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Paraprofessionals as liminal professionals: The case of physician associates / assistants in the UK NHS hospitals☆

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ABSTRACT

We examine how paraprofessional physician associates/assistants (PAs) experience and navigate their everyday work, drawing on 126 interviews and one focus group across five NHS hospitals in England and Scotland. PAs described sustained ambiguity around their professional regulation and scope of practice, their ambiguous positioning between doctors and nurses, and organisationally being physically embedded within medical teams but governed under non-medical frameworks. We explain PAs' experiences of liminal enduring status drawing on Söderlund and Borg's (2018) conceptualisation of liminal process, position, and place. Moreover, to analyse this ongoing liminality, we introduce the concept of *liminal markers* - the material, symbolic, and organisational features, such as human resource classification, pay bands, governance arrangements, uniforms and everyday artefact - through which liminality is made visible and stabilised. We explain how PAs respond to enduring liminality with collective identity work oriented towards local legitimacy, relational continuity, and narrowing temporal focus to immediate clinical practice. We also conceptually reframe paraprofessional PAs' liminality as structurally embedded and collectively sustained, rather than temporary transitionary experience.

1. Introduction

The concept of 'liminality' - a phase of transition from one social setting or identity into another (van Gennep, 1960) - has explained professional role transitions (Croft et al., 2015; Zhao et al., 2024), permanent 'limbo' between temporary and full-time employment (Garsten, 1999; Stringer et al., 2025), and how individuals navigate liminal positions within professional hierarchies (Crozier et al., 2025; Van Wieringen, 2026). However, we know little about experiences among professionals whose very profession is characterised by liminality.

This paper examines *physician associates* (PAs; initially known as 'physician assistants') in the United Kingdom (UK). These 'paraprofessionals' (Etzioni, 1969; Schupmann and Timmermans, 2023) work alongside doctors, are trained 'in a medical model' (Drennan et al., 2017) but lack the medical profession's regulatory frameworks, recognised authority, and career pathways. Unlike trainee (Zhao et al., 2024) or locum doctors (Stringer et al., 2025) - who individually experience liminality in their own careers but their professional identities and roles are publicly recognised, institutionally embedded, and stabilised within health systems - PA's *profession* is liminal. PAs' liminal experiences arise less from individual role transitions than their paraprofession's contested collective professionalisation, spanning multiple levels of analysis (Bowie, 2025; Drennan et al., 2017; Zhao et al., 2025). Studying PAs enables us to examine the research question: *How do members of a liminal paraprofession experience and navigate everyday healthcare work?*

This paper makes three contributions to the paraprofessionals and

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liminality literature. First, by conceptualising paraprofessional PAs as 'liminal professionals', we show liminality institutionalised through contested collective professionalisation projects, rather than individuals' stalled careers. Second, we extend conceptualisation of liminality by demonstrating how experiences of ambiguous 'processes, positions, and places' (Söderlund and Borg, 2018) concur and are managed across different levels in everyday work. Finally, we develop the concept of 'liminal markers' explaining how liminal states are produced, made visible, and stabilised in material, symbolic, and organisational arrangements.

2. Theoretical background

2.1. Paraprofessionals

Paraprofessions - for example, healthcare assistants (Traynor et al., 2015) and paramedics (Givati et al., 2018) - occupy an ambiguous position organised around another 'master profession' without full acceptance into it. Paraprofessionals possess expertise and perform advanced tasks delegated by their master profession but lack full professional status, autonomy, or established career. Professionalisation is a central, albeit contested, aspiration for paraprofessions but poses a dilemma. Should paraprofessions mimic their master professions - risking resistance from master professions, whose professional boundaries may erode as paraprofessionals strive for professional status - or develop their own distinct knowledge and practice? (Etzioni, 1969; Schupmann and Timmermans, 2023). Prior research has used the liminality lens to examine paraprofessionals, including paralegals and (Gustafsson and Empson, 2018) and community health workers situated between local communities and formal healthcare systems (Golden and Bencherki, 2024). However, we do not have a sufficient understanding of paraprofessionals' responses to complex, interrelated and multi-layered liminality, or how paraprofessional roles are produced, negotiated, and sustained.

2.2. Liminality in organisations and healthcare

Liminality describes an often ambiguous and uncertain stage of transition and 'in-betweenness', originally developed to explain life changes, like childhood into adulthood (van Gennep, 1960). Research has since described emotionally-charged 'permanent liminality', limbo and liminal 'hotspots' (Szakolczai, 2017), characterised by paradox, paralysis, polarisation, and, perhaps, pattern shifts (Greco and Stenner, 2017), including in interstitial, unstable, and temporary work generally (Beech, 2011; Garsten, 1999) and healthcare specifically (Allan et al., 2015; Croft et al., 2015; Gordon et al., 2020; Stringer et al., 2025; Zhao et al., 2024).

Söderlund and Borg (2018) posited three interrelated dimensions of liminality in organisations: *process, position,* and *place*. *Process* refers to the temporal transitional phase during which individuals reconstruct their identities, for example, during broader organisational restructuring (Beech, 2011; Gordon et al., 2020). *Position* captures individuals' ambiguous positioning between social and professional groups and identities, such as community first responders navigating between volunteer and practitioner roles (Roberts et al., 2014). *Place* highlights liminality embedded in spatial and organisational contexts, including temporary settings or projects (Parent and MacIntosh, 2013). While analytically distinct, Söderlund and Borg (2018) emphasise that process, position, and place often intersect, calling for comparative analyses of how different forms of liminality are structured and intertwined.

We follow Söderlund and Borg's (2018) conceptualisation of liminal place as including physical and mental dimensions to analyse liminality in everyday work. Indeed, Söderlund and Borg (2018) call for deeper empirical understanding of organisational practices sustaining liminality and related 'identity work'. Identity work describes the cognitive, discursive, and behavioural activities performed that form, maintain, or revise collective, role, and personal self-meanings within social contexts, including an individual's identity as a member of a collective occupation (Caza et al., 2018).

Healthcare research has examined liminality as a process, particularly during early career transitions. For example, newly-qualified doctors and nurses experience liminality while recontextualising clinical knowledge and when reconstructing their identity moving from trainee to fully-qualified professional (Allan et al., 2015; Gordon et al., 2020). Prolonged professional role instability can produce ongoing liminality due to constant reconstruction of identities (Stringer et al., 2025). Dysfunctional training environments and labour markets, and resource-constraints may further trap new health professionals in permanent 'limbo', where career progression is theoretically possible but practically blocked (Zhao et al., 2024).

