



Evidence to the Independent Review of Physician Associate and Anaesthesia Associate Professions

HCSA – the hospital doctors' union

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Executive Summary

Hospital doctors are clear that physician associate (PA) and anaesthesia associate (AA) roles are not safe as currently constituted in many settings, have often not been well integrated into multidisciplinary healthcare teams (MDHT) and are not enabling the highest-quality patient care. While HCSA does not oppose deployment of these roles within properly defined parameters, they have been deployed too quickly and with too much local differentiation across the NHS.

Most concerning, of those doctors surveyed by HCSA who witnessed a safety incident involving a PA or AA, the overwhelming majority were not satisfied that their report was sufficiently acted upon.¹ Many reported receiving no response whatsoever. More than a third of hospital doctors believe their workplace's system for reporting safety concerns to be unfit for purpose.²

While many hospital doctors report positive experiences working with PAs or AAs, too many MDHT are not functioning properly at present. Doctors report that associate roles are ill-defined. This has led to inefficiency in the delivery of care, wariness and mistrust, lack of cohesion, and PAs and AAs acting beyond scope.

Furthermore, the presence of PAs and AAs too often detracts from resident doctors receiving training and from senior doctors delivering it. Given that ever-present demands for service provision already mean that time to be educated or to educate is eroded, this obstruction risks contributing to a future shortage of suitably qualified and skilled clinicians. PAs and AAs can assist doctors but cannot replace them.

Foremost among the eight key recommendations HCSA hopes the Review makes to government is the implementation of universally agreed, national scopes of practice for all PAs and AAs. This is a prerequisite if these roles are to work safely in secondary care.

¹ HCSA – the hospital doctors union, *Hospital doctors' work with physician associates (PAs) and anaesthesia associates (AAs)*, online survey of 381 hospital doctors conducted March 2025.

² HCSA, *Hospital doctors' work with PAs and AAs*.

Introduction

HCSA surveyed hospital doctors of all grades working in the NHS across England, Northern Ireland, Scotland and Wales. The largest proportion of those surveyed work or have worked with a PA or AA as part of a MDHT but not directly clinically supervised them. Significant proportions have directly supervised a PA's or AA's clinical work and been the 'named' consultant with overall clinical responsibility for a PA or AA. Those surveyed also include hospital doctors who have not yet worked with a PA or AA.

