was assigning jobs and started challenging me and asking me what jobs I will be doing! That PA works alone and takes so many breaks compared to the doctors who sometimes can't leave the office for usual breaks. Some of them leave early and others start work late. However, half of the PAs we had were very efficient and helpful and would always introduce themselves as PAs and be cautious and know their limitations and never try to work in an area that they are not confident with and would tell me "I don't know I am a PA" and I would respect that very much. I believe they need better supervision and regulation. The scope of practice has to be clear so the senior PAs don't think they are physicians.
Resident Doctor, West Midlands

NP 291 – Pas doing drs role on ward with limited supervision . Mis informing patients of diagnosis and treatment as they didn't understand them . This is a frequent occurrence in the ward I work in and I often have to re educate patients.
SAS Doctor, Peninsula

NP 293 – PAs working as 'SHO's on the on-call rota for orthopaedics in a major trauma centre. This means the on-call registrar only has a PA to help with the on-call in one of the busiest trauma centres in the country, as the admitting specialty for all major trauma in the region. This is dangerous.
Resident Doctor, South Thames

NP 298 – In the afternoon, I was the only doctor on the ward covering a non medically fit ward as an FY1 with no clear path to escalation or advice.
Resident Doctor, Yorkshire

NP 301 – PA working on the medical ward seeing their own patients doing the exact same role as a doctor except expecting the doctor to do all prescribing and radiation tasks. Often comes to the other juniors just before handover with a list of "prescribing jobs" which they're expected to blindly prescribe.
Resident Doctor, Northern

NP 304 – On induction to the XXXX respiratory team, you're told as a new doctor that their PA is more or less there to supervise you and run the ward, they are doing bronchoscopies and going to clinic – while I was working there my FY/IMT colleagues were routinely left doing ward work and ward round documentation without any educational opportunities beyond bedside teaching by the few consultants/SpRs inclined to do so.

During one incident, said PA instructed me to order a CXR for an acutely unwell patient being assessed by them and a doctor colleague. This was well before any PA guidance issued by BMA so I did it, but i mentioned in the test request that I hadn't seen the patient and I was requesting it because the PA (name stated in request) had informed me that they were desaturating. When they arrived, he became aware that I had mentioned this – and effectively gave me a bollocking for doing so. I felt rubbish after this, and even apologised to him which I wish I hadn't – I wish I stood my ground and educated him further about his scope of practice.

The PA is happy for patients to call him Dr without correction, and does not introduce himself as anything other than a member of the medical/respiratory team.

One time after this rotation, said PA bumped into me in a public part of the hospital and asked how I was doing – when I asked how things were at resp he said "many of our doctors are s**t at the moment, even some of the registrar levels".

I have witnessed this PA make inappropriate comments about patient vulnerabilities, and similar inappropriate comments about colleagues.

He told me in the first week of work "not to trust" an FY colleague purely because they did an ECG for a symptomatic, hypokalemic patient.

He does not contribute efficiently to patient care and is clearly driven by his ego.

As known by other colleagues here, there's a big glitch in the hierarchy and it needs to be corrected for colleague and patient welfare.
Resident Doctor, Yorkshire

NP 305 – On my first rotation in care of the elderly, my ward's allocated minimum staffing was 3 doctors (4 staff if including ward PA). On the second last day of the rotation, there was myself FY1, GPST1 SHO, and ward PA allocated to be on, meaning the rota was approved with less than minimum staffing. The PA on this ward is also the rota coordinator.

Both the SHO and normal ward PA called in unwell in the morning. Instead of putting out locum doctors requests, two PAs from orthogeriatrics and outpatients geriatrics clinic were transferred to my ward. The consultant in charge considered this safe staffing as we now had 3 "juniors" on the ward. One PA rounded one bay with one consultant, and before the other PA turned up I rounded the second bay with the other consultant. When the second PA showed up they joined the third bay's ward round as I was sent to the office to do jobs.

I ended up doing all the prescribing for 23 patients including urgent meds recs for several unwell patients. Both PAs assisted in some of the examining (PRs), taking bloods, and the consultant did some secretarial-type work including referring to specialties and having complex family discussions. The PAs gave me a paper list of prescriptions and imaging requests with patient details for me to work through and left approx 1 hour later than allocated. I couldn't help but feel a bit frustrated as if they were each a doctor, even an F1, I could have had a significantly reduced prescribing and requesting workload.

I did not take any breaks except for one toilet break nor did I attend mandatory F1 teaching that day. I ended up finishing 3 hours late, ie total 12 hours at work.

This is an identifiable event given I was the only junior doctor working on the ward that day.

I am not sure whether this event fits better in "PA working on doctor rota" given less-than-minimum-staffing issues, or "missed educational opportunity" as I was unable to attend teaching.
Resident Doctor, South East

NP 307 – PAs working on AMU regularly 'post-take' patients with a Consultant with no other doctor present, then request junior doctors (FY1s and SHOs) to prescribe medications or fluids that the Consultant may have requested, without the doctor knowing anything about the patient. There have been several instances of PAs asking doctors to prescribe something unsafe, for example prescribing potassium replacement for a patient with hyperkalaemia, and bisoprolol for a patient with fast AF who was hypotensive, because of the PA misunderstanding the Consultant's request. These have thankfully been near-misses because the junior doctor has checked before prescribing, but this is not only unsafe but significantly increases the workload of the junior doctors. It is unfair to ask doctors to prescribe medications for patients they have not seen. I feel that Consultants should not be post-taking patients with PAs alone, or if they do they must do the prescribing tasks themselves.
Resident Doctor, Wessex

NP 308 – PA replacing FY1 doctors on the on call rota

Leaving weekend ward cover split between 1 FY1 and 1 PA, when it should normally be 2 FY1s- this will only add extra work for the other FY1, and they will be expected to prescribe for the PA despite the fact that they are not their supervisor, and this is not the FY1s responsibility.
Resident Doctor, South East

NP 311 – PAs has been put on doctors rota in AMU, juniors are bullied by consultants to prescribe for them while practically replacing doctors.
Resident Doctor, West Midlands

NP 313 – PA doesn't have medical knowledge and they can't treat patients like doctors. I have seen they are even seeing, taking critical decisions for a patient which is unsafe for people.
Resident Doctor, Mersey

NP 323 – PAs carrying the on-call Registrar bleep for a some specialties (HPB/urology and renal) and answering bleeps; not informing the caller of their position (NOT registrar, but PA) and giving advice. Extremely unsafe as caller not aware they are not receiving specialist advice from a registrar level doctor.
Locally Employed Doctor, North Thames

NP 327 – Frequently covering the medical bleep for a clinical research facility in a tertiary care centre.

Although it's a low number area, it is still very risky with all the experimental clinical research going around including infusion of monoclonal antibodies, gene therapy and medications which has not been tested in children before.
Resident Doctor, North West

NP 328 – PA assisting in surgery while SHO is covering the ward. PA share the rota cover for ward with SHO and delegate jobs to the new joined SHO's.
Resident Doctor, West Midlands

NP 330 – Continue to request CT scans. Being used in place of clinical fellows towards minimum staffing.
Locally Employed Doctor, North West

NP 331 – I received this email from the inpatient and community frailty service based at XXX hospital, outlining that SHO-grade locum doctors will be replaced with a physician associate:

"Dear all,

We have recruited a PA who is starting on the 20th May on a part time basis initially, with a plan to eventually go full time. This means we will have to reduce the number of people that we can have as locums.

Going forward we will have:

2 locum shifts available Monday-Wednesday

3 locum shifts available Thursday-Friday (until the PA starts increasing her shifts)

1-2 locum shifts available Saturday and Sunday

The posts will be booked under virtual ward and working on XXX will be dependent on the need to backfill the registrar who might be covering VW.

As a result of this, we will need to cancel some shifts that have been booked from after the May bank Holiday. We will be as fair as possible in cancelling shifts taking into account maintaining continuity and prioritising VW shifts. If there are any shifts you wish to cancel in advance, please let us know; otherwise we will email you separately with the changes by the end of this week.

Thanks,"
Resident Doctor, South East

NP 333 – I was working for the geriatric team and had been asked to go and clerk an elderly patient for the 'frailty flying squad'. Whilst I was in A&E I was approached by a PA who asked me to prescribe all of the medications for the patient she had clerked. This was a patient I had never met before and was not under my care or the geriatric teams care.

I felt lots of pressure to just prescribe the medications going off what she had written down from the PA with her stating all the other doctors just do it. I ended up getting called away to an unwell patient before the conversation went any further, but I think I would have found it difficult to say no given the pressure being put on me to 'just prescribe'.

I think examples such as these are so dangerous as if you haven't clerked the patient yourself you are fully putting your trust in someone else documenting them correctly and ensuring there are no interactions with new medications prescribed etc.

I have also had times where I feel training opportunities have been taken away by physician associates such as on my surgical rotation where they were doing exactly the same jobs as the F1 rather than focusing on jobs that would help support the F1's instead (e.g. discharge summaries, taking bloods etc.)
SAS Doctor, Severn

NP 336 – Dedicated clinic days and dedicated teaching time off. No clinic days assigned even for IMT.
Resident Doctor, North West

NP 339 – In XXX ED there is no distinction between SHO or PA. We work on the same rota and as they are counted towards medical staffing, we can swap shifts with them.

PAs are seeing patients independently and then discussing with the consultant, they are rarely also reviewed by the consultant. They discuss the plan and then ask SHOs to prescribe and order their scans. One day I questioned a prescription and a consultant turned and said 'don't worry, I trust them. Just prescribe as they ask'

On another occasion I asked a colleague if they would take a medical student I'd been working with when I finished my shift. A consultant interjected and stated there were also 2 PA students and a paramedic student who wished to get experience. I asked if we no longer prioritised medical students over other professionals. He replied 'no, we have a contract with the university. That's why all students wear the same colour of scrubs'.
Resident Doctor, South Thames

NP 344 – Physician Associate had gone onto the computer (whilst it was logged in by a Dr who forgot to log out) and prescribed Paracetemol for the child who was complaining of a headache.
Medical Student, North West

NP 345 – Physician associates are assisting in robotic theatre cases, perform independent flexible cystoscopies and transperineal prostate biopsies.
Resident Doctor, East of England

NP 347 – Physician associate was sent by the emergency department to examine a complicated paediatric patient. The patient's mother was causing trouble and is known to be challenging to speak to and satisfy concerns. A PA was the only person to examine this patient and put in a referral in the Paeds ED to a specialist trauma service. They did not state that they were a PA, and mentioned that the patient had been seen a week ago by 'a colleague of his' in the emergency department previously. This was interpreted to mean that he was in fact an Emergency Medicine physician and his colleague had examined the patient last week. The exam findings were completely inaccurate (the mother was very challenging and actively refuted many of our objective findings) and the patient did not warrant a referral. The referral would have been refused based on our objective findings. Due to this 3 hours of SHO and Registrar time was wasted speaking to a very challenging mother on a weekend service in the evening, resulting in delayed review of another patient in ED which an acute pathology requiring prompt intervention to save limb.

The concerns here were:

– PA referring to a specialist inpatient service without physician speaking to or examining the patient

– PA not identifying himself over the phone and arguably misled our service to believing they had been examined by a physician.
Resident Doctor, East of England

NP 349 – All locums taken by PAs on AMU, and PAs taken to assist with LPs and Chest drains instead of juniors (over a course of a year).
Resident Doctor, West Midlands

NP 357 – PAs in ED wear almost identical scrubs to the doctors and no lanyards. They get dedicated resus time and do night shifts. They also do hip blocks for any NOF patients. Meanwhile the F1 doctors only take ED handovers or cover the patients waiting for a bed on the ward.
Resident Doctor, Northern

NP 368 – I felt uncomfortable when they ask me to prescribe on their behalf. Usually parents think they are Doctors.
Resident Doctor, North West

NP 369 – Frequently, PAs would be paid locum rates to cover SHO on call ward cover shifts. They would then have to find a doctor to do pretty much all the jobs, as in call ward cover is mostly prescribing and requesting scans. The poor doctor then ends up doing double their work.
Resident Doctor, West Midlands

NP 370 – PAs in general surgery are going to clinics or scrubbing in while FY doctors and even trainees have to do ward work. Has been happening for month.
Resident Doctor, East Midlands

NP 373 – PAs are included in doctor numbers covering wards during the day. I've had times where due to sickness/poor rota management, it's just been me and one PA covering a whole ward. This put immense pressure on me, having to do most of the work. There was also a week where the hospital was so busy, one ward had an overflow area opened up. This created around 48 beds for that ward. This ward was solely looked after by one newly qualified PA. Even if there had been one doctor, this set up was so unsafe. But made incredibly unsafe by there just being one PA. All PAs at the XXX hospital are treated like doctors. They don't correct people when they're called doctors. They take our training opportunities away by going to clinics, IMT teaching, procedures etc. This leaves the ward with minimum staffing so no one else can go and train.
Resident Doctor, West Midlands

NP 378 – It's unsafe to prescribe medications on their behalf. In AMU it's hard to differentiate PA from doctors, even wear same scrub, performing same duties, but the burden of making decision, prescribing medication is on doctor.
Resident Doctor, Wales

NP 385 – PAs are taking junior doctors role and going beyond there training qualifications. Even in GP practices, they are being replaced by fully qualified GPs and there are no jobs left for new GPs.
GP, North West

NP 388 – '-Icu PA prescribed 1L bolus of normal saline in a hyponatraemic patient to correct Na- Na 108, risk of ODS

- trainee critical care PA (no previous experience or IAC competencies) called to intubate patients instead of the accs-anesthesia trainee-
- critical care PAs asked to perform RSI, instead of a doctor
- advanced critical care PAs work on a whole critical care ward unsupervised during nights
- trainee critical care PA called to perform bronchoscopy to a patient instead of the trainee doctors
- trainee critical care PAs holds the bleep for receiving intra and interhospital referrals
- ED ANPs working unsupervised in the A&E performing ring blocks, fascia iliac block, ed anps discharged open ankle fractures without being seen by an ED doctor or referred to T&O doctor
- ED ANPs referring low risk fracture to the T&O team and missing to refer high risk fractures to T&O especially in kids (working unsupervised and not discussing with an ED doctor), increasing the workload of T&O team
- trainee ANPs performs lumbar puncture, ascitic drain, pleural effusion drain-unsupervised
- medical ANPs asked to cross cover surgical wards during nights and perform the duties of a CT1/CT2 doctor. **Resident Doctor, North West**

NP 393 – PAs have filled in the roles of junior doctors which has resulted in fewer training opportunities for doctors in training. They were supposed to be assisting a team. However, their role has been expanded to completely replace a junior doctor. A lot of times they wouldn't be able to prescribe and order xrays when it's needed the most creating more delays in pt care. Moreover, as they haven't followed a specific medical curriculum its really hard to sometimes communicate medically with them.
Resident Doctor, North West

NP 396 – Multiple US scan were rejected by department as no input regarding clinical detail where I need to go through patient record again, re-request the scan and contact them again to get time/date for patient.
Resident Doctor, Yorkshire

NP 397 – Was asked by PA to prescribe treatment for AF. Was told that PA showed ECG to consultant and confirm AF, ask to prescribe rate control treatment.

Rate control treatment is the group of treatment, not a single medication and we need to check patient current status.

Not sure whether PA aware of this issue or simply think like prescribe paracetamol. No ECG available of system to confirm AF either. I told PA pls get ECG upload on system, does he awares of pt's BP is on lower side?, which one the consultant prefers?, you should discuss with him again then he said oh thats not urgent then left. It is really inappropriate and affect patient safety.
Resident Doctor, Yorkshire

NP 404 – The vascular department has 3 PAs. At least 1 of these regularly runs vascular hot clinics independently. Taking away opportunities from registrars. The department has 5 FY1 doctors who are not scheduled for any clinic time.
Resident Doctor, North West

NP 407 – Elderly care physician associates directly replacing doctors. Physician associates working within acute medicine doing same role as doctor and interchangeable.
Resident Doctor, East of England

NP 409 – During the junior doctor strikes, the gynaecology department got a PA to hold the SHO bleep. The role of holding this bleep includes accepting/triaging referrals and overseeing the gynaecology assessment unit, early pregnancy assessment unit and gynaecology ward. The PA explained to me that during these 'strike shifts', they were going long periods of time unsupervised. Consequently, they admitted to me that they had been prescribing antiemetics and IV fluids on the trust's paper drug charts. They were then asking the nurses to administer these medications. Several hours after administration of the drugs, the 'on call registrar' (acting down consultant/SAS doctor) was signing these prescriptions in retrospect.
Resident Doctor, West Midlands

NP 411– Young patient with severe hypokalemic hyponatremic hypochloremic metabolic alkalosis that needed ICU admission to correct electrolye imbalance. I asked switchboard to bleep the ICU registrar. I was called back and ACP I spoke to did not introduce herself by role (only first name) and I was under the assumption I was speaking to a registrar. When I was discussing patient I realised the lack of this person's concern for the patient (sodium 103, K 1.9, Cl undetectable..), and then I asked what her grade was, and she told me she was ACP. I asked her to hand over the phone to the registrar and she told me they had no ICU reg, so I asked her to put me through to consultant. She told me consultant was busy , so I asked her if the consultant can review the patient. The ACP said "There is nothing to discuss, I already told you this patient is not for ICU admission".

I later bleeped the ICU consultant and asked her to come review patient. Patient was later admitted to ICU after consultant review.
Resident Doctor, North West

NP 421 – This was back when I was IMT2 (Aug 2022-Dec 2022). There are many PAs working in Haem-Onc in XXX Hospital who do independent ward rounds, attend specialty clinics themselves (such as immunotherapy clinics), clerk in and admit patients with acute oncological issues and do procedures such as bone marrow biopsies. I was the local trainee representative at the time and I raised the issue many times however the consultants are very fond of their PAs and prioritise them over the FY and IM trainees. This results in trainees being left to do ward jobs whilst the PAs attend clinic, do procedures and get study time. This rotation has recurrent poor reports on the GMC NTS and was hands down one of the worst places I've ever worked. The PAs are downright dangerous with dubious decisions, and often bully the FYs into prescribing and requesting ionising radiation for them. There is a PA who does the rota for all doctors and doesn't even know the training requirements for each type/grade of trainee. The Haem and Onc SpRs are burnt out, there is constant short staffing and sickness in the department as well and I myself suffered from burnout. When I left, they hired even more PAs. I never felt that I got much out of my Haem/Onc rotation and the irony is that as a Med SpR, there would have been a lot of useful knowledge and experience that I could have gained when dealing with cancer patients.
Resident Doctor, Yorkshire

NP 426 – PA performing chest drains for spontaneous pneumothoraces and pleural effusions unsupervised on inpatients. If complications do occur, has to escalate to the person who should be supervising them (registrar or consultant). This also removes learning opportunities for chest drains away from trainees. Juniors are also not allowed access to the referral email for VATS or pleurodesis, whereas the PA is. Removes opportunity to learn how to make an appropriate and complete referral.
Resident Doctor, East of England

NP 427 – I was an F1 doctor working the ward cover on-call for General Surgery (and covering ENT and Urology inpatients) over the weekend with another F1 on the weekend General Surgery take on-call (their role was to take GP referrals and clerk patients in SAU with the registrar and help ward F1 with jobs). The SHO shift was short for 4 hours in the mornings on both days as the SHO assigned to the weekend shifts had Occupational Health sign off to work a shorter shift. The surgical PA took the SHO bleep for both days as locum during the hours we were short an SHO and was responsible for taking referrals from A&E/other wards and seeing those patients, going to emergency theatre with the reg as needed. They could not properly assess or manage any of the patients referred so doubled the amount of work the take F1 had to do (as he then had to go and assess patients for her and organise investigations and start management) which in turn meant he could not help me with the jobs on the ward round for all two wards of General Surgical patients (there are usually multiple scans to organise, medication changes, referrals and discharges) and with acute patient reviews requested by the nursing team. This then meant that I was also struggling to keep up with tasks and both of us F1s did not get a proper break on either day.
Resident Doctor, Thames Valley

NP 430 – In ED at XXX Hospital and XXX Hospital, there is a PA whom is routinely rostered to work ED shifts. They have never introduced themselves as a PA to me (I have even received referrals from them previously when working within a specialty and they have not introduced themselves as a PA at all over the phone – I was very surprised to learn that they were a PA). They also do not wear any identifiers of being a PA and not a Doctor.
Resident Doctor, West Midlands

NP 436 – PA working on the on call SHO rota for gynaecology. On call team consists just of one senior registrar and one SHO which is often a PA.

Reg often in theatre/required on labour ward for emergencies which leaves the PA manning all the gynae patients on their own. Increases work load for registrar as they have to do all TTAs/prescriptions.

PAs independently clerking gynae referrals as the gynae SHO in ED. Extremely busy take especially on Fridays which often does not allow for adequate supervision of juniors in the best of cases. A lot of independent assessment expected from SHOs with often only phone advice available from the very busy registrars.

From 5-8PM there is occasionally only one registrar covering both labour ward and gynae. This reg is based in the maternity unit in a separate building so they rely on the assessments and opinion of the SHO to determine whether they need to leave the labour ward and review gynae patients. **Resident Doctor, Wessex**

NP 438 – PAs working in AMU as part of the clerking team seeing often very minimally differentiated patients from ED on the medical take.

One interaction where I was asked to prescribe a medication by a PA before crucial test results were received. When I questioned which senior had suggested this medication, the PA told me it was their own plan. I was able to quickly review the case

and decline to prescribe according to my own clinical judgement, but a busier doctor might have just relied on the PAs assessment which could have had catastrophic consequences for the patient and the prescribing doctor.
Resident Doctor, Wessex

NP 439 – Multiple PA and ACPs in XXX ED introducing themselves as "associate physicians", "doctor practitioners" and not correcting patients when assumed to a doctor on numerous occasions. I was there for 3 weeks and would say this happened at least 10 times throughout my placement. Furthermore, 2 recently graduated PAs attempted to take my place with an SHO and reg when I had been there since the morning!
Medical Student, North Thames

NP 444 – Was placed on a ward where I (the F1) was the most senior person on the ward with a PA as the only other form of support for a ward with 25 patients that can sometimes directly come from AMU. I had to call the on call reg for support when I needed to escalate a patient. At the same time I was also asked to prescribe for the PA on recommendation from the consultant on the phone. I politely declined saying that I was unable to due to work pressure but I shouldn't have been put in that position in the first place- the consultant should have done it.
Resident Doctor, Yorkshire

NP 445 – While working as an FY1 in surgery, if there were gaps on the SHO rota, the PA in that department would fill in these gaps. This meant that I would be expected to escalate sick patients to someone with no medical degree who has never worked out of hours.
Resident Doctor, Northern Ireland

NP 456 – XXX has an ENT PA who sees patients independently in casualty clinic, follow up clinic and nasal fracture clinic.

Whilst knowledgeable and helpful, this means training opportunities to attend/run these clinics and learn and practice relevant skills e.g. microscope use and micro suction, nasal cautery, audiogram interpretation, FNE, nasal fracture manipulation are taken away from trainees. Meanwhile doctors are left responsible for ward jobs and admin. When we challenged this we were told that if ward tasks are complete we are allowed to observe these clinics rather than learn to see patients independently/use our clinical judgement to make diagnoses and treatment plans.

Additionally junior doctors are regularly asked to prescribe for the PA and ANP without having seen the patients. This feels uncomfortable and risks our GMC registration (as suggested by the recent MPTS ruling which struck off a doctor for not adequately supervising a PA – adequate supervision defined as taking an independent history and examination rather than going by the assessment of the PA). **Resident Doctor, Wales**

NP 457 – The PAs that I currently work with are on the SHO rota meaning that they work twilight/night shifts which only have reg level supervision after 10pm. Whereas F1s in the same department cannot work nights/twilights due to lack of senior supervison. I wondered if this should be a concern.
Resident Doctor, Severn

NP 458 – PA working on doctors rota in my department, covering evening and weekend shifts on SHO rota. Presence of PAs on team increases my workload due to need to do all prescribing on ward, means I am working without breaks to try and get all work completed safely. Compromises patient care, adds to my workload, this is work that should be done by a junior doctor.
Resident Doctor, North Thames

NP 468 – PA making inappropriate management plans for patients without discussing with seniors and getting shos to prescribe drugs the patient did not need . Also not able to read an ecg and made inappropriate plans with a an on call reg with misinformation.
Resident Doctor, Peninsula

At XXX Hospital, there is a "Gynaecology PA" who works solely with the Gynaecology team (there is no doctor-led Maternity services in this hospital). His job involves assisting on all theatre (mainly laparoscopic work) sessions. He is actively being trained in performing basic laparoscopic procedures (diagnostic laparoscopy, salpingectomy, cystectomy etc) with the aim that he will perform these procedures independently. At a recent laparoscopy skills course at XXX, the consultants openly laughed and joked about how "the PA is beating all of the Doctors on the laparoscopic skills assessment" that was part of the course. Preference is given to him over O&G trainees in assisting in theatre as the Consultants feel he is better trained and experienced in laparoscopic surgery than O&G trainees (direct quote from consultant).
Resident Doctor, North West

NP 483 – PA oncall for stroke, seeing stroke patients in ED, thrombolysis calls, providing advice to other clinicians. PA in general surgery taking referrals from community.
Locally Employed Doctor, Scotland

NP 487 – PA has a weekly surgical list, whereas I do not have enough surgical exposure to gain competency. PA is seeing their own patients in clinic unsupervised and asking GP to prescribe on their behalf.
SAS Doctor, Yorkshire

NP 491 – PAs holding the referral bleep for GP referrals, PAs "clerking" patients then instructing FYs to prescribe/ order scans. PAs declining to scribe on the ward round so they can "make the doctors job list".
Resident Doctor, Scotland

NP 498 – '-> PA-R independently going ward rounds on the HCOP and Orthopaedic wards. Making clinical decisions about day to day care independently.

– I was asked to provide some subspecialist advice for a patient over the phone. The referral was of very poor quality. Subsequently when I assessed the patient, factual information was incorrect.
Resident Doctor, East Midlands

NP 499 – New PA hired, seeing patients as equivalent of a doctor. Few Rx near misses. Senior docs are not around to double check the patient and do the medications/ reviews leading to extra work and thus unable to fulfil training portfolio requirements.

Unable to do clinics, why cant they just hire a F3 +

This programme needs to be pulled from training.
Resident Doctor, Wales

NP 500 – Physician Associate on the doctor SHO rota in Paediatrics at XXX. PA was holding the neonatal emergency bleep.

No clear guidance from the Trust about who F1s should escalate to if their senior (SHO) role is filled by a PA.

This was escalated to the Local Faculty Group (LFG) meeting for investigation. I became aware of this through attending the LFG. **Resident Doctor, South East**

NP 505 – PA working on doctor rota and providing weekend handover – due to inability to prescribe plans from day team not executed and ABx not prescribed in timely manner. Handover unsafe as patient complex.
Resident Doctor, South Thames

NP 508 – PAs are treated as SHO level (Inc in there BANK pay).

They have a set shift on the medical take clerking patients referred from ED to medicine., despite not being able to prescribe or order ionising Ix. This means that they have to ask a doctor to do this without seeing the patient.

Furthermore, I have seen them working shifts exclusively for doctors. For example, in surgery (Ortho and Urology) there has been instances where a Physician Associate is holding the '863' bleep this is ward cover SHO level bleep for weekends. This used to be carried exclusively by doctors, but is now occasionally covered by PAs. This is unacceptable as they cannot prescribe or order X rays... or complete TTOs. So this work is directed to someone else to complete.

I dont want to include the date, but it is happening frequently on weekends for the last 6 months. **Resident Doctor, South Thames**

NP 523 – PAs work on SDEC virtual clinic shifts going through investigations, interpreting them and choosing whether or not patient's need further action on the basis of abnormal/normal results. This shift was previously staffed only by doctors of SHO grade however now is frequently being staffed by PAs. It is up to the PAs whether they wish to highlight any concerns the the SDEC registrar or consultant and their work is largely unsupervised.
Resident Doctor, West Midlands

NP 524 – There is a physician associate who works in the respiratory ward a couple of days a week and often instead of helping doctors with ward work/ ward round, who goes to clinic (allowed by consultant team) leaving junior doctors to do ward work and not go to clinic. This includes pleural clinic etc. which would be a very good opportunity for doctors to learn and develop but the PA is taking away that opportunity and also not helping with ward work – avoiding ward work where he can.

There are PA students on wards who are taking away opportunities like practical procedures and the opportunity of receiving teaching from doctors as they are in direct competition with medical students. Affects their opportunities. Includes on AMU and medical wards.
Resident Doctor, West Midlands

NP 527 – PAs are used in the orthopaedic department interchangeably with SHOs. They work on the wards with no supervision, they also work as the junior on call during the day and overnight. They have indirect supervison from a resident SpR out of hours and a responsible for the ongoing care of all orthopaedic and major trauma inpatients(100+).

The SpR is responsible for all major trauma at a busy MTC so is often unable to review patients themselves.

PAs also have unsupervised clinics where they see post op patients and acute trauma.
Resident Doctor, South Thames

NP 535 – Physician associates routinely on the medical take on XXX hospital.
Resident Doctor, Thames Valley

NP 538 – I was replaced by a physician associate management deemed the pa to be fy1 equivalent for a bank post that I was placed for long term on an acute ward.
Locally Employed Doctor, Mersey

NP 539 – PAs doing their own ward rounds by themselves. Teaching medical students and doing all sort of procedures without supervision.
Resident Doctor, Yorkshire

NP 542 – Used to count towards minimum number of staffing. They have no supervision/supervision.
Locally Employed Doctor, North Thames

NP 553 – PA seeing and diagnosis undifferentiated patients in A&E.
Locally Employed Doctor, Mersey

NP 555 – PA's being included on the SIM (geriatrics / medicine) rota. I think it is unsafe that PA's are included in the numbers , as they are not a replacement for doctors. Also, as PA's are not doctors they should not be on the same rota as this implies some degree of equivalence. The rota / staffing grid in question is released weekly and PA's are routinely included. Please note the staffing arrangements for XXX on medicine are generally good , and the rota coordinator is fair, but I do not agree with the inclusion of PA's.
Resident Doctor, Yorkshire

NP 560 – I became aware that a PA had broken the news to a patient that they had metastatic cancer.
Resident Doctor, Yorkshire

NP 568 – AAs are performing regional anaesthesia without direct doctor supervision. There is a regional anaesthesia plastics hand list run by an AA and AAs are performing Biers blocks in ED without direct supervision by an anaesthetist.
Resident Doctor, Peninsula

NP 570 – PAs running the SDEC in absence of a consultant. PA comes and asks consultant for advice and prescribes using their log in for electronic prescribing system. Yet IMTs using SDT to get clinic time.
Unspecified, East Midlands

NP 581 – PAs are being used as equivalent to an SHO on the wards. The rota technically has them in a separate column to the doctors, but this has no practical impact on their role. PAs do independent ward rounds and often patients will do days at a time seeing only a PA and no doctor. There is an expectation that the junior doctors will supervise the PAs and prescribe/request scans for them; there is often no named consultant supervisor on site as the consultants cover several hospitals.
Resident Doctor, Yorkshire

NP 584 – I am a final year medical student at XXX and there was teaching from a PA on more than one session on an ED block. A PA was called 'Dr' and later on we searched his name as the teaching was so awfully terrible. We found him on LinkedIn and he is not a doctor and does not have a PhD. The university seem to think that this was a 'genuine mistake' (that was made more than once!) and that one of the ED consultant, Dr xxxx deemed him 'competent' and 'very good in his field' to give final year medical students a chest pain workshop. Shouldn't she be asking other junior doctors if they need teaching first as we will all be seniors one day and need teaching skills and portfolio feedback? This is hugely blurring the lines and should not be normalised.

What is extremely ironic is that on the XXX hospital website it literally says calling yourself a doctor when you are not is illegal in the medical act and needs to be

reported. When we raise it though we are called elitist and apparently we are professional discriminator.