Prior work has highlighted that liminality is embedded within healthcare organisations beyond role or career transitions. Bar-Lev and Vitner (2012) showed crisis conditions transformed neonatal intensive care units into liminal organisational spaces, characterised by moral ambiguity and contested responsibility, making standard procedures, ethical and legal conduct difficult to apply, resulting in staff feeling helpless. Schrøder and colleagues (2021) described adverse clinical events leaving midwives and obstetricians-gynaecologists in liminal 'fallibility', temporarily suspending their sense of competence and professional identity.

As a result, healthcare workers may transition through or becoming stuck in liminal processes, positions, or places. However, existing research examines liminality within relatively stable professional hierarchies and institutions, where ambiguity is expected to be temporary or resolvable. Less research has examined paraprofessionals, like PAs, where liminality is structurally and institutionally embedded between the polarities (Greco and Stenner, 2017; Zulato et al., 2025) of a prestigious medical or non-medical professional identity, independent profession or dependent paraprofession.

2.3. Material and symbolic dimensions of liminality

Liminal transitions are often marked by rituals involving material and symbolic artefacts (van Gennep, 1960). For example, material objects and labels producing and organising liminal states; uniforms labelled 'student' in police and medical education signal trainees' liminal status as 'not quite full' members of professional communities (Rantatalo and Lindberg, 2018). Schrøder and colleagues' (2021) study of midwives and obstetricians-gynaecologists show that adverse clinical events operate as key transitional markers and rituals destabilising established professional identities. However, there are calls for greater analytical attention to thresholds through which liminality is produced and recognised. Banfield (2022) argues that liminal states can be multiple, nested, and mobile; one setting can contain multiple overlapping liminal spaces, which shift geographically and temporarily, and are experienced differently by diverse actors. Accordingly, we need to attend to how thresholds and markers of liminality are produced and sustained.

Material and symbolic objects can be implicated in the construction, maintenance and transformation of professional and organisational boundaries, with implications for professional liminality. The concept of 'boundary objects' (Star, 2010; Star and Griesemer, 1989) denotes material or symbolic artefacts bridging social worlds. Boundary objects have ambiguous and interpretively flexible meanings, which vary across social worlds but are robust enough to enable coordination and collaboration without consensus. Even seemingly mundane or insignificant boundary objects may connect global and local practices as part of wider infrastructures supporting work (Nicolini et al., 2012; Star, 2010). For example, PowerPoint templates may function as boundary objects between occupational groups, temporally aligning time-limited collaboration and horizons, while projecting different future interpretations and priorities (McGivern et al., 2018). Boundary objects can be used to

impose jurisdiction, interpretations or priorities, triggering conflicts or negotiations over objects, practices and infrastructure they form part of (McGivern et al., 2018; Nicolini et al., 2012).

Drawing on boundary object theory, our paper develops the concept of 'liminal markers' to explain how material, symbolic, and organisational features mark, organise, and stabilise liminality.

3. Research context

Physician assistants were established in the UK's NHS in the 2000s to expand clinical capacity and address workforce shortages (Aiello and Roberts, 2017; Drennan et al., 2017). In 2025, there were over 3500 full-time equivalent PAs in the NHS, including over 1600 in hospitals (Leng, 2025). 708 candidates sat national exams for registration and entry into the PA profession (Royal College of Physicians, 2026).

Modelled on US physician assistants, PAs are usually trained at a postgraduate level in the medical model to assess, diagnose, and treat patients under doctors' supervision (Drennan et al., 2017). Early policy discussions anticipated statutory regulation for PAs within a defined scope of practice, including requesting ionising radiation and prescribing medications (Straughton et al., 2022). The British government expanded PA training numbers and placements during the 2010s, as pressures on the health workforce intensified (Straughton et al., 2022). 'Physician assistants' were renamed *'physician associates'* in 2014, to avoid confusion with lower-banded 'support' staff, and existing assistant roles, like surgical assistants (Aiello and Roberts, 2017).

PAs have sought statutory professional regulation in the UK since their inception. The General Medical Council (GMC, the UK medical regulator) and the Health and Care Professions Council (which regulates other allied and health and care professions) were initially considered as potential regulators for PAs (Department of Health and Social Care, 2019). In 2019 the Government confirmed that the GMC would statutorily regulate PAs (Straughton et al., 2022), which began in 2024, although without prescribing rights.

Statutory professional regulation and the Government's intended expansion of PAs outlined in the NHS Long Term Workforce Plan (NHS England, 2023) might have stabilised the PA role and profession in the UK health system. However, these developments fuelled opposition among sections of the medical profession and wider debate over PAs' role, safety, and impact on medical specialty training (McKee et al., 2025). Consequently, the Faculty of Physician Associates - the professional body for PAs housed within the Royal College of Physicians (a major medical professional body) (Royal College of Physicians, 2024) - dissolved, following debates within the Royal College (Waters, 2024), exacerbating the fragility of PAs professional status.

In response to the debates about PAs, the Government commissioned an independent inquiry (Leng, 2025). The 'Leng Review' recommended reverting PAs' title back to 'physician assistant' and developing formal credentialling programmes through which PAs could assume additional responsibilities (e.g., prescribing). However, these recommendations were advisory, not mandatory, and applied within England, rather than all UK nations (Leng, 2025). At the time of writing, few of Leng's recommendations have been implemented, subject to further consultation and policy decisions (Limb, 2026), so the impasse over the PA profession remains.

Overall, despite PAs' statutory regulation, their proposed expansion in the UK health workforce, and an independent inquiry, uncertainty remains about the PA role and profession. Consequently, some NHS employers reduced or discontinued employing PAs (Colivicchi, 2025), and several PA training programmes paused admissions (Bowie, 2025). These developments posed existential questions about PAs' professional identity and legitimacy, making PAs an exemplar case for examining a liminal paraprofession.

Empirical research on PAs has predominantly examined their safety, effectiveness, implementation and patient perspective (Boaz et al., 2025; Zhao et al., 2025). Sociological research on PAs' is limited. One exception is Drennan and colleagues' (2017) study of PAs in English primary care, based on interviews with national and regional stakeholders and general practice staff. They found introducing PAs challenged professional boundaries and involved boundary negotiation at the micro-level of service delivery. However, we know little about how PAs experience and navigate their contested professional position, particularly within hospitals amid recent regulatory and policy changes.

4. Methods

This paper is based on qualitative research conducted in 2024-25 exploring the PA role in five NHS hospitals in England and Scotland, which we purposively sampled by varying geography, maturity of PA deployment, and links to PA training programmes. Fieldwork within each site was conducted over three months, providing retrospective and current accounts during a period of policy change, as described above. To contextualise empirical findings, we reviewed relevant policy documents, reports, and position statements from government departments, regulators, trade unions, and professional bodies between 2000 and 25 (Zhao et al., 2025).