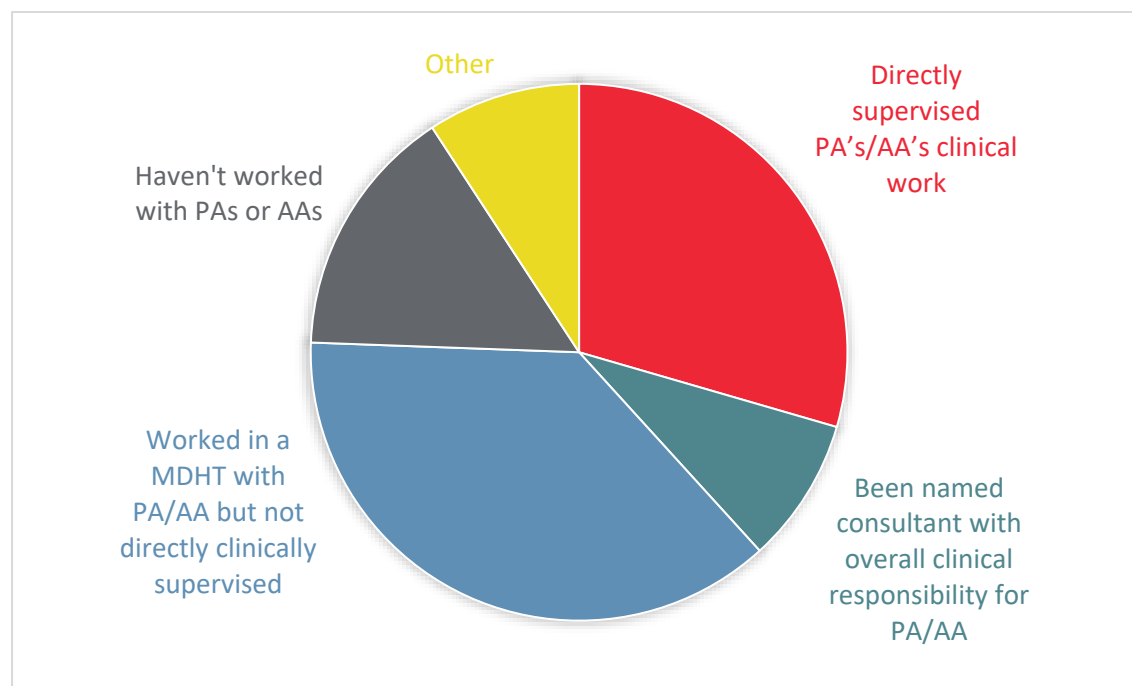


Figure 1. Answers to the question 'Please provide details of how you have worked with PAs or AAs'³

Eighty percent of hospital doctors would be concerned if a PA or AA were to join their team. More than half strongly agree with the statement 'I would be concerned if a PA or AA were to join my team'.⁴ Significantly more doctors describe their overall experiences of working with PAs and/or AAs as negative or very negative than positive or very positive (Figure 2).

³ *Ibid.*

⁴ *Ibid.*

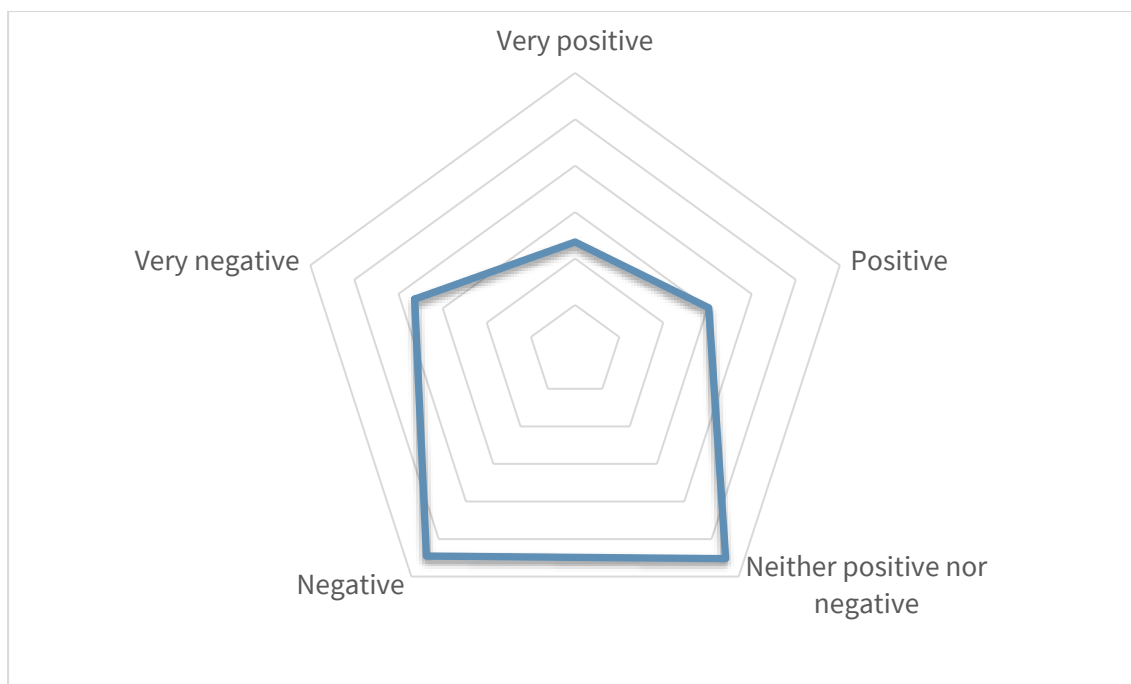


Figure 2. How hospital doctors would describe working with PAs/AAs 'overall'⁵

However, there is variation between the experiences of doctors who have directly supervised a PA's or AA's clinical work, those who have worked with a PA or AA but not directly supervised their clinical work and those who have been the named consultant with overall clinical responsibility for a PA or AA. Those who have been the named consultant are more likely to reflect positively on their experiences (Figure 3).