A PA is an assistant, they should NOT be teaching final years.
Medical Student, South Thames

NP 588 – Asked to step up from SHO rota to reg rota to fill up rota gap for a shift in paediatric ED. SHO rota gap allegedly put out for locum shift- rota gap filled by PA. This is unsafe as PAs cannot prescribe or see undifferentiated patients in Emergency Department.
Resident Doctor, Thames Valley

NP 594 – PAs doing ward round in replace of Junior doctors. Patient deteriorates throughout day, nurse asks PA to review as they were their patient on the WR. Patient newsing a 9. PA fails to say this is out of her depth (which it is) and fails to redirect information to a doctor.

Three problems

1) PA asked to review a patient with a NEWS of 9. Even if the PA does review patient, this will need to be repeated by a doctor, taking away time from said doctors already busy job list.

2) PA fails to say this it out of their remit. Patient safety risk.

3) PAs are being used on doctors rotas during ward rounds.
Resident Doctor, East Midlands

NP 597 – As part of a department with Doctors and ANPs, we have a patient under our care with complex urological issues. We therefore have needed to consult urology multiple times for urgent issues for this patient. Multiple times, we have been made aware only later that a PA is covering the registrar bleep (when the PA unexpectedly contacts us back to relay advice given by their SpR). They do not identify themselves on the phone as a PA, and their information gathering and advice (as a "specialist" PA) appears to be insufficient for the complexity of our patient. I do not remember the exact date this occurred.
Resident Doctor, Thames Valley

NP 600 – AA performed anaesthesia for bariatric patient undergoing Roux-en-Y Gastric Bypass surgery with remote supervision (I was rota'd to be directly supervised by the same Consultant supervising the AA, however was left with indirect supervision (case mix of my list was appropriate for me to manage with this level of supervision) to allow the Cons to supervise the AA). I feel this case was inappropriate for an AA given the complexity of a bypass patient (need for orogastric tube to be moved potentially affecting the airway, multimodal analgesia and antiemetics).
Resident Doctor, Northern

NP 602 – Again, a PA being asked to review unwell patients by nursing staff. PAs failing to mention that they should not be seeing patients independently and again, failing to recognise their limitations.
Resident Doctor, East Midlands

NP 603 – Attended trauma call at 5am – physician associate for T&O first point of call for trauma call and primary survey. No other T&O doctors present for local supervision. Given time of day, highly likely to be taking doctor rotation locum. At best distant supervision arrangements.
Resident Doctor, South Thames

NP 606 – There is a physician associate regularly holding the paediatric urology SHO and registrar bleep, taking both internal and external referrals and calls for advice.

They do not identify themselves as a PA on speaking to them, indeed I had several conversations with them where they clearly did not know what they were talking about and they were working outside their competence, and not once did they say they were a PA.

I was informed of this by other staff. They are clearly not competent to be taking this role.

I have worked at XXX and in other hospitals within the region, and staff in other hospitals were also under the impression that he was a surgical SHO or registrar and felt he was not competent to be taking calls for advice and referrals.
Resident Doctor, Mersey

NP 610 – Reduced training opportunities and patient safety risk due to student AA performing unsupervised spinal anaesthesia.
Resident Doctor, North West

NP 611 – Physicians associate is down on Rota as c section assistant during strikes.
Resident Doctor, Yorkshire

NP 613 – Physicians associate down on c section list. Assisting with c section list.

Consent form does not mention use of PA during caesarean section.
Resident Doctor, Yorkshire

NP 615 – Anaesthesia associate running gynae list. He was only anaesthetic representative present during the brief. He is the only anaesthetic representative on the operating note. Consultant anaesthetist was present for 5 minutes of the operating list when associate was not present. Anaesthetic associate was not directly supervised at any point during operation. In addition, anaesthetic associate was giving medications during gynae operation, no one directly supervising him.
Resident Doctor, Yorkshire

NP 617 – At least one PA I know has been given the ability to prescribe on our EPMR and do TTOs. I was aware of this when called by pharmacy to correct a wrongly done TTO to only recognise the name as a PA.
Resident Doctor, East of England

NO 624 – PAs are planned to work on the Drs rota during the strikes. Overheard consultant telling PA that he'd heard she was picking up shifts and was thankful!
Resident Doctor, East Midlands

NP 626 – MAPS work on same rota and have done for 5 years covering Acute Medicine and Care of the Elderly.
Resident Doctor, North West

NP 632 – PA was asked to cover night shift on doctors rota during strike for escalated rate.
Resident Doctor, South Thames

NP 634 – PAs are covering the gen surg oncall rota, and rejecting surgical referrals from A&E. this is delaying patient care as we have to keep escalating to their reg or consultant.
Resident Doctor, West Midlands

NP 636 – In T&O at XXX, PAs conduct ward rounds and are sometimes the only "clinician" to see a patient. They then don't always hand over the jobs or advice received during the day e.g. in AKI or hypernatraemic but patients not prescribed any fluids and only spotted to need them by nursing colleagues overnight or automatically generated lab flags for abnormal results. Specific example where the date is given is a hypernatraemic patient with a clear plan from endocrine for fluids scaled to output and no fluid prescribed. Also plan from endo included fluid overload assessment every 12 hours due to HF and none documented. Only reviewed due to automated flag for high sodium. Reviewed at 10pm and at that point would technically have needed 2L further by midnight which would not have been safe.
Resident Doctor, East Midlands

NP 638 – ED PA prescribing medications for patient on paper chart, then prescription being signed off by multiple different ED doctors. Medications then given at completely inappropriate times- e.g. anti-hypertensives given at midnight - unnecessarily, no analgesia prescribed for the same patient who presented with 9/10 pain.
Resident Doctor, Wessex

NP 640 – PAs carrying out the following activities but considered unsafe by BMA guidance:

Assess, diagnose, or manage undifferentiated patients (this includes areas such as ED, the acute medical take, and general practice)

– Make independent decisions regarding initial management or ongoing care of patients

– Be consulted for, or provide, specialty specific advice unless documenting on behalf of a consultant/senior registrar in that specialty (it must be clearly stated/ documented as such)

– Triage or vet referrals received to the specialty/department/practice in which they are employed

– Direct/instruct a doctor or other professional to prescribe a medication or to alter an existing prescription

– Direct/instruct a doctor or other professional to request an investigation or procedure

– Be involved in giving specialty advice (unless repeating a consultant/senior registrar's advice and making it clear who the advice has come from)

– Make any independent treatment decisions

– Attend, prepare, or give any teaching or seminars to doctors as part of their specialty or foundation teaching. PAs or AAs are not eligible to attend doctor teaching of any specialty unless offered to the wider MDT

– Review or clerk new acute patients in the ED, Surgical triage units, surgical admissions units etc.

– Hold referral bleeps, be involved in vetting referrals, or be acting in a way where they need to give specialist advise
Resident Doctor, Scotland

NP 643 – The strike cover for the gastroenterology ward this weekend will be PAs and a consultant. The PAs will be doing the role of a resident doctor. PAs in this department do not usually work weekends or out of hours.
Resident Doctor, North West

NP 644 – I took a phone call referral to the neurology SpR on call. It was from a person who introduced themselves as <Name> from GP practice. I asked them if they were a GP. They said they were a physician associate. They described a referral that I felt was clinically inappropriate. I asked them if they had discussed it with a supervising clinician. They said they were supervised by an ACP that day.
Resident Doctor, East of England

NP 646 – Pyrexial patient within a few days of chemotherapy. Stable. I started ABx, saw patient and ordered Ix. Bleeped oncology reg – spoke with someone who identified themselves as a PA towards the end of the conversation when they asked me to order a CXR. They stated there was no SpR on today.
Resident Doctor, South Thames

NP 651 – I was working to cover a haematology/oncology night shift on a Saturday night and turned up to see that a physician associate who normally only works in the haematology department had been covering the long day on call shift instead of a junior doctor. They had not been given any training in how to use the on call phone and were not able to prescribe or order investigations so patients had gone throughout the day without adequate pain relief, for example, for this reason.
Resident Doctor, East Midlands

NP 655 – Physician associates working in acute medicine in place of doctors. Doing duties of doctors. Serious patient safety issues as they are counted in the safe staffing number.
Resident Doctor, East of England

NP 659 – MAP training to be an endoscopist leaving the ward to F1/2 to do the ward work. Two MAP part of the formal MDT for gastro
Resident Doctor, North West

NP 660 – Strike days in May xxxxx had x2 PAs on the F1 rota and had them both listed as Dr X.
Resident Doctor, Northern Ireland

NP 665 – Medical rotas include the gastro, respiratory and stroke PAs in the minimum numbers for ward cover doctors. Recently I was the only doctor covering a specialty with a PA working with me instead of a doctor. I essentially had to take over all the tasks they couldn't do such as radiology requests and prescriptions. If you get in touch with the BMA reps of XXX Hospital, they'll be able to provide you with the rota file as evidence.
Resident Doctor, West Midlands

NP 666 – Med student on placement – was timetabled to be with T&O on call – the on call was a PA carrying the bleep.
Medical Student, South Thames.

NP 667 – Normal urology staffing is 1 consultant, 1 reg, 1 Fy1 during a normal weekend.

During the strike weekend: the department put out locums for the PAs to help cover the f1 shifts despite them never working the weekend anyway.
Resident Doctor, North Thames.

NP 669 – Regularly on the obs & gynae department, the PA would cover the gynae SHO shifts and be paid at SHO locum rates for these. Often times being the sole gynae SHO level in the department.

This is a routine occurrence in the department.
Resident Doctor, South East

NP 670 – At XXX, the AMU clinics are run by PAs + the Registrar. Whilst the PAs work is greatly appreciated, it's very disheartening that the AMU department doesn't allow junior doctors to do clinics with the Registrar and only rotates the PAs for clinics. While the junior doctors working in the AMU department have to search for clinics in other departments. It seems very unfair, and it hinders us trainees from gaining experience in outpatient clinics and meeting our clinic numbers for the e–portfolio.
Resident Doctor, West Midlands

NP 677 – Physician Associate covering the neonatal resus bleep overnight. I noted this whilst holding the obstetric anaesthetic bleep (I am a core anaesthetic trainee). They attended all deliveries where neonatal resus team attendance was required in delivery suite and maternity theatre. I did not observe them providing neonatal resus outside of simple newborn checks on that shift. I have noted them in the past and didn't realise they were a PA until I saw their badge last night. They introduce themselves as "a member of the neonatal team" or "I'm from the neonatal team".
Resident Doctor, Wales

NP 679 – We are short staffed on my ward. Supernumerary doctor gets placed with a PA for 1 bay and 3 side rooms for ward round. I get placed on 3 bays and 3 side rooms (18 patients) on my own for WR. If the PA was a doctor, then the supernumerary doctor could have done the WR with me and the other doctor done the bay and 3 side rooms by themselves (8 patients).
Resident Doctor, East Midlands

NP 680 – PAs take consultant log ins for the electronic prescribing system and just use that to prescribe all day.
Resident Doctor, East Midlands

NP 681 – PAs not supposed to work on the ward when consultants leave. As in, PA can only work under supervising consultant. But now PAs are working weekend shifts and bank holidays at XXX Hospital after 2pm when their named consultant or any other consultant has left the building. PA told me this was an agreement that was had on a teams meeting between consultants. They are knowingly using PAs (who have absolutely nil medical knowledge) in the place of doctors. It is unsafe and something needs to be done about the PA situation at chesterfield royal hospital. They run their own clinics on SDEC all day while the juniors run around like blue arsed flies writing discharge letters. Sickening what is happening.
Resident Doctor, East Midlands

NP 682 – PA hired to support the acute ward team with ward work however often conducts clinics independently (very limited supervision) while junior doctors in training are performing clerical work on the wards which deprives trainees of clinical opportunities. Does not often introduce themself as a PA. Makes prescribing decisions and requests junior doctors in training to prescribe on their behalf if senior is unavailable. Due to limitations in PA training, does not understand some key physiological principles required for clinical judgement and safe decision making – not safe for patients. Does not recognise their scope of practice or their limitations. Does not value advice of senior experienced nursing colleagues when they raise their concerns. Senior colleagues are not aware of these issues and feel the PA is an asset to the team. However, junior colleagues feel they are of no use to the juniors. Juniors do not know how to raise these issues as PA is well liked by the seniors.
Resident Doctor, Wales

NP 685 – PAs are conducting ward rounds for inpatients (multiple specialties including general paediatric patients) without a senior. Patients can go a number of days without seeing a doctor.
Resident Doctor, West Midlands

NP 688 – PA on doctors ward round. SHO due to be with PA calls in sick. So another SHO is pulled to be with PA (as they are unable to do anything a doctor can because they have not been to medical school and are being used inappropriately) leaving the remaining SHO to cover double the work load on their own whilst a PA gets 8 patient with an SHO. Currently SHO who has been shafted will be staying an hour late and working through lunch whilst PA goes to regular Tuesday teaching. Another day on EMU.
Resident Doctor, East Midlands

NP 697 – During A&E induction the clinical lead consultant for A&E made clear there was expectations for doctors to prescribe, order ionising radiation and re review patients to make discharge decisions. This includes on night shifts when there are 2 PAs working and no consultant on site. His reasoning was that PAs are an important part of the workforce with extensive knowledge and we had an expectation to "be kind". There was no reassurance of any protection if we were to prescribe/order based on PA request inappropriately. The way this was "asked" of us was in a way where it felt it could not be challenged.
Resident Doctor, North West

NP 700 – PAs at XXX have long taken the role of doctors and acted above their remit. They see undifferentiated patients constantly on the acute medical take and in the ED, and are often given resus shifts and first refusal at procedures.

One ED PA once complained to me that they thought it unfair that the SHOs were paid more than them on locum shifts when they were also locuming (although now the PA locum rate is not available to be compared to other roles) because they claimed they could do "much more" than the doctors. This same PA was also seconded to anaesthetics for a couple of weeks to learn airway skills. PAs have been passed on ALS courses despite not achieving the minimum safe points following pressure from one of their consultants, with the logic being, "they would never run a cardiac arrest," so they should be allowed to pass, despite that being the very nature of the course.

My main concern however is that on the acute medical team, a PA who became the go–to go LPs, ahead of training doctors, now runs an LP clinic, where they do four or five of these a day and will teach doctors how to do them. **Resident Doctor, Severn**

NP 702 – Vascular surgery PAs regularly covering SHO shifts.
Resident Doctor, North West

NP 703 – At our induction for medicine in XXX there was mention of a physician associate working in MAU. We were told that she does her own ward rounds, and is "excellent".

They mentioned that she is not allowed to prescribe, but the consultant then told us that when she asks us to prescribe or request imaging "your job is just to do it". One of my colleagues asked if she has a defined scope of practice and was told "no, she can do anything".

They also said that we won't need to do any lumbar punctures because she does them all.

Meanwhile as an IMT2 I am not allowed to discharge anyone on the take without discussing them with a registrar.

I think there is a role for PAs when their scope is defined – I have worked with one in a better setup before and they worked well. However this attitude, and the fact these things were mentioned in an induction concerns me.

In the same induction we were told that calling in sick for an on-call shift is difficult for them due to the size of the hospital, so we are expected to sort out cover ourselves. Then told "so just don't call in sick" in a "jokey" manner. **Resident Doctor, Scotland**

NP 709 – General medical PA xxxxx highlighted to me (cardiology SHO) that he was feeling unsupported in his general medical team under locum consultant xxxxxxx. He felt that his role in the team was becoming unsafe and was worried about the patients. Note as PA he is aware of his limitations and will ask for help. However, he has been repeatedly been put in the position as the only member of the team to review medical patients that day with no supervising doctor. He may present to his consultant later in the day but it is his plans that are mostly followed. He has been a PA for maybe 2 years now and feels that this is not appropriate for multiple reasons.

Multiple instances of the 'middle grade' on the team Dr xxxxxx), who has since been downgraded to the SHO rota but still considered the most senior junior doctor on Dr xxxx's team, sending ABGs or other results to the PA via Whatsapp asking for advice on management or escalating down to the PA for unwell patients. I understand he and others are working with Dr xxxxx regarding further medical education, including CBD/ sims but has been signed off by the medical consultants as safe to work at reg level.

The PA has raised multiple verbal concerns to Dr xxxxxx), xxxxx and Dr xxxx. While complaints acknowledged ("at least he is not as bad as xxxxxx) there was no action. In fact, most XXX trainees put off from raising concerns regarding IMG (most of who are very good mind) as one F1 was told by Dr xxxx she was being racist in doing so (I am unaware of exact wording of complaint but understand it was genuine from people who spoke to F1 directly). xxxxx the PA, is hesitant in putting any complaint in writing despite my encouragement, and is hoping changeover would result in safer doctors joining his team.

Ultimately, there is an unsafe environment here and no action has been taken to remedy this, and there is a concern for patient safety. I am unsure who to raise this with within the XXX, as it appears the immediate managers are aware but have done nothing and there is instability above them with no clinical or medical director of xxxxxx in post. **Resident Doctor, Northern Ireland**

NP 713 – No difference between the duties of a doctor and PAs. Rotating doctors told at induction that they would be expected to order imaging and prescribe for PAs with new GMC guidance around "being kind" quoted. PAs running paeds ED OOH and discussing patients with SpR. These patients are not physically reviewed by a doctor unless requested by the PA.
Consultant, Mersey

NP 719 – PA as sole clinician in paeds.
Resident Doctor, North West

NP 724 – PAs work in ED seeing undifferentiated patients. Not all patients are discussed. Also work nights when no direct consultant supervision available so SpR's have to supervise (even if they don't want to) so rotational training grade reg's are left to shoulder the responsibility. Allowed training opportunities at expense of junior doctors including rotational F2s.

Same department also has training ACPs (several years away from RCEM credentialing) on their 'middle grade' (reg) rota so acting alongside ST4+ reg's & given equal training opportunities to the reg's. They wear the same colour scrubs so are indistinguishable to juniors/nurses & give advice to junior doctors.
Resident Doctor, Northern

NP 735 – PA logged into registrars account and prescribing/signing TTOs/ordering scans etc.
Resident Doctor, East of England

NP 736 – Triage undifferentiated in a and e.
Locally Employed Doctor, Wales

NP 740 – There is a physician associate in plastic surgery who does on calls. He pretends to be a 'registrar' and reviews patients with an SHO who he asks to document for him and prescribe meds for him. It is not clear to A&E doctors that that the patients they refer are not seen by a senior doctor in plastic surgery.
Resident Doctor, North West

NP 742 – Anaesthesia associates at XXX do pre-op assessments on NOF patients on ward.
Resident Doctor, Northern

NP 743 – PAs in xxx do nights and weekends. They all get allocated resus time as the 'junior doctor'. They also see patients in minors.
Resident Doctor, Northern

NP 745 – Paediatric PA working in PAA seeing and diagnosing undifferentiated patients.
Resident Doctor, Northern

NP 752 – PAs working on SHO rota for ward cover, consultants not directly supervising, expecting the registrar and SHOs to supervise.
Resident Doctor, North Thames

NP 755 – Patient referred via the medical oncology team at xxx to my hospital. Referral letter and various other patient letters from referring person signed as "associate physician" and written with Dr title. Said person does not exist on GMC register and other letters for the patient written by other physician associates.

This shows that PAs are being used to replace doctors frequently within this service.
Consultant, North West

NP 759 – PA consenting patients for ERCP, OGDS and Laparoscopic Cholecystectomies etc. It's a bit odd as an F1 can't consent but PAs can. Despite some a F1s have actually seen and understand anatomy and the procedure.
Resident Doctor, Wales

NP 763 – Frailty take is run using PA resource doing exactly the same work as the frailty junior doctors, sometimes prescribing / ordering using the consultant's card or if this is not possible dumping their jobs for admitted patients onto the take F1 at 4pm when they go home (they work 8:30–4 – the take F1 has their own patients and is doing 8–8)
Resident Doctor, South East

NP 765 – I am on the locum bank for emergence medicine at this hospital. The hospital has a published rota with an SHO tier of doctor. This hospital xxx is using Physician Associates to fill SHO doctor gaps on the medical rota.
Resident Doctor, West Midlands

NP 768 – PA is making Registrar rota, and refusing study leave to Registrars, impacting their training opportunities.

Also holding Registrar bleep at times.
Resident Doctor, Thames Valley.

NP 774 – AA as sole named provider for regional anaesthesia and sedation for ophthalmic theatres. Only 'supervised' by duty floor anaesthetist however they are in a separate theatre complex and there is no guarantee they would be able to assist urgently as they might not be able to leave their theatre. Also negative impact on trainees who get very limited exposure to ophthalmic anaesthesia.
Resident Doctor, Peninsula

NP 775 – I worked in XXX between October 2023 and October 2024 – there were 2 PAs in the gynae oncology department. While the STs/PAs were on wards or carrying the on call bleeps or elsewhere doing service provision – the PAs were in theatre getting gynae oncology experience. They left on time – bang on 5 and on these days when the gynae onc lists would take longer it was then the STs/FYs job to go and finish assisting. the PAs would also sit in MDTs and run their own clinic as well as have dedicated time on rota to do audit while actual trainees would need to do that in their own time. As you can imagine the trainees raised this as an issue and The consultant who supervises them sent an email essentially telling them that the PAs are here to stay anf we basically need to play nice as they have invaluable skill sets and they will be able to train doctors. The other 2 gynae onc consultant ask the ST to leave their theatres as they don't need them and they should find something better to do. This had been an issue throughout the year – said gynae onc consultant would then berate and complain how STs skills leave a lot to be desired...you cant make this stuff up.

I never thought I'd be fighting for exposure with non doctors in a highly specialised field as gynae-oncology – these are people with 2 year degree being allowed to assist and scrub in complex surgery because they are PAs

I got tired of rising it as an issue as it seemed engrained in department and the senior boss signs off on their job plans and even approved for more funding for them to do clinics etc while STs are stuck doing service provision.
Resident Doctor, Wessex

NP 780 – Practicing out of scope, with insufficient knowledge and training. Also providing misleading information to patients by suggesting/not clarifying limited scope of PAs – eg letting patients assume qualified doctor and not correcting the assumption.
Locally Employed Doctor, Yorkshire

NP 781 – Running gynae clinic – pessary clinics, working on SHO tier on gynae rota, rota'd on theatre lists etc.
Resident Doctor, Wessex

NP 791 – Physician associate working at registrar level in the neonatal unit.
Resident Doctor, East of England

NP 793 – Haematology PA holding haematology registrar bleep.
Resident Doctor, Yorkshire

NP 796 – XXX oncology department uses PAs within their minimum staffing.

State 4 doctors or PAs across 4 wards. This means that on any day there could be 3 doctors and 1 PA covering 4 wards, meaning 1 per ward. The PA will review patients independently on their own ward round.

Oncology management refuse to accept any concern because "they like the PA".
Resident Doctor, West Midlands

NP 798 – In A and E the PA are misdiagnosing and also not able to manage sick patients as they are not prescribers delaying patient management. As for medical

emergency it is expected A and E to initiate initial management which PA fail to do. They will refer every patient to speciality as they lack confidence to treat simple conditions like sore throat and Urine infection. Also for . Further PA in GP surgery hesitate to prescribe, misdiagnose and refer inappropriately.
Resident Doctor, West Midlands

NP 799 – PA lead ward rounds are frequent on wards such as elderly wards.
Resident Doctor, Yorkshire

NP 801– PA worked on the acute medicine rota 9–5, no on call responsibilities, throughout entire rotation, preferential treatment by consultants over trainees.
Resident Doctor, Severn

NP 804 – PAs on resp rota consistently asked SHOs and FY1s to prescribe and order ionising radiation for their patients management.
Resident Doctor, Severn

NP 806 – PA was holding medical registrar evening ward cover bleep which is also an arrest bleep.
Resident Doctor, East of England

NP 810 – A PA attends our CT2 teaching which is specifically designed for membership exams preparation. During this they have stated their supervisor is encouraging them to "do everything a trainee does" including taking on psychotherapy cases in line with CT psychotherapy requirements. There is no clear evidence of them having appropriate training or supervision to do this. Additionally, they are allowed to attend this teaching informally, whilst for CTs this comes out of our study budget. Non training grade doctors have previously been denied attendance.
Resident Doctor, West Midlands

NP 811 – As regards the 'safe scope of practice for MAPs' BMA document. XXX A+E daily has PAs making independent treatment decisions, seeing undifferentiated patients and being allocated resus training time which precludes doctors from having it.
Resident Doctor, Yorkshire

NP 813 – PA (geriatrics) performing inpatient Parkinsons reviews with no immediate support from a doctor.

PA (respiratory) performing, and teaching, pleural procedures while on a non-respiratory ward and with no consultant support present.

PA (acute medicine) formerly on doctors' rota.
Resident Doctor, West Midlands

NP 814 – 2 fulltime PA's rostered at tier 2 on the A&E rota for the duration of my time working there (over a year). They were encouraged to pick-up A&E SHO locums at £50/hour on equal footing with actual SHOs. "Date occurred" below is obsolete, as it was day in-day out for over a year between 08/2022 & 01/2024.
Resident Doctor, North West

NP 815 – In ACU most of the roles that would normally be performed by a doctor are performed by PAs who are directly employed to work in ambulatory care. I do believe that they have good supervision but that it does not meet the extent applied in the MAPs guidance such as their discharge letters being screened. Their main role is assessing, diagnosing and formulating management plans for ambulatory medical patients.

I also have heard one PA introduce himself as "one of the medics" to a consultant who did not realise this man was not a doctor. I have also been told along the lines of "this PA is trustworthy, if they ask you to prescribe anything, just do it" by the registrar. They also take acute medical referrals for ambulatory patients over the phone.

I have not witnessed anything that makes me feel this particular PAs are not practicing safely.

At XXX there are also several PAs that are performing the role of a ward doctor but I have not worked with any of them.
Resident Doctor, East Of England

NP 818 – There is actual evidence of doctors locum and contractual posts being filled by PAs and ANPs. In the emergency department, doctors are part of a tier system which includes allied professionals. All bank A&E doctors have evidence of this within emails going back many years. Those shifts can be picked up by us or any allied professional. A confirmation of the A&E rate card was sent on 23/02/24 to all ED which includes all the evidence

Medicine and surgery do not show the shifts offered to allied staff and rates. Likewise with ward shifts, clinics and surgery staffing. We are then often asked to sign off prescriptions and radiology requests from PAs, hence the responsibility lies on us in the midst of working in an extremely busy hospital

I am a GP registrar and have now finished all my hospital placements. In my GP practice there are 2 PAs (1 just recently left with a potential replacement on the horizon). This has not affected me as a trainee but i have been told by partners that the ARRS funding means they benefit financially by hiring ARRS roles compared to GPs. Theyve had more applications for jobs from GPs than ever but only 1 recently hired. They also admit that hiring GPs is better for productivity and patient care but the funding just isnt there.
Resident Doctor, North West

NP 822 – PA in XXX being able to order CT TAPs on nervecentre. **Resident Doctor, East Midlands**

NP 825 – Haematology & Oncology Department – PAs substituting for registrars, completing independent ward rounds

Also similar issue present on acute med and geriatric departments **Resident Doctor, Yorkshire**

NP 828 – In Haematology at XXX, a PA has their own clinic and writes there own clinic letters, normally independent of supervision

The same PA seems to also count in doctor numbers for counting ward staff and will see their own patients without senior review and ask resident doctors (SHO level and below) to prescribe for them and will be upset/shocked when this is questioned/ challenged. **Resident Doctor, East Midlands**

NP 838 – The cath lab cardioversion list is always conducted by an AA without supervision in a remote location. I have grave concerns about this.
Resident Doctor, Yorkshire

NP 840 – Physician associate runs Parkinson's clinics and if we refer to elderly care he is the one who comes to see the patient, not a doctor.
Resident Doctor, West Midlands

NP 841– An Anaesthesia Associate is doing sedation for cardioversion at XXX. Clearly a high risk list, most patients ASA 2 or 3. No supervisor listed on rota, indirect supervision provided if any but from other trainees who have attended this list, no consultant present. AA also refused to allow ST7s to do the sedation themselves, impacting training.
Resident Doctor, East Midlands

NP 842 – On the 8th or 9th September 2024 the Trust hired 4 locum PAs in their ED department. As locums, it was not clear from their uniform or name badges that they were PAs and many trainees assumed they were Drs. Additionally, none of these 4 PAs currently work in the ED department on a substantive basis.
Resident Doctor, Mersey

NP 852 – PA working in xxx, handed over multiple patients with plans that had not been discussed with any doctor. Became apparent that they had seen/treated/ discharged patients during that shift that had not had any involvement/ discussions with a doctor.
Resident Doctor, Wessex

NP 862 – PAs working as doctors in XXX: clerking diagnosis and coming up with management plans. The admin of which is lumped onto doctors shoulders (checking all their work for safety concerns of which there are many, re doing lots of the work and having to explain why, dealing with the conflict as a result of PAs being affronted by their incorrect diagnoses being corrected as if it is a personal affront, prescribing etc) which increases our fatigue. They do not make this clear to patients and I am constantly finding patients coming to me frustrated with no improvement after poor management of their condition by "a doctor" which on questioning turns out was a non doctor such as a PA or ANP who introduce themselves as "part of the medical team" or something similarly ambiguous to masquerade as doctors to patients who have poorly managed the patient due to their clinical incompetency because they are not qualified to do our job. This has happened over many shift.
Resident Doctor, Thames Valley

NP 864 – They are given shifts where they diagnose and come up with management plans which is totally out of their competency. Instead we would be stuck on the ward prescribing paracetamol on our own whilst they got clerking experience with consultant and reg teaching every day. It causes more work seeing a PA first because then a doctor has to re do all their work and check it, probably re do it, explain that to the patients and deal with resulting frustration and destruction of trust in the teams abilities, and do all the admin because they aren't allowed to do it.

It is frustrating because they are happy to refuse admin as a result of "not being competent or allowed", but will pretend to be doctors to patients and pretend they know more than they do/competent to do minor procedures they should not be doing etc just because they've seen it a few times. It seems like they just do all the things that they find interesting at the detriment of our training and patient safety, but won't do the admin because it's less interesting and also easier to prove that they are acting out of their competency.
Resident Doctor, Thames Valley

NP 865 – Incorrect diagnoses and conflict as a result when we try and buffer this for patients. It makes our job of keeping patients safe even harder than it needs to be

We need to know, recognise and safely manage more conditions than ever. And now because of PAs we have to pick up the pieces of when this is done badly, re do their work, and do all their admin in the same time frame. They should do clinical admin with basic procedures similar to an experienced nurse, that is it. I do not believe they have the training and therefore competency to do anything further than this at all.
Resident Doctor, Thames Valley

NP 868 – Whilst a novice on anaesthetics my "supervisor" for one list was an AA. This was due to consultant sickness.
Resident Doctor, East Midlands

NP 871 – PAs classed as "juniors" and doing their own ward rounds in the same role as resident doctors. Patients were not reviewed by a doctor after this and consultants only saw patients 1-2 times weekly or when deteriorating. PAs shift finished earlier than doctors so would often hand over large volume of jobs from their WR which hadn't been completed to FY1s to complete this in the last 90 minutes of shift. Some patients jobs weren't handed over and WR plans were left unactioned then picked up when a different team member reviewed patient at a later date.
Resident Doctor, Yorkshire

NP 877 – The FY1s on ward xxx are told by the consultant body to do a ward round led by the Physician associate on the ward. They are asked to scribe + prescribe drug on his recommendation. They do not introduce themselves as a PA and do not correct people when they call them Dr.
Resident Doctor, West Midlands

NP 881– PAs on XXX SHO rota used in place of doctors – ongoing. New doctors sometimes compared to PAs in insulting manner.
Resident Doctor, North Thames

NP 889 – 2 PA are regularly on the ward. They are sometimes the only person to see a patient when referred for consideration of anti virals for Covid. They write a note advising the lead team on prescription despite not having any prescribing qualifications. The lead team then to safely prescribe would have to duplicate work.