Four research team members, all health and social science researchers without clinical backgrounds collected, data. One PA researcher contributed to interviews with PAs to support rapport-building during a period of political and professional sensitivity towards PAs in the NHS. Non-PA researchers led data analysis, with interpretations drawing on insider (e.g. healthcare professionals) and outsider (e.g. academic social scientists) perspectives, which enhanced contextual sensitivity, reflexivity, credibility, and minimised bias (Thomas et al., 2000).

We recruited interviewees through purposive and snowball sampling, following ethics and site approvals, facilitated by local research collaborators (including managers, PAs, and nurses), to capture diverse perspectives on PAs. We were guided by the principle of information power (Malterud et al., 2016), whereby the multi-site design, breadth of participants, and depth of interviews provide sufficient explanatory power to address our research question.

We conducted face-to-face and online interviews with 126 participants (37 face-to-face; 89 online via Microsoft Teams; duration 24-137 min; average 44 min) between October 2024 and November 2025. Interviewees included 37 senior managers (e.g., chief-executive, divisional managers), 61 clinical staff (consultants [senior doctors], resident [junior] doctors, nurses, allied health professionals, and 23 PAs), and 28 other stakeholders involved in developing, placing, supervising, and working with PAs. Interview questions initially focused on recruitment, integration, and retention of PAs (see anonymous authors reference (2025) for sample and data collection details). As data collection and analysis progressed, we refined our interview questions to explore emergent themes; ambiguity, differentiation, belongingness, how role titles, responsibilities, and everyday organisational arrangements shaped PAs' position within clinical teams. We audio-recorded, transcribed verbatim, and pseudonymised interviews.

To explore shared experiences of the PA role within the same organisational context, we also conducted one face-to-face focus group with eight PAs in one site (lasting 68 min), which enabled participants to collectively discuss similar and different experiences. We transcribed and analysed focus group data alongside the interview data using the same analytical approach.

Data analysis was iterative (Gioia et al., 2013). Initial coding reflected participants' accounts, producing first-order concepts that were compared and categorised into theoretically informed second-order themes. We then identified multiple, overlapping forms of liminality across participants' accounts of their experiences and organisational arrangements. We subsequently drew on Söderlund and Borg's (2018) conceptualisation of liminal process, position, and place to theoretically organise and interpret concepts. Drawing on boundary object scholarship, we also analysed references to material, symbolic, and

organisational markers of liminality, which we call 'liminal markers', signalling their role in sustaining liminality, although the two concepts overlap as we discuss. Subsequent data collection and coding focused on titles, artefacts, practices, and organisational arrangements differentiating PAs from, while simultaneously embedding PAs within, established teams. Iteratively moving between data and theory, we identified dimensions and theoretical constructs of liminal process, position, and place, liminal markers, and associated identity work. In Fig. 1, we show first-order themes emerging from data, which we aggregated into second-order thematic codes and combined into theoretical constructs.

5. Findings

Interviewees' accounts of PAs' experiences described prolonged ambiguity and in-betweenness, shaped by *macro-level* national policy and professional governance, translated through *meso-level* organisational and team arrangements, and experienced in *micro-level* everyday practice and identity negotiations. From these accounts, drawing on Söderlund and Borg's (2018) conceptualisation, we identified three inter-linked dimensions of PAs' liminal experiences: *process*, characterised by professionalisation during prolonged uncertainty and rollback; *position*, characterised by an ambiguous professional identity between professions and career limbo; and *place*, characterised by unsettled spatial-organisational belonging, reproducing or challenging boundaries. Within and across these dimensions, PAs engaged in relational identity work to manage uncertainty, construct and maintain their professional legitimacy. Participants also discussed related symbolic, organisational, and socio-material arrangements and objects, which we term *liminal markers,* that we used analytically to show how liminality was experienced, negotiated, and reinforced in everyday practice across process, position, and place. Table 1 summarises liminal markers identified in our analysis.

5.1. Liminal process: prolonged uncertainty and rollback in professionalisation

Interviewees described *uncertainty* lasting over a decade about the PA profession's development at a national-level, particularly statutory regulation and prescribing rights, which were key markers of PAs' professionalisation process conferring legitimacy and stabilising professional boundaries. Repeated delay and shifting policy were described as leaving PAs *"in a limbo":*

> *When we first started … back 2016 … they said, after you qualify you will be regulated, you'll be able to prescribe and [order] radiation … Ten years down the line, and we're still in similar situation as when I started … in a limbo. – Hospital C PA focus group*

Prolonged policy uncertainty stranded PAs between past expectations of professionalisation and an unresolved anticipated future, reflecting descriptions of stalled transition and paralysis characterising liminal hotspots (Greco and Stenner, 2017).

Policy uncertainty produced meso-level organisational policy limbo. Organisations hesitated expanding PA roles. Managers delayed PA recruitment. PA training programmes were paused until clearer national guidance emerged. Even after the Leng Review's (2025) recommendations, uncertainty remained, and managers described feeling powerless to act without coherent national guidelines*: "National decisions need to be made, and they need to happen. It's not something that the [hospital/board] can do or change" (Hospital A 01 Manager)*.

PAs' professionalisation process involved *cycles of professional and organisational progress, suspension and rollback*; developments expanding PAs' roles followed by retraction or restriction. Nationally, the medical profession contested statutory regulation for PAs. After emotionally charged debates within its host medical professional body, the Royal College of Physicians, PAs' professional body, *the Faculty of Physician*