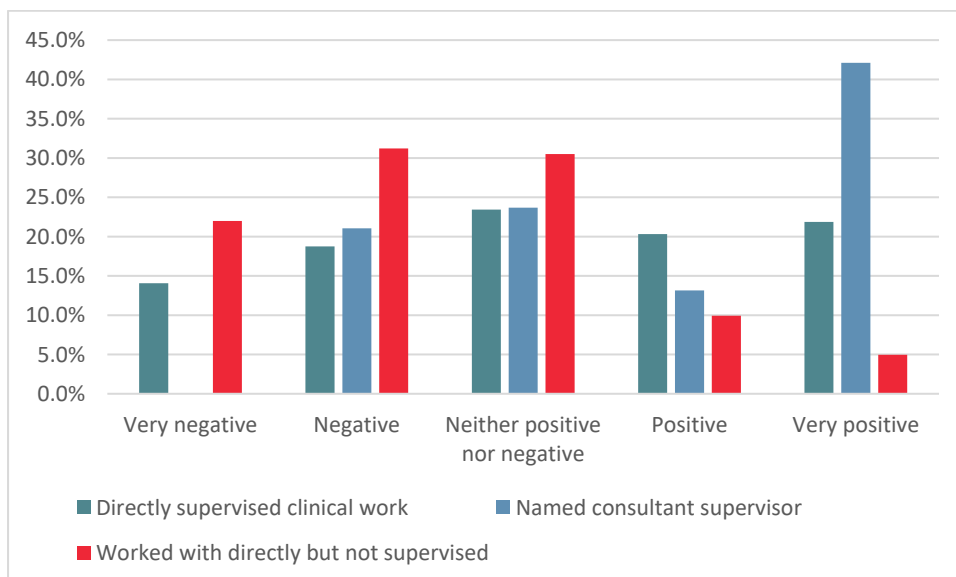


Figure 3. How hospital doctors would describe working with PAs/AAs 'overall', by nature of working relationship⁶

⁵ *Ibid.*

⁶ *Ibid.*

There is further variation by grade (Figure 4). The most common experience for a consultant or SAS doctor working with a PA or AA is neither positive nor negative. However, fewer than one in 10 resident doctors report a positive overall experience, with just 1% very positive.



Figure 4. How hospital doctors would describe working with PAs/AAs 'overall', by grade⁷

Hospital doctors cite a number of factors behind their negative views of working with PAs and AAs (Table 1). More than three-quarters point to the unclear scope of roles within their team as a key factor. More than 60% are concerned about safety incidents involving a PA or AA, while significant numbers report that the presence of PAs or AAs in their workplace has taken time and/or opportunity away from them as a doctor to either receive or deliver training.

Unclear scope of roles within a team	77.4%
Concerned about safety incidents involving a PA or AA	62.4%
Time and/or opportunity taken away from me to receive training	48.9%
Time and/or opportunity taken away from me to deliver training	38.4%
Witnessed a safety incident involving a PA or AA	29.3%
PA/AA had insufficient clinical knowledge or competence	13.5%

Table 1. Popular factors contributing to doctors' assessment of their experience working with PAs/AAs (percentage of respondents who provided each answer as one of up to three main factors)⁸

⁷ Resident doctor data includes locally employed doctors working in an equivalent role to a resident-doctor grade. HCSA, *Hospital doctors' work with PAs and AAs*.

⁸ HCSA, *Hospital doctors' work with PAs and AAs*.

Safety

Over a third, 36.8%, of hospital doctors have witnessed a safety incident, error or near miss involving a PA or AA in their workplace. The myriad incidents cited include:⁹

- Errors in procedures performed by PAs and AAs, including abdominal taps, chest drains and more
- Performing procedures not on the list devised locally by supervisors, such as anaesthetised fiberoptic intubation
- Failure to recognise the severity of patient presentation, including severe heart failure
- Unsupervised ward rounds
- Inability to provide emergency medical support to patients on wards who deteriorate
- Misdiagnoses
- Illegal prescription (and incorrect prescription) of medication
- Asking and pressuring doctors to make incorrect prescriptions
- Involvement in ordering scans involving ionising radiation or requesting medicines, beyond their scope of practice
- Poor screening of patients
- Misidentifying themselves as doctors to patients
- Signing forms in place of doctors.