Secondly the PA are also directly involved in ward rounds and often ward round with the consultant while the resident doctor is not available. However they will not do any of the jobs this leaves the resident doctor doing jobs including admin for patients they are not directly involved in and has a patient safety issue as the PA did not discuss discharge medications (many being held) with the consultant and so was a decision made by a clinician without direct patient involvement unless the doctor duplicated a large amount of work. They will see patients on their own on ward rounds sometimes and expect the resident doctor to prescribe based on their judgement. This creates a difficult environment if the doctor chooses to assess the patient themselves before prescribing. They also ward rounded on patients, did not do the jobs and did not escalate or handover jobs before leaving. The nurses expectation is the resident doctor complete their ward round plan, despite no handover. This means urgent jobs cannot be prioritised. From talking to colleagues this is an ongoing trend on this ward and not specific to this date. I cannot see how their role is beneficial to resident doctors. They increase my work load and it would be easier to ward round on patients I am responsible for. They did not identify or review all the medication (they are unable to as not prescribers, but often key to patient care) which was a direct patient safety issue. I felt very uncomfortable raising this issue as the consultant on the wards is very senior in the hospital. **Resident Doctor, Peninsula**

NP 891 – PA (XXX) requesting chest XR (ionising radiation) for unwell patients.
Resident Doctor, West Midlands

NP 896 – At XXX there are Physician Associates being used to directly substitute for SHO doctors on the medical rota on a daily basis. I have screenshots of the medical rota which show this.
Resident Doctor, West Midlands

NP 904 – There was a PA on our ward who would wear blue scrubs, purposely not wear/hide his PA badge so that other people thought he was an F1 – to the extent that all of the medical students in my group thought he was an F1 until we saw his badge on the office desk. He also used to try to stop us from talking to patients on the ward without asking for permission from him prior, claiming that patients were distressed (however we always ask for consent from patients to talk to us beforehand and would never talk to a patient who would say no/ seemed distressed in the first place). He also insisted that we introduce ourselves every time we entered the doctor's office and that we were rude for not having done so, more than halfway through our clinical placement block (3 weeks in) and having seen us enter the office on numerous occasions before mentioning this, further making us feel like we were not part of the healthcare team.
Medical Student, North West

NP 906 – PAs seeing patients independently, shared rota with resident doctors.
Resident Doctor, North West

NP 917 – PAs in radiology doing ascitic drains etc. I was asked to supervise them on one occasion when I should be the one doing them!
Resident Doctor, Thames Valley

NP 918 – Taking on responsibilities that they have not been trained for and not having insight that putting patients at risk.
Consultant, Yorkshire

NP 919 – XXX rota has a physician associate who is rostered on F1 and F2 doctors. Department use PAs and foundation doctors interchangeably on this rota and gives them identical responsibilities.
Resident Doctor, Peninsula

NP 921 – Breaking the laws of IRMER (radiation) by mass requesting by these new roles for studies well beyond scope of practice. These referees have no capability to understand and act on results. We have no way of policing this in the era of electronic requesting.
Consultant, Yorkshire

NP 923 – XXX Unit has 3 PAs working on Doctor rota. They were also utilised during strike periods**.**
Resident Doctor, Thames Valley

NP 926 – PA in Cardiology Prescribes and Sees patients with no Supervision. she Orders Chest Xrays MRIs and CT Scans with no Supervision at all.
Resident Doctor, Wales

NP 927 – There is a PA in XXX ward who regularly covers the SHO slot for medical liaison shifts or discharge ward rounds on weekends etc. I have also seen an example where he prescribed fluids (NaCl with added KCl) and signed for them, then later crossed out the KCl, then told the nurses to give it with the KCl. I saw this because later on I was on call and the nurses raised the concern to me as they did not think PAs could prescribe.
Resident Doctor, Wales

NP 937 – A PA works on the xxx SHO rota and sees patients entirely unsurprised. If they need advice they contact the registrar in XXX hospital. They cannot prescribe so others need to. They also refuse to identify themselves. They wrote "XXX Surgical on call" no PA anywhere. I challenged him over the phone last year over who he was and what title and he refused to say before answering "yes" when I said was he the surgical SHO (I initially asked were they the reg or SHO).
Resident Doctor, Northern Ireland

OP 13 – Experience with physician associates is they are frequently used as a line on the rota where a doctor should be, and are used as though they are a doctor by Trusts, rather than to assist doctors. They do not introduce themselves to make it clear they are not doctors, and are often completely uncertain of any clinical details or nuance when having a discussion. I have frequently seen miscommunication from PAs as a result of their lack of clinical expertise relative to that of a doctor, and delays in patient care. I have also seen this result in incorrect prescriptions as a result of inaccurate assessments from PAs, but there is a pressure/expectation on doctors to prescribe on behalf of the PAs based solely on their assessment. This also applies to the requests for ionising radiation. As an added point, the fact these individuals have a higher basic pay than doctors of ST2 and below, despite working fewer hours, having less expertise and holding less responsibility, while simultaneously being given many of the training opportunities these doctors should have, is absolutely ludicrous.
Resident Doctor, Severn

OP 55 – Long-term PA in dedicated specialties eg ENT are more reluctant to undertake discharge summaries or basic ward jobs. Instead as they would like career progression, they leave F1/2s to do service provision doing this, with PAs in ENT taking all the theatre time and training opportunities instead – which defeats the point of these doctors undertaking training in ENT/particular placements. For example, the PA in would be very skilled now due to taking these opportunities, and in instances PAs have been put on the registrar rota – but how safe is this really? How fair is it that junior doctors' education is limited due to this? How professional is it that they introduce themselves as registrars/hold the on-call bleep? I don't feel it is, especially as they are not regulated nor holds their own GMC number/not fully responsible.
Resident Doctor, Peninsula

OP 167 – Paediatric PA is regularly used as last minute cover for unstaffed SHO shifts as they are already on the building. They have no understanding of anything deeper than poorly written protocol in our XXX and cannot function as an SHO due to limits on prescribing etc. Leaving the SpR to do all the work solo whilst covering xxx, xxx, xxx, and the XXX and any NLS/PLS as the PA is not qualified. This is not safe and has significantly slowed down the management of paediatric emergencies. They are also completing NIPE examinations unsupervised. The PA has no professional awareness of their limits and makes it clear they take the shifts for money. They also cover strike SHO shifts and again make a point of the money earned whilst ignoring the increased risk of skeleton staffing. Senior staff leading the department do not supervise training doctors, let alone the PA's and simply use them to minimise rota headaches. The PA has also been allowed to run a specialist diabetic clinic in this department, when they don't understand the physiology of diabetes or DKA, nor can they prescribe the insulin themselves.
Resident Doctor, Severn

OP 185 – I work as a hepatology SHO at XXX Hospital. A large part of our job involves clerking elective admissions. The PA routinely documents their clerking and expects the SHO to prescribe all the necessary meds without handing over the request to do so. We frequently find out from nurses during the night shift that medications have not been prescribed. The PA regularly fills SHO locums and receives the same rate as us.
Resident Doctor, South Thames

OP 186 – I was in the treatment room preparing medication for a patient the nurse I was with was assigned as we shared the drug round (have learnt way more clinical skills from nurses as doctors as so overstretched they find it hard to find time to teach!) and overheard another nurse expressing concern over a doctor who just saw their patient and said they'll prescribe a time critical med. the nurse wasn't sure whether to give this as a verbal order and wait for it to be put on the MAR as an order but decided to wait and asked a colleague about this doctor (who spoke to the nurse when we were both in there) and it turns out they were a PA who didn't introduce

themselves as such and instead misled a staff nurse by stating they were "covering the medical reg rota for the ward". Med never got prescribed (assume doctors found it completely unwarranted) but the PA didn't introduce themselves correctly and gave a verbal prescription to a nurse and also informed the patient.
Medical Student, South Thames

OP 201 – PA on registrar rota in gastro.
Medical Student, North West

OP 216 – I have only just realised that I have spoken to a physician associate twice who was working with the xxx team at XXX. This was about a year ago and it is only from reading the reports on X now that I have realised that this person is a PA.

They answered the xxx reg bleep without saying their role. I asked at the end of the call for their name, and then asked whether they were the xxx reg? They said no they weren't the reg. I can't remember exactly how they described their role but I was confused and asked them to clarify, were they the SHO? They said no, they're carrying the reg bleep and I think they said something like they're an associate on the xxx team. Again I was confused who they actually were and tried again to ask their role. Eventually they said don't worry they'll speak to their consultant and get back to me, and that they work really closely with the consultant.

I spoke to the same person two days in a row and I still didn't understand their role after the second call.

My concerns are twofold. I've been a doctor for many years and on that day I had time to ask multiple questions as to who they were. Yet I couldn't work out who this person is. I think others are also likely to not understand their role. And secondly this is a xxx service, I worry that if the reg bleep is carried by a PA that this is reducing training opportunities for doctors. **Resident Doctor, West Midlands**

OP 223 – I am aware of a PA in my current work place who holds the SpR bleep in a speciality. I have heard informal reports but not personally experienced an incident where they answered the bleep and it was not immediately clear what role they were, on the end of the SpR bleep. I'm concerned this would mean someone would think they were speaking to a person who had undergone core surgical training and formal ENT training, not someone given responsibility outside their competency or training. There have also been reports, that this is impacting training opportunities for trainees as this PA attends theatre and assists in cases, outside of the remit of PAs. There have been astounding discussions of whether they'd be able to perform procedures independently. They are also running outpatient clinics on their own, with consultant support directly which I'm concerned about.

These 'reports' would need to be formally verified however before being used as fact in media information. Fact however is that a PA is being used on an on call rota for a surgical speciality and answering a bleep and running outpatient clinics independently.

As a trust, I have concerns about the massive increase in recruitment for PAs. I have seen first hand on XXX wards that they are being used to plug a gap and have now appeared on medial rotas. I am concerned that this will then encroach onto them then being included in core staffing numbers.

In addition, they are independently seeing patients on ward rounds without direct supervision and making clinical plans. I find this astounding that a PA who is newly qualified is allowed to do this and documenting 'junior ward round' in their notes. If this was an F1 I'd expect them to have far more supervision if newly qualified. In addition, in the absences of daily senior or consultant ward rounds, I'd be hugely

concerned about the lack of review by a medical doctor for 48 hours, in the case of a clinical incident – who is then held responsible?

I believe they should not be making formal clinical plans – their role was to enable qualified medical staff to carry out these plans.

I have concerns about supervision discrepancies too, whereby there are no clear cut guidance on who supervises PAs, especially when staff rotate around new areas, this leaves the PA in situ to essentially then dictate or be left to their own devices, as new staff appear.

Furthermore, newly qualified PAs are being supervised by PAs, who have never received training in education or leadership or are formally qualified to train a new member of staff. I fear this represents a case of the blind leading the blind, where clinical incompetence will become rife as they 'don't know what they don't know'.

The mass drive by my trust to plug staffing gaps is a huge concern and I fear represents huge encroachment on physicians and difficulty to then reduce numbers of PAs in future or manage their role appropriately. As a trust – there is a huge dearth in understanding between management and clinical practise.
Resident Doctor, Peninsula

OP 228 – Stroke PA answering a bleep as thrombolysis SHO and coming to review patients in ED saying this is their role. Only becoming clear they were a PA and not an SHO as wearing a PA lanyard. Advising scans to be ordered to ED juniors unaware of their true role.
Resident Doctor, Northern

OP 250 – Today on a xxx rotation there were only two f1s down for the rota (meant to be supernumerary) and the only SHO on the rota was a PA. This meant there effectively wasn't a SHO all day due to the PA covering this gap.
Resident Doctor, Peninsula

OP 258 – PAs work on the junior doctor rota in medicine at this trust. They expect the FY1s to prescribe on their behalf, often coming up to you and saying things like "I have a tiny prescribing job for you". No prescribing job is "tiny". They can ask you to prescribe for them giving wrong clinical details – once I was asked to prescribe fluids for an AKI3 and when I checked they were in AKI3 a few days ago but was now resolved – being given this information could have completely changed what I was going to prescribe. PAs independently review patients routinely on ward round and put prescribing/ordering scans in their plans and it is just expected that the other foundation doctors will do these tasks for them without re–reviewing the patient. Last week I followed BMA guidance and told a PA to ask their supervising consultant instead of me to prescribe. I was met with such hostility and the PA found my number in a work WhatsApp group and proceeded to message me outside of work hours with questions like "Do you not think I am medically trained" and "do you not think I am clinically competent" and "why did you refuse to prescribe for me". This was unpleasant as an FY1 to have to deal with just for following my union's advice. We have no guidance from the consultants on how to work alongside PAs and most of them treat the PAs like a junior doctor.
Resident Doctor, Yorkshire

OP 336 – At XXX Hospital in XXX A&E, junior doctor particularly F1s and F2s are being forced and coarsed into prescribing for PAs. If they refuse they're told that they are not acting as team player and several emails have been sent around essentially telling junior doctor to prescribe for PAs as they work at a level of "junior doctor" and ignore BMA guidance.
Resident Doctor, North West

OP 339 – I'm a final year medical student who had to shadow the surgical F1 on call for a twilight shift. I turned up and instead there was a PA who was doing the job. It was quite frankly dangerous how this PA was not able to prescribe anything for anyone, even the sickest of patients had a delay in getting prompt treatment, she was woefully out of her depth and worst of all, her handover list for the night f1 was nearly 3 pages long!! Absolutely disgusting how this PA managed to be on this rota.
Medical Student, Wales

OP 350 – Physician Associates at XXX Hospital are being put on the SHO rota and xxx registrar rota. This is extremely unsafe as they take referrals from other centres, are scheduled as SHO's when they can't prescribe which increases workload and they have even taken SHO nights.
Resident Doctor, West Midlands

OP 374 – In general, PAs on the same rota as docs. PA on resp doing independent clinics.
Unspecified, Peninsula

OP 375 – I have never seen a consultant supervise any of the PAs on a day to day basis apart from xxx and maybe xxx. There are very few consultants on the shop floor across wards. They ask the junior docs to prescribe and order CT scans which increases work load. Independently seeing patients across wards. On the same rota as juniors across many departments eg xxx, xxx, xxx.
Unspecified, Peninsula

OP 393 – While working as a junior doctor we were told that the physician associate on the team was 'registrar level' and would be acting as such. They were frequently the 'senior' on the ward and we were told to escalate problems/queries to them as our senior.

On a different team, a physician associate was filling rota gaps by acting as the speciality's registrar on call, holding the speciality registrar's bleep. While working as the 'registrar on call' they would review referred patients (usually referred by the acute medical unit or other specialities) themselves and advise on management.
Resident Doctor, Severn

OP 402 – XXX hospital, paediatric referral bleep often held by a PA meaning delays in care or advice.
Resident Doctor, Peninsula

OP 423 – PA works on medical ward. Found to have been reviewing blood results and writing them in notes but not taking action on AKI. PA's 'supervisor' informed of knowledge gap and risk to patients but no action taken.

PA as above given equal responsibility on rota for a group of patients as a junior/ resident doctor.

PA as above found to have been prescribing electronically by using doctors login details. No serious consequences, clinical managers very secretive about whether any action has been taken to address the situation at all.
Consultant, Northern

OP 427 – Cardiology PA caries the outliers bleep. Referring very sick ICU patients to cardiology – bleep answered by PA who tries to give advice and then says "will escalate" after you double down and emphasise how urgent the referral is.
Resident Doctor, South Thames

3 Other patient safety issues

NP 24 – PA reviewed a young patient with chest pain in ED and was discussing the case with me as the registrar. I did not understand really what their role was as a PA and no safety information given by the department. They told me a vague history and that the examination was entirely normal. After inadequate responses and the feeling the PA did not know what they were doing, I reviewed the patient in-person. They were a young man with sudden onset left sided chest pain which was pleuritic. I put my stethoscope on the left side of his chest and there was NO air entry whatsoever. Not even subtle. Looking at the chest x-ray there was a radiological tension pneumothorax. The patient was immediately moved to Resus where I took over his care and a chest drain was promptly inserted. He had been sitting in a far away part of the department in a chair.
Resident Doctor, North Thames

NP 61 – A respiratory PA at my hospital recently inserted a chest drain in a patient unsupervised. This patient was a haematology patient who had platelet levels of 8. Normal platelet levels are >150. Therefore, this patient was at extremely high risk of having uncontrolled bleeds. Chest drains are an invasive procedure which involves cutting through all the layers of the skin to enter the pleural cavity. The chest drain, as expected, caused the patient to have a significant bleed and deteriorate over night. The PA told no doctors from either the respiratory team nor the haematology team that they were inserting the chest drain. Luckily the night doctors transfused the patient and gave medication to control the bleeding. However, this could have easily resulted in a catastrophic outcome.

This would not have happened if the PA acted within their capabilities. This would not have happened if the patient was seen by a real doctor. This would not have happened if the NHS had enough doctors.
Resident Doctor, East of England.

NP 256 A physician associate refers to themselves as doctor/junior doctor to other staff and to patients, resulting in confusion within the workforce.

This same PA assessed a patient independently on a ward round. This patient had had an iatrogenic opioid overdose due to her poor renal and hepatic function. Her oxycodone and buprenorphine patch were stopped by the on call doctor who was alerted of this. During the PAs ward round, they restarted the buprenorphine patch and Oxycodone, asked their colleague to prescribe it, without any documentation of discussion with the consultant. This resulted in another opioid overdose in this patient.
Resident Doctor, East of England

NP 288 – Physician associate on xxx. Patient spiking temps with CRp >400. CXR looked like effusion so I asked resp to see for chest drain ?empyema. The PA said "I can do chest drains". I said "are you signed off for pleural USS?" He said "I can do ultrasound and chest drains". I said "I'll call respiratory". The PA got the ultrasound and said "there's loads of fluid, come on let me tap it" I said "no we will wait for respiratory as you are not pleural ultrasound trained" he was very insistent but I stood my ground. respiratory came and scanned the patient. The lung was collapsed and the PA was scanning the spleen, he was very close to sticking a needle into the patients spleen.
Resident Doctor, North West

NP 575 – Student Anaesthetic Associate 9 months into training left in theatre alone and unsupervised with intubated and anaesthetised patient for 20 minutes whilst supervising doctor out of theatre. Patient undergoing laparoscopic surgery. **Consultant, West Midlands**

NP 578 – I work in ED and clerked a patient that had been discharged from XXX 3 days prior.

Patient presented with progressive shortness of breath when moving. Starting at rest. Light headed, dizzy. palms and conjunctive were pale. Minor chest pains when work of breathing is really hight. History and examination was clearly symptomatic anaemia.

In XXX, this history comes directly from the patient and thier daughter. I will raise this with dpt and internally.

Patient reports that she was told she didn't need to be there and nothing was wrong – seen and discharged by a PA around 4pm. She and her daughter then got phone called around 23:00 saying come back as they've checked her bloods and the tropine was elevated. The next day pt attended, saying she was still really short of breath. Rpt trop was the same – discharged as anxiety high hypertension.

HB on both occasions was <80

No mention of HB in any documentation. no follow up arranged.

Today – sob at rest. Admitted to medics for blood transfusions and work up. **Resident Doctor, East of England**

NP 794 – I was working on the acute take overnight and picked up a patient that had been accepted by my medical team for ?UTI.

This patient had been clerked by a PA in the emergency department and this PA referred this patient to the medical team for admission.

There was documentation that this patient had been discussed with a senior ED doctor but there was no indication that this patient had been formally reviewed by this ED doctor ,certainly no documentation or examination from a doctor before this patient was moved to AMU where I saw the pt.

Upon clerking the patient I noticed he had been admitted with a fever, UTI symptoms and tachycardia. The inflammatory markers were raised on bloods.

The patient had a recorded fever in ED and at the time of me undertaking formal medical admission clerking.

There were several critical steps missing from the PA's plan:

– Blood cultures were not taken in ED despite a concern for urosepsis and a current fever, this was not mentioned in their plan. Antibiotics had been given already by the time I took cultures.

– a VBG had not been taken in ED, I took one when seeing him and his lactate was 5.0. No IV fluids had been given despite him appearing clinically dehydrated. I had to initiate this.

As you can see from above sepsis 6 was not completed and a half hearted assessment by the PA was completed. It is serious that a VbG was not performed by the PA and therefore lactate levels not discovered.

Luckily the patient responded well to IVF and the lactate fell on subsequent VBGs. However this patient could have easily deteriorated and this PA failed to meet basic treatment of sepsis.
Resident Doctor, East of England

NP 843 – PA working in ED. PA assessed a patient with severe rash covering side of face. Also noted swelling to periorbital region. Treated by PA as impetigo. Seen by doctor. Significant periorbital oedema. Also rash extended to cover the ear and pus in canal. Urgent CT done which showed extensive otitis externa with pre-septal cellulitis (neither of which were appropriately identified or treated by PA in ED), Doctor had to consult ophthalmology and ENT for plans (should have been initiated by PA).
Resident Doctor, North West

NP 885 – PA discussed paediatric patient with consultant, who advised antibiotics. PA asked myself to prescribe antibiotics. I checked whether any allergies were documented (none) and asked PA whether the patient had any allergies (the PA replied "no"). I prescribed the antibiotics as per guidelines. After a few minutes I overheard the PA asking another doctor to prescribe different antibiotics for the same patient. When I enquired why, the PA informed me that the patient was in fact allergic to the class of antibiotics I had prescribed, but – I cannot remember exactly – had either forgotten to ask about allergies during their history, or had mistakenly answered "no" when I asked about the same.
Locally Employed Doctor, South Thames

OP 33 – I work as a consultant and on a ward round, I clearly asked for a specific patient investigation to be done immediately. After leaving the ward, I later learned that my decision was over-ruled by a PA, which caused a delayed diagnosis and patient harm. The PA confessed to me later on, after the complication was identified.
Consultant, Wales

OP 73– I worked a night shift at a huge XXX hospital's ICU. As we are so short of doctors in XXX, and paid so little, there was only one doctor for each entire intensive care unit, responsible for keeping all of the patients on life support – the sickest in the hospital – alive throughout the night.

As the most senior ICU doctor (registrar) present in the hospital overnight, I understood that the other ICU doctors, independently running their separate ICUs single-handedly, would immediately call me for any support or advice needed. None did so.

It was only at the very end of the night shift that I realised none of the other ICU doctors were actually doctors. They had no supervision. They were working as doctors. As is normal in the UK, to my knowledge there were no consultants in the hospital overnight. I was never approached for any prescriptions, so presumably these non-doctors independently running intensive care units unsupervised were prescribing for these unconscious patients, and carrying out all necessary critical care interventions. The unconscious patients did not know they were not doctors. Even I did not know they were not doctors – it has been made intentionally unclear. One of them had not yet even qualified from their non-doctor training course, yet they were single-handedly working as an unsupervised doctor overnight in a major XXX hospital, overrun with extremely sick and dying patients.

I have since asked other doctors what on earth is happening, as I had thought this was a criminal offence in the UK. I have been told it is now completely normal to have unqualified people pretending to be doctors in XXX hospitals, without patient consent or even the other doctors realising. Presumably this is why it was not even mentioned to me that I was actually the only doctor on all of the ICUs for a thousand-bed XXX hospital.
Resident Doctor, South Thames

OP 115 – I have witnessed / heard of several serious drug errors made by anaesthesia associates giving drugs without direction from their supervising consultant. They consistently work outwith their scope of practice which includes giving drugs which are not prescribed (they do not have prescribing rights) and doing procedures which are not supported by the RCOA.

My work load is doubled when I am supervising them as I have to watch everything they do. I have real safety concerns for patients as they do not possess the baseline medical knowledge to manage any complication or recognise when they are out their depth.
Consultant, unspecified.

OP 152 – Patient death as a result of a PA missing a DVT (likely patient was not examined, PA did not discussed with supervisor despite CLEAR supervision protocols in place.
GP, England

OP 178 – Trainee and full trained AA's completely unable to recognise an acute concerning arrythmia on monitor or ECG for a patient on a gynaecology list. No knowledge that the presence of active cardiac/renal disease would impact on anaesthesic plan (delay surgery) or require support. No insight that the patient would need further cardiac input. Situation truly highlighted their lack of basic knowledge and was a patient safety risk.
Resident Doctor, West Midlands

OP 179 – Patient had multiple reviews by physician associate in GP with acute change in bowel habit, significant weight loss, anaemia and abdominal lymphadenopathy. Symptoms and risk of possible underlying malignancy not recognised, not referred for further investigation instead diagnosed with functional condition which should be diagnosis of exclusion. Required acute presentation to ED during which was diagnosed with GI malignancy.
Resident Doctor, West Midlands

OP 233 – As an F1 was told by the PA on stroke, who introduced himself as ''one of the medical team'' and who all the nurses and patients thought was a doctor, to "just prescribe some fluids" for a man who was recovering from a haemorrhagic stroke as he had an infection and wasn't eating or drinking a lot.

I reviewed the patient before prescribing (I might as well have just seen him myself) and the PA was really angry I insisted on doing this, and embarrassed me in front of the team, but I felt the patient had clearly worsening focal neuro features on exam and requested an urgent CT Head.

The patient had re-bled and had raised ICP. If I'd have "just prescribed fluids" this would have significantly worsened the clinical picture and he might of died. And it would have been my prescription and my medico-legal responsibility, not the PAs. He humiliated me in front of the team for "questioning his senior judgement" but I'm really glad I did. I told the consultant what had happened but he just said "Oh no-one really knows who supervises the PAs, good catch though".
Resident Doctor, East Midlands

OP 276 – PA reviewed an oncology patient who was admitted with severe radiotherapy side effects and dehydration, did not think the patient needed IVF, the patient became peripheral shut down and required admission to ICU for further management. The PA (aggressively) blamed the out-of-hours doctor for not prescribing fluids stating it was the doctors 'fault' the patient had been admitted to ICU although the PA did not raise any concerns about the patient's condition.
Resident Doctor, unspecified.

OP 349 – Physician associate unaware the DKA can cause abdo pain – this was in a known T1 diabetic with a cap glucose of 18 and urinary ketones +++. Their recommended plan was senior review and home. Assured me urinary ketones were normal, thankfully I checked and saw they were not and arranged for blood ketones to be checked. A 1st year Med student would have known to assess for DKA in a T1 presenting with abdo pain.
Resident Doctor, Scotland

OP 352 – I am a GPST3 working in primary care. There are PAs working at the practice.

I encountered a middle aged gentleman in September 2023 who was presenting for the fourth time since Feb 2023. He was complaining of severe, unrelenting and atraumatic back pain. This is a summary of the events leading up to this telephone consultation with myself.

During his first consultation about his back pain the patient had seen a PA who had documented that this patient had requested a PSA blood because a friend of his had recently been diagnosed with prostate cancer. The PA agreed to the blood test. No bone profile, fbc or myeloma screen was ordered. The PA documented that his impression was that this was muscular back pain. No analgesia was offered. No physiotherapy was offered

The patients PSA result was over 700 in Feb 2023. The PA reviewed the result and sent the patient a text asking him to make a routine appointment to discuss it. He made no further attempts to contact the patient. A two week wait referral was not done. He failed to discuss the result with his supervisor. He failed to make the link between the patients back pain and the fact this result certainly indicates a diagnosis of advanced prostate cancer.

The same patient presents again a month later. Again with severe back pain. This time he saw a different PA. This PA failed to notice the patients recent PSA. A diagnosis of trochanteric bursitis was made. No ultrasound was ordered. No analgesia was offered. No physiotherapy was offered. No questions were asked to establish just how severe this patients pain was. No information about weight loss was obtained. This patient was not discussed with a supervisor

The same patient presented for a third time. This time to the original PA who had ordered the PSA at the patient's request. There was no discussion with the patient about the raised PSA. Once again no analgesia or physiotherapy was offered. No attempts were made to establish a history indicative of sinister, malignant pain. No questions were asked about weight loss or systemic upset. The patient was not discussed with a supervisor.

By the time I spoke to the patient a repeat PSA was >2700. He gave a detailed history of progressively severe pain, including night pain to his back and right hip. He had lost 10kg of weight unintentionally. A two week wait was done and a face to face appointment offered for a full neurological examination. The following day the patient was admitted to hospital for suspected cord compression.
GP registrar, unspecified

OP 396 – One of the physician associates had seen a patient with me- a GP referral they were concerned about abdominal pain. To cut to the chase, the patient had undergone an abdo X-ray ?obstruction and the PA looked at it and said it was fine. After seeing the patient, I booked a CT for them and arranged for it to be done over the next few hours, to rule out obstruction. The x-ray had shown some loops of small bowel, and the patient's symptoms could fit SBO. The PA suggested we bring the patient back to the Hot Clinic the next day for the scan, and didn't seem to realise why this would be inappropriate if we were considering obstruction. They were very confident

and even recommended a colonoscopy, which I am still not entirely sure what they would be looking for with this. After I explained the patient would be staying for the scan, the PA proceeded to write out the drug kardex (It's still paper prescribing in this hospital). They copied a kardex from a previous admission. They asked if I could go through the prescriptions with them. I was baffled as to why they had written it out in the first place, but then noticed that they had written out two lots of prescriptions for the same drug, so the patient would have had double doses for the same drug. This was because the patient's regular medication was a brand name, and the Pa had just copied it over. When I asked them, they admitted that they didn't know what the drug was but because the pharmacist in the previous admission had written it under the drug reconcilliation, they had copied it over. I showed them that they had prescribed two drugs therefore twice. However, most of the PAs I have worked with seem to copy out drug kardex and say things like, "We'll have prescribing rights soon," and yet don't seem to realise they shouldn't be doing it.
Resident Doctor, Mersey

OP 417 – I was working as ICU SpR yesterday on call. Referral from ED from a PA. Asked me to review a patient in respiratory failure. They told me the patient was independent as a functional baseline. On arrival, I retook the history from both the patient and her sister sitting next to her, and later her daughter. The patient was extremely frail, with an extremely poor functional baseline, and a clinical frailty score of 8.

Secondly, the PA had seen this very sick patient that was brought in on 15L NRB with sats in the 50's. They had seen this patient themselves, unsupervised, taken a history and examined, and started investigations including VBG and ABG and only THEN (as per their own documentation) did they involve an ED consultant. The patient had been in resus since mid-day. I was bleeped at 15:30. The patient then suffered almost complete cardiogenic shock.

Time was wasted having to repeat the entire history and clerking because the PA's assessment could not be trusted.
Resident Doctor, South Thames

NP 51 –

1) Patient seen by a PA with acute cough. Sent home. PA's notes recorded tachycardia, hypotension (and maybe hypoxia). PA's written diagnosis and plan: "Impression: bacterial infection plan: oral antibiotics". PA attends scheduled debrief with supervising GP an hour later. Supervising GP immediately spots abnormal physiology and asks PA where the patient is. "At home.". Supervising GP calls patient back in immediately and arranges emergency hospital admission (fortunately no harm to patient).

Said PA no longer working at the practice.

2) At a different practice. Middle aged patient with acute dyspnoea. Sees two or three PAs on repeat presentations; patient says "I'm having panic attacks", PAs take this self-diagnosis as correct and treat as such. (I am not sure why the practice did not recognise that multiple presentations to PAs for the same acute problem is highly risky). Eventually attends ED - diagnosis of acute heart failure.

3) Patient sends in econsult "I want to be referred for a colonoscopy". Locum PA reads this and automatically refers for routine colonoscopy without any attempt to understand the indication for this. The indication was actually to evaluate a suspicious colonic lesion on a CT, which would need to be done as a 2ww. (Multiple points of failure on this one, including the people who did the CT not arranging the colonoscopy, but it is very bizzare that the PA did not collect any more details – it is not appropriate to send a colonoscopy referral without knowing what the clinical indication is).