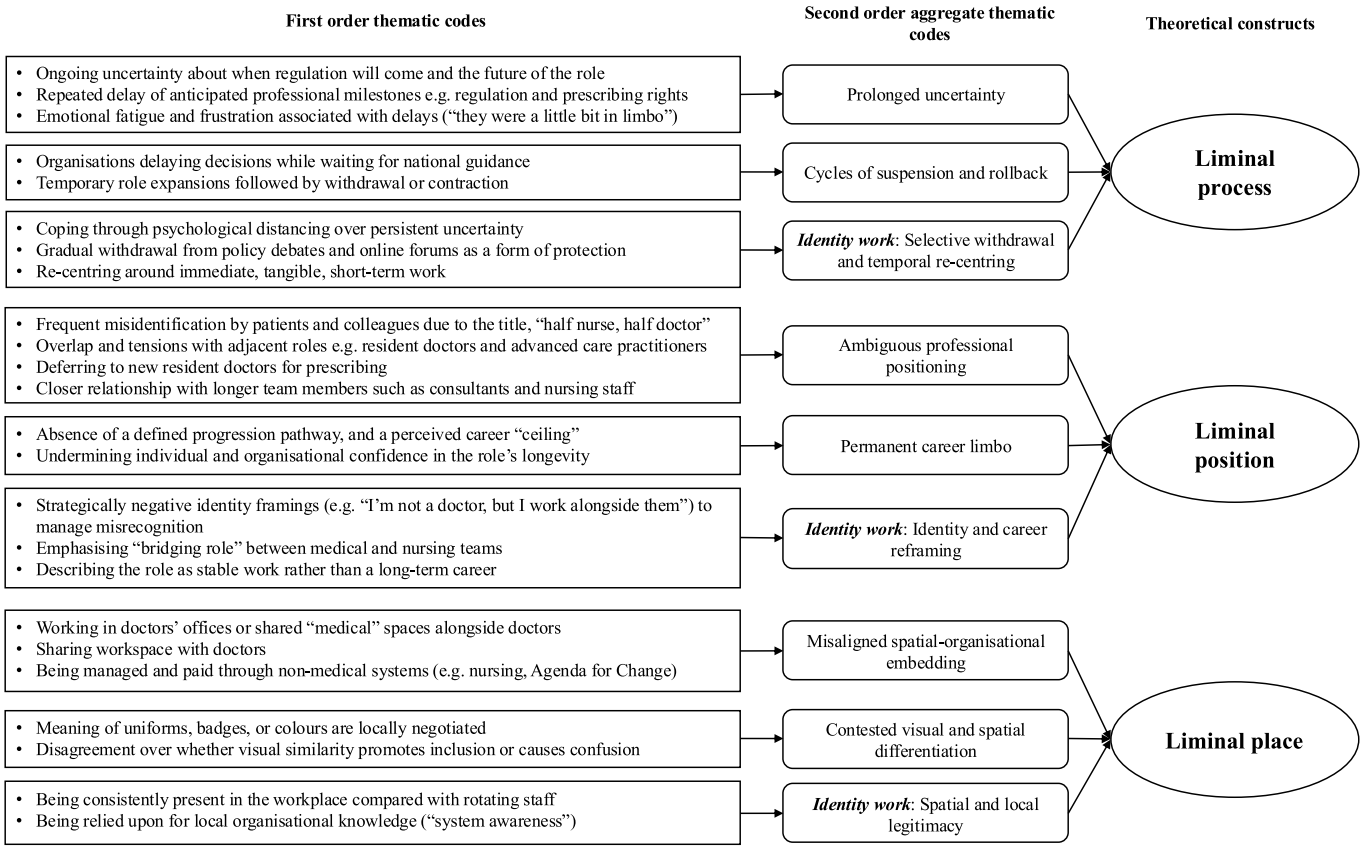


Fig. 1. Coding table.

Table 1
Liminal markers shaping experiences of liminal process, position, and place among PAs.