Notably shocking reports included a PA discharging a patient with a brain haemorrhage and, in one particularly severe example, 'a failure to discuss and disclose a clinical plan with other more experienced clinicians which led to a patient's avoidable death'.¹⁰

Of doctors who have reported a safety incident involving a PA or AA, 86.5% have not been satisfied that their report was sufficiently acted upon. Many report having received no response whatsoever. Perhaps unsurprisingly therefore, more than a third of hospital doctors believe that their workplace's system for reporting safety concerns is unfit for purpose.¹¹

In this context, a worrying but inevitable development for patient care, not to mention the mental health and professional lives of doctors, is that working with a PA or AA will affect how a hospital doctor practices. Of those surveyed by HCSA, 79.7% say as much, with almost half of all those surveyed strongly agreeing with the statement 'knowing that I am working with a PA or AA affects, or would affect, how I practice'. Just over one in 10 disagree or strongly disagree with the same statement.¹²

Only 6.5% of hospital doctors agree that 'PAs working in the emergency department should be allowed to provide initial care for untriaged patients'.¹³

Identification

In a prevention of future deaths report following the tragic death of a patient who had received care by a PA in East Surrey Hospital emergency department, coroner Dr Karen Henderson raised

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² *Ibid.*

¹³ HCSA, *Hospital doctors' work with PAs and AAs*.

concerns that ‘the term “Physician Associate” is misleading to the public’ and that there is a ‘lack of public understanding of the role of a Physician Associate’.¹⁴ In the case in question, the patient’s ‘son was under the mistaken belief that the Physician Associate was a doctor by this title in circumstances where no steps were taken by the Emergency Department or the Physician Associate to explain or clearly differentiate their role from that of medically qualified practitioners’.¹⁵

HCSA members report PAs and AAs failing to properly identify themselves as dependent practitioners to patients. Such cases have also been well-documented across the media, with significant and widely reported concerns among members of the public.

While it is imperative that PAs and AAs are brought under mandatory regulation, HCSA firmly opposed, and continues to oppose, the General Medical Council being the regulatory body. It represents a dangerous blurring of boundaries for non-doctors to be regulated by the doctors’ regulator. Of doctors surveyed by HCSA, 69.6% are not at all confident that GMC regulation of PAs and AAs will improve patient safety, with a further 13.7% not confident. Three-quarters think that PAs and AAs should instead be regulated by a different healthcare regulator.¹⁶ With that said, with the GMC now regulating PAs and AAs, it is paramount that a PA or AA misleading a patient by describing themselves as a doctor be treated as a Fitness to Practise matter.

Role in multidisciplinary teams

Many hospital doctors, particularly consultants, report positive experiences of working with PAs and AAs. There is no doubt that a number of PAs and AAs throughout the NHS are considered valued colleagues. HCSA is not opposed to the deployment of PAs and AAs in MDHT within defined parameters.

However, of the large numbers of doctors who report negative experiences, three-quarters cite a lack of clarity in their teams over roles as a main factor. The most commonly mentioned issues are:

- Insufficient knowledge or competence on the part of PAs or AAs for them to be able to fulfil the desired or most helpful role in a team
- The need to replicate or check PAs’ and AAs’ work distracting doctors from other tasks
- Failure of PAs or AAs to properly identify themselves to colleagues and patients.

These reflections are summarised by one doctor’s view that PAs ‘do not add value for money to the team as all their work needs to be checked – [which] just removes me from seeing my own patients or supervising more junior residents’.¹⁷

Another common complaint in testimonies received by HCSA is that PAs’ comparative lack of competence actually detracts from doctors’ ability to gain appropriate experience, rather than

¹⁴ Dr Karen Henderson, ‘Pamela Marking: Prevention of Future Deaths Report’, Courts and Tribunals Judiciary, 26th February 2025, <https://www.judiciary.uk/prevention-of-future-death-reports/pamela-marking-prevention-of-future-deaths-report/>.

¹⁵ *Ibid.*

¹⁶ HCSA, *Hospital doctors’ work with PAs and AAs*.