4) A PA booking themselves double appointments (30 mins total) for things like 'painful ear' as a catchup.
GP, North Thames

NP 100 – PA saw my mother in GP with a deterioration in asthma symptoms having been newly diagnosed. Did not seek senior guidance, planned investigation (CXR, bloods)for ? Infective cause with no features of infection (other than cough exacerbation) and this resulted in further deterioration and admission to hospital as an emergency via 999 at 4am a week or so later with a peak flow of 90. Management plan dangerous and resulted in significant harm to the patient (my mother).
GP, East Midlands

NP 377 – One PA saw a patient who had recently undergone a liver resection and had swinging pyrexia, gave a course of doxy for ?LRTI, I saw a week later and sent her straight to hospital as she was septic from the liver abscess she had.
GP registrar, Severn

NP 97 – Knowledge gap and dangerous practice. Patient with known acute c-spine fracture left immobilised in waiting room while the job to immobilise the patient was delegated to nursing staff and put on the list of nursing jobs to do when they get to it. No sense of urgency noted.

On a separate occasion a PA refused to accept the advice given by myself (ST4 at the time) to scan a patient's head, and attended to an A&E consultant to get a second opinion.

The history that was then presented to the ED consultant did not have all the details that was presented when the patient was discussed with me. I could hear the discussion between the PA and the consultant, and the plan was to send patient home based on the presented findings to the consultant. Stroke team came down to see the patient as it was initially referred to them and they had refused to see. They incidentally decided to come and see the patient immediately prior to discharge (they had not been contacted after the initial attempt at triage) and the patient ended up having an ischaemic stroke following further examination, visual field assessment and scan.

On another occasion, a PA was seeing a very sick patient in resus. Brought in SOB low sats had some abdo distension. Paramedics suggested he might be obstructed. I had reviewed the patient and examined them in resus and a totally different differential was reached (heart failure). Patient did have a distended abdomen which likely was splinting his diaphragm to some extent therefore exacerbating his breathing, however the patient was not obstructed. The PA was so anchored on thinking it was obstruction that they continued down that management pathway despite being advised that this is not the likely diagnosis. The patient was made to lie down flat while the PA examined the abdomen and listened for bowel sounds. Following which patient deteriorated significantly after. Urgently started on diuretics and GTN infusion which lead to improvement in symptoms and reduced oxygen requirement. Patient then noted to have a very high troponin level and in CCF on echo. A lot of resistance was met when trying to explain that to the PA and highlight knowledge gaps.

A PA had a patient with CP that needed senior sign off and was approaching breach time. Band 7 senior sister had been coordinating the area and advised the PA to discuss the patient with an ED registrar. PA in question then bypassed d/w the ED registrar and contacted cardiology registrar directly which was not necessary for the particular case. Recurrent theme of behaviour for this current individual has been noted. Bypassing the ED senior decision maker and referring straight to speciality can create unnecessary work for the specialities involved who are likely already pressured and their input may be required with a more unwell patient in the dept. It also creates

poor relationships btwn ED and specialities due to the low standard of referrals. Some individuals believe they can behave in such a way to prove they can practice independently and make their own plans without going through the proper channels.
Resident Doctor, Yorkshire

NP 6 – I was doing ENT sho on call one time and got a referral from a PA in a GP surgery saying the patient has mastoiditis. Over the phone I asked him whether the mastoid was red and whether the auriculomastoid sulcus was lost with bulging ear the PA said yes. So I asked him to send patient to ED. When I hurried to see the patient, none of those red flag signs were present. Clearly the PA didnt know what he was talking about. It was such a waste of nhs resource, patient's time, and my time.
Resident Doctor, Yorkshire

NP 32 – A consultant holding a referral bleep for the xxx team left on holiday. Subsequently, the bleep was handed to a PA to take inpatient referrals acting in the consultants position. This PA only has 5 years experience at work.
Resident Doctor, South East

NP 45 – PAs regularly introducing themselves as doctors.

PAs prescribing on the old paper charts.

PAs taking poor quality history and exams, failing to exclude significant differentials and subsequently missed when discussed with supervising consultants who assume that this has been done.
Resident Doctor, North West

NP 60 – PA in Gastro is completing TTOs and therefore prescribing.

NP 104 – I was consultant on call for O&G. Bleeped by switchboard "GP to speak to you". Was a PA in Devizes. "I'd like to refer a patient ?ectopic pregnancy". On my querying from me: Patient was negative pregnancy test, 4 weeks from last period. Correct diagnosis was having a period. I asked PA to discuss this conversation with me with GP supervisor.
Consultant, Severn

NP 124 – Very unwell patient having emergency surgery. PA in theatre (despite there being other surgical doctors back on the ward) inserts catheter. 2 hours in to operation, still no urine output. Ask surgeons to inspect bladder, very full. Surgical reg removes catheter, it is completely bent backwards on itself within the man's penis, with the balloon inflated. Surgical consultant, angry: "I told [PA] to wait until there was urine before inflating!" Should this even need to be said? Has this happened before? Dreadful execution of a very basic task. New catheter inserted, 1.4L drained over 15 minutes. Now this patient who presented in hypovolaemic shock has had urinary outflow obstruction for 2 hours.
Resident Doctor, East Midlands

NP 243 XXX ED – they've had 3 physician associate students join the morning shift and then another 3 join the late shift. All were dressed in smart looking bottle green scrubs; but this isn't clear that those scrubs mean PA students (I thought they were medical students for about an hour). In fact, I only realised when a pa student was assigned to shadow me and I asked them what they wanted to do / achieve and their background. Over the day I noticed only 4 were wearing trust ID badges which their title is "student physician" – there is NO mention of associate or PA. No other ID was worn to show / demonstrate that they were pa students. The one shadowing me saw a patient before me for their learning, and I went to take a collateral, check history and make a plan. The patient then asked how my training was and if I'd learnt a lot from the physician – cut a long story short; the patient thought that I was a student (my badge

says "Doctor ST trainee") and the PA student (with a badge saying student physician) was the qualified doctor and my boss. It was more awkward when my plan was slightly different the what the student pa said and the patient asked me several questions to check I was right because it wasn't what the physician said.

I asked the student PA if their badge ever confused anyone or if they had another ID / name badge that made their role more clear. The student got awkward and short with me, saying it was the trust / hospital that issued the badges.

I've subsequently checked with the security office (the issue ID badges) who said they just print whatever the title says on the ID

Form application. They mentioned all titles are normally filled out by the staff member asking for the badge and then this form is countersigned by a tutor of some form – they suggested the student pa's would have put down student physician down and would have been aware there wasn't enough characters for associate to be added. I havnt been able to confirm this but the whole experience was a moment that highlighted patient perception, understanding and how titles can be confusing.
Resident Doctor, East of England

NP 488 – In A&E I triaged a patient and wrote a plan to refer to ENT. The patient presented with an otitis externa to the extent the canal was fully occluded. Before I could refer to ENT myself, a PA put their name next to the patient. I later checked on the patient and the plan and the PA did nothing for the ear, reported no ear examination and instead sent the patient home with anti-emetics (the patient also reported nausea).
Resident Doctor, North Thames

NP 704 – During departmental induction the clinical lead said "we are a multidisciplinary team so if a PA asks you to prescribe your answer will be yes".

This department has a PA who performs all of the ascitic drains, given the recent tragic news I am concerned that rotating resident doctors are being forced by the consultants to take medicolegal responsibility for facilitating the PAs.

PAs conduct solo ward rounds and post instructions on WhatsApp for resident doctors to prescribe based on these ward rounds.
Resident Doctor, Severn

NP 712 – Trainee AA working with consultant anaesthetist in theatre. Consultant introduced the trainee AA as "this is X, she's another anaesthetist".
Resident Doctor, Mersey

NP 792 – I found a PA prescribing antibiotics under a consultant using my log in details whilst I was in the bathroom.
Resident Doctor, Yorkshire

NP 867 – PA from GP saw patient with unilateral leg swelling and pain and said they did not know what the cause was and needed to discuss with GP, but then said they should just wait to see the GP because they had a routine appt booked with GP in 8 days time. Was a wasted GP appt because nothing was done and when they eventually saw GP they referred for same day assessment? DVT.
Resident Doctor, North West

NP 924 – When I worked on dermatology there was an influx of referrals which were completely inappropriate to the service. There were hinders of USC referral for seb Ks, a benign skin growth with no photos and a referral akin to 'i dont know what this is but it looks bad, please see'. They were impossible to triage and clogged the service. One read 'there are 40 melanomas on this gentleman's back and I have informed him of this.' I reviewed this man and he had nothing that looked like anything of the sort and this was confirmed by the dermatologist. This man spent 3 weeks thinking his life was over.
Resident Doctor, Wales

OP 59 – One of the PAs insisted she "liked seeing patients alone" and would get very upset when this wasn't allowed. She once came across a patient with a potassium of 2.5 and wanted an F1 to prescribe 500ml of saline with 40mmol stat, of course to which it was explained that was very dangerous and due to her "seniority" in the department, she was offended by the correction.

Another experience, with another PA, she handed over a patient in the whatsapp groupchat stating "patient has bowel obstruction surgical team didnt come today, day team review tomorrow". This was stated at 5pm on the day before industrial action. I was on call that night and was called to this patient as she was vomitting; no ryles tube in place, pt was nbm but no fluids prescribed and a CT was not done. The patient was urgently reviewed by surgical team once I explained the situation.

These are part of many inappropriate events that have occurred as a result of lack of appreciation of the medical scenario. As medical students medical emergencies, both surgical and medical, are reinforced throughout the 5/6 years. Obviously this is not possible in a 2 year degree. I understand that PAs don't have rotational training which means they know a lot about one specialty but very poor understanding and appreciation of others. Thus, they can never be safe practioners!
Resident Doctor, South East

OP 100 – Whilst working as a long term locum I raised concerns to my consultant that a physician associate working in the department had not done ANY documentation for 5 patients she had seen on a Friday evening and instead opted to go home half an hour early. There were no clinical notes/documentation or any discharge summaries for these 5 patients. So no record of these patients being seen, history/examination findings or plans. My consultant was supportive, thanked me for highlighting this and assured me he would look in to it. I was pulled in to a meeting not long after by the clinical director who informed me my contract was being terminated as the physicians associate had accused me of bullying. Apparently I was keeping too close an eye on the work she was doing. At no point was there any investigation done in to these allegations and after working for 2 years on this department, and 4 years in this hospital I was simply told to collect my things and go home. I lost my job for escalating this very valid patient safety concern. There seems to be an ego issue with a few of the physician associates I have worked with whereby they can ask us to prescribe things or request tests but if you ask any questions or challenge any decisions they make then you are met with extreme hostility.
Resident Doctor, Northern

OP 88 – Have witnessed physician associate advising an F1 doctor to give the incorrect course length of antibiotics then berating them when it was questioned. only when 2 more senior doctors advised it was wrong did they admit the formulary should be checked.
Resident Doctor, Mersey

OP 138 – I worked on call recently and took 2 surgical referrals from a medical ward staffed by PAs as junior doctors. I was astonished to discover the complete lack of patient care or comprehension of their inadequacy. One patient had had a perforated peptic ulcer for 4 days and had not been treated or referred despite being severely unwell with significant GI bleeding. Having read through the patient notes it was clear that the level of care was egregiously sub standard and this traced back to the incompetency of the PAs staffed as junior doctors. I also saw at the same time a newly qualified PA attempting to put another patient on end of life care without consultation with a senior. All notes and reviews were also written by PAs and I had no confidence in the assessment or clinical knowledge of the reviews.
Resident Doctor, unspecified

OP 144 – Last year as a fourth year medical student I was placed in the clinic of a breast 2ww PA. A lady came in and after hx/ex he said he thought it was benign but that he would 'send her through anyway' to mammogram. It turned out to be a huge tumour and the registrar was shocked he had reassured the pt based on what was very much concerning ex findin
Medical Student, North West

OP 190 – I have video evidence of a PA illegally completing TTO prescriptions which often include drug errors eg. inappropriately high opiate doses. Thankfully the dose they entered were not formulations that can be given so this prescription was stopped. Eg. 53mg oxycodone BD in a frail elderly patient. The same PA copies and pastes ward round entries from one day to the next without even amending the date. This was shown to consultants at the trust in question who, as far as I am aware, did not act. At the weekend, I would pick up the patients he had been independently responsible for during the week and no jobs had been completed and many required urgent management. Consultants would round the patients but would only see the patients if the PA raised concerns and would not look through the bloods etc without the PA alerting them to it. He also introduces himself as the orthopaedic SHO on the phone and never corrects patients and nurses on the ward who refer to him as doctor. PAs at this trust are able to pick up SHO locum shifts at SHO locum rates. PAs are also paid to attend theatre and clinic which FYs are not.
Resident Doctor, South East

OP 257 – I'm a derm reg and was on call today. I took a phone call from someone who called themselves a "doctor practitioner" at a GP surgery. I later established they were a PA. They tried to refer a man in his 20s with a 5 day history of tachycardia, fever, hypertension and a rash with intermittent angioedema of the lips and eyes. I said this patient sounded sick and asked if he was- to which she replied "yes he is definitely". I quickly told her this patient needed an inpatient review by the acute medics for a full work up and investigations as he was unwell. He did not need an outpatient dermatology review. I find this worrying as identifying a sick patient is a basic skill of a doctor. We do not expect new juniors to know the cause of what makes patients sick all the time but at the very least we rely on them to know when a patient is sick and direct to the right escalation. I also don't know if this was discussed with a supervisor or they made their own triage decision. Either way, I was concerned with the referral as it seemed inappropriate for an outpatient setting.
Resident Doctor, Peninsula

OP 244 – Physician assistant students at a hospital in Liverpool have the same id cards as student doctors that says "medical student", feel this is a little misleading for patients.
Medical Student, North West

OP 270 – AAs in XXX still working to extended scope of practice despite leaked email and RCOA EGM. Independent induction and extubation with supervisor in coffee room.
Consultant, Yorkshire

OP 310 – I have come across one physician associate from XXX who told staff at my hospital that he was a GP. I informed our local PA supervisor, who told his Mid Wales equivalent. I am concerned that he was doing this to his patients and hence creating patient safety issues. For clarity, he was attending our hospital as a relative, not in a professional capacity.
Consultant, Wales

OP 330 – PAs are being used for focused skills without the broad based training to understand the full scope and impact of the skills they are now holding. For example – a PA I worked with runs the ascitic drain clinic and trains IMT trainees and signs off their DOPs for ascitic drains, and yet when one of the IMTs asked them about calculating the dose of lidocaine they responded "I don't know I just give them Xmls". Same PA is then looking at a coronal CT scan of a patient who has had a huge intrabdominal haematoma following ascitic drainage, when myself and the registrar look at the scan and comment on the size of the collection, the PA agrees that it appears huge whilst pointing to the patient's pelvic bone. So we have a scenario where the PA can complete ascitic drains to a good practical standard, but they cannot appreciate any variation from the norm, and they haven't the knowledge to understand the pre-procedure checks or the post procedure complications. The same PA also works on the Acute Unselected Take but cannot recognise a pelvis on a coronal CT.

I also find it very difficult to work alongside PAs on ward rounds because I absolutely cannot know the depth or breadth of their knowledge, and find it challenging to know when I need to question their action plans, as they will present cases with only the information that they themselves have gathered.
Resident Doctor, West Midlands

PAs are also being used on the rota regularly to cover on-call Post-Take shift with the F1 which is usually covered by an SHO and again F1 is being forced to do all the Prescribing for the PA despite the fact that F1 is unlikely to have the seen the patients.

PAs are covering medical on-call ward cover shifts, reviewing the patient and bleeping F1s to prescribe for them.

PA are locuming on Medical Take SHO shifts again asking F1s to prescribe for patients they've clerked.

PA are running their own Haematology clinic at xx.

PAs are covering on-call Orthopaedic shifts.

There is a large group of BMA members at xx hospital who are very concerned about this, especially for the medical take shifts and on-call shifts and A&E where there have been a few near misses.

We are too afraid to speak up as afraid of retaliation from Management and Medical Directors especially as many of the consultants act as our supervisor.

We would be grateful if you could raise this issue on behalf of us
Resident Doctor, Thames Valley

OP 353 – I have worked with a few PAs in the last two years or so. I think the gap in knowledge is really stark but insidious because you are not wholly aware of it unless you probe or there is a suggestion of something that indicates the gap in knowledge. I usually have to go and re-review patients before I contemplate prescribing what the PA colleague has suggested, but it does not reduce my workload when it comes to reviews and if anything can cloud the real picture of how sick a patient might be

before you get there to review. I personally think that sick patients should be only reviewed clinically by doctors given how many times there has been erroneous plans.

One incident comes to mind a year ago where I worked with a PA in a community rehab setting. I was still on the bus a half hour until my shift was to start and I got a phone call by the PA asking me if I was in the building because there was an emergency. I told them to escalate it in the hospital and that I could not even really give advice on the busy bus. On arrival, I took over the acute situation but later on was debriefing with them and asked if there is an escalation plan in place for them in case of situations like this OOH so they can contact the medical team at Hospital at Night for example etc. They took offence and said that they are the medical team and that they just needed someone to prescribe the end of life medications for the patient. The lack of insight that they did need to escalate this situation, as making the decision to palliate someone is completely outside of their remit and I would argue out of a lot of junior doctor colleague remits, was shocking. Also, having called a colleague not yet meant to be at work for help, clearly they were not prepared for the scenario. This is not a singular event in terms of the behaviour and perception of what the PA role is. I also think its completely unsafe to be having to prescribe for them. Being handed a kardex to prescribe things when you haven't seen the patient or know their history is not safe and I refuse to do it without reviewing the circumstances. Therefore, in that interaction their involvement is pointless. It does not reduce workload. The amount of times I have been handed a kardex and asked to prescribe something unsafe that would be obvious to other doctors (such as dalteparin when they're already on a DOAC or just had a stroke etc) is not reassuring . I do not believe this is a marker of individual PAs, I think it is a symptom of a larger systemic issue. I am happy to discuss this further but I have a lot of experiences which are not reassuring of the future of this role. They are all lovely people personally and if the scope was relegated to scribing, discharges, bloods, cannulas etc that would be wholly appropriate but what is happening now is worrying.
Locally Employed Doctor, Scotland

OP 418 – Patient couldn't see GP, attended nearby A&E where they were seen by a PA. Progressive red flag headaches and dizziness – a neuro exam was documented as normal and sent home. They re-presented to me soon after this when things kept getting worse. On exam it wasn't only clear there was a neuro deficit, but I was able to localise it clinically. The lesion, likely a tumour, was confirmed on imaging. This could have been diagnosed (and treated) sooner if they had seen a doctor on their first A&E visit.
Resident Doctor, North Thames

OP 405 – I work at xx Hospital and we had one patient with pneumothorax with a PA that inserted the chest drain because they were the only one who was available and signed off to do so and it was only inserted around 2cm (?!) – when CXR was done you could see it was barely inserted and it had had no impact and another one had to be urgently put in the next day. When removing the first one it came out straight away as it had barely been inserted.

Another PA in ED had done a catheter on a old guy in ED. He started bleeding from the penis and when I went to check and insert another one as no urine had been draining all day and the PA had not identified this even though urine in the bladder, I realised he hadn't inserted catheter up the urethra at all and had instead blown up the balloon within the foreskin!!!

I think the most dangerous thing is that they act like doctors and so the patients, sometimes even us as staff, don't know if they are a doctor or a PA. We all make mistakes but there just seems to be a much higher rate of mistakes and mis-diagnoses amongst the PAs. They are nice enough but act above their knowledge level I often find (and the most dangerous part is that they never seem to admit or know that they

are in above their head if they don't understand something) and because they are let loose they can continue to do this which puts patients at risk.
Resident Doctor, East Midlands

NP 138 – The PA in the practice undertakes a minor surgery clinic once a month, draws up and administers local anaesthetic, removes seb ks, skin tags, etc.
Medical Student, Northern

NP 166 – PA seeing patients within GP independently and prescribing drugs (including controlled drugs such as tramadol). GP supervising would sign-off on prescriptions without ever seeing patient. Quality of history/examination was incredibly poor and unfocused. Saw several patients after this PA who had been given very incorrect diagnoses (e.g. dx with calf strain but actually had peripheral vascular disease).
West Midlands, Severn

NP 180 – PA's seeing "category 1" patients in resus. Patients safety – cannot prescribe emergency meds. Cannot request ionising radiation. Training issue – ED trainees in department therefore are not seeing acutely unwell patients in resus which is hugely detrimental for our training. Further – PA needing constant consultant supervision means trainees lose access to consultant supervision for discussions / education.
Resident Doctor, Yorkshire.

NP 106 – 1. PA working on the ENT reg rota and leading ward rounds

2. PA working in breast seeing 2ww patients and discharging back to community – no documentation that they had been seen by anyone else

3. PAs and ACPs working in same day emergency care seeing undifferentiated medical patients on take. Has resulted in at least one serious incident due to missed diagnosis/ mismanagement

4. ACPs on ED rota being prioritised for shifts in resus over ACCS trainees. **Resident Doctor, Peninsula**

NP 13 – I was on placement in the xxxxxx emergency department and observed/ shadowed PAs whilst there. There was a particular PA who I witnessed performing a range of malpractice issues. They introduced themselves to patients as "one of the juniors here in A&E" – not once acknowledging their role as a physician associate. I am certain that patients under their care would have assumed they were being treated by a doctor. In this hospital, doctors often had to discuss scan requests directly with radiology before ordering them. As I followed the PA to radiology reception, I watched them hide their hospital ID badge. I asked why they were taking off their lanyard and the PA answered, "I have to hide my ID because if radiology know I'm a PA they will never accept my scan requests". The PA proceeded to order chest X-rays. I witnessed this behaviour on multiple occasions but did not understand the role of a PA or feel able to report the behaviour as I was only a third year medical student.
Medical Student, Wales

NP 20 – I have worked with a number of PAs and I am regularly shocked and appalled that these "medically trained professionals" have so little understanding of basic anatomy and physiology, certainly below the level I would expect of a medical student, let alone a doctor- for example, not knowing a heart has 4 chambers. On more than one occasion I have heard PAs informing nurses and discussing with other PAs that they are "equivalent to a medical registrar". This, in my opinion, is a profoundly dangerous attitude.

NP 54 – When I was an XXX SHO there was a physician associate who despite being a substantive member of staff would introduce herself as 'one of the locums' to imply that she was a doctor. The clinical reasoning that she displayed was also very poor. Her behaviour was reported but continued.
Resident Doctor, West Midlands.

NP 79 – Today I came across A DNACPR form that had been completed by a PA. It had been signed by a PA who used the countersigning consultant's GMC number under their own name (the electronic form does not allow the form to be completed without a GMC number).
Locally Employed Doctor, Northern

NP 98 – I was the night SHO clerking on medical take. At the start of my shift, a PA who had been doing medical clerking handed over to me. They wanted me to request a CTPA for a patient.

I did not feel comfortable to request ionising radiation for patient that I had not seen, and that had not been seen by a doctor (they had been assessed by an ED ACP before referral to medics).

I reviewed the patient's notes. They were a pt with known COPD who had come in with shortness of breath and wheeze. Slightly tachy and sats were around 87%. Raised inflam markers, normal ddimer and chest x-ray. By this point they had been in ED for 10 hours. They had not received any abx or nebs, but had received a dose of LMWH (which the PA had asked an ED doctor to prescribe).

I reassessed the patient myself, re-diagnosed them with iecopd and initiated the appropriate management.

This episode led a type 1 error for the patient – receiving a high dose of LMWH for the incorrect diagnosis. And a type 2 error – long delay in correct diagnosis and initiation of correct treatment.

It also led to a doubling of workload – morally and medicolegally I took it upon myself to reassess the patient. This led to extra work for me and rendered redundant the PA's role in the patient's care. **Resident Doctor, Northern**

NP 172 – PA would routinely mismanage patients with diabetes who were for theatre. PA would routinely not stop DOACs in time for surgery. PA would have independent lists carrying out tendon repairs (which most registrars couldn't do) but always state a consultant was supervising, despite not being in theatre.
Resident Doctor, North West

NP 223 – PA being trained up to insert pacemakers. This is actively being encouraged within the department and not one isolated event.
Resident Doctor, Peninsula

NP 232 – Multiple referrals to outpatient neurology clinic of patients seen in GP practice by PAs with inappropriate management and no evidence of discussion/ oversight by GP. Example – mismanaged migraine headache, mri scan done through GP referral, and incidental finding of pineal cyst miscommunicated to patient as a potentially worrying pineal abnormality. Anxious patient made further anxious, and then referred to neurology in appropriately on 2 week wait pathway to sort out.
Resident Doctor, East of England

NP 338 – I have noticed an increase in referrals from PAs in primary care that are unnecessary and if they had seen a GP, would not have been referred onto secondary care. For example, a PA saw a tiny infantile haemangioma and referred it on for diagnosis.
Resident Doctor, West Midlands

NP 465 – I'm currently working on xxx. I picked up a patient that was still in ED, and when I looked at the notes I could see that he'd had a scan suggesting a space occupying lesion in his brain. It had been reported 4 hours earlier and included "urgent referral to neurosurgery" in the recommendations, as well as further imaging to better characterise the mass. When I reviewed the notes there was not mention of further imaging and no referral had been documented. I went to see the PA who had seen the patient in ED, and when I asked her about the referral she said "I discussed it with the consultant, and he didn't tell me to do that". When I asked about the imaging she said "I can't request imaging". There was no appreciation that these things had needed doing and that they take time, so getting the process started promptly can be important. While no actual harm came to the patient, it was disappointing to see a lack of understanding of the important steps necessary for a patient with a serious new diagnosis, especially as 4 months ago I was working in that department and was effectively working at the same level.
Resident Doctor, Northern

NP 517 – An acute medical consultant saw a patient with a PA then came into the office where it was me and both of them. The PA then wrote all the drugs for this patient on a drug chart and asked me to sign it whilst the consultant was there. I suggested the consultant should sign as they have seen the patient, the consultant ignored me. It was very awkward and after checking patients allergies and drugs myself I felt forced to sign for the medications. The PA then asked me to sign for fluids. I checked the patients bloods and BNP was >35000. Having not seen the patient I declined and said the consultant can sign for that and was met with resistance by the consultant again. I had to just walk out to avoid this. I'm concerned as I've seen a lot of PAs writing on drug charts at my trust and writing drug TTOs then asking juniors to sign it off. The consultants should be doing all their medications prescriptions.
Resident Doctor, Wales

NP 625 – Politely declined to prescribe on behalf of a PA as I wasn't on their ward round and didn't see the patients. Caught the PA discussing me (and the fact I had refused) to two separate members of staff. Asked her politely to stop and to discuss with her named consultant. PA came back and told me that said consultant wanted to speak to me. Said consultant told me I wasn't being a team player and that the juniors always prescribe if it's documented in the ward plan. I informed him that this isn't what the GMC/BMA states. He said it has been decided locally and he could give me the minutes to show if it made me feel better. I said those minutes don't help me if I get in trouble for prescribing the wrong thing. Consultant then went on to tell me that he has prescribed it all anyway.

Asked another consultant for advice. Was told PAs help me so I should help them. I asked how they helped me, was told they write DC letters for you. I replied that's never happened for me. I asked why that job couldn't just be a Jr Doctors job as it would eliminate these issues. Was told that PAs make things smoother as they are constant members of staff. It's all well and good them making the consultants lives easier when the responsibility is shafted to the juniors.
Resident Doctor, East Midlands

NP 705 – Told at induction by consultant – The PA is very experienced. if they ask you to do something then your job is to do it.
Resident Doctor, Scotland

NP 858 – I worked with a PA during my placement on diabetes and endocrinology as an F1 doctor. She was very kind and well meaning, however her knowledge was poor and led to several issues of patient safety.

For example, despite having worked as a fully qualified PA for 2 years and been on a diabetic ward for 5 months, she did not know what a DKA was (a common diabetic

emergency). We all took turns to try to teach it to her but she still did not understand it by the end of my rotation.

Nursing staff did not realise she wasn't a doctor and would come to her with medical emergencies, which she did not appear to realise were emergencies. For example, an experienced nurse highlighted that a neutropenic patient was newly tachycardic and pyrexic. Her only response was that he had been tachycardic the day before and didn't do anything. This nurse knew to escalate this to me – he was septic. I sorted everything else but asked her to examine him for a potential source of infection, she examined and said she could not find one. I examined him and found pus coming from his PICC line.

Due to her lack of clinical skills, she ended up mainly writing discharge summaries. However, these were often poorly written and lacked key information. This led to vital bits of follow up being potentially missed – for example, a patient being discharged out of area required vascular follow up due to a toe amputation. She not only didn't arrange follow up, but didn't include it in the discharge summary, meaning the receiving hospital would have no knowledge about it. This happened multiple times, meaning that I would check and often rewrite all her discharge summaries. I tried to use these as teaching opportunities for her. However, it was frustrating as she was being paid considerably more than me despite working less hours, and yet I was supervising her and often redoing her work. This has made me feel like I am undervalued within the NHS and has made me want to leave to work elsewhere, where I am appreciated.
Resident Doctor, North West

OP 35 – I worked with a PA for about 18 months in General practice. She was employed by the PCN. She had to have a named supervisor, so I put my hand up for the role. I was led to believe by the PCN that she was an independent healthcare professional who was fully trained and that the type of supervision I needed to provide was just to be available onsite if she had any queries. It was made clear by her employer that I did not need to discuss all of her cases with her. I was quite surprised by this at the beginning. I was also incredibly surprised by her scope of practice. However it became clear over time, mainly by chance, that she had huge gaps in her knowledge. I am concerned that there will be patients in the future with missed diagnoses potentially because of her lack of knowledge.

I believe PA's (and other ARRS roles) have been used to replace GP's. As a consequence there are thousands of GP's currently unable to find work at the moment.
GP, North West

OP 39 – While at university, a PA student once introduced herself to the patient as a medical student. When I told her that was wrong, she told me that she was doing a medical degree in 2 years while I was doing it in 4. This is the attitude of many PA students I have encountered and is extremely unsafe. Patients will not know who is treating them if PA continue to label themselves this way. It is a massive probity issue and if a medical student labelled themselves incorrectly in this way it would be an FTP issue. Additionally their knowledge base is poor. Having done a biomedical degree myself I know categorically that it does not provide enough of a medical knowledge base to then do a 2 years masters and be ready to see patients. If we used this logic we should let physics students be PAs. Biomedical students are scientist and are taught lab based knowledge on a cellular level. This is not the same as understanding a medical condition and its symptoms in a clinical setting. To suggest this is enough puts every medical degree undertaken in vane.
Resident Doctor, Severn

OP 87 – My concern with patient safety is with regards to PAs in general practice. I work in rheumatology and the quality of referrals from PAs is so poor that we are considering refusing to continue to accept. Most of the time referrals are inappropriate eg clear chronic pain rather than inflammatory. However, last week a new patient had been referred as tired all the time and ana positive. This has been triaged as routine. The referral did not state that the person had myalgia, muscle weakness, hair loss, new raynauds and widespread joint swelling. This resulted in a delay in assessing what should have been an urgent patient. I think this is because the PA lacked the ability to interpret the ana or to perform an appropriate examination (the patient had very very obvious synovitis and no hair!)