Marker of liminality	Level of analysis	Process, Position and Place	1st order analysis	Illustrative empirical narrative extracts
Statutory regulation	**Macro (origin) → Meso/Micro (effect)** Regulation introduced nationally, but experienced at clinical team/ individual levels	**Process** (*primary*, professionalisation of paraprofessionals) **Position** (*secondary*, alignment with the medical profession)	Expected to act as threshold marker conferring professional legitimacy on PAs (liminal process) and signal role's alignment with its master profession (liminal position). In practice, delays revealed and destabilised the in-between status of the paraprofessional, sustaining prolonged transition, producing organisational suspension, triggering rollback, extending liminality rather than resolving it.	*One of the [PAs] who came to the [trust/board] to talk about physician associates. And I said in private, "When are you thinking you're going to get registered? Where are you in that pathway?" "Oh, very soon. We're talking. We're really keen." And I'm thinking, yeah, perfusionists [professionals operating lung machinery during heart surgery] are really keen too, and they have been pushing for it [statutory professional regulation] for ten years … they're still not registered. – Hospital A 07 Nursing manager*
Prescribing rights	**Macro (origin) → Meso/Micro (effect)** Prescribing rights governed nationally, but felt at clinical team/ individual levels during clinical work	**Position** (*primary*, in comparison with other roles) **Process** (*secondary*, associated with professionalisation)	PAs' non-prescribing status symbolically reflects limited competence compared with other liminal roles who can prescribe, which contributes to tensions with other roles (liminal position). Concurrently, repeated delay of prescribing rights signalled prolonged liminal transition (liminal process).	*We [PAs] are constantly a profession that's been compared to Advanced Nurse Practitioners [ANPs] … professionals who can prescribe … that puts us even further below people's expectations of us … there must be a reason why you can't do it [prescribe]. – Hospital C PA focus group*
Title	**Macro (origin) → Micro (effect)** Title defined by legislation, but experienced in interactions with patients/team members	**Position** (*primary*, symbolic identity)	PA role title intended to signal proximity to medicine but in practice led to widespread misrecognition among team members and patients, reinforcing ambiguous professional positioning rather than resolving it (liminal position).	*Lack of understanding … if I wasn't in the role that I'm in, I wouldn't understand what a physician associate is. I would probably go in thinking this is a doctor. Because the word physician is in there … we all trust doctors, so I wouldn't question it. – Hospital C 02 Manager*
Offices	**Meso (origin) → Micro (effect)** Offices/workspaces determined by local organisations, but experienced in everyday work	**Place** (*primary*, spatial embedding) **Position** (*secondary*, alignment with the medical profession)	PAs were embedded in the 'medical' workspace, often labelled 'doctors' office' and occasionally 'multidisciplinary team office'. This contributed to partial embedding within medical spaces (liminal place) and simultaneously reinforced ambiguous identity (liminal position).	*PAs kind of lurk in the doctor reaches, where they sit in the [doctor's] office … it's a little bit more confusing how that works … PAs aren't the only allied health profession that has a slight role definition issue. – Hospital A 20 Resident doctor*
Uniforms	**Meso (origin) → Micro (effect)** Uniform arrangement decided by organisations, but experienced in everyday work	**Place** (*primary*, visual social-material markers) **Position** (*secondary*, alignment with the medical profession)	Attempts to visually integrate PAs by placing them in scrubs like doctors (at times a different colour) signalled inclusion but often contested by calls for differentiation. This produced partial embedding in medical space (liminal place) and simultaneously reinforced ambiguous identity (liminal position).	*We wanted them [PAs] to be part of the team, so we put them in exactly the same scrubs as our consultants and junior doctors. We didn't want them to feel different, I guess, so it was very much, 'How do we make them look a part of our team?'. – Hospital E 03 Manager*
Lanyards and badges	**Macro/Meso (origin) → Micro (effect)** Lanyards/badges provided through national professional bodies/ organisations, but shaped everyday interactions	**Place** (*primary*, visual social-material markers)	Lanyards (with 'Faculty of Physician Associates' on them) supposed to function as visible identity marker, providing a clear differentiation from doctors within clinical spaces (liminal place). However, PAs' professional body dissolved, making these artefacts unstable.	*Appearance-wise, we have these lanyards, but I don't think they will be available anymore because they're [provided] by the Faculty of Physician Associates, which doesn't exist anymore. So, this used to be … oh, that's a PA. Unfortunately, that's not the case. We have these badges that says physician associate on them. – Hospital E 13 Consultant*
Rotas	**Meso (origin) → Micro (effect)** Rotas designed through organisational systems, but experienced in everyday work	**Place** (*primary*, organisational placement in work system) **Position** (*secondary*, in comparison with other roles)	In some organisations, PAs allocated to separate rotas acknowledging distinct roles/responsibilities. In others, PAs treated similarly to earlier stage resident doctors. This produced unstable organisational placement in work systems (liminal place) and reinforced ambiguous identity (liminal position).	*There's a challenge where hospital management, in designing rotas, doesn't understand the role of PAs … thinks that PAs and junior middle grade doctors or FY1s [first year foundation doctors] are interchangeable. When actually they're two discrete groups … with separate responsibilities and skillsets, and … abilities in terms of prescribing … to put a PA in that position actually isn't feasible, but they still use them [PAs] to stuff the rota or consider them as rota fodder. – Hospital D 19 Resident doctor*
HR classification	**Macro/Meso (origin) → Meso (effect)** HR classification designed through national/organisational IT systems, but influenced HR management functions	**Place** (*primary*, organisational placement in work system) **Position** (*secondary*, in comparison with other roles)	HR classification systems functioned as an organisational/spatial liminal marker. PAs inconsistently recorded across occupation codes and job titles, making their organisational placement unstable (liminal place), leaving their professional identity ambiguous (liminal position).	*When we report on PAs, it's been challenging because sometimes they might be in the PA role, but they might not be recorded on the system as a PA … You have to look at occupation code, we have to look at the job position title, the job role, and the staff group to understand. – Hospital C 05 Manager*
Pay bands	**Macro (origin) → Meso/Micro (effect)** Pay bands set through national structures but experienced at organisational/individual levels	**Position** (*primary*, career progression) **Place** (*secondary*, organisational placement in work system)	Pay band standards/structures designed for traditional roles constrained PAs' career progression, leaving many in permanent career limbo (liminal position). PAs' placement within non-medical pay structures, despite performing medically aligned work, produced organisational misplacement (liminal place).	*The main frustration with PAs is where do they progress? They're a PA and that is it. At the minute there's no progression … [or] scope for progression … If they start a Band 7 PA, what's the retirement plan? They end as a Band 7 PA. – Hospital B 15 Other allied health professional*
Line management	**Meso** (origin) → **Micro** (effect) Line management/governance mostly designed by organisations	**Place** (*primary*, organisational placement in work systems) **Position** (*secondary*, in comparison with other roles)	In some organisations, PAs managed through non-medical governance structures aligned with nursing, despite primarily working with medical teams. Lacking clear structure, produced organisational misplacement (liminal place), reinforcing an ambiguous professional identity (liminal position).	*[PAs] haven't come onto my radar … I think they get looked after by nursing management, which is a bit odd … I'm not sure they quite have a home. – Hospital A 06 Clinician-manager*

Associates, was dissolved.

At both the individual and team-level, PAs were asked to stop performing advanced procedures they had learned, avoid night shifts, and some PAs faced redundancy. Over time, these retractions eroded PAs' confidence in their individual and collective professional future:

> *Our [PAs's] development is about to go backwards. I feel like we're about to get our wings clipped and I'm genuinely concerned that when I come off [maternity] leave, I'm not going to have a job … or my job is going to be unrecognisable. – Hospital D 05 PA*

As confidence in their collective and individual professional future weakened, and individual PAs were personally, publicly and professionally criticised, many PAs individually adopted a defensive coping identity work response we characterised as *selective withdrawal and temporal recentring*. Rather than engaging with policy debates or online forums about their profession's future, PAs withdrew from public discussions, instead focusing on their immediate work. As one PA described, *"you just have to turn up … do your day-to-day job really. It's really out of our hands" (Hospital E 12 PA)*.

5.2. Liminal position: ambiguous professional identity and career limbo

Participants described PAs occupying an ambiguous, continually negotiated and changing position in relation to other health professions. PAs' title - 'physician assistant' or 'physician associate' - function as a key liminal marker of this position. The 'physician associate' title was introduced at national level to signal proximity to medicine and PAs' training *"in the medical model" (Hospital A 04 Manager; Hospital A 16 PA; Hospital B 11 Clinician-manager; Hospital E 08 PA)*. However, there was confusion about what PAs were permitted to practice. The overlap between PAs' clinical activities and other roles - resident doctors, advanced nurse and care practitioners - generated confusion and misrecognition among some clinical colleagues and patients. Thus, PAs' role title and scope of practice, reinforced their *ambiguous professional identity and boundary*.

Participants described PAs' role as difficult to explain. To help colleagues and patients understand their role, PAs were described by managers and senior clinicians as "*long term F1" [first year 'foundation' trainee for doctors]*, "*like a mini doctor*", or "*half nurse, half doctor*". One PA noted, "*I always introduce myself as a physician associate … But people don't know what it means. We're such a small profession. So, they just either correlate it with nurse or doctor" (Hospital C 10 PA*), echoing descriptions of paralysis and polarity in liminal hotspots (Greco and Stenner, 2017).

PAs' positional ambiguity intensified when other liminal roles - rotating resident trainee doctors, locum doctors, advanced nursing and care practitioners - were present in clinical workplaces. These groups were themselves navigating transition, competing for training opportunities, and worrying about uncertain future careers. Resident doctors particularly expressed concerns that blurred professional roles destabilised their future careers:

> *We've had lots of talks amongst junior doctors, about the future of our role, especially if physician associates do have the scope to prescribe one day … They'll basically be acting in the same capability as us … We [resident doctors] are also not sure what our role is anymore, and how these lines blur and what the boundaries are. – Hospital B 16 Resident doctor*

Prescribing restrictions functioned as a liminal marker for position at the micro-level of everyday clinical practice. Some PAs had worked within clinical teams for years, gaining deep knowledge of local services and clinical routines. Yet even experienced PAs had to defer to resident doctors, some just beginning clinical practice, to request prescriptions for patients, which was described as creating a *"weird power imbalance" (Hospital D 13 Clinician-manager)* and confusion over accountability.