¹⁷ All quotes are from first-person testimonies provided to HCSA by hospital doctors in the survey *Hospital doctors’ work with PAs and AAs*.

effectively assisting them in their work, as PAs can only be safely deployed in certain ways. This is encapsulated by a resident doctor who writes that PAs:

‘are, for lack of a better term, useless on the wards. So instead, the PAs go to theatre and clinic whilst the F1s and F2s have to stay on the wards to complete ward tasks that rarely provide educational value.’

Three principal changes are needed to rectify this. Firstly, and most importantly, the introduction of a national scope of practice would reduce the significant, confusing and potentially dangerous variation by employer.

Second, there is an ongoing need for clarification that PAs and AAs are dependent practitioners who are supposed to work in support of doctors – not replace them, hinder their clinical work or detract from their training. This need has become more profound following the decision for PAs and AAs to join the medical register by December 2026.

Third, the GMC’s educational standards underplay the importance of PAs and AAs being trained in how they work within a team. The varied testimonies provided by hospital doctors to HCSA illustrate why these standards must be revised. One doctor, for example, reports that ‘working on a stroke team in a tertiary centre [PAs] were very useful, but in a respiratory team in a district general hospital they were given too much control and created some conflict over clinical roles and responsibilities’.

More positively, a consultant anaesthetist who has directly supervised AA clinical work says:

‘They have always been helpful and have generally made the list more efficient, and we have been able to give each other breaks, which is pleasant and good for wellbeing and safety ... If there is a problem, it appears to be with the implementation/ management of AAs and PAs’.

Similarly, a consultant gastroenterologist reflected positively on the clearly defined roles of two senior PAs working in their department. In this instance the tasks performed were limited and training opportunities for resident doctors were not adversely affected – a negative point cited by doctors of all grades in testimonies to HCSA:

‘The FibroScan service is supported by them developing this skill. [Their] ward work is good and... resident doctors are positive about this. Not taking training opportunities away from residents which is important. Always supervised. Shouldn’t be assessing and managing emergencies/unselected medical take without direct supervision. Better suited to task provision such as paperwork, basic clinical skills, wound care/dressings. Any more advanced procedures shouldn’t impact upon doctors training for these competencies.’

However, senior doctors have also raised concerns about PAs’ and AAs’ roles in teams on clinical grounds. For example, a consultant anaesthetist working in a MDHT with an AA reports:

‘Our AA was appointed to help with CEPOD. This did not make any sense. I am currently implementing our [medical] trainees working with 1:2 supervision using the AA model. We have to train them to run the on-call rota and the AA was

surplus to requirements ... They may have a role in standalone orthopaedic units but if our trainees can do this more then it is not the right time for AAs here either.'

And a clinical lead in specialist critical care at a teaching hospital says:

'We would never employ PA as the depth of their clinical knowledge is poor. We have senior band seven neurocritical care sisters who are far more skilled and yet paid the same or less.'

Supervision

Consultants who are working or who have worked as the named supervisor of a PA or AA are more likely to reflect positively on their experience working with PAs or AAs than those who have not (see Figure 3).¹⁸

However, HCSA is extremely concerned that supervising doctors are held responsible for PAs' and AAs' work while the scope of those roles remains undetermined. Precedence has been set by the 2017 case of Dr Steven Zaw, a registrar who was found by a tribunal to have failed to supervise a PA in his team because he did not replicate her work by taking a collateral history and performing a further examination of the patient. This contributed to his receiving a 12-month suspension. He was eventually removed from the medical register.¹⁹

Hospital doctors are rightly concerned about the status quo: 80% of hospital doctors worry about being blamed for PAs' or AAs' errors, with more than half strongly agreeing with the statement 'I am concerned about being blamed for errors in care involving PAs or AAs, now or in the future'.²⁰ Far from enhancing patient care by assisting doctors, the presence of these associate roles has bred an atmosphere of fear within the medical profession.