With regards to training, in my previous job in respiratory we had PAs. They were useful for ward admin but would delegate any challenging jobs to F1s. They had clinics and regular chest drain lists that INTs and registrars were often unable to attend as they had to cover wards / resp referrals. I think they negatively affected my training as they were prioritised for education and non ward jobs whilst the medics were used for service provision.
Resident Doctor, Yorkshire

OP 89 – I am studying at XXX University and met a PA on my ID/micro placement. She did not introduce herself and I believed she was one of the Regs. She took me on a ward round and asked me to scribe for her, at no point did she tell me or any of the patients that she was a PA. All the patients called her 'Dr' and at no point slide she correct them. Several nurses also addressed her as Dr with no correction. She saw all the micro patients independently without supervision or support and I got the impression she never asked for any support. At one point she told me she will 'only speak to Regs' when she is on call as more junior drs 'don't know anything about micro and are wasting her time' I found this comment highly derogatory about colleagues. A senior staff nurse requested her to prescribe IV fluids to an older gentleman with T2DM as his colonoscopy procedure was being delayed again. She took the chart from the nurse and agreed but then put the chart down by the patient's bed without doing anything. As we left the ward I asked if she wanted me to grab the chart (as I was worried she had forgotten and the nurse definitely thought she had done it), I had also noticed the gentleman's BM was abnormal so thought IVFT was indicated and only then did she say 'oh I can't prescribe', I asked why and she told me she was a PA. She said she would ask the reg to go back later but she never did. In the afternoon session I was worrying and mentioned it to the reg but she knew nothing about it and the PA said 'oh well his glucose was normal so he doesn't need any fluid' I totally disagreed both clinically (it was not normal) and more importantly because the nurse thought it was done and had been misled. I believe the reg did check but by this point around 5 hrs had passed. I passed my concern to the placement lead, both about patient safety failings but also the dishonest attitude of the PA who completely misrepresented herself to staff and patients and, I feel, was unsafe and not clinically competent. The next day she delivered a teaching session but just came in and said 'this is boring you can all go for coffee if you want' the session was c.diff on and ID week so I felt like we missed important teaching because she couldn't be bothered.

There are also training implications as this PA told me she 'slid into a micro training programme as she happened to work I. The department' I feel this is hugely unfair when the competition ratio for the specialty programme is so high and there was no advertisement of the role she took. It is likely this is even illegal in employment law terms.

In general PAs are prioritised above med students at XXX, whilst GEM students are being sent to peripheral hospitals and sent on phleb rounds (very useful but not something PAs are sent to do) the PAs are always on the wards in major specialties in the local hospitals. Also they wear the same uniform which is very confusing and the website advertising the course is laughable – it basically suggests that being a PA is

being a dr bit without the hassle of rotational training and better hours!
Medical Student, Wales

OP 92 – I have been asked a number of times to prescribe medication that was contraindicated or stop medications that the patient was supposed to continue on. For example prescribing clexane for patient with egfr of 11.
Resident Doctor, North West

OP 98 – In duty GP, MAP pledging diazepam for back pain without appropriate safety netting, offering antibiotics over the phone for a cough without offering examination. Not consulting the duty doctor with queries as have fixed in on a potential diagnosis and management, and are not aware of their own unknowns.
GP registrar, South East

OP 99 – Patient was seen for weight loss in primary care

Fbc ue lfts and tfts were only done , two weeks after apt booked to discuss results (by the PA) – a gp colleague then arranged a f2f same day- essentially history was back pain worsening dm weight loss 7kg plus over a month and reduction in apeitite – delay in referring for a 2ww due to first consultation with a PA.
GP, East of England

OP 154 – As a medical student I have witnessed many instances of PAs clearly out of their depth. One such instance is when I was timetabled to sit in a geriatrics falls clinic – I turned up and the consultant told me to sit in on the PAs clinic. The PA was meant to fully review each patient, including rationalising their medications etc, and then tell the consultant at the end what needed doing for each patient. The PA clearly did not know what half the medications were (as a medical student who was meant to be simply observing, I had to tell them what several were for and whether or not they could be contributing to falls) and also raised many clinical concerns unnecessarily, e.g. saying a patient needed a dermatology referral for a 'florid maculopapular rash' when they just had a few cherry haemangiomas which they had had for years. Moreover, several times patients would refer to the PA as 'doctor' – the PA only corrected one patient once, leaving all the other patients thinking they had been seen by a doctor. Frequently the PA would leave the room to discuss cases with the consultant and I would be left with the patients who would say things like 'why didn't that doctor know what my medications are for?' and it was left to me to explain that they hadn't seen a doctor, and that if they have concerns about that they should request to see the consultant running the clinic or talk to their GP. In the same department, PAs are regularly on ward rounds and I would see them telling foundation doctors to prescribe for them without any clinical context. It was clearly the presumed norm that the doctors would do so without reviewing the patients themselves or even asking questions.
Medical Student, Thames Valley

OP 168 – I was a GPST1 in a paediatrics rotation. I called a tertiary hepatology unit to ask for advice about a patient. My call was taken by a PA.

After I dropped the phone, I spoke to my consultant about it because I was very uncomfortable. She said, and I paraphrase, if that's who they decide to man the referral line, then it's their responsibility.

The PA said they were going to get back to me after speaking to their consultant. This was after they had asked me to do additional hepatology investigations that we had already done.

They never got back to me.
GP Registrar, Peninsula

OP 176 – I am a GP partner – we had a PA student on placement with us for 4/52. I was horrified by not only her lack of clinical knowledge, but the lack of insight into her limitations and her various repeated statements about how she would be 'just like a GP' on finishing her course. This wasn't a viewpoint that evolved during her placement and she left us none the wiser than she started despite our repeated attempts to teach her about unknown unknowns! We have declined further PA students since.
GP, Scotland

OP 217 – Worked in a in large tertiary ED in the XXX. Physician associates were sometimes allocated to 'lead' a team in majors, which sometimes included fairly senior SHOs (ST2/3s etc).

Yet – this level of responsibility would never be trusted to an FY1 doctor, who of course would need to run every patient past a consultant. Especially in majors where patients can be severely unwell and complex

Make it make sense!
Resident Doctor, East Midlands

OP 224 – I work as a long term locum in a GP practice. Part of my role is to supervise the ARRS staff. One of these is a PA. He is without doubt the most worrying person I have ever had to supervise in over 30 years as a GP. His basic knowledge is poor, he is unable to present a coherent history and examination, he is unable to formulate a differential diagnosis. And he is unable to recognise his limitations. He seems to have learnt nothing in the time he has been here (over 18 months) and shows no interest in being taught in any way. Patients frequently believe they have seen a doctor. I will no longer sign off on any prescription for him without reassessing the patient myself. It is only a matter of time before a patient comes to serious harm at his hands.
GP, West Midland

OP 343 – I was working with a MAP and the patient was being cardiac monitored. There was some baseline wander in the ECG and the MAP reviewed it as STEMI, starting acs treatment even before getting a 12 lead which did not show any territorial infarct. The consultant looked awkward and didn't actually correct the MAP, because the patient was too sick for PCI transfer anyway and so the consultant said discuss with cardiology in the morning, who said not an MI! This just goes to show that supervision is not the panacea, if the underlying fundamental training is so poor.
Resident Doctor, Scotland

OP 357 – In my trust, there was a full morning where the entirety of ED majors, including resus and pit stop was staffed entirely by PAs, two of whom were one year out of uni. I don't know how they were prescribing medication or ordering XRs or CTs if needed.
Resident Doctor, Severn

OP 360 – I am both a GP and a patient.

A physician associate recently missed a relative's presentation Wira dyspnoea (three presentations). Seen by GP. Referred to ED. Myocarditis.
GP, South Thames

NP 103 – I noticed that our PA is given undifferentiated, complex cases, doing unnecessary investigations like CXR/ ECG for pre shingles pain on right side chest, not checking self harm or suicidal risk in depressed patients, inadequate history in patient with PR bleeding, taking part in minor surgery clinics, home visits, referring patients to hospital. He is working in this GP surgery for 4–5 yrs, doing GP equivalent job. They made the salaried GPs to supervise PA during their Oncall days as GP partners do it when oncall.
GP, Yorkshire

NP 142 – I am a salaried gp but have a nominated list of patients that are my responsibility over 6 sessions. PAs in the practice see undifferentiated patients by themselves in clinics all day, approx 12-13 patients per clinic. Some will be my 'registered patients'

The partners expect me to take on 'supervising' responsibility for any patient registered to me that a PA sees, even when I have no contact with the PA or the patient or anything to do with their episode of care, and am not asked to review by the PA and do not have any allocated time to perform any supervision. I have told them I refuse to accept this responsibility and don't want to supervise PAs in this way, and the partners don't seem to accept this and can't understand what my concerns are! The PAs see any and every type of patient of every age. They are not supervised , unless they ask for a prescription or task you with a query.

(Which is a minority of the time)

Can you provide me written support to prevent me supervising PA without my agreement?
GP Mersey

NP 440 – I am a 3rd year medical student and was at said GP Practice for a 4 week placement. Myself and my partner had consultations in which we took a history from a patient before they saw the GP, presented our findings and then the GP would also see the patient. We would see maybe 3 patients a day, amongst shadowing the HCA, GPs and private study. After 1 week a 1st year PA Student was also placed at the practise. She was immediately placed on the EMUS system (we were not placed on the system despite being there a week longer) and given a dedicated morning and afternoon clinic, seeing up to 10-15 patients per day in 20 min appointments. Not only did this take away learning opportunities from myself and my partner as we were often left in the staff room with nothing to do, but I also think it posed a huge risk to patients safety as the (1st year) PA student was seeing, diagnosing, discharging and recommending prescriptions for patients (including babies and children) completely unsupervised with no requirement to see a senior GP unless she 'got stuck'. I do not think the patients were under the impression that they were seeing a PA, having booked the appointment under a GP.

It was incredibly frustrating as a 3rd year medical student to have opportunities taken away by a 1st PA student with no prior degree or experience. We would spend a whole day shadowing a HCA helping with blood pressures whilst she led consultations.
Medical Student, Mersey

NP 62 – Worked in a department with more PA's than FY1's

PA's used in the week on the ward to make up numbers, always extremely understaffed out of hours. Every weekday all doctors on the ward but 2of the 3 PA's would be running clinics, reviewing outpatients and doing procedures like bone marrows.

IMT's given extremely minimal clinics when PA's have clinics every week. They take time during ward days to prep for clinics so not even helping with ward work.

PA's doing ward rounds alone, telling juniors what to prescribe/de-prescribe on their behalf

PA's doings procedures such as LP's and doctors not getting chance to do them

PA's calling other departments and not specifying that they are a PA. Doctor on other side would have assumed they were a fellow doctor.

Saw PA having discussion with radiology over phone saying 'can you change the request or I can easily do it here' – lying about ability to order scans.

PA holding reg bleeps in multiple departments across ARI

PA's genuinely coming across with the confidence of registrars. Nursing staff ect. Don't seem to realise PA's can't prescribe and they aren't clear about this.

PA's coming to review paediatric patients alone and then telling medical staff which medications to prescribe. Very worrying when these PA's come from adult departments and solely review children. Didn't actually say they were a PA, I knew from working with them previously on placement.

Have 2x had to de-prescribe after PA got another junior to prescribe unnecessary medications. Have only been in this job 3 months.

PA students observing and completing procedures instead of medical students. PA students unable to take bloods with less than 12 months left of their course when medical students are competent with 2 further years of study. PA students needing less 'sign offs' to complete procedures alone than medical students (PA – 3 attempts, medical students – 4 attempts). PA students telling medical students their final exams are equivalent to medical school finals.

Have seen patients refer to PA as 'Doctor' and PA has not corrected them. Moreover there is obvious confusion from patients, I've seen a very large number refer to PA's as doctors.

They are thoroughly ingrained in departments here and it is very difficult for junior doctors to argue with their requests.
Resident Doctor, Scotland.

NP 78 – Physician associate working in ambulatory care unit independently and leaving clerking forms to be completed by SHOs.

Physician associates are given priority in bedside ultrasound training (by a consultant supervising ultrasound training in acute medicine department) over locally employed doctors (who are completely refused any training).
Locally Employed Doctor, South Thames.

NP 175 – At morning handover it became evident that the only clinicians overnight in NICU were: ST5 registrar, ANNP, and PA.

The consultants have now merged the rotas- where previously there was an ST1-3 and a separate ANNP rota. There then became the ANNP/PA rota. Now there is the ST1-3/ ANNP/PA rota. This now means there are nights and days where the only doctor is the registrar. This is a tertiary medical level 3 NICU receiving babies from all over xxxxx.

It was then revealed that the ANNP overnight supported the PA to intubating a term baby who needed therapeutic hypothermia for hypoxic ischaemic encephalopathy. It isn't clear why they were doing it instead of the experienced ANNP or the ST5 when its a high risk procedure. This event was rejoiced by the consultants who saw it as a brilliant step. I have been told by consultants that now that RCPCH have taken away neonatal intubation from core competencies (because so few were getting signed off for them) that there is no reason I should be trained or allowed to do them.

This PA began working here in September at the same time as me. They said during induction that they were the same as an SHO and would be working as a reg in a few years (in the same breath as admitting they were rejected from undergraduate

and graduate entry medicine after completing their psychology degree). They had done 1 year working at xxxxx before this role. There was a 2nd PA who commenced in October having just completed their PANE. She has now left after completing her supernumerary period and being signed off as competent at almost all neonatal procedures.

They were given until February as supernumerary- working 8:30-16:30 Mon-Fri, rotating between ITU, Special Care, and Postnates. ANNPs were required to supervise them (without being given the option not to) and I was frequently mandated to supervise and teach them. During this time they were sent to ST1-3 weekly teaching. They have attended more teaching sessions than I have as a result. The ANNPs aren't allowed to attend ST1-3 or ST4+ teaching and haven't had dedicated CPD or education. They are all Band 8A despite some of them working at this trust over 20 years. They've been deliberately held back from career and pay progression.

The PAs were prioritised for opportunities every week- PICC and umbilical lines were given to the PAs over trainees or clinical fellows. They were taught to do lumbar punctures, and allowed to access ventricular reservoirs (initially supervised, then unsupervised). They are now expected to attend all high risk deliveries independently and have been deemed safe to do so by the consultants. They are prioritised for procedures still. I have been working here since September and never had a consultant supervise any procedure or show me how to do them. I have never had any teaching for NIPEs, or formal sign off (despite telling them I had never done them before this). The PAs have had all the educational opportunities siphoned off for them at the expense of doctors and ANNPs. I am expected to sign off any prescription that they give to me. Overnight the PA is now included in the numbers so is assigned 3-4 ICU babies that they are responsible for- this includes starting/modifying inotropes, modifying ventilation settings, titrating nitric oxide, and for deciding prescriptions which ANNPs or doctors have to complete.

There has been no engagement with the ST1-3/JCFs regarding the impact of the PAs on workload or training opportunity, or perceived safety. We are used as risk sponges for them. I am expected to have them discuss patients they see with me so that they can document "discussed with Dr X" and so all risk then lies with me.

They have since reduced the number of ST1-3 trainees they take from the deanery, and dropped the number of hours on the rota for each junior doctor to reduce spend, as a result of hiring PAs. **Resident Doctor, Severn.**

NP 497 – One PA stayed within scope and was super helpful and great at providing updates to families (xxx patients).

OP 107 – Our local respiratory team for a specialist respiratory condition with community management, has almost no input from medical doctors and is lead exclusively by MAPs. The MAPs in question are really excellent however

1) they identify that some patients need medical input (i.e. from a doctor due to complexity) but feel unsupported

2) some are non-prescribers but have pre-signed prescriptions so they can prescribe de facto.

3) those who are non-prescribers are not keen to do prescribing qualification given that they are "doing a job that a doctor would traditionally do", would have no additional pay for becoming a prescriber, and becoming a prescriber "would be taking on alot of additional responsibility".
Resident Doctor, South East

NP 2 – The xxx PA sees patients independently on ward rounds and makes plans.

They use the term DDR in the notes prior to writing their ward round.
Medical Student, South East

NP 9 – The XXX department at XXX in XXX has a PA on the SHO rota, but he only works 9-5 Monday-Friday (whilst earning as much as an ST3 p/h).

This job was extremely busy and often short-staffed, with very little opportunity for the SHOs to attend theatre/clinics due to on-call commitments.

It was therefore particularly upsetting to learn that this PA had been given a protected XXX clinic once/week in which he was supervised remotely by a consultant – often independently reviewing patients who had been waiting >1 year for a 'specialist review'.

He was also allowed to hold the SHO referral phone once per week, which involved giving specialist advice to GPs/ other specialties and making admission decisions.

He was a friendly colleague and I had no issues working with him, but I was concerned to see such dangerous practice in terms of the responsibility given to him, as well as the unfairness of his protected clinic time etc.
Resident Doctor, East Midlands

NP 11 – I worked in xxx department. As junior doctor I need to learn to do Lumbar punctures and lumber drains. For 6 consecutive months I have seen one PE that employed by the department doing Lumber punctures and drains by himself not supervised! He even goes to ICU to insert ICP bolts! Unfortunately the department has cultural issues and they want home to continue to do so , they don't care about patient safety but they care about less time of work this PA provide. In other hospitals ICP bolt is an invasive procedure needs to be done in theatre!
Resident Doctor, North West

NP 12 – Knowledge gap is remarkably poor. First hand seen a PA student introduce themselves as a medical student.
Consultant, North West

They are often reluctant to ask for help/escalate concerns and regularly fail to identify the acuity of an unwell patient. I have seen dangerous disregard for clear red flags in a fairly straightforward history leading to deterioration in patients, poor diagnostic processes, poor task prioritisation and management. Despite many concerns being raised within our hospital to senior management about the expansion of PAs into higher acuity environments (XXX etc) and the introduction of AAs (the anaesthetic department are almost wholly in opposition as a body of doctors) these changes are being introduced.

As Medics, we know this will be unsafe for patients who do not know better and cannot advocate for themselves.
Resident Doctor, West Midlands.

NP 23 – Newly qualified PA performing unsupervised lumbar punctures while delegating bloods/discharges and other similar tasks to doctor colleagues.
Medical Student, Wales

NP 27 – It was the norm in my F1 general surgery placement for PA's to be leading the ward rounds. I would be told to prescribe and stop medications from PA's (whom supposedly doubled checked with their consultants) only to receive a Datix from pharmacy for prescribing errors. Following the ward round, they would attend

their "planned" theatre time and leave me jobs for more than 20 patients involving discharge summaries, bloods, cannulas, catheters, chasing up scans. When contacting the team for help regarding a deteriorating patient I would be told to "contact the med reg". It's funny I actually wanted to be a surgeon but following 4 months of lack of training experience/theatre time/poor supervision from senior colleagues I was completely put off.
Resident Doctor, Mersey.

NP 34 – On XXX, I've been on one station and been asked to prescribe on behalf of a PA covering the other station. I've had to re-assess patients all over again multiple times before feeling comfortable to prescribe. I have raised my concerns with my seniors that this is unfair. There have been instances where dose adjustments have not been actioned by the PA team and where clinical presentations have been missed, including decomoensated heart failure and failing to prescribe antibiotics for suspected chest infection.
Resident Doctor, West Midlands

NP 37 – I wanted to raise the fact that PAs (inc. students) wear the exact same coloured scrubs as not only medical students but also doctors. This is extremely dangerous as a patient may think they are speaking to a qualified doctor when they are in fact speaking to a PA student. This is exacerbated by the fact XXX does not allow lanyards; it is only written in small print on a name badge what everyone's roles are, which can easily be hidden. This is misleading and must be addressed by the Trust immediately.
Medical student, East Midlands.

NP 38 – I was asked to stop the antibiotics for a patient. On reviewing the notes; no documentation regarding who advised to stop or who decided. Discussing with consultant of the week, the patient suffered from complex Crohn's with intra abdominal collection and needed to continue the antibiotics.

Another patient I was asked to start them on VTE prophylaxis as it was not started since admission. Reviewing their bloods they had an eGFR of 13.

Another patient with portal vein thrombosis and I was asked to start them on treatment dose enoxaparin. The patient's platelet were 20.

Another patient I was asked to hold their furosemide because their eGFR dropped from 40 to 38.
Resident Doctor, North West

NP 47 – Recently in XXX Physician associates are confused with doctors amongst the medical team and also patient are confused. This lead to one particular PA being mistaken for Doctor "for a while". The trust introduced a new scrub colour for them but I am not aware of what colour it is and how to differentiate them myself.

Of few encounters with PAs both in person and over the phone they are not clinically primed unlike doctors as we spend 5-6 years doing a medical degree. Their knowledge is worryingly superficial and I don't know how they can provide safe care to patients.
Resident Doctor, Yorkshire

NP 48 – Team PA being invited to regional subspecialty training event our unit was hosting – SpRs were not invited.

Multisource consultant feedback heavily focussed on training and developing PAs – with no such mention made for more junior doctors instead.
Resident Doctor, South Thames.

NP 50 – The PA that covers gastroenterology sees referrals and often signs off as if he is a doctor. It is often signed off as "Dr (consultant last name) / (PA last name)".

The way he signs off portrays he is a doctor. A medical student would always add "medical student" before their last name to ensure no confusion. This PA should do the same.
Resident Doctor, West Midlands

PA XXX in XXX is doing WR by himself, pts often never see a doctor after their op and are being discharged with a host of medical issues which are not picked up. They arrive in the community very unwell and often need readmitting or being seen by a doctor. His DC summaries are poor and he also appears to prescribe on the TTO in EMPA.
Resident Doctor, East Midlands

NP63 – I was working on the ward as a junior doctor. A PA student came onto the ward and introduced herself as 'one of the students' and not physicians associate student. I didn't worry about it but when she was shadowing me whilst I was clerking a patient in I asked her to introduce herself and she introduced herself as 'one of the students' again to the patient and the patient's partner.

I was a bit shocked but didn't feel it was appropriate to discuss during the consultation and afterwards I was called away to support another part of the unit.

This introduction is entirely against RCP introduction guidelines. I initially mistook her for medical student until I looked at her badge but not once during the morning did she mention PA. I don't have her details but she was a student from the local university.
Resident Doctor, East of England

NP 71 – There is a PA who is normally based in ED at XXX who is now also working once a week at the XXX in XXX Hospital. There is not always a doctor working on site at this centre as it is usually staffed by nurse practitioners, so queries have to be escalated by telephone to the consultant in charge in ED at a different hospital. There is no regular doctor oversight of this PA whilst working at the XXX.
Locally Employed Doctor, Northern

NP 72 – A PA independently (with no supervision) discussing incredibly important resuscitation status with patients family. Independently offering her guidance on what she feels the resus status should be.
Resident Doctor, South East

NP 95 – Asking to prescribe meds for a patient whose diagnosis doesn't make sense. Requesting imaging again for a patient who should have other ddx considered.
Resident Doctor, Yorkshire

NP 107 – PA on xxx unit and PA on xxx ward ordering XRs and CT Scans for the past 2 years. Evidence available on scan ordering system. Also seen DNACPR form on xxx unit only signed by PA for 24 hours pre consultant countersigning.
Consultant, South East

NP 129 – PA in ED reviewed a baby and diagnosed bronchiolitis, for which they provided Salbutamol as TTO. This is the wrong treatment for this condition.
Resident Doctor, South Thames

NP 131 – Physician Associate introduced themselves to me as "one of the ED doctors". I found it they were a PA mid-way through my shift, when another team member told me. How on earth am I meant to supervise PAs if they don't even have the decency to tell me they're a PA?
Resident Doctor, North Thames

NP 135 - PA working in the emergency department seeing undifferentiated patients, including patients in resus which is inappropriate. PA also doesn't introduce herself as a PA when referring patients which leads me to believe they don't introduce themselves properly to patients either.
Resident Doctor, North West

NP 150 – I was performing a private Ultrasound. The patient was completely unaware that they had seen an associate and not a doctor when they were seen in the GP surgery. They were surprised when I explained who they had seen.
Consultant, Wessex

NP 184 – I was on an AMU consultant led PTWR – and had to request and vet CT scan for patient I didn't know as they had been seen by PA + consultant and then the job was passed to me. I was also told to prescribe dermovate for a different patient (also seen by PA and consultant) – this was unclear if it was a direction from the consultant or the PA. Either way, the patient had no indication for dermovate when I did my due diligence prior to prescribing (not on any other topical steroids, hadn't had treatment for his eczema for years, no reason to give very potent steroid), and when I questioned it, it was clear they didn't realise they were instructing me to prescribe a very potent steroid (and perhaps meant dermol which is wildly different).
Resident Doctor, Yorkshire

NP 185 – This was back in 2018. I was an F2 working in a GP practice in XXX. A student physician associate at the practice was using the title Dr and her door sign also said Dr because she had previously undertaken a PhD in an unrelated subject. I immediately raised the issue with the partners who acknowledged my concerns but did nothing to change this situation.
Resident Doctor, Peninsula.

NP 208 – Currently a JCF on an unbranded (no OOH) rota. I have been told for next year I will have to move onto an on call rota as the funding for my current role is going to PAs.
Resident Doctor, Peninsula

NP 221 – I have frequently received phone calls direct to the on call anaesthetist requesting help with "difficult" venous access or even with LPs from PAs where no senior doctors within their own team have even been contacted first.
Resident Doctor, Yorkshire

NP 237 – retrospectively was caring for a patient. a physician associate had requested a MRI head via our online requesting portal.
Resident Doctor, Mersey

NP 253 – PA seeing undifferentiated patient in a&e – diagnosed anaphylaxis and gave IM adrenaline (prescribed by registrar but not documented if reg reviewed or any assessment of the patient). Then did not handover patient to the team in the assessment unit and no medical staff in the unit were aware of this patient until the nursing staff asked for a review some hours later.
Resident Doctor, Northern

NP 259 – I am a radiology registrar who was manning the phone for radiology queries at XXX hospital. I took a call from a physician associate in GP who was requesting an MRI pelvis for a lady with pelvic pain. On further discussion I realised her request was based on only pelvic pain and a mildly raised ca125. She had not done an internal examination or discussed with gynae or even her own supervisor and had no idea how she would action it if it showed something. She didn't know the limits of her own competence. She just thought pelvic pain + borderline CA125= scan. When I refused and asked to speak to her supervisor she tried to argue that I wasn't accepting the

scan request because she was a PA (she didn't directly say this however). While I didn't get the details to do a datix because I was busy taking referrals and I was also a bit worried because I didn't know how they did things as I had just started this rotation, I told her to either go back to her supervising GP or if she was unhappy with my advice to discuss it with my consultant. This just goes to show how not knowing what you don't know can be so dangerous.
Resident Doctor, Mersey

NP 278 – Been told the PAs and ANPs working in XXX are working in 'registrar' level, therefore if they want us to sign a prescription for them, it is consider rude to question the rationale. Have received negative feedback from nurses specifically for 'less willing to sign off prescriptions for the PAs and ANPs'.
Resident Doctor, South Thames

NP 283 – There have now been two instances (that I know of) in the last few weeks of TTOs being signed under doctors names who have not completed the TTO. As in a doctor has left their computer open and a PA has used the doctors account to sign a TTO without informing the doctor, and we have only found this out when going back to print the letter.
Resident Doctor, Northern

NP 284 – 1. Clinic and theatre time for PAs in urology and none for the foundation training doctors who have to cover wards

2. PAs are requesting CT scans because the computer system allows them to and they don't care that they are not allowed

3. Consultant body in urology very pro PA and difficult to raise any issues with

4. Core trainees already taken away from department due to lack of opportunities but nothing has changed.
Resident Doctor, North West

NP 292 – Geriatrics PA being sent to see medical outliers ALONE. Allowed to make medical decisions regarding discharge.
SAS doctor, East of England

NP 309 – PA working in the assessment suite stated that their erecord access has them set up as a "clinician" allowing them to prescribe and request ionising radiation. It wasn't clear whether they have been using these privileges but it is likely other PAs within the trust have similar access.
Medical Student, Northern

NP 316 – Patient with large lung collapse and massive tracheal deviation.

PA exam included findings for a complete lung collapse:

Tracheal central

Chest expansion equal

Dullness to percussion on right upper lobe

Resonant everywhere else

Some crepitations on auscultation

Reduced air entry R. lower lobe –

Obviously this is all wrong and begs the question as to whether they even examined.
Resident Doctor, Yorkshire

NP 319 – Was working on xxx with a consultant who had a first year PA student shadowing her. At one point while the consultant and I were busy, a nurse came up to the PA student sat beside us and said to her "Doctor, can you help me with something?" to which the student replied "Sorry, I'm a PA." The nurse continued to explain the issue to her (high BMs in a diabetic patient) at which point I said "I can help. This is a PA student." I raised this later to the consultant who had not observed this, and she said she would speak to the student about this for the student's own protection, however the student soon left and I believe there was no opportunity to.
Resident Doctor, East of England

NP 325 – PA calling herself one of the juniors to members of staff (including myself), when questioned said that "if she not one of the juniors" makes it difficult for staff to work out who they are talking to.
Resident Doctor, South Thames

NP 351 – PA had prescribed antibiotics during a surgical consultant-led ward round. Consultant did not check the antibiotics or dosage (neither did anyone else). I am not sure if the PA has prescribing rights from a previous ANP job. I only went to check whether the antibiotics had been prescribed after the ward round as I had seen the PAs pen scribble something in the drug chart, but was not sure if he had actually written up the antibiotics
Resident Doctor, Peninsula

NP 395 – Patient was given contraindicated medication to them who then presented to us with complication of that. Later it was found out that they were prescribed that medication in Primary Care
Resident Doctor, West Midlands

NP 398 – At the adjacent xxx unit, PAs have been addressed and documented as doctors, using the doctor title. This hasn't been raised nor have they actively refused the title – in my time at the hospital.

Raising potential patient safety concerns.
Resident Doctor, North West

NP 403 – PA in ED overnight using registrars card to prescribe (with registrars consent). **Resident Doctor, South Thames**

NP 412 – Wrong diagnosis and labelled as dementia, patient safety is compromised because of miscommunication.
Resident Doctor, East Midlands

NP 420 – I work at a xxx hospital. I routinely receive patients from the XXX who have only been seen for weeks by a PA.

Their pain is poorly controlled, they often arrive with infections and other significant issues.

One patient in particular who has arrived recently has prompted this concern. The had a #NOF and had declined surgery. They hadn't been seen by a consultant for weeks. They had an OBVIOUS likely malignant breast lump for which the PA managing their care referred to DERMATOLOGY.

Derm thankfully told them to do a 2ww, which they did, but didn't talk to the patient, whose first language is not English. They would not have consented to this. They also

didn't seem to think about the implications of an unstable and un-repaired #NOF would have on the patient's ability and comfort to attend a 2WW clinic.

The patient hadn't been properly informed about the inability to 'rehab' an unprepared #NOF nor the impact on their lifespan and quality of life. They were deemed MFFD by a PA and transferred to us for 'rehab'. They didn't even have a DNACPR.

Mentioning about the XXX department. This has come directly from the lead.
Resident Doctor, East Midlands

NP 442 – It is my understanding that Physician Associate students under XXX are permitted to place NG tubes and take bloods for cross match or group and save, skills which medical students at XXX are forbidden from practicing outside of simulation. When raised anonymously with XXX by another student questioning our level of practice in these skills, the following feedback was returned as to why medical students are not safe to perform these skills in real patients on placement: "And finally, whatever other medical schools/courses do is not our concern – for our students and their indemnity, it is clear they should not be doing these in any other context other than simulation. Whatever the perception, these are high risk procedures and not for students."

I am concerned that if this is indeed the case and the PA course is allowing their students to perform these skills in patients, even under supervision, that given the reasoning medical students cannot is to protect patients from risk of avoidable harm, there is a risk of such harm occuring.
Medical Student, South Thames

NP 447 – The Consultant logs into Encompass to allow PA to use her account to order scans and prescribe medication (?illegally). The PA also introduces herself as 'one of the medics' rather than a PA.
Resident Doctor, Northern Ireland

NP 452 – Feel pressured to prescribe and order investigations for physicians associates whilst coworking at work, more junior doctors are repeatedly being replaced by physicians associates in all directions, our training posts are reduced, rather than Co working , we are working for physicians associates.
Resident Doctor, South Thames

NP 454 – I was phoning a patient parent to update them on their child's blood result. The parent informed me the child, who has a complex medical history, was unwell so took them to the doctor. The diagnosis they had given them was odd, so I checked the GP records. They were not seen by a doctor, but a PA. This PA didn't record they'd discussed the consultation with a GP. I had to inform the patient they did not see a doctor, which confused them as they were convinced they had seen a doctor. The treatment the PA was giving had obviously not been working, and this case should have been escalated to a doctor. I ensured that the parent bring their child to see an actual doctor or attend A&E. What is worse is they really thought they had seen a doctor, and had the trust in the odd diagnosis because they thought it was a doctor.
Resident Doctor, East of England

NP 459 – Physician associate students were introducing themselves to patients and consultants as medical students.
Resident Doctor, East of England

NP 464 – Physician assistant in Urology bosses over F1s. Makes no attempt to help in any way or form and does her own cystoscopy lists.
Resident Doctor, North Thames

NP 475 – PAs on the general surgery team prescribing and requesting ionising radiation.
Resident Doctor, Peninsula

NP 476 – PAs in emergency department forming a significant proportion of those assessing undifferentiated new patients, often prioritised for standbys and trauma calls. Often a PA will be managing paeds ed alone.