PAs long-term presence in clinical workplaces fostered close working relationship with consultants (senior doctors) and nurses, which some resident doctors saw as undermining their medical training and careers:

> *Because (PAs) don't rotate, like resident doctors do, they're often friendlier with the consultants and the nurses than the resident doctors … which does sometimes lead to the resident doctors, particularly the more junior ones, feeling even more side-lined. – Hospital A 10 Resident doctor*

Thus, PAs were in the paradoxical liminal position (Greco and Stenner, 2017) of supporting and undermining other liminal health professionals they worked with in clinical teams. Yet unlike other liminal roles, which are transitional for a period but eventually settle, PAs faced enduring positional *career limbo*. Without structured career pathways, PAs' faced a career "ceiling", which undermined individual and organisational confidence in the PA role's longevity.

> *It's such a shame for the PAs, and also why I'm very surprised they're still with us, because some of them have been with us for over a decade and they're basically stuck at the same level. – Hospital D 13 Clinician-manager*

In response, many individually PAs engaged in *identity work and career reframing* of their positional and career limbo, adopting flexible and often negative identities - *"I am not a doctor, but I'm part of the medical team" (Hospital D 08 PA)* - to manage misrecognition. This reflected ambiguity and ambivalence in PAs' positional identification; simultaneously claiming proximity and belonging to medical teams, while signalling differentiation and (non)belonging to the medical professional. Several PAs' identity work emphasised their function as "bridges" between medicine and nursing, when describing their role in order to maintain legitimacy.

> *PAs have a really good way of introducing themselves … 'I'm one of the PAs, I work with the medical team but I'm not a doctor, but we are kind of allocated to do tasks to support the doctors.' And it's always really well received." – Hospital B 14 other allied health professional*

For some PAs, this reframing extended to their career orientation; repositioning PA roles as short-term, stable '9-5 jobs' offering more predictability than medical careers. This was not PAs' motivation for entering their paraprofession but a response to prolonged positional limbo, redefining PAs' work's value, work-life balance, and sense of control.

> *I enjoy my job. Can I see myself doing it forever? Probably not. But I don't know what that involves. I don't think anybody that's currently working in [clinical specialty] can see themselves working in [clinical specialty] forever … I'm considering leaving the profession entirely … I love my job. The rest of the stuff is … becoming less worth it. – Hospital D 02 PA*

5.3. Liminal place: contested spatial-organisational belonging

Liminality was reinforced by PAs' position across physical and organisational workplaces. PAs were physically co-located within medical spaces, while organisationally situated within non-medical employment and governance structures. At micro-level, PAs shared offices and ward areas with doctors, which was viewed as crucial for communication, workflow, and coordination; advanced nurse or care practitioners were based in separate clinical spaces and operated within more clearly defined professional boundaries.

> *We all sit in the same office together … in allied doctor and PA pair because we work together. We do the ward round together … The IT system is the same, except the doctors have access to prescribing and imaging, which we don't. – Hospital E 12 PA*

At the meso-organisational level, PAs primarily worked within medical teams but were formally managed under 'Agenda for Change' - an employment framework for *non-medical* and nursing staff, which dictated pay structures and line management responsibilities. Managers often expressed uncertainty about who should oversee PAs, how to

structure their rota, and which departmental budget should fund PA posts. Together, these organisational arrangements operated as liminal markers of PAs' ambiguous place; on the medical side of professional boundaries in clinical work but on the non-medical side of organisational employment and management structures:

> *Nursing sits under the same pay structure as the PAs … doctors all sit under a different structure … [PAs] didn't fit into that very neat bucket. – Hospital E 03 manager*

The conflict between PAs' physical and organisational places confused PAs who did not fully belong with either the medical or non-medical workforce, again echoing the paralysis and polarisation associated with liminal hotspots (Greco and Stenner, 2017). Thus, PAs' experienced liminal place as physically and psychologically 'in-between' organisational structures and professional groups.

> *The nurses sit in one place, and the doctors sit in another place. And you're probably with the doctors, but you're paid like a nurse. And that's the bit that we always end up with difficulties. – Hospital D 02 PA*

Material visual artefacts contributed to this liminal place. Uniforms, lanyards, and name badges signalled inclusion or differentiation but their meanings differed between hospitals. Perspectives also differed across participants groups in whether visual similarity with doctors fostered inclusion or confusion, reflecting the contested meaning of these liminal markers. In some hospitals, PAs wore uniform with distinct colours from doctors to signify their different roles. In others, PAs were "*in exactly the same scrubs as our consultants and junior doctors" (Hospital E 03 Clinician-manager)* to foster inclusion. These varying liminal markers exacerbated ambiguity about PAs' professional positioning.

> *In [specialty], PAs wear [colour] scrubs … the same as the consultants [senior doctors]. So, that can be a bit awkward sometimes. Some nurses, who don't normally work on the wards, they'll come up to me and be like, 'Oh, are you the consultant?' I'm like, 'Do I look like a consultant? No, I'm not the consultant. I'm a physician associate.' – Hospital C 10 PA*

Some PAs developed *spatial and local legitimacy* by emphasising their reliability and continuous presence within wards and offices, unlike resident doctors on short-term clinical rotations. Over time, PAs acquired organisational knowledge of local pathways and informal routines, which enhanced their professional legitimacy for patients and clinical colleagues. Accordingly, PAs engaged in identity work selectively mobilising material visual professional identity markers to signal value and belonging in clinical spaces:

> *Our scrubs are [colour] … Here we're known as the [colour] people. If someone's new to the department, is struggling, [clinical colleagues] they'll say, 'Oh, just find someone in [colour] and they'll give you a hand.' And you hear that and you automatically turn on and say, 'Yeah, I'll come help. It's fine.' – Hospital D 10 PA*

6. Discussion

In this analysis we explored how PAs experience liminality as members of a new paraprofession. We explained PAs' prolonged, multi-layered liminality across policy, organisational, and everyday practice contexts, and relational identity work sustaining their legitimacy while their profession is in limbo. This liminality was sustained by symbolic, organisational, and socio-material arrangements and forms of boundary objects we conceptualise as *liminal markers*. We offer three theoretical contributions.