In its response to draft guidance on safe and effective practice for PAs produced by the Royal College of Physicians, the GMC says that 'We do not think that the role of clinical supervisor can only be delivered by a consultant, GP or specialist/associate specialist. While there should be a named consultant with overall responsibility, we believe clinical supervision may be delivered by other members of the team including trainee doctors, provided they are competent to provide this supervision and there is appropriate clarity around delegation'.²¹

This contrasts with the interim guidance pending the publication of the Leng Review produced by the RCP, which recommends that 'resident doctors are not, and must not be expected or asked to be, responsible for the clinical supervision of PAs'.²² Hospital doctors surveyed by HCSA overwhelmingly support the position of the RCP. Only 8.3% believe that resident doctors should be included in the grades of doctor responsible for supervising PAs' or AAs' clinical work. Only

¹⁸ HCSA, *Hospital doctors' work with PAs and AAs*.

¹⁹ Medical Practitioners Tribunal Service, Record of Determinations – Dr Steven Zaw, 26th October 2017, <https://drive.google.com/file/d/12hWTQ5Oany7GmFx7IUyI8U2sYiC3hw7o/view?pli=1>.

²⁰ HCSA, *Hospital doctors' work with PAs and AAs*.

²¹ Charlie Massey, *Letter to Dr Hilary Williams*, 12th September 2024, https://www.gmc-uk.org/-/media/documents/12-09-2024-dr-hilary-williams---pa-guidance-consultation_pdf-109475252.pdf.

²² Royal College of Physicians, 'Physician Associates: Interim guidance on supervision and employment in the medical specialties', December 2024, p. 3, https://www.rcp.ac.uk/media/m3djpfbj/pa_interim-guidance-on-supervision-and-employment-in-the-medical-specialties.pdf.

1.5% feel an F2 doctor is sufficiently senior to clinically supervise PAs or AAs.²³ HCSA firmly believes that clinical supervisors must be appropriately senior, drawn only from consultant and SAS doctor grades. The case of Dr Zaw, where a clinical fellow was suspended from practising because of his perceived failure to appropriately supervise a PA in his team, brings the risks for less senior doctors into sharp focus.²⁴

In addition to seniority, it is important that supervising doctors have actively and willingly agreed to fulfil that role through their individual, formal job planning process. This process should ensure that appropriate time is ringfenced for them to undertake this supervision, that they are working to clear limits on the appropriate numbers of PAs, AAs and resident doctors under their supervision, and that they are appropriately remunerated for this responsibility.

Similarly, the Department of Health and Social Care must require all employers to assess and appropriately identify capacity for supervising PA or AAs *before* beginning the recruitment process for any PA or AA role. Where there is no adequate and willing resource, a PA or AA should not be appointed.

Further, it is a matter of urgency that the GMC work with medical indemnity organisations to define the level of responsibility for which doctors supervising PAs and AAs are culpable. Safeguards should be agreed before any further expansion of these roles in secondary care.

Supervision is a key component of the registration of dependent practitioners. This should be reflected universally in each PA's and AA's registration with the GMC (or, in the future, a more appropriate regulatory body), such as in an 'active' status with a named consultant or SAS doctor supervisor on record.

The issue of supervision obviously has a direct impact on patient safety: following the death of a patient seen by a PA in an emergency department, the coroner highlighted the 'lack of guidelines for direct supervision and consideration of an appropriate level of autonomy' for PAs.²⁵ The coroner outlined how cases such as this, in which the PA was 'effectively acting independently ... without independent oversight by a medical practitioner', give rise to a concern 'that inadequate supervision or excessive delegation of undifferentiated patients in the Emergency Department to Physician Associates compromises patient safety'.²⁶

The degree of variation and absence of universal, systemic boundaries mean that current supervision practices are not safe for patients or for doctors, and do not enable PAs or AAs to practise safely in support of doctors within clearly defined parameters.

Training

In too many cases the presence of PAs and AAs is currently detracting from resident doctors receiving training and from senior doctors delivering it. Given that ever-present demands for service provision already mean that time to be educated or to educate is eroded, this is a huge problem which risks contributing to a future shortage of suitably qualified and skilled clinicians.

²³ HCSA, *Hospital doctors' work with PAs and AAs*.

²⁴ MPTS, Record of Determinations – Dr Steven Zaw.

²⁵ Henderson, 'Pamela Marking: Prevention of Future Deaths Report'.

²⁶ *Ibid*.