In surgical specialties, PAs will often be in theatre or clinic, will rarely assist with ward jobs, leaving Foundation and CST doctors to deal with this.
Resident Doctor, Mersey

NP 493 – PA not doing their job to assist on the ward. They are usually in the mess or cafe. Does not answer bleeps and even when agreeing to do a job will delay it as much as possible or find an excuse not to do it even when an urgent blood is required.

Consultants made aware of the problem and know it has been going on for years with no consequences to the PA in question. I brought it up recently with consultants as a patient was due urgent bloods and he refused on the grounds that there was no foil to cover the bloods for vitamin levels. Despite me telling him he can leave the vitamins out he walked off without doing the urgent amylase levels. The consultants handled my complaint as a communication issue between us instead of the fact that no other doctor would ever dare walking off because someone didn't get them foil when doing urgent bloods.

This is on the xxx ward at the XXX.
Resident Doctor, North Thames

The other was writing up drug charts and presenting them to a foundation doctor for signature. A patient was prescribed daily alendronic acid (instead of weekly) and weekly amlodipine for blood pressure, instead of daily... (Date of occurrence estimated) The same PA was also seeing acutely unwell, undifferentiated patients.
Resident Doctor, Wessex

NP 458 – Requesting imaging when they are not a IR(MER) referrer. This was picked up by the radiographer. There is a file to check if someone is a IR(MER) referrer. I don't have access despite asking multiple times. It contains many files, every practitioner with many pages detailing which scans they can & can't request depending on department and patient age. It's not fit for purpose to check through during a busy oncall.
Resident Doctor, North West

NP 554 – The PAs on the XXX Unit routinely perform lumbar punctures unsupervised, are the first port of call for doing so, and act as supervisors to junior doctors learning to perform lumbar punctures. If they struggle, they sometimes refer to the medical registrar but also refer directly to anaesthetics.
Resident Doctor, Yorkshire

NP 556 – I noted when attempting to book scan on ECR for XXX that it appears to allow PA to order scans with ionizing radiation.
Resident Doctor, Northern Ireland

NP 558 – Individuals (primarily but not exclusively PAs) who do not have the right to request ionising radiation attempting to do so is such a frequent occurrence that the radiology SpRs have been asked to check every request not from a doctor against a list of registered non-medical referrers. This not only increases the workload of busy on call sessions, but is often easier said than done when people do not clearly identify themselves ("one of the team", "[first name] in ED", "one of the clinicians") and are

sometime evasive when directly asked. Surely it cannot be the sole responsibility of the vetting radiology trainee to check that their colleagues are not attempting to commit a crime!
Resident Doctor, North West

NP 559 – Working on call for ENT. Call from PA on community / GP home visit, asking for advice on managing patient. First didn't introduce themselves. They became apparent that supervisor not present and had not examined the patient. They claimed they had spoke to the supervisor who had recommended phoning ENT. Unclear from Hx or examination if patient required admission, the PA was asking if 2ww was appropriate. Said the GP would not examine the patient and I had to give advice, tried calling practice but phone lines shut, safest to admit patient, but this also has its own risks.
Resident Doctor, Yorkshire

NP 563 – PA student introducing themselves as 'a student' when asked who they are. Most of the ward staff assuming they were a medical student.

Then when nursing team attempted to carry out procedures such as PICC line bloods and NG tubes, the student asked and pressured the nursing staff into letting the student do these procedures. The nurse politely declined multiple times whilst the student still asked. When the student was further questioned on this by the nurse they admitted they hadn't received training on either of the procedures listed above. They eventually agreed to simply watch the procedure, however kept emphasising that they wanted to be signed off on these skills.

I stepped into to agree that the nurse should do the procedures as the student hadn't received any training. However the combination of not properly introducing/ identifying themselves and then attempting to do procedures they had no training in felt very unsafe – as someone with less confidence or unaware of their role/training may have said yes to the student. Which is a patient safety issue.
Resident Doctor, East Midlands.

NP 564 – Respect form completed by PA, presumably in general practice. No GP or senior clinician signature. Patient end of life, died without valid respect form in place.
Resident Doctor, West Midlands.

NP 566 – Consultant logged on to electronic prescribing system before morning ward round. PA left to do all prescriptions for the day.
Resident Doctor, East Midlands.

NP 577 – Trainee AA being supervised by a SAS doctor, who left the theatre, thus leaving the trainee AA alone with a patient under general anaesthesia. Happened twice during the same operating list, inclusion one period of absence of several minutes.
Consultant, West Midlands

NP 579 – I am currently working in XXX and there are multiple PAs that work there. One of the PAs today was approached multiple times by different members of the MDT as Dr 'name' and went along with it. When asked to prescribe medications they then went on to divert and say they were looking after them so could another dr prescribe (me). They never said they werent legally allowed to or qualified to prescribe and responded yes when asked are you Dr 'name'.
Resident Doctor, East of England

NP 589 – I work in the xxx team in XXX. The department have just finished advertising for a PA to be working on the xxx. The advert states the PA will be working 08:00 to 20:00. There will be no junior doctors on the xxx between 08:00 and 09:00 and the consultant frequently turns up much later so the PA will be working independently during this time. There is also no other doctor designated to be doing xxx ward cover between 18:00 and 20:00. There are doctors on the take team clerking. But is not there job to help with ward cover in the xxx. So again this PA will likely be working independently.

In addition, I have been reliably informed that this PA role is being funded by ending a previously funded XXX role in the department. Clearly stopping employment/training opportunities for doctors trying to get into a training post whilst replacing a doctor's slot on the rota with a PA.
Resident Doctor, Wales

NP 591 – I have seen that PAs have been given permission by consultants to make patients MFFD. Meaning without a consultant or reg actually making the decision on making a patient MFFD.
Resident Doctor, East Midlands

NP 592 – Student anaesthesia associate in her first 5 months of training repeatedly left in theatre alone by her supervisor for up to 20 mins at a time. Times where the student AA was on their own include before pneumoperitoneum established for a laparoscopic gynae case with very difficult entry. When the supervisor reappeared, the patient began moving as they were not sufficiently paralysed. At no point did the student AA seek to escalate to get a supervisor in the room I have submitted a datix.
Resident Doctor, West Midlands

NP 593 – PAs in charge of Bays on the ward. These patients will get daily reviews, often for days or weeks on end without a doctors review. Investigations and management is prepared by the PA and then Juniors are asked to prescribe and order investigations without knowing these patients.
Resident Doctor, East Midlands

NP 595 – PA working on doctor rota (taking part in PTWR and WRs sometimes only person for 2 bays). Nurse asks them to do x y and z jobs throughout the day when patients need anti-emetics, analgesics. PA says no problem without reviewing patient and states she will prescribe. PA cannot prescribe so can only presume they are using someone else's log in.

1) PAs shouldn't be asked to do these things

2) PAs should not be prescribing

3) PAs should not be used on jobs intended for doctors as when they reach their limit (which is maxed out very quickly) that job is then passed to a doctor who has already a lot of their own jobs. If the PA was replaced by a doctor, there would be none of these issues.
   Resident Doctor, East Midlands

NP 639 – PAs requesting ERCPs and Endoscopies.
Resident Doctor, Scotland

NP 661 – I'm a Radiology Registrar at XXX. Multiple PAs in primary care are referring patients for CXRs without GP sign-off. PAs are not allowed to request ionising radiation in line with IRMER.
Resident Doctor, Mersey

NP 663 – PA holding the urology SpR bleep while SpR is in theatre.
Resident Doctor, North West

NP 664 – My prescription was changed by a PA without me being informed. The PA changed the timing on the drug chart and indicated which dose should be given now and which dose held. This wAs for treatment dose LMWH anticoagulation.
Resident Doctor, Severn

NP 673 – The PAs in IR at our trust perform procedures with indirect supervision.

They performed an US guided pleural TAP for a very sick patient with complex vascular issues. There was "indirect supervision" from the consultant.

We were interrupted during our board round to print the stickers for the pleural tap as the PA didn't want to.

I am shocked and angry that as a CT2 in surgery, due to start ST3 in a few months, that I am spending most of my time on the ward doing F1 level jobs. Due to the understaffing and Clinical work load, I am unable to attend theatre or clinic, I stay late and I don't have any form of break. I also get paid less than a PA but have to do all the clerking and DCS/TTOs for the IR vascular elective patients.
Resident Doctor, South Thames

NP 678 – Anaesthesia associate prescribing (afaik outside of AA scope of practice) – unsure if using previous qualifications prior to AA accreditation. Includes prescription of controlled TTO medications. Understand this is a routine occurrence at the trust for some of the AAs employed.
Resident Doctor, Northern

NP 686 – Patient attended ED from care home with an apparent DNACPR in situ. DNACPR had been discussed with their NOK (patient did not have capacity) in the community by a PA and a PA only. In their EMIS documentation they wrote that they had tasked a GP to countersign. This had not been done. Therefore they had an invalid DNACPR in place which had not been identified until ED attendance (~1 month).
Resident Doctor, North West

NP 690 – I have witnessed PAs telling GPS what to prescribe over the phone while carrying the referral phone.
Resident Doctor, Scotland

NP 693 – AA 'consented' patient for spinal, despite not being trained to do the procedure. No evidence that any salient side effects / risks / complications were discussed. Anaesthetic chart left incomplete.
Resident Doctor, Yorkshire

NP 694 – New 2nd year PA student started on my geriatrics ward today. Her supervisor is also my supervisor and the ward consultant. The consultant is off work this whole week, student was not aware of this. Juniors and ward reg not made aware by the med school or consultant of PA student starting a 4 week placement today, also happens to be doctor changeover week. No induction to the hospital provided by the med school, the student had never been in a hospital for a rotation before, never visited the hospital. I as a junior gave her a hospital tour because I had time in the morning. But I feel it is unacceptable to have a student start a placement without adequate senior supervision, no one to check in with her this week, no prior notice to the ward staff about her starting, no correspondence about the PA curriculum, no contacts for us to use if we had concerns for her practise or welfare. It's not fair to the student and not fair to the medical team.
Resident Doctor, South East

NP 696 – F1s being told by the consultant, as part of their "induction" (first meeting on day 1 of the rotation) to prescribe whatever the physician associate on the ward requested.
Locally Employed Doctor, Yorkshire

NP 698 – Perpetually having to deal with PAs attempting to circumvent requesting ionizing radiation. Active omissions of role at the beginning of discussion, resultant unjustified irradiation of patients.
Resident Doctor, Wales

NP 701 – At ED induction we were told that there are two PAs and that we are expected, as registrars, to supervise them if required and to do their prescribing/ IRMER as needed. When I queried the medicolegal liability of this I was told that 'they're just as good as the trainee ACPs' and the expectation was reinforced.
Resident Doctor, East of England

NP 733 – I was in a clinic being run by an ACP and a PA. At no point were any of the patients made aware of the professional roles of any of the staff present, bar my own as a Doctor.
Resident Doctor, Northern

NP 738 – PA misdiagnosed patient , patient was told he has msk pain in his back after PA examined them . This assessment was re looked at and MRI ordered by team- he had discitis . The probability he had discitis was high as the patient had endocarditis . Examinations and info told to patient is not supervised , errors like this are picked up days later when we do a consultant ward round.
Resident Doctor, Peninsula

NP 750 – 1) PAs doing flexi cystoscopy lists while FYs, CTs and SpRs stuck doing ward based service provision... As an FY I have 2 days of 'theatre days' per 4 month block. 0 dedicated difficult catheter/guidewire teaching. Absolutely flexi cystoscopy etc teaching.

2) Gentamicin (and other drugs) required for these lists – flexi cystoscopy & biopsies will be written up by the PA and handed to a reg to be blindly signed. I have been asked and refused. (Urology dept).
Resident Doctor, East of England

NP 756 – The consultant had offered his login so that the PA can prescribe**.**
Resident Doctor, East Midlands

NP 795 – Physician associate in gynaecology prescribing medications.

Often post op meds/discharge meds, using consultant login/PIN. Unsure whether consultant aware or not.
Resident Doctor, Yorkshire

NP 800 – PAs in ED regularly wear royal college of medicine lanyards.
Resident Doctor, Yorkshire

NP 809 – PAs are not receiving adequate levels of supervision in surgery (mostly orthopaedic), as there is rarely a consultant ward round so practicing independently with little support.
Resident Doctor, Severn

NP 817 – Physician associates getting to go to theatre and being rostered to go to theatre weekly whilst the doctors were stuck on the ward and only get one week of theatre exposure 1 week in every 4 months whereas the PAs get to go once a week!

Also instances observed when PAs made clinical decisions that led to patient harm. Things such as PAs doing VTEs that suggested patients shouldn't get anticoagulants even though they're admitted with a Pulmonary embolism. PAs not working as a helpful member of the team, instead bullying and treating FY1s badly, not helping with tasks such as preparing the list for surgical ward rounds and instead expecting the fy1 to do this. Things like PAs very patronisingly telling the FY1s to pull the curtains and document in ward rounds instead of us actually doing our jobs. PAs writing very bad substandard discharge summaries because they know we will have to double check them and sign off on them with our names if we need to prescribe drugs. PAs not really being useful in any way because they can't request scans, sometimes struggle to speak to specialities, don't review patients properly but still won't do the tasks we as doctors tell them they need to help with such as taking bloods. In our surgical department some PAs intentionally say no to the FY1s when we ask them to do bloods, saying no they're not phlebotomists and they're here for clinical work! That is ridiculous because we as doctors can't say no to doing bloods if they need to be done. The PA role is not helpful to any doctors on the ward, it is in fact a hindrance, they make our lives much harder not easier. I would rather have either another fy1 or the ward or in absence of that, have no one at all to help than have a PA to 'help' because they don't actually help, they instead double the work load and the department doesn't care because it thinks it has enough staff but we as doctors end up working overtime to cover up their mistakes.
Resident Doctor, East of England

NP 819 – PA introduced themselves as doctor. Nurses on ward assumed PA was doctor. Had a mental health patient who went to leave and needed review by doctor. PA then had to admit they were not a doctor. Had also been introduced themselves to patients incorrectly.
Resident Doctor, Mersey

NP 830 – Being asked to sign prescriptions for local anaesthetic that the PA uses to excise small lesions. Asked to sign without ever seeing the patient, before PA even saw the patient herself.
Resident Doctor, Severn

NP 831 – Working at XXX paediatric ED. I was asked by a PA to write a prescription for a patient I hadn't reviewed or seen (and was under a different team) who was about to be discharged. When I refused to do this I was met with hostility and treated as if I wasn't a team player. I directed them to ask their parent team/supervisor senior.
Resident Doctor, East Midlands

NP 836 – My newborn baby daughter needed to return to hospital for a check-up for jaundice. She was assessed by a PA who introduced himself only as "X, from the neonatal team". He didn't identify himself as a PA; I only knew from seeing his ID badge that this individual in scrubs and stethoscope wasn't a doctor.
Resident Doctor, Scotland

NP 848 – It's my own experience

I went to my GP surgery for a repeat prescription for migraine prophylaxis- metoprolol. I have new onset of aura (previously it was without aura) She was not concerned at all . Throughout the consultation she was looking at a screen reading out of it. It's not safe.
Resident Doctor, East of England

NP 866 – PA from GP referred a patient with new low sats (91%) and collapse to SDEC rather than sending them to A&E.
Resident Doctor, North West

NP 873 – When I started on a rotation, a colleague who I thought was a Reg (wore their own clothes and wore stethoscope and RCP lanyard with no ID) and kept going off to clinic (so obviously seems completely like a Reg) kept on handing me prescribing tasks.

I assumed they were so busy doing reg stuff they passed all their repetitive prescribing to me, and they were giving me orders all the time. Turns out they were a PA and had never actually introduced their role to me.

Found out 5 weeks into the rotation.

If I had no idea what they were, how on earth are patients meant to know?!
Resident Doctor, North West

NP 883 – AAs left unsupervised with ASA 1 and 2 cases with 2:1 supervision ratio from consultant anaesthetist. They complete pre-op assessment independently. They also do their own spinals.
Resident Doctor, Northern

NP 886 – PA giving lidocaine for a bone marrow biopsy. No prescription.
Resident Doctor, Wessex

NP 895 – I witness a PA discuss that she needed a CT head with a doctor

The doctor opened their computer access and the PA requested the CT head using their access

I then lost track of her and couldn't challenge her.
Resident Doctor, South East

NP 915 – Asked by nursing team to check a prescription as 400mg metronidazole had been prescribed IV. Noticed the signature was from a PA.
Resident Doctor, Wessex

OP2 – I have worked with PAs in my F1 surgical placement. In addition to loss of training opportunities (they would frequently go to theatre/clinic and we were unable to) they would frequently assess patients and ask us to carry out their management plan. Except this plan was often incorrect once a doctor would review the patient, such as missing DKA, giving a septic patient bisoprolol to correct fast AF, reviewing an unwell pt and coming back to ask me what the "D" in the A–E assessment stands for (meaning they cannot have reviewed the patient appropriately), and handing over a BBG after a 3 hr WR for an unwell pt. I always felt I had to review patients myself but this greatly increased my workload. Their reviews were not safe or appropriate, and they were not asking for senior reviews. I feel their clinical baseline and attitude is dangerous for patients and puts FY doctors in a difficult position. In hospital at least there are others to pick up these issues, but I feel especially in areas such as GP this is even more dangerous.
Resident Doctor, North West

OP 14 – As a consultant, I know what is expected of for training and standard of care from trainee anaesthetists but NOT AAs. What is my responsibility when supervising them? How much responsibility are they taking or am I solely responsible? This is a difficult question when I have no concept of their understanding in the same way I do a doctor and anaesthetic trainees. I am not willing to take responsibility for their actions, hence it will not save any time/ money having them around. Their limited scope is dangerous in anaesthesia as we are not set up for supervising this. The low risk patients that they will be 'able' to look after makes their 'value' very low as it doesn't reflect the population/ NHS needs. What are we waiting for, to be proven wrong?
Consultant, South East

OP 19 – Concerns regarding patient safety, have heard cases from colleagues of PAs misdiagnosing things such as thinking a palpable rib/sternum junction was a breast abscess, PAs stating that they just 'push a prescription under a GP's nose to be signed' seemingly not taking responsibility for it but making the GP take the onus despite not having seen the patient. PAs are taking up time to discuss each patient they have seen with a GP, whilst waiting along with GP trainees for the GP to be able to discuss. At my childrens hospital, The PAs hold an SHO bleep which seems very unsafe and go to emergencies on the crash team but obviously cannot prescribe drugs even in emergencies or request scans. They work on an SHO rota at times despite being newly qualified; which a new FY1 would not be allowed to do, despite having much longer training. I have heard of PAs having no doctor on site to discuss with at times. I do not Understand why they would be expected to start work at an SHO level when an SHO doctor has at least 1 year experience working as a doctor plus longer time training in university. It makes no sense and is not fair for the PA either, it just seems an excuse to train people who the NHS thinks won't be able to leave and work elsewhere, which is unethical.

As a medical student, student PAs would arrive first to doctor's clinic and insist on staying so medical students were turned away, yet it is us who would be doing that sort of work also.
Resident Doctor, West Midlands

OP 20 – PAs regularly introducing themselves as doctors.
Unspecified, North West

OP 22 – Although qualified, failed to pass on the pt had had VT 3/7 previously during their last anaesthetic.
Consultant, unspecified

OP 28 – As a medical examiner I note the involvement of PA's in the domain of acute medicine and please note I am not criticising the standard of care offered. However they are not able to fulfil the role that I require when it comes to discussing the content of the MCCD and then signing it off. Because their involvement in the deceased patient's care may have displaced/replaced that of a qualified doctor I am thus in difficulty when trying to find a trainee to sign the MCCD [I can, of course, always ask a consultant!]. This function of PA's needs to be considered as they are frequently to be found in acute medicine, an area where by far the largest number of hospital deaths occurs.
Consultant, East Midlands

OP 30 – I have assisted in training and was seriously concerned about the breadth of knowledge possessed by students close to finishing their training. The timescale of training does not permit them to have the wide range of knowledge needed to safely fulfil the roles given to physicians assistants. I have also experienced treatment provided to members of my family and had similar concerns.

I am also concerned that doctors are increasingly given only the most complex of patients as nurse practitioners, physicians assistants etc are generally (tho' worryingly not always) given the more complex cases. However the doctors are not given the extra time needed to manage a relentless list of complex patients, and therefore also not given enough time to adequately supervise the assistant.
GP, unspecified.

OP 31 – I work in mental health and we did employ some PAs briefly in our inpatient unit but found they lacked the skills to make them useful in medical roles within that setting. Most moved one quickly to other non mental health roles. We are now looking at nurses with prescribing training and possibly AC training to support medics in the inpatient setting.
Consultant, Severn

OP 34 – Patients don't understand the role of a PA and have usually never heard of them. They often assume they are seeing a doctor. The depth and breadth of training of PAs does not equate to medical training. We have one PA in my dept & talking to junior doctors they are fairly frequently asked to prescribe or arrange imaging based on the PAs opinion. I have always advised them to make their own assessment. I have heard of PAs undertaking operative procedures under variable supervision. I think this entirely inappropriate and wrong, and needs to be stopped immediately.

Our PA has come to one of my clinic each fortnight. She is very pleasant, but very slow and despite it being a year now, can only see 6 patients (who I then also see) & she struggles to take a concise and clear history & examination. Her letters are rambling, and there is no specific coherent thread, which I then have to correct and change the nuance of. I have realised that she will always need tight supervision with me always seeing the patients and although she enjoys the clinic, she is of no benefit to me, the service or the patients in this context. I am redeploying her for this session to the wards to help out. Here she has a positive impact in continuity and she does know the patients.
Unspecified, South East

OP 36 – Choose the jobs they want, refusing to do ABGs and bloods as they consider these menial jobs. Refusing to do discharge summaries. Instead keen to do clinics depriving trainees of the opportunity. Trainees are left instead to do ward jobs.
Unspecified, Thames Valley

OP 38 – PAs ultimately create more work for doctors. They cannot prescribe (nor should they), but think they can make prescribing decisions and dictate them to junior doctors. They cannot sign discharge letters, yet they present themselves as medical professionals to patients and their families, and are allowed to attend family meetings of complex patients as representatives of the medical team. All this without adequate understanding of out of hours work, different approaches in different medical and surgical specialties, and no prescribing experience. This has to stop.
Resident Doctor, Scotland

OP 42 – Patients do not always understand what the PA role is. There is a risk they will work outside their professional competence. this is already seen in the NHS where non-physician healthcare professionals have the grade of "consultant". Patients understand this to be a highly qualified doctor. They would be a highly qualified allied healthcare professional, but NOT a doctor. I also wholeheartedly disagree with the title of "consultant" for non physicians.
Consultant, South Thames

OP 43 – Receive referrals which are often lacking in essential details to provide appropriate clinical advice.
Unspecified, Yorkshire

OP 46 – I did not train for 5 years at medical school, then do a further 10 years of training to pass arduous exams, and go through extensive training to have some person be brought into the system to have done 2 years apprenticeship post some degree, get to give the same care, have the same rights of prescribing, with the fraction of training. This is utterly preposterous. This is deliberately undermining the role of Dr's and specialists , with the clear object of blurring the difference between PAs and specialists. This is a disgraceful and overt attempt from a desperate government that has willfully created this mess and is being enabled by an abject and weak governing body in the GMC, and poor specialist college leadership. Turkey's voting for Christmas springs to mind.
Consultant, South East

OP 48 – Poor quality referral for imaging. More reliance on images – increasing demand for imaging due to lack of medical knowledge.
Unspecified, Yorkshire

OP 49 – PA function as a house officer without the ability to sign a prescription, I have been asked to sign a prescription for a PA with no real hand over or rationale on around 4 occasions. I have then had to see the patient and make my own assessment, changing the management plan/prescription on round 2 of these cases. I asked the OOH provider for their SOP on supervision of PAs and escalated my concerns. I was told they work unsupervised and were to be supported where needed. I did not feel this was in keeping with my experience of working alongside PAs.
GP, unspecified.

OP 50 – I think this role needs clarification of scope and responsibilities. There are very clear instances of where their use is inappropriate.

One of these is seeing undifferentiated patients in General practice. General practice is a hugely demanding specialty which requires years of training. This is not an appropriate place to put this kind of a role. They need very clear support from senior clinicians.
Consultant, Yorkshire

OP 52 - Hepatology consultants have given PA login to prescribe under their name and they take all procedures (drains etc.)
Medical Student, Yorkshire

OP 53 – I receive increasing numbers of inappropriate referrals from PAs (and nurse practitioners) working in General Practice which demonstrate a lack of basic medical knowledge. A high proportion are seen and discharged with no further investigation or treatment. These take up a huge amount of unnecessary clinic time (and patient time) which impacts on clinic availability and is increasing waiting times. GPs clearly do not have enough time to supervise them sufficiently to filter out these referrals.
Consultant, East of England

OP 54 – PAs without prescribing rights prescribing medication for patients on paper drug charts

PAs ordering ionising radiation
Unspecified, Thames Valley

OP 58 – I was a CD for a 2 site anaesthetic department. I and our managers did a review of staffing and if we filled all our rotas at 1:8 and included all Anaesthetists who for some reason or another could not do on call we could easily meet elective staffing requirements. No AA would be able to do on call unsupervised. I also know that to fully staff on call rotas away from major centres is an ongoing problem which has major safety implications.

I am now retired (3 years ago) but one of the considerations driving retirement was the fact that there are no easy anaesthetic lists any more. Even day case list now have unfit patients where advanced anaesthetic skills are required so the concept of AAs working in this area is not safe. My assessment after 40years in Anaesthesia

Anaesthesia as a speciality is by its nature stressful and has a very high out of hours commitment. My view is that the nations needs would be better met by anaesthetic who can share out of hours work not AAs.

I am not sure even the financial argument for AAs are sound as they are on a relatively high salary but you also have to add in the cost of the supervising consultant.
Consultant, Northern

OP 65 – The PA on stroke is seeing stroke patients on her own and making plans on her own with no clear consultant oversight

She also writes DDD (designated doctor review) in the notes before her name.
Medical Student, South East

OP 68 – I was a medical student sitting in on a clinic for a morning for upper GI surgery patients. Throughout the whole morning, the PA introduced themselves as "Mr" and I was under the impression that he was a consultant. He also indicated that he had been the primary surgeon for some of the post-op patients. I only found out that he is a PA later in the day when discussing with another member of staff.
Medical Student, North West

OP 77 – I am a Medical Student and have had limited experience with PAs. One experience that sticks in mind is sitting in on two PA clinics in a GP practice. Firstly the PA never made it clear to the patient that they weren't seeing a doctor. They would just introduce themselves on the phone by name working at XX practice, and in person they rarely said they were a PA. Even when the patient called them doctor they never corrected it. The PA was practising independently, and although a GP was available to debrief, the PA never went to see them – no cases were presented despite the PA obviously being out of their depth and not knowing what was going on in some cases. Even as a medical student I identified areas of deficiency in awareness of competency and thought the PA should have been discussing cases with the supervising GP. When they didn't know what was going on they just ordered roughly the same panel of bloods every time and sent them away. Furthermore the PA was essentially prescribing and ordering imaging. They would request whatever they liked on the computer and it was sent to a supervising GP who seemed to sign everything off without ever reviewing the patient personally. I thought this was risky for the GPs, I would never sign off a prescription or request without seeing the patient myself.
Medical Student, unspecified.

OP 84 – I was the evening ward cover of the Acute medical unit.

I received jobs from various non consultant doctors and a PA. There were a number of sick patients handed over from all of the above, the PA handed over two jobs that were 'urgent as the patients were unwell' (both were jobs were to prescribe an antibiotic). As they were handed over as urgent, and there had been no management started because they were a PA, I prioritised these jobs.

I went and read their notes, assessed the patients and neither were physiologically unstable or demonstrating any sign or symptoms of infection. Because of the nature of how the jobs were handed over, and because I couldn't find anything I spent far more time investigating than I would have normally. I ultimately did not prescribe any medication/ fluid or order any investigation for those patients.

It took up approximately 45 minutes of my evening on call.

They delayed me attending other unwell patients who were handed over, and delayed my actioning tests with a negative result, that allowed other patient to go home.

Because those jobs were handed over by a PA, especially one who I did not know, I had no idea on the accuracy of their assessment or handover. I now know I cannot trust their assessment and regardless of the nature of the job, if they hand things over I will have to re do their assessment. Further worsening already busy ward cover shifts.
Resident Doctor, Severn

OP 85 – AAs performing regional upper limb blocks such as supraclavicular or interscalene blocks unsupervised.
Resident Doctor, North West

OP 102 – 41 year old female with history of ETOH XS and fall at home. ITU stepdown to gastro ward following treatment for subdural haemorrhage. Only seen by Gastro PA on ward round for 2 consecutive days and failed to escalate new drop in GCS, "patient was sleeping". On 3rd day, patient seen by doctor, urgent CT head shows led re-bleed and patient considered to be end-of-life. Had to explain to 13 & 15 year old children and also the patient's angry elderly father why the consultant had then decided why we were no longer giving IV fluids. Patient ideas within a week.
Resident Doctor, Severn

OP 110 – I sat in with a PA – observing them doing session of seeing urgent, same day, undifferentiated patients- at my general practice surgery induction, which included sitting in with other members of the MDT as well as GPs.

I was concerned because I saw many times that the patients would address the PA as 'doctor' and he did not correct them.

I saw them take a focused history and examination of the urgent complaint, which was fine, but with one patient he was only acknowledging the child's rash and didn't further question the parent when they brought up that the child had diarrhoea for 1 month. I then interjected and asked further questions about the diarrhoea, suggesting that we do a stool sample etc. making the PA rather flustered. This made me concerned, because if I hadn't been there, would the diarrhoea have been addressed?

The PA prescribed medications electronically on the system, for it to be signed off later in the day by a GP. This PA is seeing so many patients in a day (2 sessions a day, 10 minute appointments for 4 days a week) how can it possible that a supervising GP can go through every prescription safely before it is signed off?

On one occasion, I have seen the PA being used as the 'duty doctor' for half a session, to cover urgent sickness for a GP.

As an individual, I find my colleague professional and we get on. But raising concerns about a colleague who has worked in a practice for years, who from the outside appears to be working well and effectively, when I am just a rotating doctor makes it very difficult. I worry about speaking up and the effect it may have on my training. I worry that due to ARRS funding, that GP partners are encouraged to expand the MDT and hire PAs, pharmacists etc. (and not being able to afford salaried/ locum GPs) and using them to help cover GP staffing gaps, rather than to use them as they were intended. However when it comes to PAs, they don't come with regulation or a scope of practice for them to follow to ensure that PAs are being used safely in general practice.