6.1. Paraprofessionals as liminal professionals

First, we advance understanding of liminality in relation to paraprofessional roles (Etzioni, 1969) and occupations positioned between established professional hierarchies (Golden and Bencherki, 2024; Gustafsson and Empson, 2018). Existing studies frame paraprofessionals' liminality as career immobility, primarily focusing on individuals navigating, enduring, and attempting to transcend 'in-between' roles. Our study shows paraprofessionals' liminality as collective and institutionalised at the national/macro level through ongoing disputes over professional regulation, scope of practice, and professional authority. PAs are trained in 'the medical model', working alongside doctors, often sharing clinical spaces but lack their master medical profession's privileges and recognition, or a defined pathway out of liminality. The PA profession's prolonged liminal position between the polarities (Greco and Stenner, 2017) of non-medical and medical, paraprofessional and professional status creates continuing uncertainty over the occupation's role, scope, and future.

PAs' professional liminality persists within a context of turbulent, fragile and reversible professionalisation. At the national-level, advances towards statutory professional regulation for PAs were accompanied by medical professional contestation, resulting in the dissolution of PAs' own professional body. At the organisational and team levels, PAs experienced withdrawal of responsibilities, stalled role development, and employment insecurity. Therefore, rather than resolving liminality, PAs' professionalisation became a source of uncertainty, creating enduring and emotionally-charged conditions in which attempts to move beyond liminality instead reproduced or intensified it (liminal hotspots) (Greco and Stenner, 2017). This finding echoes Rosell's (2025) study of collective leadership in surgical teams, where macro-level policy aiming to reduce hierarchical authority, instead intensified ambiguity and tension at meso- and micro-levels of practice.

By conceptualising paraprofessionals as liminal professionals, we explain how professionalisation processes may institutionalise and sustain liminality at macro- and meso-levels, for example, through policy turbulence and contested legitimacy. Prior research has focused on liminality at individual level across career stages (Gordon et al., 2020). Our work offers a new lens for analysing emerging professions and roles, such as advanced nurse and care practitioners (Gill and Foli, 2024), whose professional futures remain unsettled despite formal recognition and expanding responsibilities.

6.2. Liminal dimensions and experiences

Second, we advance Söderlund and Borg's (2018) framework by explaining how *liminal process*, *position*, and *place* are experienced simultaneously, and in everyday work, rather than separately. Söderlund and Borg (2018) argue that liminality's temporal dimension of (i.e. process) is well studied but its spatial and relational aspects - where individuals are located within organisations and how they are positioned relative to others - are under-researched. We address this gap by highlighting how these dimensions concur and interact, producing multi-layered, mutually reinforcing liminality.

Temporally, PAs remain in limbo between statutory regulation and professional recognition. *Relationally*, PAs occupy ambiguous positions compared with resident doctors, advanced nurses, and other liminal role that, paradoxically (Greco and Stenner, 2017), PAs both support and undermine. *Spatially and organisationally*, PAs are physically embedded within medical teams but organisationally governed through non-medical frameworks; sharing spaces with but professionally differentiated from doctors, including being required to clarify they are *not* doctors, reflecting polarisation in liminal hotspots (Greco and Stenner, 2017). Accordingly, we argue, liminality emerges through interaction between multiple dimensions.

Our analysis also extends understanding of *liminal place*. Prior studies conceptualise liminal places as spatially and temporally-bounded *physical* spaces (Bar-Lev and Vitner, 2012), or temporary projects (Parent and MacIntosh, 2013). Drawing on a conceptualisation of place as socially produced and embodied (Tuan, 2011), we show organisational and managerial arrangements constituting a liminal place spilling over into a liminal identity, in which paraprofessionals remain uncertain

where they psychologically and emotionally fit. Studies describe organisational arrangements, like training environments (Scaratti et al., 2021), functioning as liminal places suspending or blurring formal hierarchies, but frame liminal places as temporary or episodic. We show liminal places being sustained through ongoing spatial-organisational misalignment, producing enduring, rather than transitional and episodic, physical, organisational, psychological, and professional place limbo.

We respond to calls to research the lived, embedded, affective and identity dimensions of liminality (Greco and Stenner, 2017; Söderlund and Borg, 2018). We show PAs trapped in a liminal paraprofessional status, neither ratified nor abandoned, facing prolonged, affectively charged uncertainty they are unable to resolve or escape (Greco and Stenner, 2017; Szakolczai, 2009). In permanent liminality, the central question is how to generate sufficient stability for a meaningful life, and one answer is developing a sense of personal integrity (Szakolczai, 2009) through identity work (Caza et al., 2018). Reflecting permanent liminality (Greco and Stenner, 2017; Szakolczai, 2009), research has described marginalised professionals resolving institutional contradictions through identity work, internalising and reconciling contradictions, and claiming and enacting roles visibly disconfirming wider prescriptions (Creed et al., 2010; McGivern et al., 2015).

PAs' identity work involved 'deparadoxification' (Greco and Stenner, 2017) through temporal and spatial strategies, narrowing *temporal* horizons by bracketing past stalled expectations of professionalisation and deferred professional futures, and focusing on clinical work in the present. While Zulato and colleagues (2025) described deparadoxification of liminality through mobilising the past into a liveable present, PAs can neither mobilise their stalled past professionalisation trajectory, or indefinitely deferred professional future, so focus on the present.

PAs' identity work also involves *spatially* rescaling professional legitimacy from national to micro-departmental level, and through continuous presence and knowledge of local systems establishing its value locally. PAs' liminal identity work involves a sense of personal integrity (Creed et al., 2010; McGivern et al., 2015; Szakolczai, 2017), relationally and dialogically earning local colleagues' recognition (Zulato et al., 2025), and refusing to engage in wider paralysing and polarising liminal hotspot dynamics (Greco and Stenner, 2017).

Our findings resonate with research on community health workers who mobilise their liminal position between communities and health systems as a discursive resource, while drawing on their expert knowledge of local communities to establish legitimacy within local contexts (Golden and Bencherki, 2024). However, our findings show paraprofessional identity work as a widespread but individualised, inward-facing personal survival strategy, rather than an outward-facing identity work aiming to re-shaping of collective professional boundaries. By creating manageable routines, redefining the value of their work in local clinical teams, and reframing their own understanding of PA roles' benefits for the moment, PAs manage disturbing emotions associated with liminal hotpots, function and sustain legitimacy while their collective professional status is in limbo.