Just under half of those who describe their experience working with PAs or AAs as ‘negative’ or ‘very negative’ tell HCSA that a main factor in this assessment is that time and/or opportunity has been taken away from them as a doctor to receive training (see Table 1). Four in 10 cite how time and/or opportunity has been taken away from them to deliver training.

PAs and AAs are often recruited without proper scoping of training resources and capacity, into an environment in which doctors’ training is already devalued. HCSA research shows that 64.5% of trainees believe their employer doesn’t make their training a priority. This is no surprise when 29% never receive training while on duty and only a quarter receive training more than once a week.²⁷ The struggle to receive adequate training is further illustrated by ongoing issues with exception reporting. Resident doctors face difficulty in getting training signed off because of service demands, and experience pressure not to exception report.

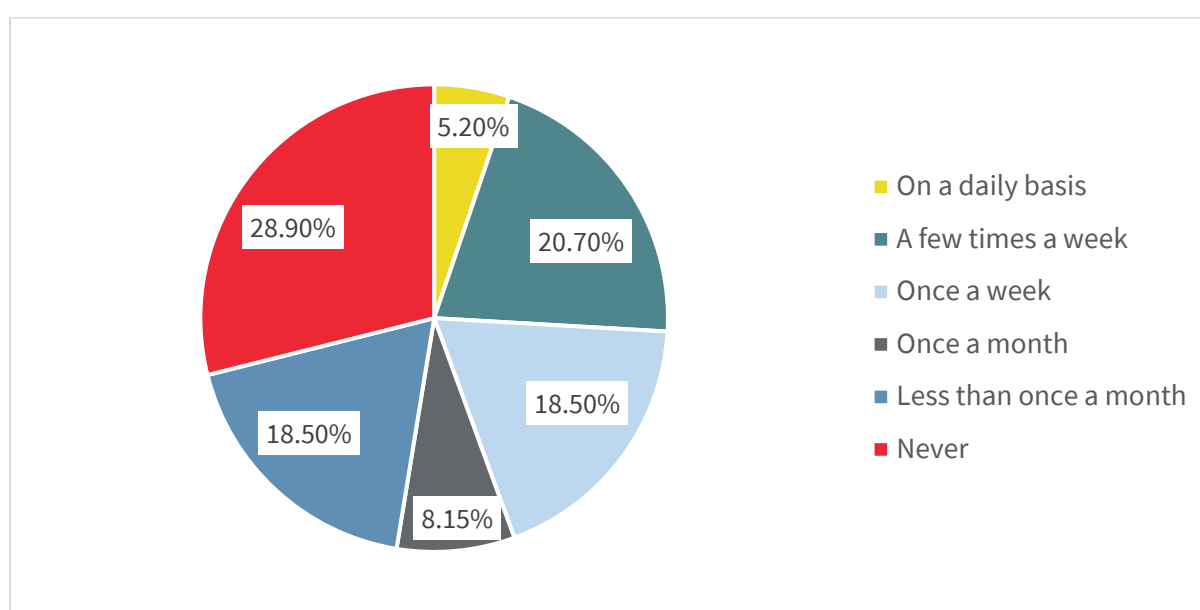


Figure 5. Frequency with which resident doctors receive training²⁸

Resident doctors report PA and AA colleagues receiving opportunities to perform procedures that they themselves do not. Unfortunately, the nature of doctors’ rotational training means that there is an incentive for employers and departments to invest time and resources in a permanent PA or AA within a team over a resident doctor who is ‘passing through’ for a few months. Many resident doctors would benefit greatly from working with a particular consultant for a year or more as PAs and AAs are able to do. As it is they often spend significantly less time working with senior clinicians than those in associate roles.

Meanwhile, there has been a concerning absence of information from the GMC on how medical education will be protected during the introduction of PA and AA courses. The GMC’s educational standards for PAs and AAs should be updated to reflect that their training is focused on workforce and service provision, so as to help ensure training opportunities for resident doctors are safeguarded. Medical training provision – including on-the-job training such as opportunities in

²⁷ HCSA – the hospital doctors’ union, *Hospital Doctors at Work 2024*. Online survey of 646 hospital doctors conducted October–November 2024.