I believe PAs could be used appropriately in a hospital setting where there is guaranteed consultant supervision day-to-day, but I think that allowing PAs to see undifferentiated patients in primary care, with only a fraction of the training that a GP has to go through, is extremely dangerous and we will be seeing more horror stories like those of Emily Chesterton coming out in the near future.
GP Registrar, Severn

OP 113 – Involved in training AAs. Their course provides almost zero teaching materials; those which are provided are dated and poorly written in places. Questions from recent exam, which had a 100% pass rate: "what position is the hand in for cannulation", "when in the cardiac cycle does the aortic valve close". Seeing the course inspires little confidence in the rigour and educational governance/oversight

of these trainees. When comparing this to undergraduate and postgraduate medical education, the difference in standards is vast. I trained in anaesthetics to deliver anaesthesia, not to work in a "n:1" model where my role is to firefight and absorb liability for substitutes with questionable training.
Consultant, Scotland

OP 117 – With increased multi-morbidity more deep understanding of the risk age, co-morbidity, past medical history and drug interactions in the perioperative period is required, potentially requiring adjustments of medication.

This requires the knowledge of a medically trained anaesthetist.

In some countries there is even a subspecialisation emerging to deal with patients who have an altered physiological response due to operatively adjusted malformation of organs/anatomy at birth.

Failure to recognise and anticipate medical problems in the perioperative period would not allow any precautions being taken and unnecessarily increase the risk of patients undergoing anaesthesia.

Junior doctors are confronted with a more and more diverse and complicated discipline, requiring sufficient exposure during training and as much experience as possible in order to learn, judge and deal with perioperative risks and complications as well as building up confidence during less stressful cases.

The employment of AAs carries a greater risk for patients being operated and trainee doctors of all levels to lose out on experience. This comes on top of the reduced exposure to giving anaesthetics due to nights on call, emergencies and intensive care.

I have worked with AAs during a trial about a dozen years back.

As a fully fledged anaesthetist must be present during inducing and ending an anaesthetic, it is inevitable that that the the anaesthetist in charge is dealing with one patient, whilst another would have to wait for attendance because of that, resulting in extra delays in one theatre

In case of a complication requiring the anaesthetist to stay with the patient for a while in recovery, delays would apply to 2 theatres.

another problem was for the anaesthetist learning to know about strengths, weaknesses and ways of working of the often 'roaming' AA and how to attune to that or direct a different approach, which is hardly aver feasible.

Reasonable support saving time could be provided if AAs would establish a standard 1.2mm venous access whilst the patient is waiting for the anaesthetics, help the patient filling in the anaesthetic questionnaire, and drawing up the ever increasing number of drugs for injection whilst being fully and solely responsible for the right drugs are being provided with the right label and drawn up in a sterile manner.

It would make more sense in my view to keep the current system based on an ODP assisting the anaesthetist and increasing their remit and allow for the a.n. tasks to be performed by them.
Consultant, unspecified

OP 120 – As a trainee, I am being asked to supervise these unregulated practitioners in my current hospital. The consultants allow them to practice way beyond the RCOA scope of practice and therefore they expect to do this on a list supervised by a trainee as well. This puts us in a very unfair position.
Resident Doctor, unspecified

OP 122 – As a consultant physician, I recently referred a retired consultant cardiologist as an out-patient to orthopaedics. She attended the clinic with her husband, a recently retired geriatrician.

It was only on receiving their copy of the clinic letter that she learned she had been seen by a physician's assistant and not by a consultant orthopod.

If this can happen to two consultants, what chance does the average patient have?
Consultant, South Thames

OP 124 – They are working in Ed. I have witnessed them

Miss acute abdomens, ACS. They discuss with any SPR not Just consultants. They get very junior SHO's who are new to the uk to prescribe for them.

PA are put into resus over the trainees.
Resident Doctor, Thames Valley

OP 126 – Newly qualified PA on geriatrics ward. Informed of an unwell patient in the afternoon, NEWS 6. PA was 'shadowing' the F1 for 2 weeks as part of a longer period of shadowing of other F1s and other PAs for several weeks.

PA was unable to complete an A-E assessment nor offer any differentials or propose investigations and management for the deteriorating patient. Took an extremely passive approach and performed an extremely limited physical examinations.

Patient subsequently seen by F1, diagnosed and treated for HAP following discussion with SHO.
Resident Doctor, Yorkshire

OP 130 – If PA's form main 'SHO'-level workforce in teams where Registrars often not available for immediate ward reviews/advice (eg surgeons in theatre), they may be left short of skills & knowledge to manage ward-based medical issues (whether simple or emergency). I have seen this relating to simple Paediatric conditions (eg constipation, asthma etc) – including when PA's unable to prescribe to initiate treatment.

Essentially I feel PA's should support mainly medical trainee/non-trainee (eg Fellow) teams; however their restricted ability to fulfil all the same duties should be reflected in their shift allocation & pay (ie if a junior doctor is legally responsible for prescribing/ordering imaging – including when asked by PA colleagues 'because they can't' – I would feel uneasy about the PA earning the same/more than the junior doctor).
Unspecified, North Thames

OP 133 – I have come across multiple episodes of substandard or even unsafe care from PAs in the last year or so. Encompassing all aspects of clinical care: prescribing, mental health assessment, suicide risk assessment, general clinical assessments etc.

Difficulties in understanding responsibilities for GPs who are 'supervising' them.
GP, South Thames

OP 134 – Physician associates are not well trained as GPs which is leading to serious clinical errors and putting patients at risk of misdiagnosis or delayed diagnosis. Plus requesting investigations and referring to consultants when it is not needed.
GP, Peninsula

OP 136 – I have worked with a number of PA's with some years of experience and whilst I could see the value they brought to the team, the limitations of their knowledge was also apparent. For example, despite having reviewed numerous bloods, there was a clear lack of clinical knowledge and skill in interpreting the results. The underpinning knowledge was lacking and the skills of the Doctor required in order to make decisions and interpret findings. The value was added more in an administrative capacity, such as record keeping during rounds.
GP registrar, Mersey

OP 139 – Blurred lines between medical professionals. Not investing in training more doctors using a quicker less qualified plug of the gaps in the nhs. Paying them more than an F1 is undermining the whole medical degree/qualification.
GP Registrar, Thames Valley

OP 141 – Worked with them in XXX hospital. They were only able to pre op patients. Could not be left alone. Helped in anaesthetic room but disappeared into the general theatre staff and were often not available to help.
Consultant, Scotland

OP 143 – In GP, PAs (and ACPS) have too limited background knowledge to think of all differential diagnoses for a symptom. E.g. patient with cough– they tend to go for the simplistic diagnosis , but do not have the depth of background knowledge , to have a high enough level of clinical reasoning to be able to safely exclude other causes e.g. heart failure, reflux.
Salaried GP, Yorkshire

OP 146 – 16 y/o female with unilateral ear ache, seen by a paramedic twice at her practice. Full ENT exam was not performed and patient got unwell with underlying paratonsillar abscess and presented to OOH. Throat was not examined during both consultations as per GP records.
GP, unspecified

OP 153 – I'm a Senior SpR in ED and have been the lead for our PA students in Emergency Medicine for the last 3 years now, and Educational Supervisor for 8 PAs during this period. Whilst the students themselves have been great, very proactive and trying to learn as much as they can in the time that they have, I and many of my colleagues have significant concerns about their training. Most come from a science background but I've known one student who came from an IT degree (I'm not sure if they had science A-levels or gained further qualifications, but still), and then they have only 2 years to learn all of their clinical skills and medicine. The teaching they receive in classes is very variable, and skims over topics that we as doctors spend years going over again and again, and even then we might still struggle to get our heads round it. ECGs for example, from what my students have said, are very poorly taught and then they are expected to be able to interpret them by the time they qualify. It feels as though the universities rely too heavily on clinicians to deliver teaching whilst students are on placement, whereas this should really be an added bonus to supplement an already comprehensive teaching programme at the uni. During the last rotation of PA students, their weekly teaching programme had not been organised at all and I was asked to take responsibility and arrange speakers, which should have been entirely the responsibility of the university/undergraduate team, and planned well in advance. Their attachments are also too short and, through no fault of the students, there is too much focus on getting assessments signed off with not really enough time to become good at each skill – at least from what I've

seen anyway. Out of sympathy there can be a temptation to give them the benefit of the doubt sometimes rather than give them more time to practise, like you can with a medical student that spends 8 weeks with us. A PA student only gets 2 weeks in ED and will never come back, some of these actually want to work in ED eventually, but how can we justify employing someone with 2 weeks experience and allow them to work almost independently as the Government intends? Even FY2s struggle at first and need a lot of guidance, and that's with 5 years medical training and at least 1 year experience as a qualified doctor under their belt. This is why our department will never employ PAs, because it will take up more doctor's time having to supervise/ potentially duplicate their work rather than free it up, which is apparently what the role was designed for. I remain enthusiastic for the sake of the students, who are investing their time and money in good faith that they will be properly trained by the end, but the reality is I don't believe in their course and feel it needs to be completely reimagined. Most of my colleagues feel the same way and we are seeing evidence in the press now of what such inadequate training can lead to in terms of misdiagnosis and treatment. I think PAs could make a good addition to the workforce, but if we want them to be able to perform like doctors, then they need to be trained as such. Their course needs to be longer as 2 years is simply not enough, and taught properly with sufficient depth and breadth. Give them time to settle into an attachment and practise and become proficient in all the necessary skills, assess them regularly to ensure their competence, and have them properly regulated by the GMC.
Resident Doctor, Mersey

OP 157 – The issue with PA's I have found is that they are not confident to manage undifferentiated presentations e.g. Mental health, Paediatrics etc. PA's require debriefing and supervision, which increased workload, means less time spent with GP Trainees and Med students as reduced capacity, PA's do not often in my experience differentiate themselves from being a GP, e.g., they do not wear a uniform e.g. Nurses, HCAs etc and patients are often confused when you consult with them about who they had seen previously. The public does not know what or how qualified a PA is. Additionally, PA's generate and request extra tests including bloods etc which puts a strain on a finitely resourced system and create extra patient angst with more referrals/investigations and increasing demands on a stretched system which has limited capacity. We need practitioners that work autonomously, independently , can prescribe and take responsibility for completing the care cycle for a patient.
GP, East Midlands

OP 160 – The AA's in my current hospital regularly work beyond their scope of practice. This includes their supervising consultant not being in the theatre suite (regularly in the office or the canteen) and more than 2 mins away. This represents a direct threat to patient safety.
Resident Doctor, Scotland

OP 165 – PA in cardiology at XXX regularly taking up regular oncall medical shifts something they have no experience in.
Unspecified, Thames Valley

OP 166 – I am a medical student and during my placement in paediatrics I saw PAs acting in ways that made me hugely worried about patient safety. They would routinely brag about covering the SHO rota and would introduce themselves to medical team members as one of the SHOs. I saw consultants having to double check exactly which team members were doctors and which were PAs because the PA made it purposefully confusing by continually calling themselves an SHO. They introduced themselves to patients and their families as 'a member of the medical team', again making it really unclear that they weren't a doctor. This made me really uncomfortable and concerned for the vulnerable paediatric patients in their care. They would also massively favour the PA students over the medical students in terms of teaching opportunities and call the medical students 'lazy' for going to teaching in the

afternoons (which had been organised by the consultants we were with!) rather than staying on the ward with them.
Medical Student, Thames Valley

OP 169 – I was working in psych, a dementia inpatient had stroke symptoms. Was bluelighted very efficiently to nearest A&E (also major trauma centre). Only record of patient being seen was by PA and a "quick review" by stroke nurse which was documented second hand by PA.

This was a complex dementia patient with BPSD and unable to provide any history yet the only review was by PA.

Patient sent back to Mental Health Unit with no handover. Just a note in the paper A&E summary (which we have no electronic access to) stating patient had TIA and will need aspirin 300mg on return to Menntal Health unit.

The patient was in A&E for around 9-10 hours. PA can't prescribe so patient went without treatment for this whole time. Aspirin eventually prescribed by overnight psychiatry doctors. **Unspecified, Yorkshire**

OP 170 – Called my GP surgery and asked for appointment to see a doctor as concerning symptoms ?cancer. Receptionist offered same day appointment. Checked in, called into room, consultation took place. Towards the end I thought it was curious the 'doctor' hadn't asked me a single red flag question; nothing about weight loss, night sweats, pain, change in BH, bleeding, fatigue…. Literally no lines of enquiry. It was only right at the end of the consultation I figured out this person was a PA. Had I been a member of the public, I would never have known. Very frustrated and concerned by the lack of transparency and the lack of very basic knowledge. Furthermore, this person used to be a paramedic, of which we have a dire shortage**!**
Resident Doctor, Peninsula

OP 172 – I did note that sometimes they don't correct patients when they call them doctors by mistake. My experience was in orthopaedic rotation, they were not willing to listen to f2 doctors about advice on diagnosis and signs sometimes they just wanted to do things their own way even though they were not doctors. I personally would not employ or work with a PA for this reason. I would much rather they see an ANP who has more clinical experience and in my experience come and find you if they are unsure about something.
Locum GP, unspecified

OP 181 – When I was an FY1, the PA on the ward who had been there longer used to fill out drug prescriptions (it was paper prescribing) and hand them to me to sign for her. She would say the only reason she couldn't prescribe was because of how much time Brexit took in parliament, and soon she'd be doing her own ones anyway. I would have to go and sit and check her prescriptions before I signed them, all the while feeling uncomfortable with her staring at me and telling me that they were correct. Looking back, I was new to the ward and working with PAs and I thought this must be true, but now I'm amazed at this behaviour because it was so presumptuous and risky for someone that hadn't done any prescribing learning or exams to write out prescriptions.
Resident Doctor, North West

OP 183 – About a year and a half ago, I had been a senior ICU reg in the department for 3 months with extremely patchy training, with a lot more "air time" given to the issue of how to train the PAs in airway management, transfers etc so they could be an 'out of hour non–airway reg' (I don't think this has happened yet though), so they could keep the PAs happy and increase their banding, than was ever considered for the anaesthetic or the ICU trainees. So I worked with the individuals in question.

2 weeks after I had rotated on to a different hospital, my father in law was admitted to the same ICU with sepsis and multiple organ failure. He was there for approx 3 days, of which I was there for 2 (midweek, daytime, normal staffing). Whilst I am sure that the consultant would have had involvement in his care, I never saw a consultant – or even a doctor at all properly (apart from a brief introduction, see below) – during the entire time I was at his bedside which was at least 12 hours total over the two days. The only person who came in and gave us updates over those last 2 days of his life was a PA who I'd worked with. Bearing in mind that he was one of the sickest people on the unit on two vasopressors, intubated, filter, etc etc and for full escalation at the time.

The PA came in with the SpR (who introduced themselves, but said not a single word other than that) and so it was the PA who led the end of life discussion, who suggested that we turn off the filter, who said that he was not going to be for resuscitation. My mother in law didn't question this and agreed to everything, but when I talked to her later, it turned out that she thought the PA was the consultant. I'm sure that the PA had introduced themselves at some point, but my family aren't medical and you don't listen well when you're grieving.

To be clear, the PA was professional and conducted the conversation well (and potentially was the only one who gave a damn about my relative seeing as everyone else was so distant, or perhaps they were stuck doing all the prescriptions and referrals). My mother in law is content with his care. As far as I can tell, his care was generally appropriate. I have nothing against the PA as a person.

However I can't know that his care was appropriate for sure. I didn't feel able to ask for a doctor at the time because I didn't want to offend my ex-colleague; I didn't want to cause a fuss and derail the conversation; and I was grieving myself and trying to support my partner. It was also extremely difficult and disorientating grieving my own relative in a side room where I'd intubated someone two weeks previously. And, frankly, I was angry about it, and I didn't trust myself to stay calm. But the more time goes on, the more I wish I had asked to speak to the consultant, even to reassure myself that his case had been properly considered by a consultant rather than relying on second hand information from the PA.

There's also the issue of mistaken identity which my mother in law would never have known if I hadn't actually worked there. For this reason – as well as the complete lack of professional courtesy and respect to me as a colleague – I really don't think it's appropriate for a PA to be leading end of life discussions, or to apparently be the main individual looking after someone with multiple organ failure. Honestly, with hindsight, the lack of involvement from doctors at the end of his life makes me feel like they had written him off by that point. I don't think we should have been put in this position – or the PA for that matter.

I hope to go to PALS when the time is right but the department has such a pro PA environment that I'm worried that I'm going to be branded as a bitter trainee rather than an upset relative, and I don't think it would change anything there. I think the only way forward is better regulation, definition of scope or sanctions because GSTT ICU does seem hell bent on replacing its doctors with PAs.
Resident Doctor, unspecified

OP 184 – Introduced as part of the anaesthetic team, did not tell patient role and there was no informed consent whatsoever that this patient was treated by a non doctor. **Resident Doctor, South Thames**

OP 188 – They have been seen to be posing themselves as doctors in A&E departments! They have been challenged by the senior nurses many times but are still getting caught doing so.

They are getting paid SHO rates for £45/50/hr.
GP West Midlands

OP 191 – I have serious safety concerns regarding anaesthesia associates. Anaesthesia is routine 95% of the time but the skill (and hence 9 years of postgraduate study following medical school) is recognising and predicting when things are not routine. Put simply, AA's do not have the knowledge or experience to recognise this and therefore represent a direct threat to patient safety. I have witnessed multiple examples of this in my own clinical practice working with AA's.
Consultant, Scotland

OP 194 – PAs work in primary care in my region and refer children to both the ED and outpatients without any obvious input from a GP. It's like receiving a referral (or a query on the GP hotline) from a 3rd year medical student. It is not clear where the responsibility for the patient lies. The queries show very little paediatric knowledge and experience. I don't feel I am discussing a patient with another responsible, fully trained healthcare professional. I feel my time is being wasted. I now ask them to discuss with their supervising GP first. Most have not discussed the patient with a primary care doctor before ringing the consultant hot line. The PA outpatient referrals are pitiful and demonstrate totally inadequate paediatric training. It is unsafe for PAs to be seeing children unsupervised in primary care. Do they all have level 3 safeguarding competencies for starters?

In secondary care, as an assistant to the doctors on the ward (in an F1 sort of role), they could provide continuity and a measure of support for the rotating doctors. I feel that that would be a safer, more effective use of well meaning people who want to work in healthcare but lack the insight into their own paucity of training. In time, they could become an integral part of the service, responsible for its smooth running, but not be tasked with autonomous patient care as seems to be the case currently in primary care.
Consultant, North Thames

OP 203 – I shadowed a PA in A+E. Patients and even some staff called them doctor on a number of occasions and they did not correct them at all. I did not feel comfortable in raising this at the time but I'm concerned that this is misleading patients.
Medical Student, South East

OP 204 – Due to the outsourcing of radiology services, PAs are referring to themselves as FYs as the outsource company won't speak to PAs.
Unspecified, Scotland

OP 206 – 1) The PAs seem to get engaged for a multitude of jobs, ranging from at one end doing record searches for reaching ''targets'' set by local primary care, to coding incoming clinical letters or trying to contact patients for fulfilling targets of regulators , to at the other end directly seeing patients and help out with a GP list when pressure goes up. What they do differs per week and differs per person and practice. As time passes, it will be difficult to see how much of clinical competence is left over, since their graduation. Without regulation, this may infringe on patient safety in the long run. A minimum amount of hours of patient exposure per year or 3-5 years would be able to remedy this for those wishing to remain clinical. This can be combined with CPD.

2) The PAs differ a lot in their perspectives on safety and this may have to do with their training curriculum, rather than their personal attributes. Was any human factor training included as mandatory training in their curriculum? If not, it should be one of the recommendations of the BMA to do so.
GP, North Thames

OP 207 – Patient was started on DVT treatment and and doppler was requested as the PA was concerned about DVT. Patient discharge was delayed 3 days and given treatment dose enoxaparin for 3 days because PA unable to differentiate between foot contusion and signs of DVT.
Resident Doctor, North West

OP 208 – I work as GP in a practice where we had some PA's in training on attachment for a few weeks. They had no clinical acumen. They relied entirely on following fixed protocols. Very narrow knowledge of medicine.
GP, Wessex

OP 209 – Most recently had a patient referred to the medical team with a letter from GP practice (without calling to refer to me prior so I could mark the patient as medically expected) by PA for consideration of 'stronger analgesia such as fentanyl' as the patient had fallen and bumped themselves at home. The patient had no external bruising and a normal CT. The were discharged with codeine and a single dose diazepam for possible muscle spasm causing sx.
Unspecified, North Thames

OP 210 – We were doing an assessment, I was in my second year of med school but they were in their final year of PA studies. I knew more of the steps of the respiratory exam we were being tested on. Bear in mind they've been in clinical placements for a year already at that point but I hadn't had much formal clinical training yet. It showed to me that our training wasn't on par with each other. They were about to be working as a full PA but didn't know the steps to a resp exam which is one of the first exams we're taught in medical school. It's very strange now reading that they're employed in GPs.

Separate incident: I was supposed to be in an ENT clinic but I got turned away by the doctor so 2 PA students could go into the clinic instead. I understand that they need to learn but I do as well. Sometimes don't feel like I get my money's worth for this degree.

Another incident: was in a surgical speciality, the foundation doctors and some specialty trainee doctors were on the ward doing ward jobs while the PA was in a surgery with me just standing around doing nothing. They were acting exactly like me (even though I'm the medical student who's not being paid to be there). When I found out how much they were being paid to linger around and I was sooo annoyed. It is unbelievable that the foundation doctors who are being paid less are doing more work.

Another one unfortunately: I know a person applying to be a PA student who goes around telling people that she will be doing medical school in 2 years and will basically be a doctor after 2 years. Most non medics don't know that this isn't the case; the non medics that I knew genuinely believed her and weren't aware of the differences.
Medical Student, Severn

OP 211 – Performed an image-guided drainage procedure on a patient with diminished capacity due to dementia. This patient required a consent form 4 – the other countersignatory was a PA-R from ward team (care of elderly). I am uncertain if this is within the remit of a PA to make decisions regarding capacity or make decisions on behalf of a patient for such a procedure. I felt compelled to countersign this as patient was septic and needed the drainage.
Unspecified, North West

OP 215 – Impacting both patient safety and education and training–

1) a cardiology PA answers referrals but also takes medical SHO locum take shifts and clerks patients independently. Furthermore she was able to get an escalated rate , even though the actual SHOs were refused the higher rate and bullied for asking

2) respiratory PA gets to do all of the clinics whilst the trainees continue with service provision.
Resident Doctor, Thames Valley

OP 220 – On GP placement under an ACP on a nursing home visit, the clinical reasoning showed by the ACP was very poor and he essentially prescribed every confused elderly patient with antibiotics regardless of the history. He also relied on the non–medically trained secretary to present the patient history and did a less than basic history/ examination before proceeding to come up with management.
Medical Student, East Midlands

OP 222 – The acute medical team heavily uses PAs. Some of them are excellent but there are a couple who ruin it for everyone involved and go around calling themselves "Senior PAs".

The PAs are given the same scrubs as the consultants and given the responsibility of answering the GP phones for referrals (often independently, and often these PAs do not seek advice from consultants when deciding to accept referrals or not).

I now work in ED and I saw a patient who had a letter from the GP which said " I have tried to call the SAU and AMU. After discussion with Dr [PA's Name here] we have agreed the patient to go to ED for assessment and CT scan"

I do not know the true details of the discussion but it felt inappropriate that the PA did not make it clear they were not a doctor, and possibly had given advice that pt needed a CT.

Some of the PAs on the acute medical team can be funny when junior doctors double check details and assessments when asking for prescriptions and radiation for PTs. The consultants are not always available (e.g doing PTWR or RTMT) and often it is SHOs or F1s who are asked to sign PA paperwork and due to the heavy workload it is difficult to accommodate checking over these tasks.

I have heard also that even registrar's feel pushed out of the team, as they were the junior doctor scrubs (unlike PAs who wear consultant scrubs) and some of the PAs do not make it clear they are not doctors when seeing PTs (though to my knowledge none have outright declared themselves to be doctors).
Resident Doctor, Peninsula

OP 226 – Running clinics when they should be on the ward. Getting junior doctors to sign prescriptions and order scans for patients they have not seen.

Complete lack of regulators for PAs.
Resident Doctor, Scotland

OP 231 – Currently on SDEC – we have roughly 55 patients a day on average (+/- 15).

3 SHOs and 1 SpR during the day and then 3-4 PAs. The PAs are not identifiable compared to the doctors at all. Often they look more suited in the role as they are perm staff so have department scrubs where the rotating doctors are all mix in clothing. Most PA ID badges that I've seen have physican associate as the title but there is a "I've had my fly jab" sticker or something similar stuck over the associate

part of the name tag. Most of the nurses think the regular PAs are the doctors – a nurse told me X has changed the plan on a patient id seen. When I asked who X was, the nurse said 'the senior doctor'. I went to see the reg and it turned out that X was a regular PA. I challenged this immediately and they immediately apologised and said there was a miscommunication but my main concern was that the nursing staff had just gone along with the new verbal advice from the PA.

There is no SDEC specific consultant within the ward. I've asked some of the PAs who their supervisor is and most give a vague answer but most agree they have no accessible supervisor. If they 'feel they need to discuss' then they speak to the SpR on the ward.

I don't really know how drugs and scans are being requested. The SpR isn't doing a lot of them nor are the SHOs but yet lots of PA seen patients are heading off for chest X-rays and knee X-rays and I can't work out who's requesting them.

In short I suppose my main concern js that the department seems to be very PA led with little oversight by a consultant. It seems PAs are seeing and running plans without any doctor input and I'm not sure how scans and drugs are being issued as well as the lack of identifiable features of PAs such as badges or lanyards.
Resident Doctor, North Thames

OP 236 – PA student introduced themselves as trainee doctor and misleading patients.
Medical Student, Wales

OP 240 – Whilst covering on-calls in ENT, we receive referrals/ calls for advice from primary care. On a number of occasions I have received calls from PAs who have not even discussed the case with their supervising GP and provide completely inadequate/ confusing referral information – clearly reflecting a lack of underlying knowledge/ communication skills which has been traditionally acquired through 5 years of medical school/ foundation years.

In my opinion ALL medical referrals should take place between 2 doctors (or a doctor and an advanced nurse) – over the phone it can be very difficult to advise appropriately and assess whether a patient needs urgent review etc. with a poor referral. I am under no illusions that doctors can make poor referrals too but my experience is that there is a noticeable gulf in quality between even foundation level doctors and PAs in this particular skill. It's not safe!
Resident Doctor, East Midlands

OP 242 – PAs in this department do their own clinics, go the theatre regularly and dump ward jobs on junior doctors including asking them to prescribe and order scans for patients the doctors haven't seen. PAs only work 9-5, often disappear whenever. They also do flexible cystoscopy independently and being trained to do several surgical procedures independently.

PAs here are given a registrar timetable and are considered a registrar by consultants.

F2s and CSTs are treated terribly and only there to do ward work. CSTs have to compete with these PAs to go to theatre. I didn't go to theatre or clinic once.
Resident Doctor, East of England

OP 247 – PAs used to fill junior doctor rolls on ward round and at end of ward round given a list of prescriptions and scans to order for patients I haven't seen/am not responsible. No other choice but to do these otherwise patients suffer.
Resident Doctor, Yorkshire

OP 248 – I am disappointed in the way physician associates are used at XXX Hospital.

In ED, physician associates are used in the same role as SHOs. They see their own patients (completely undifferentiated, whoever is next on the list to be seen in Majors) independently and then discuss each case with the ED consultant. As for SHOs, ED consultants typically will not review the patient in person. PAs often then ask SHOs to order ionising radiation / prescribe for their patients. I will only do that after they have discussed with a consultant and had their plan approved. In departmental induction, it was strongly pushed that we should help to 'facilitate' PAs in this way. PAs also get more training opportunities than F2s – for instance, F2s get 3 or 4 days in resus during the four–month rotation. PAs are often allocated resus slots.

In general medicine, I have worked on wards where PAs are used interchangeably with SHOs. On days without a consultant ward round, PAs are doing a ward round of their own bay as the SHOs/F1s do. They then come to SHOs/F1s with a list of prescriptions / TTOs / scan orders. Very inefficient for working and likely unsafe.
Resident Doctor, South Thames

OP 249 – I have been asked multiple times to just prescribe a medication or a whole set of medications for a clerking shift a PA or MNP is doing. I felt a lot of pressure to prescribe and feel it is a very unsafe way of working.
Resident Doctor, Severn

OP 251 – PA's conducting solo TIA clinics, have a consultant on other end of phone who reviews patients in evening however junior doctors covering Ward have to do prescriptions and order scans for them without seeing patient.
Resident Doctor, North Thames

OP 253 – Neurosurgical team doctors DECT phone being routinely held by a PA who gives advice/clinical management suggestions to ICU doctors over the phone re neurosurgical patients – often does not identify themselves as a PA over the phone.
Resident Doctor, North Thames

OP 255 – PA doing ward round with registrar, going ahead without me, and demanding I do the TTOs. They hadn't checked any regular meds or allergies. Asked me to prescribe fluclox to a pen allergic patient (I was diligent which meant this didn't happen). Created me twice as much work.
Resident Doctor, Wales

OP 259 – Wife gave birth in XXX Hospital, Northern Ireland. PA reviewed a lady in the next bay. When ask if she was a doctor, she stated the usual fudge, part of the team or such like.
Unspecified, Northern Ireland.

OP 263 – XXX A&E using PAs in resus. F1s regularly prescribing for PAs. PAs treated the same as doctors. Harming training and development. Preference by consultants towards PAs over doctors.
Medical Student, Northern

OP 265 – A family member recently saw a physician associate at their GP practice for an intimate health issue.

The PA did not provide an adequate introduction as the family member came away believing they had been seen by a doctor.

The PA made my family member feel uncomfortable during the consultation as they were very awkward (smirking etc) when talking about PR issues and did not use a chaperone for a PR examination. I was frankly horrified to hear of this experience and

I feel this could result in significant patient safety issues. The family member now feels less comfortable talking to a HCP about intimate issues as a consequence of this. Were this to have been a case of something such as a rectal cancer it could have led to massive delays in care and potentially life threatening consequences as a result.
Medical Student, East of England

OP 268 – I work regularly in theatre with anaesthetic associates, it is not often clear what their role is as they introduce themselves as members of the anaesthetic team. This is in direct contrast to anaesthetic ODPs or anaesthetic nurses who will be completely transparent about their role. If I notice then I question how open they are with patients.
Resident Doctor, Northern

OP 271 – Physician associate in XXX ED is regularly requesting X-rays and CTs, labelling herself as a doctor on the form.
Unspecified, North Thames

OP 278 – Working in general practice; physician associates seeing undifferentiated patients, having their own clinics, newer physician associates reporting to a more senior PA rather than to a doctor.
Resident Doctor, South Thames

OP 279 – A number of patients are being referred with no prior work up and no provisional diagnosis. It leads to delayed treatment. Also leading to delayed diagnosis of a cancer. All the burden has now been shifted to the hospitals with minimal support in primary care setting.
Consultant, Yorkshire

OP 283 – Early this year, I witnessed a physician associate introduce themselves to patients as a doctor (including a blind elderly patient) and undermine the consultants expertise to medical students.
Medical Student. Yorkshire

OP 292 – I have found at times that PAs can be over-confident in their abilities, and have not appreciated the subtleties of managing a difficult patient in primary care. I have found that they do not follow instructions, and will go ahead and requests rafts of unnecessary blood tests, which can often interfere with patient care. The issue is that they don't have an appreciation for what they don't know, which can be dangerous in medicine. In a hospital setting, I feel that they are trying to work to a similar role to a CNS, however many of them are doing this without the experience of a CNS – nurses work for many years in different clinical roles before they settle in one specialty and gain their expertise in that field, and this experience is vital to their ability to perform that role. I feel that the higher pay and better working conditions of PAs in comparison to junior doctors is unfair, and undermines the hard work that is put in to qualify as a doctor. My thoughts are that I would love to have a 'physician's assistant' – somebody to work alongside me and assist with the work, but their role seems to have diverged from the original work they did when this position emerged in the US.
GP, South Thames

OP 299 – I have seen first-hand a PA being used inappropriately and way beyond their scope. We have a PA who, albeit competent as a PA, is now left to see and manage patients alone on our ward. This ward has complex, multi-morbid patients. Like all PAs they have a named consultant responsible for their training but their consultant is part time. This means for at least half the week, they are seeing patients completely independently and making management plans for those patients completely independently. For at least half the time, the PA is NOT supervised and is making adjustments to medication, adjustments to medical plans and or wanting ionising radiation without discussion with a consultant or senior as whichever senior doctor

is on the ward is understandably busy and looking after only their own patients or patients who are very sick. The PA then has to ask the juniors, on an already understaffed ward, to action these jobs as obviously they cannot do these themselves.
Resident Doctor, East Midlands

OP 301– A PA asked me to request an x-ray on her behalf when I was working in ED, in early 2023.