Accordingly, PAs' identity work made liminal entrapment habitable without reconciliation in the present. Whether PAs' local individualised identity work brings a pattern shift (Greco and Stenner, 2017) and changes wider professional norms (Creed et al., 2010; McGivern et al., 2015) remains an open question. This question matters for policy, because, as Szakolczai (2017) warns, under conditions of permanent liminality, further changes - reviews, consultations and role designs - risks perpetuating liminal hotspots.

6.3. Liminal markers

Our final contribution is the concept of 'liminal markers', which explains how liminality is marked, organised, or stabilised in everyday organisational life. We respond to Banfield's (2022) call for attention to the 'threshold of liminality', as liminality may be multiple, nested, and mobile. Liminality involves symbols, rituals, and practices, for example, uniforms during training (Rantatalo and Lindberg, 2018) and adverse events (Schrøder et al., 2021). These markers typically signal temporarily bounded episodes of liminality. By contrast, we show liminal markers stabilising limbo, especially when embedded across multiple levels and organisational arrangements (see summary in Table 1).

Liminal markers operate and link across macro-, meso-, and micro-levels, in relation to multiple liminal dimensions (process, position, and place). Markers originating at one level (e.g., national policy), are experienced and negotiated at other levels (e.g., organisational systems and teams), and simultaneously shape temporal uncertainty (process), relational ambiguity (position), and spatial-organisational misalignment (place). For example, nationally defined pay-bands and workforce classifications, alongside governance structures defined at local organisational level, functioned as liminal markers embedding PAs within the non-medical system, despite PAs doing medicalised work. PAs *"didn't fit into a neat bucket" (Hospital E 03 manager)* and were not categorised as medical professionals, so were positioned in the 'other' residual category (Bowker and Star, 1999) on the HR classifications and pay scale. Thus, liminal markers sustain paraprofessionals' ambiguous place (in which paraprofessionals are classified, situated, and governed) and position (within professional hierarchies). By mapping liminal markers across levels and dimensions, we show liminality sustained through interactions between multiple liminal markers.

Our conceptualisation of liminal markers echoes literature on boundary objects (Meier, 2015; Star and Griesemer, 1989) but differs in important ways. Boundary object scholarship primarily examines objects facilitating collaboration across social worlds, despite different interpretations of objects (Meier, 2015; Nicolini et al., 2012; Star, 2010). However, boundary objects can be strategically and politically mobilised to assert jurisdiction (McGivern et al., 2018; Nicolini et al., 2012), thus becoming a site of power relations. We explain how liminal markers, including organisational arrangements, such as HR classifications, pay bands, rotas, line management, and shared offices, and material artefacts, like titles, uniforms, lanyards, badges, reveal how liminality is produced, reproduced, and stabilised (Greco and Stenner, 2017). Boundary objects and liminal markers may therefore overlap, in that they bridge different social worlds, are interpreted in ambiguous and different ways by them, and may be used in political ways. However, analysing liminal markers and the relationship between them usefully highlights how liminality is produced and stabilised through socio-material, symbolic and organisational arrangements crossing macro-, micro- and micro-levels.

Liminal markers, like boundary objects (Nicolini et al., 2012; Star, 2010), may appear mundane but become political sites where professional identity threats are experienced, professional resistance is enacted, and power relations are negotiated across multiple levels of the health system. For example, uniforms may be liminal markers shared by different professions in one local setting, signalling local inclusion and enabling collaboration, while differentiated elsewhere to reinforce professional hierarchies and occupational closure. Shared spaces were described as 'doctors' offices' (occasionally 'multidisciplinary team office'), symbolically reinforced PA's marginality and (non)belonging. These examples show how routine organisational arrangements became resources through which professional hierarchies were reproduced in everyday work, and the meaning of local liminal markers depends on wider institutional contestation. Consequently, even where micro-level liminal markers (e.g., uniforms or shared office) signal a stable and legitimate professional identity in some local settings, they could become orphaned signifiers when macro-level liminal markers (e.g., statutory regulation and title) are undermined at the institutional level.

6.4. Implications, limitations and opportunities for further research

The policy and practical implications of our study include the recognition that introducing new paraprofessional roles without

aligning them across regulatory frameworks, organisational structures, and everyday work arrangements can trap these roles in limbo, rather than alleviate workforce pressures. Expanding new professional roles' scopes of practice or responsibilities without aligning them with workforce classification, governance structures, and lines of accountability can undermine the way work is performed. Attention is also needed to mundane but important objects marking legitimacy, such as uniforms, badges, and access to clinical spaces, which shape how roles are recognised and understood in everyday practice. Organisations must also recognise that professionals in liminal roles may need emotional support and spaces for collective reflection to help manage ongoing uncertainty.

Our study has limitations that offer opportunities for further research. Our research was conducted during a period of policy turbulence and professional contestation over the PA role, which may have influenced some individuals' willingness to participate and narration of experiences. We also focused on acute hospital-based PAs. Organisational and boundary dynamics in other settings (e.g., primary care and mental health) may differ, so further research on PAs in other settings would be valuable. Finally, our research design enabled us to identify tactics and liminal markers through PAs' and other' reflections. However, more longitudinal ethnographic research is needed to explain how liminal markers and identity work practices emerge, are enacted in everyday work, and change over time, especially as professional and policy contexts change.

7. Conclusion

We examined how PAs, as paraprofessionals, experienced and navigated liminality in organisational practice. Drawing on qualitative data from 126 interviews and a focus group (with eight participants) from five UK NHS hospitals, we showed that PAs experience professional liminality across policy, organisational, and everyday work contexts. We explained how PAs engage in individual identity work to sustain their professional value and legitimacy during ongoing limbo over their profession's collective future. This liminality was sustained through specific symbolic, organisational, and socio-material arrangements organised around what we conceptualised as 'liminal markers'. Our findings show that, for paraprofessionals, liminality may not be an individual transitional stage but sustained and embedded in everyday organisational practices. As organisational roles are increasingly characterised by blurred boundaries and structural ambiguity, our findings highlight the importance of recognising and supporting liminal roles by aligning policy, organisational, and frontline work arrangements.

CRediT authorship contribution statement

Yingxi Zhao: Writing – original draft, Visualization, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Rhys Swainston:** Writing – review & editing, Validation, Investigation, Data curation. **Tricia Tooman:** Writing – review & editing, Validation, Investigation, Data curation. **Reece Williams:** Writing – review & editing, Validation, Investigation, Data curation. **Stephanie Nzekwu:** Writing – review & editing, Validation. **Shobhana Nagraj:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Funding acquisition, Conceptualization. **Gerry McGivern:** Writing – review & editing, Validation, Supervision, Methodology, Conceptualization.

Ethical approval statement

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Data availability

The data that has been used is confidential.

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