²⁸ *Ibid.*

theatre, simulation time and the availability of resources – must be ringfenced for doctors in training.

Where the presence of a PA or an AA is contributing to a doctor not receiving sufficient or appropriate training, that doctor is in effect being replaced by a far less qualified practitioner, putting patients at serious potential risk.

Scope of practice

Ensuring patient safety

A coroner has warned of the ‘lack of national and local guidelines and regulation of the scope of practice’ for PAs, stating ‘a concern they are working outside of their capabilities’.²⁹ The absence of regulatory responsibility for scope of practice effectively gives employers carte blanche to implement these roles as they see fit. This is compounded by ongoing service pressures, which motivate trusts to attempt to fill gaps by using PAs and AAs beyond scope and competence. Indeed, certain employers have already pushed or blurred the boundaries in the interest of expediency. This is placing patients at risk and, when mandatory registration comes into place, will mean PAs and AAs will risk GMC action.

The situation does not serve patients, doctors, PAs or AAs, and will only worsen if the power to prescribe is extended to PAs and AAs, as has long been mooted. These professions cannot be expected to have the full range of knowledge required when simpler procedures go wrong, or to assess cases where wider medical factors may be involved. To prevent further mission creep and dangers to patient safety, HCSA firmly opposes the granting of prescribing powers to PAs and AAs.

A third of hospital doctors surveyed prefer ‘medical assistant’, ‘physician’s assistant’ or ‘doctor’s assistant’ as a term to refer to these professions. Just over a third prefer using ‘assistant’ in some form that further stresses the difference and distance between these roles and doctors.³⁰ For the sake of patient safety, and in line with an agreed national scope of practice, the titles ‘physician associate’ and ‘anaesthesia associate’ should revert to the previous and more appropriate titles ‘physician’s assistant’ and ‘physician’s assistant (anaesthesia)’ respectively.

PA and AA education

The GMC has wrongly chosen to set educational standards for PAs and AAs ahead of there being a universally agreed scope of practice for these roles. This cannot be left to individual employers or royal colleges. It follows from the lack of such a scope of practice that the GMC’s PA/AA curriculum standards are insubstantial and ineffective. The GMC should be benchmarking the standards and identifying where supervision is required, with input from doctors.

Universally agreed, national scopes of practice for PAs and for AAs would allow for more focused training. This training should be based on the principle that a PA or AA will require less training of an interventional or procedural nature than a resident doctor. It is not appropriate for their training to involve more invasive procedures or procedures requiring ultrasound localisation of anatomical structures or endoscopic and endovascular practice.

²⁹ Henderson, ‘Pamela Marking: Prevention of Future Deaths Report’.

³⁰ HCSA, *Hospital doctors’ work with PAs and AAs*.

Instead, training for these roles should be restricted by the scope of the roles. This means training should be of the level required to perform basic skills as part of a MDHT, such as neurovascular supply of the arm for bloods and cannula, urinary tract for catheters, and upper airway and stomach for nasogastric tubes.

Where a PA or AA is keen to undergo training on more invasive procedures, the appropriate pathway is for them to take a medical degree.

Recommendations

HCSA calls on the Review to make the following recommendations to government.

1. The implementation of detailed, single, national scopes of practice for all PAs and AAs.
2. That PAs and AAs not be granted prescribing powers.
3. That PAs must not be allowed to provide initial care to untriaged, undifferentiated patients.
4. That only consultants and SAS doctors be responsible for both direct clinical supervision *and* overall supervision of PAs and AAs.
5. The dissemination of new national guidance to all employers in secondary care setting out how consultants' and SAS doctors' supervision of PAs and AAs should be appropriately decided with each doctor's consent as part of their job-planning process.
6. The requirement that all employers formally assess and appropriately identify capacity for supervision of PAs and/or AAs prior to beginning the recruitment process for any such roles.
7. The ringfencing of medical training provision (including simulation time, the availability of resources and on-the-job training such as opportunities in theatre) for doctors in training.
8. For the terms 'physician associate' and 'anaesthesia associate' to revert to the previous and more appropriate titles 'physician's assistant' and 'physician's assistant (anaesthesia)' respectively.

