Embargoed 00.01, 03.05.2025

BMA PA and AA portal submissions: Explanatory notes

Extracts are re-published as submitted. Explanatory notes and definitions in square brackets and footnote, added by the BMA.

- 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**

- Physician associate on xxx. Patient spiking temps with CRp >400[1]. CXR[2] looked like effusion[3] so I asked resp to see for chest drain ?empyema[4]. The PA said "I can do chest drains". I said "are you signed off for pleural USS[5]?" He said "I can do ultrasound and chest drains". I said "I'll call respiratory[6]". 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[7], he was very close to sticking a needle into the patients spleen. **Resident Doctor, North West**

- Student Anaesthetic Associate 9 months into training left in theatre alone and unsupervised with intubated[8] and anaesthetised patient for 20 minutes whilst supervising doctor out of theatre. Patient undergoing laparoscopic [keyhole] surgery. **Consultant, West Midlands**

- PA working in ED[9]. PA assessed a patient with severe rash covering side of face. Also noted swelling to periorbital[10] region. Treated by PA as impetigo[11]. Seen by doctor. Significant periorbital oedema[12]. Also rash extended to cover the ear and pus in [ear] canal. Urgent CT[13] done which showed extensive otitis externa[14] with pre-septal cellulitis[15] (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**

---

[1] CRP is a marker of inflammation. The upper limit of normal is often taken as 5.
[2] CXR: Chest X-ray
[3] Effusion: fluid in the chest outside the lungs but inside the rib-cage, between the linings of the chest cavity covering the lungs and inside of the rib cage (pleura)
[4] Empyema: when the effusion is pus
[5] Pleural USS: ultrasound scan of the pleura
[6] Respiratory: the specialist doctors who deal with medical conditions of the chest
[7] Spleen: the organ on the left side of the abdomen that makes and removes blood cells and is important in making the cells that fight infection
[8] Intubated: having a breathing tube down the windpipe through which oxygen is delivered into the lungs when someone cannot breathe for themselves
[9] ED: Emergency Department
[10] Peri-orbital: around the eye socket
[11] Impetigo: a bacterial skin infection
[12] Oedema: tissue fluid causing swelling
[13] CT: a computerised x-ray
[14] Otitis externa: infection of the outer ear canal
[15] Pre-septal cellulitis: a deeper bacterial skin infection

- PA working on surgical SHO [senior house officer, a resident doctor in second year of foundation training] rota and stating they are a surgical SHO. This is impersonating a doctor. **Unspecified, Northern Ireland**

- 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 [Royal College of Physicians] guidance as far as I am aware. **Resident Doctor, Wales**

- This PA holds the speciality referral bleep for Gastro[16] registrar[17]. 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[18]. **Unspecified, West Midlands**

- 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**

- AA not following guidance/instructions of consultant when performing IJV CVC[19] access - resulted in carotid puncture[20] prior to cardiac surgery with cardiopulmonary bypass. Could have been avoided had the AA followed the instructions of the consultant supervising. **Consultant, Northern**

- 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.**

- A respiratory PA at my hospital recently inserted a chest drain in a patient unsupervised. This patient was a haematology patient who had platelet[21] 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

[16] Gastro: gastroenterology, the specialty treating medical conditions of the gut
[17] Registrar: an experienced resident doctor with often more than 4 years of post-qualification clinical practice
[18] Scopes – using long flexible cameras inserted either through a patient's mouth or bottom
[19] IJV CVC: a major vein in the neck, the Internal Jugular Vein, to insert a Central Venous Catheter – a plastic canula (tube)
[20] Carotid puncture: making a hole in the major artery to the head, the carotid artery
[21] The small blood cells that clump together to form a clot

enter the pleural cavity[22]. 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.**

- 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[23] due to her poor renal [kidney] and hepatic [liver] 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**

- 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**

- 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 [Royal College of Anaesthetists]. 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.**

- Patient death as a result of a PA missing a DVT[24] (likely patient was not examined, PA did not discussed with supervisor despite CLEAR supervision protocols in place. **GP, England**

- Trainee and full trained AA's completely unable to recognise an acute concerning arrythmia[25] on monitor or ECG [the heart rate tracing] 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.

[22] Pleural cavity: the potential space between the pleura, which are normally close together, unless something goes wrong, like filling with air, blood or fluid

[23] Iatrogenic opioid overdose: an overdose of opiates (like morphine) arising from being administered them by those caring for them

[24] DVT: deep vein thrombosis, a potentially serious blood clot of deeper veins of the body

[25] Acute concerning arrythmia: a sudden heart trace abnormality that needs medical attention and possible treatment

Situation truly highlighted their lack of basic knowledge and was a patient safety risk.
Resident Doctor, West Midlands

- As an F1 [a doctor in their first year after graduation] was told by the PA on stroke[26], 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[27]. 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**

- I am a GPST3 [experiencedGP registrar] 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[28] 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[29] 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[30] screen was ordered. The PA documented that his impression was that this was muscular back pain. No analgesia [pain medication] 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[31] 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

[26] Stroke – the stroke service
[27] Raised ICP: intra-cranial pressure – a high pressure in the head
[28] Atraumatic: no history of trauma ie of knowingly sustaining an injury
[29] PSA: the blood test that may be raised in prostate cancer. Levels above 4 are mostly taken as abnormal
[30] Blood tests looking for more serious conditions of bones, such as bone cancer and a blood cancer that affects bones – myeloma
[31] Trochanteric bursitis: hip pain from irritation of tissues around the outside of the hip bone

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[32]. **GP registrar, unspecified**

- One PA saw a patient who had recently undergone a liver resection[33] and had swinging pyrexia[34], gave a course of doxy[35] for ?LRTI[36], I saw a week later and sent her straight to hospital as she was septic from the liver abscess she had. **GP registrar, Severn**

- 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[37], 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 [cancerous skin lesions] 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**

- 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[38] for 4 days and had not been treated or referred despite being severely unwell with significant GI [gastrointestinal] 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**

[32] Cord compression: pathological pressing of the spinal cord from injury or collapse of the bones that normally protect it (the vertebral column), an acute emergency to prevent permanent damage of the spinal cord
[33] Removal of part or all of the liver
[34] Swinging pyrexia – high temperature going up and down, and often associated with a collection of pus (and abscess)
[35] Doxy – the antibiotic, doxycycline
[36] LRTI: Lower respiratory tract infection eg pneumonia
[37] hinders of USC referral for seb Ks: possible typo, but USC [Urgent Suspected Cancer] referral for seb K [seborrheic keratoses]
[38] Perforated peptic ulcer: an ulcer in or just down from of the stomach that has eroded enough to leak blood into the gut, or blood and gut contents into the abdomen

- 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 [neurology] deficit, but I was able to localise it clinically[39]. 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**
- PA is conducting ward rounds unsupervised, signing DNARs[40] and covering doctors' rotas, diagnosing undifferentiated patients, prescribing medication. **Consultant, Wales**

For media queries please email mediaoffice@bma.org.uk or call 020 7383 6448

[39] Clinical examination of the nervous system that allows identification of the specific nerves affected and thus the likely locality of a specific injury, lesion or disease process

[40] Do not attempt resuscitation order: a medical order that instructs healthcare professionals not to perform CPR or other resuscitative measures if a patient's heart or breathing stops