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Medical associates: the introduction of PAs, ANPs, and ACPs is creating new challenges for doctors on rotational training

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The addition of new clinical staff on hospital wards is welcome. The steady introduction of physician associates (PAs), advanced nurse practitioners (ANPs), and advanced clinical practitioners (ACPs) has undoubtedly helped to manage the ever increasing demand in UK hospitals. However, this new blend of different clinical ward roles is disrupting the training, skill development, and professional autonomy of rotating doctors. Given that these non-traditional clinical roles are likely to stay and expand,[1] attention needs to turn to navigating the new dynamics these roles bring and to ensuring that clinical work remains collaborative and safe.

Rotational training brings several challenges.[2] Doctors arriving on hospital wards need to navigate new systems and adapt to new processes of working every three to six months. It takes time to develop professional relationships with colleagues, nursing staff, and ward consultants. The presence of permanent ward clinicians can be valuable in easing this transition, helping disoriented doctors to navigate the nuances and complexities of a new ward. For rotating doctors, however, a lack of clarity around roles and responsibilities is making it less clear how to escalate clinical concerns, who can delegate tasks, and where the buck stops.

Safety challenges due to mismanaged hierarchies are not novel to healthcare,[3 4] but new roles mean new hierarchies and, with them, new risks. The traditional hierarchy of consultant-registrar-core trainee-foundation doctor is fairly well understood by doctors and nursing staff. As decisions increase in complexity and importance they're relayed higher up the chain, with senior doctors holding ultimate clinical responsibility.

The addition of physician associates, advanced nurse practitioners, and advanced clinical practitioners onto rotas for senior house officers, registrars, and consultants has blurred those lines of skill and responsibility for clinical decision making. Doctors on rotational training may be left uncertain how to respond to instruction or clinical advice from staff in non-traditional clinical roles, particularly when the doctors remain responsible for clinical decisions made. Similarly, pressure to prescribe on behalf of other clinicians can leave doctors in the uncomfortable position of not knowing where the boundary or responsibility lies for their prescribing decisions.

Instructive approach

The introduction of permanent ward clinicians has also created new "natural" hierarchies that present themselves in the day-to-day running of wards. These softer power imbalances will vary significantly, but they typically develop off the back of experience of working in the department, age differences, and strong professional relationships with consultants. Younger and more junior doctors, as a result, increasingly find themselves at the bottom of the stack and subject to delegation and instruction from people in overlapping roles. In a job where professional autonomy is already limited, this can make the work not only unrewarding but frustrating.

During our foundation training my colleagues and I often found ourselves instructed by those in non-traditional clinical roles, rather than working in collaboration on account of our age and newness in the role. We were told which wards to cover, which patients to prioritise, and how to divide up work. This instructive approach not only created a degree of resentment and limited professional trust but also denied us the opportunity to gain skills in sharing clinical responsibility and deciding priorities. Colleagues felt wary of challenging advanced nurse practitioners who decided rotas and controlled the ability to take holiday or swap shifts.

Permanent clinical staff also often had access to easy mechanisms of communication with ward consultants. While this was a useful route to consultant advice, it regularly created a gatekeeping step for us to escalate or raise queries with consultants, leaving us uncertain as to whether concerns had reached the right ears and whether the information coming back was reliable. In an increasingly litigious medical environment this created considerable unease.

Establishing and supporting flat hierarchies is therefore essential. This means challenging the increasing grip of medical tribalism in secondary care, through open and blameless conversation. Overlapping responsibilities and ambiguity around backgrounds, training, and seniority of non-traditional clinical roles are contributing to this confusion, so clarification of roles is urgently needed. Staff occupying these newer roles will need to adapt to different, more collaborative ways of working and recognise that age and previous experience in other clinical roles aren't necessarily tools for exercising authority.

Working openly

Recognition of these challenges by senior doctors is also important. Doctors who are new to wards should be offered accessible senior support, clear escalation pathways, and direct mechanisms of communication with relevant consultants, early into rotations. Not only will this provide a safe and productive clinical environment but it will improve the professional satisfaction of junior doctors, something currently in

short supply. In turn, rotating doctors must be proactive in forming these key relationships and must work openly with staff in newer professional roles.

This undoubtedly works both ways, and early career doctors must recognise that longer training at university doesn't equate to an entitlement to instruct or direct. Doctors would also be remiss not to recognise the expertise and experience of medical associates or take the opportunity to learn from their specialty and wider experience.

The onus is on all clinical professionals to generate and maintain this shared understanding and ensure that clinical teams remain safe and collaborative.

Competing interests: AM completed his foundation training in Manchester and has worked as a locum senior house officer in London.

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1 NHS England. NHS long term workforce plan. 30 Jun 2023. https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

2 Best J. The case for reform of rotational training. *BMJ* 2024;384:. doi: 10.1136/bmj.q410 pmid: 38423581

3 Brennan PA, Davidson M. Improving patient safety: we need to reduce hierarchy and empower junior doctors to speak up. *BMJ* 2019;366:. doi: 10.1136/bmj.l4461 pmid: 31266748

4 Kmietowicz Z. Challenging NHS hierarchy can save patients' lives-I've seen how it saved my son. *BMJ* 2023;383:. doi: 10.1136/bmj.p2687 pmid: 37967921