A second PA, even more recently qualified than the first one, tapped the first PA on the shoulder and said she would be able to request the x-ray through her special account. I was not sure enough if this was within or outside of her remit so I did not challenge it at the time.

I am concerned about how I saw that freshly graduated PA flout an extremely clear limit of her scope.
Resident Doctor, South East

OP 302 – We employed a PA at our GP practice in 2020. My colleagues told me we needed to use the ARRS money and that 'everyone else was doing it'. I agreed to be the supervisor. The PA was a gentleman in his 50s who had previously been working as a journalist. His initial degree was over 30 years ago and not in a relevant subject. His 2 yr PA course had in no way prepared him for working in a clinical role in the NHS. He was a nice man who meant well but his clinical knowledge was minimal. Our weekly 'tutorial' was painful as I sat for an hour telling him what he had done wrong. He was clueless but understandably so due to the nature of his course. PA studies is extremely sketchy, nobody ever fails it and he had never set foot in a hospital. We let him go after a month because his complete lack of clinical knowledge made him unsafe around patients. We won't employ PAs again. We use our ARRS funding for useful staff such as physios, pharmacists, care coordinators and social prescribers.

The whole experience made me realise that PAs should not be working in primary care. It is too difficult for them. The enormous range of patients and conditions requires a high level of intelligence and many years of clinical experience. A newborn one minute, a 95 yr old the next. Dermatology, mental health, paediatrics. Heaps of clinical risk and challenging ethical dilemmas. Prescribing the right medication in primary care is critical. PAs have no knowledge of drugs or pharmacology and are rightly not allowed to prescribe. PAs should not see patients by themselves. They are so unskilled that a GP needs to review every patient they see. They therefore do not help with workload. Much cheaper and quicker to do it yourself.

I advised the PA to get a job in hospital. If he stayed in one department (e.g. gastro), he would see a much narrower range of conditions and gain knowledge on a small selection of drugs.

I am a GP trainer. When I look at my GP registrars, they are experienced doctors, highly intelligent individuals who have spent years working in hospitals before embarking on GP training. They have to pass competitive expensive exams and jump through difficult hurdles. But the government thinks it's okay to let an unregulated individual from PA school loose on patients and pay them the same as a GP registrar. It is ludicrous. I also hate how NHSE and the GMC are lying to the public and telling them that PAs are 'highly trained medics'. My PA's zoology degree from over 30 years ago did not have any relevance to him working in healthcare. PA courses are not in any way academically or clinically stringent. They do hardly any basic science, anatomy or physiology. They cannot recognize cancer. They don't understand referrals as they have never worked in a hospital. They end up being abused by some GP practices who try to save money by getting them to consult autonomously. This will inevitably result in harm to patients.

There are many other properly trained and regulated MDT professions that can safely and appropriately help with patient care. I cannot see the purpose of PAs. They are expensive and unsafe.
GP, South Thames

OP 306 – PAs "running" areas of ED including resus and minors. no direct supervision. they are supposed to be giving advice to the doctors but cannot do any of the advice they are giving. ACCS trainees in minors/paeds doing all the leg work because they can prescribe and discharge without advice.

Complete neglect of teaching opportunities and disregard for pt safety. **Resident Doctor, Severn**

OP 307 – Physician associate refusing to state their grade when asked, queried with their colleague (who it turned out to also be a physician associate) who also refused to state their grade other than 'one of the medical team'.
Resident Doctor, South Thames

OP 314 – PAs reviewing patients and not recognising medical emergencies and raising appropriately

PAs clerking patients but being unable to prescribe or request radiology increasing work load of available doctors who have to then re-review to assess appropriateness of PA request leading to delay in Critical medications etc

PAs working without direct supervision/not getting their supervising doctor to review patients they have seen

Limited knowledge limiting differential formulation.
Resident Doctor, Mersey

OP 319 – Medical student on placement in an inpatient ward. Asked a PA if there were any patients I could practice clerking on. They took us to a bay and introduced themselves as "I work on the ward"—not stating their role at all. They were wearing a smart jumper with a stethoscope around their neck and could so easily be mistaken for a doctor without proper introduction.
Medical Student, East of England

OP 322 – I regularly receive outpatient referrals from PAs working in general practice. I believe many referrals would not have been sent had the patient been reviewed by a GP and demonstrates a concerning lack of support in GP surgeries. Of the referrals which are likely to be appropriate it is often impossible to interpret from the information provided if the patient should be reviewed on a routine or urgent basis.
Consultant, Wales

OP 328 – I shadowed a PA in paediatric a&e. During the consultation the child's mother said thank you doctor to the PA. The PA did not correct them. I also saw them fail to correct staff members who referred to them as doctor.
Unspecified, South East

OP 335 – I'm due to finish GP training and am being told there are no jobs because practices are employing PAs!!
GP, unspecified

OP 337 – Working on a ward with clinically unsafe PA

As very understaffed and busy didn't have time to check work they did but would be asked by them to prescribe for them medications for patients and request scans as

they were not able to. I was trusting their judgement however was too busy to be able to check all the management plans and decisions they had made for each patient and ultimately my licence would be at risk if something went wrong and they were prescribed incorrect medication etc. Rather than helping it also makes more work for doctors.
Resident Doctor, North West

OP 343 – AAs currently run the eye lists at xx hospital which are performed with blocks. The eye theatres are geographically separate from main theatres. They are technically "supervised" by a consultant in EPOC (the enhanced post op care unit) however these consultants may not perform blocks themselves routinely and in some cases do not provide anaesthesia themselves. The "supervision" in these cases is by name only and I highly doubt consultants would be able to attend these theatres within the 2 minutes required for AAs (and on occasion I would suspect they aren't even confident where they are).

Eye blocks are generally safe however the patients cohort is on the frail end with multiple significant comorbidities. This seems highly inappropriate to me

Because these lists are run by AAs, there are no trainees attached so we are losing out on this experience and these skills.
Resident Doctor, Birmingham

OP 345 – F1s being advertised rates less than PAs for same locum shifts despite increased responsibility and training at xx hospital.
Resident Doctor, Thames Valley

OP 348 – Senior PA was acting as an EPIC once during my rotation in A&E – I don't remember his name but all juniors including regs were reporting cases to him as EPIC. I was surprised but didn't ask further questions.
Locally Employed Doctor, Wessex

OP 359 – Not safe

As PCN employed partner isn't bothering to care

Poorly supervised with no plans and no allocated time

Not bothered answering my emails with my concerns

Salary gap forced into supervising against wishes. **GP, unspecified**

OP 361 – A physician associate was managing an acute asthma exacerbation in A&E and was unaware how to proceed after giving salbutamol.
Medical Student, Northern

OP 368 – PA's in AMU and ED are entrusted to see undifferentiated patients with extremely minimal supervision – and will push rotational trainees (usually F1-2s/IMGs) to prescribe for them and request radiation.

This has been repeatedly raised with local consultants and local freedom-to-speak-up processes - no progress has been made.
Resident Doctor, East of England

OP 377 – Seeing patients on their own and then asking doctors to prescribe. When checking what's asked to be prescribed, patient has sometimes had allergies, incorrect reason for prescribing eg Apixavan for DVT when it's for AF. Unsafe for PAs to be seeing patient without consultant who can prescribe for them.
Resident Doctor, South East

OP 380 – I am an F1 – done 5 years medical education, 3 of which have been placement based. Still do not feel confident diagnosing undifferentiated patients due to awareness of capabilities and limits. It is a safety concern PAs with 2 years of studying are able to see patients by themselves diagnosing undifferentiated patients.
Resident Doctor, Wales

OP 384 – I currently work in a tertiary neonatal unit, we have a PA in the tier1 rota. They are considered a very junior medical practitioner in their experience and knowledge and they can not prescribe medications, this puts a huge pressure on the registrar supervising them as they need to do many jobs on their own and not rely on the assessment of the PA, and this could be a patient safety risk.

Usually as only paediatric trainees got to rotate in a very specialised intensive care unit. The type of patients we care for requires specialist training which is not found in PAs. That's why other trainees (like GP trainess) do not rotate to cover tertiary neonatal units. I think the same should apply to PAs, as they are less trained than GP trainees in the field of paediatrics.
Resident Doctor, East of England

OP 385 – I have worked with a number of PAs over the years. I have found them compassionate, professional and competent individuals who care a lot about high quality medical care. They integrate well into the medical team, and their continuity seemed to be received well by senior medical and nursing staff. However, the two PA's that come to mind have often concerned me for a number of reasons. One PA integrated well into the Neurology team, and became the predominant LP practitioner in the team. He would efficiently and competently do a few LPs a day. This seemed quite reasonable but often the junior doctors on the ward would do the TTAs, ward rounds and clerical jobs, whilst he developed a technical skill that trainees would struggle to do. Because of being a permanent member of staff he knew where the kit was, the bosses trusted him, and the path of least resistance was for him to do it. I do not think this was a safety issue, but certainly a training issue.

Secondly, another PA colleague worked at the trust for a long time in ENT. They took referrals, supervised junior medical colleagues in procedures, provided remote medical advice to specialties, attended emergencies in resus when ED asked for ENT assistance. They clearly knew the pathways and the team well, and were very confident. To all intents and purposes, they could have looked like an ENT SpR and I know that some of my colleagues thought that they were. Often they would introduce themselves as 'one of the medical team', which added to confusion. If Drs were confused about this person's background, then almost certainly the patients would not know who they were seeing. Last saw this clinician working 18months ago so not sure if they have changed how they introduce themselves lately, but can only talk for my experience.
Resident Doctor, Peninsula

OP 387 – Asked to train physicians associates, students turning up late given far more time with me than medical students no idea why. Knowledge lacking. Overconfident. Introducing themselves as medical students. Generally felt worried about the fact they were at the end of their training as not at all confident in their abilities. Not asked just assumed I would teach them.
Resident Doctor, South East

OP 391 – xx Hospital respiratory department. PAs prescribing and administering drugs for chest drains.
Resident Doctor, Peninsula

OP 399 – I was a foundation doctor working in ICU. One of my jobs was to refer to haematology as the ICU consultant wanted their opinion on a platelet transfusion. I sent the referral and shortly after a man appeared in a shirt and tie and British Society of Haematology lanyard on. He advised yes to give platelets to this patient. It wasnt until he left and I read the notes that I saw he was a PA. He had not introduced himself or discussed with a registrar or consultant. I think this is deliberately misleading about what his role was and a big risk to patient safety, especially in ICU with the sickes patients.
Resident Doctor, West Midlands

OP 404 – In the ED at xx Hospitals, PAs routinely see undifferentiated patients alone (including, horrifyingly in children's A&E occasionally seeing babies and complex, unwell children alone).

They are meant to 'discuss all cases' but I have grave concerns regarding 'unknown unknowns' in their knowledge and their ability to accurately present cases to seniors such that correct senior decision–making can occur. Inevitably the senior then has to go and physically review the patient even when routine – which is ridiculously inefficient.

I have also seen PAs 'leading' teams of clinicians in Majors, which may include IMT/ ACCS/GP trainees with far more clinical experience. This is frankly ridiculous and an insult to qualified doctors working there.

I would feel unsafe if myself or a family member were assessed by a PA in this hospital.
Resident Doctor, East Midlands

OP 407 – I worked an f2 weekend medical on call and was on ward cover. I was the only doctor as the others were all physician associates. Felt unsafe and sure we missed lots of unwell patients as I had to do all the prescribing and ordering so couldn't see as many patients. They don't add anything, they just make jobs harder for doctors and unsafe for patients.
Resident Doctor, South Thames

OP 409 – I have personally witnessed a PA who routinely pretends to be a doctor by calling themselves "one of the locums", which implies that they're a doctor to both colleagues and patients, knowing full well what they were doing. This has obvious repercussions, for example colleagues being more trusting of clinical information provided, and patients being misled.
Resident Doctor, South East

OP 412 – Currently working with physician associate in GP. The PA has very little supervision and will often request investigations where I am unsure whether they are appropriate for the patients presentation. As junior doctors we have repeatedly refused to request scans on behalf of said PA and have directed these requests to the supervising GP. It has now gotten to the point where the PA has requested X-rays herself despite not being allowed to request scans with ionising radiation.
Resident Doctor, North West

OP 413 – Whenever I am working with physician associates, I have to prescribe, order investigation, review sick patients on their behalf all that is just adding more responsibility, time and stress on my working shift.

They are also allocated to theatre where it only takes away my opportunity of training.

Pay grade is similar despite I have to pay loan back for my education.

I have no reason to think allocating many PAs to junior rota is leading to less work load on juniors. In the contrary, it leads to more additional work load.
Unspecified

OP 420 – PAs being used to see undifferentiated paediatric patients in ED – very low/ poor levels of supervision provided by ED Consultants/SpRs/other seniors who are often unwilling to provide level of oversight needed for PAs on busy shifts.

Results in paediatric on–call team reviewing children managed initially by PAs who often have bloods and ionising imaging (waved through by ED seniors) unnecessarily.
Resident Doctor, Peninsula

OP 421 – Unsafe staffing over weekends- F1 doctor and PA on MAU.

Being asked to prescribe things by PAs which have been verbally handed over to them from consultants/ registrars without any documentation from the doctors handing over these tasks.
Resident Doctor, Yorkshire

OP 426 – At xx hospital the PA in the stroke department is almost always the 'on call' member of staff. It is almost impossible to speak to a doctor in this department. They are recommending management plans, imaging requests and prescriptions constantly. They appear to make the decisions regarding which patients move to the ward and are accepted by the department. Had a patient with a significant stroke never reviewed by a doctor from stroke.

In respiratory department PA's doing clinics and chest drains. Doctors at all levels losing the opportunity to learn chest drains

In haem/onc department PA's are running clinics and ward rounds. Ask juniors to prescribe constantly. Phone calls to radiology without specifying they're a PA.
Resident Doctor, Scotland

OP 430 – Working in xx hospital, an acute medicine PA answered the phone and introduced himself as the medical registrar.
Resident Doctor, Peninsula

NP 437 – PAs are being used to fill vacant shifts instead of doctors and thus meaning extra work for doctors who are already overstretched and understaffed. They then have doctors as their assistants because we need to do their prescriptions and because it is on our licence we either blindly accept their examination or work or halve to completely re do all the work ourselves to ensure they are correct in their approach and history.

This is placing undue pressure on the already overstretched medical staff on duty. This is causing doctors being unable to provide as much training and shadowing abilities with education for medical students who are just seeing the complete lack of planning and the dissolution of doctors through the use of Associates.
Medical Student, East of England

NP 448 – PAs do clerking shifts and expect you to prescribe their meds, often just Before handover. They hand over a list of meds and ask you prescribe so your name is on the line if wrong. I've been asked to prescribe things that's are wrong eg reconcile and ACEi in patient with AKI and taking the time to review their work slows me down considerably
Resident Doctor, South Thames

NP 4 – This relates to my experience as a patient. Last February (2023) I contacted the GP surgery that i am registered with, with an abdominal symptom. I was seen by a PA who did not introduce himself as a PA; performed only a regional examination and omitted critical elements including inspection and palpation of full abdomen including regional lymph nodes. I was surprised, but did not say anything at the time (was not too well physically at the time too). If this occurred now, i would challenge and demand to know their identity. I believe every PA must provide their name and their supervisor's name plus contact details in writing to the patient.
Associate Specialist, North West

NP 29 – Working as a locum GP, I have seen first hand the effect of MAPs. The PAs I have worked with have been unaware of their own limitations, and the partners I work with have not realised the limitations in their work. As a result there has been an increased rate in complaints and errors such as delayed urgent suspected cancer referrals. I have been asked to sign prescriptions on behalf of these clinicians without having seen the patients myself, and have not been given the time or the oppurtunity to do so. Some of these clinicians are reluctant to discuss cases each time a prescription is needed as this is felt to be a "step backward" in their experience. They are unaware of their "unknown unknowns". I have also noticed partners being forced into hiring this staff due to the ARRS funding, where hiring a GP would be far more cost effective for patient care. Overall unfortunately a negative experience.
GP, Severn

NP 57 – PAs being used as the central duty doctor for 4 practices, making multiple errors and creating extra work for GPs, introducing themselves as duty doctor, not making it clear to patients they aren't a doctor. Clearly being used to maximise profit for the sole partner.
GP, North Thames

NP 76 – PA requesting ionising radiation scans – not informing supervising GP during debrief.

Flagged up when supervising GP noted PA had requested X-Ray via paper request form given to patient without discussing with them. On review has happened multiple times.

Practice has implemented restrictions of practice on this PA when has come to light.
GP registrar, South Thames

NP 92 – Physician Associate seen requesting xrays electronically and filling out prescribing at point of consultation. Some of this then goes to duty doctor to be signed. Not sure whether some go straight through. Saw some pre filled electronic prescriptions with the GP name already automatically filled in. This was last week and in February. This seems to be a data governance issue.

Also med3 requests are sent to PA list, completed and sent electronically. There may be some duty doctor supervision but we are unclear.

Their lists sometimes include patient cohorts known to have learning disabilities/ impairment and those that are in need of the language line eg Polish, Urdu etc and are unaware of whether they can articulate any choice to see a physician. GP Partner is xx known to be hostile to GP trainees for several years, whom feel unable to speak up.
GP registrar, Yorkshire

NP 140 – Patients being booked in with PA at the practice, saying that diagnosis was missed as a result. Also was not informed a PA would be booked for them and thought they were being booked with a GP. This has occurred numerous times. Patient thinks they've described their issue to a doctor when in fact they have been seen by a PA. **GP North Thames**

NP 163 – A newly qualified PA is seeing unfiltered patients with very light touch supervision in my practice. The GP named to supervise each clinic has only one slot blocked for discussion of the PA's patients which means that every patient isn't being discussed. The PA decides what they think should be prescribed and GPs are just signing the prescriptions, without seeing or even discussing the patients sometimes.
GP, Severn

NP 173 – 60 year old man seen by PA with voiding dysfunction for several months and some back pain. Examined by pa adequately including pr which it was written patient smooth mildly enlarged prostate. Treated as a uti with antibiotics by pa and little to no improvement in symptoms. Patient had bloods arranged by pa including pa. Patient then saw another doctor due to groin and back pain and an xray was arranged. Back pain continued to worsen and 4 weeks later psa came back >500.

Patient diagnosis metastatic spinal cord compression due to prostate cancer.
GP, West Midlands

NP 203 – PA and paramedics see undifferentiated patients routinely with inadequate level of supervision in the GP practice where I work. They certainly do not discuss every patient with a doctor, only when they believe necessary. GP trainees often get prescriptions and sick notes to sign for them (as they are often the only doctors on site) – when this issue was raised trainer directly answered that if an ST3 is not ready to sign off prescriptions of antibiotics and such for other professionals they were not ready to be signed off. The PA is the "duty doctor" for an entire session every week.
GP Registrar, South Thames

NP 429 – I am a salaried GP

My practice has employed a PA and I am occasionally asked to supervise her for a day (about once a month). This largely seems to involve her sending me antibiotic prescription requests via screen message, there seems to be a lot of antibiotic prescribing with less stewardship than a doctor would employ. I don't have time to see the patient myself as I do a full clinic of my own with variably 10-30 mins of supervision time blocked out. She does not usually come to me in person during the clinic. I am not comfortable with the medicolegal consequences of this. My probation period comes to an end in July and I will ask for BMA advice about my permanent contract (re supervising PAs) prior to this. I enjoy the job otherwise and have a good relationship with the team. One partner likes the idea of PAs and the other does not.
GP, South East

NP 461 – I am a GPST1. I have a clinical supervisor and it is his role to supervise me as I am a trainee, meaning that he is a point of contact on site if I have any questions or queries regarding patients I am seeing. He is a fully qualified GP. However on one day he was off work and I was told I'd be supervised by the practice's Physician Associate that day.

When I went to ask the PA how to refer a patient for an investigation the PA had never heard of the investigation therefore was unable to give me advice or guidance.

It was concerning that I did not have a GP there to supervise me, and demeaning as well as dangerous that I was a doctor was being "supervised" by someone without a medical degree, and clearly without the same clinical knowledge I have.

I didn't feel I could ask for any clinical advice from the PA as I know that their judgement, experience and clinical knowledge is inferior to mine as they're not a doctor. They should be being supervised by doctors, not the other way round. Therefore it was unsafe that I as a doctor who is not a fully qualified GP was essentially acting without proper supervision.
GP registrar, North West

NP 495 – A 94 year old lady who lived alone, had a fall a week prior to me seeing her on a home visit. She went to A&E for a head laceration and was discharged home. She had been experiencing severe pain in her back. On my assessment, she had significantly impaired mobility due to her pain, and multi-level vertebral tenderness with a graze. She had a telephone consultation with a PA the day previously who did not arrange a F2F appointment, and discussed the case of back pain with the GP who suggested issuing methocarbamol, without actually considering the whole picture, and the fact that she needed to be assessed, and imaged to rule out spinal fractures, as well as her social needs due to her profound pain and the fact that she lived alone.
GP registrar, North West

NP 601 – Whilst on my FY2 rotation at a GP practice, I sat in with PAs during my shadowing weeks before I started independently seeing patients. During this time I saw PAs repeatedly order imaging with ionising radiation. They were able to put in the supervising GP's name into the box when they ordered it and as far as I'm aware that allowed them to order the imaging, the GP wasn't required to vet it. With prescribing the PAs would request the drug, then it would be sent via EMIS to the GP who would sign the prescription later in the day usually after discussion with the PA – PAs debriefed every case by phone at the minimum at the end of each session. However with ionising radiation I don't think it needed to be signed by a GP.
Resident Doctor, East of England

NP 692 – PA referring patient to dermatology and signed of as clinical practitioner rather than physician associate.
Resident Doctor, East Midlands

NP 782 – PA GIVEN GP PARTNER COMPUTER USERNAME AND PASSWORD TO LOG IN AND REQUEST X-RAYS AND PRINT PRESCRIPTIONS TO ADD THEIR SIGNATURE ON PAPER. REQUESTS AND PRESCRIPTIONS FILLED OUT ON DATES WHEN GP PARTNER NOT AT WORK.
GP, South Thames

NP 123 – Preference given to PA's for teaching opportunities over Foundation year ones. PA's / ACP " work at SpR level" often quoted.
Resident Doctor, Severn.

NP 275 – PA working in resus. Outside scope. Taking training opportunities. Doing Dr's job.
Resident Doctor, North West

NP 277 – 1. PA carries trauma bleep,

2. PA does RATA,

3. PA asking doctors to prescribe meds on their behalf,

4. PA asking junior Doctors (even FY1) to request x-Ray or CT bases on their (PA) assessment,

5. PA are supervising medical students,

6. Medical student allocated to shadowing PA.

9. PA doing Locums on shift Doctor Rota,

10 Junior doctors find it hard to get advice or help from senior doctor as PAs often occupied the Senior doctor time,

11. Patient refer to PA as Doctor,

12. PA wears the identical scrubs as junior doctors (given to them by hospital

13 PA given 1st choice to work in Resus instead of trainee

Resident Doctor, Severn

NP 507 – I have missed many opportunities throughout my entire career (not just in my current hospital) due to PAs being prioritised over doctors, including clinics and key mandatory procedure skills. These experiences in my career, I note, mean that PAs get the 'good parts' (e.g. the clinics and experience, with protected admin time and (not to mention the financial perks of their training and being paid more than doctors)) but not taking the responsibility of acute care, beyond the remit of their hours, the responsibility of medicines used (prescribed by a doctor (adding the the Dr's work load and stress) but also not attending the MDT meetings before work to discuss complex cases. These are just the most recent things to mention. There are many, many more example from my previous training rotations.
Resident Doctor, South East

NP 824 – PA in tertiary centre in at least 3 departments holding department bleep instead of registrar, giving telephone advice including prescribing advice. Have received prescribing advice from one PA about paediatric patient. PA was the only person to actually come across to see this child.

In another department they are doing bone marrow biopsies and lumbar punctures unsupervised and regular clinics.

In oncology regular clinics and independent ward rounds daily with cancer patients (have seen them telling junior doctors what to prescribe regularly).

Junior doctors left on the ward whilst PAs go to clinics instead of IMT/other doctors throughout the hospital.

PAs trained to do chest drains independently and junior doctors not being trained. Know some doctors that did not get any opportunities to do them in rotation as PAs would do them all.

I have seen PA's multiple times doing NG tubes, lumbar punctures and other procedures instead of JMG being given opportunity to learn

Frequently seen PA's not introduce themselves as PAs, not explain the role and not correct if patient calls them a doctor. Many wear scrubs and have a green lanyard (same colour as GPST lanyard) so cannot distinguish them from a doctor.

PA's in multiple departments regularly having dnacpr discussions and writing up documents for a senior to sign (when doctors have not had chance to review patient themselves)

Multiple patients are sent up from the emergency department without a review from a doctor documented, appears they have only been seen by a PA and they decide where patients go. This means patient can go all this time without medications prescribed inc. time sensitive ones. I've seen multiple inappropriate tests ordered by PAs inc troponin in patients almost 100 v close to end of life. Have had colleagues in the dept asked to prescribe on behalf of PAs many times for patients they have not met.
Resident Doctor, Scotland

NP 860 – 'Experienced' or 'longer term' PA's than rotating foundation doctors, who know the consultant team, going to theatre when time allows. No equal sharing of these opportunities with foundation doctors on the rotation.

Pressuring and expecting rotating doctors to prescribe and request when told to, based off of PA assessment or judgement, and almost bullying if this is questioned.
Resident Doctor, West Midlands

OP 17 – 1. PA training is either too short or too superficial to equate with even just an undergraduate medical training. Major gaps in basic medical knowledge noted.

2. Medicine and pharmacology cannot be separated. Asking to prescribe while not taking into account what medications the patient is already on and how they could interact, what the organ function tests indicate, what side effects could occur is very inappropriate.

3. Introducing (or not clearly introducing) oneself as a "physician" associate is generally misleading as most patients would not be able to differentiate. As a patient I would like to know who I am speaking to and what that person can do for me.

4. Lack of career progression means lack of competitive assessments and therefore a lack of incentive to improve one's practice.

5. Inability to practice independently especially in an acute setting is more work for the already short staffed doctors team.

6. Accountability.
Resident Doctor, North West

OP 363 – My concerns are both in patient safety and the impact on education.

I have heard of incidents across trusts where PAs order ionising radiation or prescribe medications "on behalf" of a doctor which is clearly outside their scope. Working within competency and qualification is a principle drilled into healthcare professionals throughout their studies and in their careers, but clearly is not a principle PAs uphold. Furthermore, working outside of competency and endangering patient safety for established roles in healthcare should have heavy repercussions. Doctors in this country have been struck off for much less.

I am concerned about the unclear role of PAs. I see many PA students on social media and have worked alongside PAs who only describe their role as 'an important member of the MDT who works under the supervision of a doctor'. While I do not aim to undervalue members of the MDT, I think it is important that roles are clearly defined. PA students struggle to explain the difference between their role and the role of a doctor, particularly in GP. Some have described their roles as better than being a doctor because of the free rein over specialties, increased pay, much less studying and many other perks. When they mention the restriction in prescribing and requesting ionising radiation, they are expecting this to be changed in the future, providing regulation by the GMC. It makes no sense for the regulating body for doctors to regulate anybody but doctors.

The role of a PA can be useful when used and regulated correctly, as exemplified in other health systems. However, the NHS has many many other problems to deal with which, if resolved, would likely negate the need for PAs and other medical associates.

It is entirely unfair and unsafe to have PAs and other medical associates replacing doctors in training experiences and on shifts. I have seen rotas for departments where middle grade doctors are wholly replaced by PAs. If the work of a doctor far into their

career can be done with the knowledge from a two year masters, what then is the point of the rigorous training pathways for doctors across the world?
Medical Student, Northern

OP 364 – My concern relates to all of the above, for all roles. I have seen constant examples of each. E.g. PAs being used permanently in gynae onc theatres taking training opps from ST/CT doctors, who will be performing life saving gynae onc procedures at night with now less training than if the PA was working within their scope. AAs being given autonomy with anaesthesia, completely unsupervised, incredibly dangerous. Not just for simple day cases – complex, long, cardiothoracic surgeries. PAs demanding JDs prescribe for them – JDs simply don't have the time to take on double the patients so prescribe without reviewing themselves – risk to patient safety AND JDs license but must comply to avoid displeasing consultant and team. Non doctors should not be doing doctors jobs. It is unsafe and frankly bizarre. People are dying as a result, never event ratio in xxxxx for PAs is many times higher than doctors. A physician associates role is as a doctors assistant – the name shouldn't have changed. They should be used to HELP, not hinder. Majority of doctors agree they are of no benefit or have a negative impact. With a clearly defined and limited scope, this could be fixed. Thank you.

Even an ODP has 3 years of training. 2 years is nothing in clinical practice.
Medical Student, Northern

OP 147 – The baseline knowledge of PAs is not sufficient to be seeing patients independently. (One example a PA about to qualify asked my friend (IMT3) what a PE was). Across the board – Seems to be an enormous gap of 'unknown unknowns.' Recently last month PA unable to identify de compensated T2RF on blood gas, did not really know what this was or what needed to be done.

The PAs I have worked with have no out of hours commitments and don't rotate (lack of breadth of knowledge and experience). Some PAs have protected clinic time ahead of doctors. Because they're not rotational they can easily build better relationships within departments and have better opportunities for audit and research. Pay feels way out of proportion to service provided. Frequently add to work load eg if asked to prescribe something I will double check it's indication allergy status etc and will often go and see the patient myself.

MDT and patients do not understand they are not doctors.

Re anaesthetics associates. (I'm not an anaesthetist but do not support AAs). Feel 1:1 care from a trained doctor is the standard I would wish for my parents. Why are AAs being trained when so many doctors nationally are waiting to get into ST4 (and are appointable).
Resident Doctor, Northern

OP 94 – '– PA's running clinics instead of doctors in multiple departments

– PA's having weekly dedicated clinic days when IMT's do not get to clinic more than a handful of times during their rotation

– PA's not correcting patients when called doctor

– Surgical PA's hold the on call bleep (multiple departments)

– Surgical PA's going to theatre and ward jobs left to junior doctors (multiple departments)

– PA's asking junior doctors to prescribe for them, without making it clear they are a PA and unable to prescribe for themselves

– PA's doing procedures such as lumbar punctures instead of IMTs that needed to learn

Sometimes there are 4-6 medical students and a PA student on one ward. PA training is impacting medical students – they need to do the procedures, histories and examinations we also need to do. Have had opportunities go to PA students instead of me/other medical students.
Medical Student, Scotland

OP 175 – Multiple issues with PAs working in xxxxxx A&E:

– PAs went from not being allowed to 'sign off' ECGs, to being allowed to, with no extra training or course

– one of the PAs repeatedly requested CT scans for the wrong patients

– one of the PAs kept interrupting chest compressions during an arrest because he was feeling for a pulse throughout compressions rather than during pulse/rhythm checks and was convinced that the patient (who was in asystole) had a pulse

– if you declined to sign a prescription for the same PA because it was incorrect or didn't make sense, he would just go to find somebody else rather than explain or correct the mistake.
Resident Doctor, Northern

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