Royal College of Physicians

Physician associates

Interim guidance on supervision and employment in the medical specialties

December 2024

Contents

Recommendations

Supervision

1 A supervising doctor must hold full GMC registration with a licence to practise, be on the specialist register and/or under the specialist/associate specialist contract, and actively practise medicine in the UK without restrictions that prevent fulfilling supervisory roles.

2 PAs must have an educational supervisor (ES) and a supervising clinician (SC), who may be the same person. An ES must be formally trained in educational supervision and have at least 0.25 SPA time allocated in their job plan for every PA that they supervise. An SC must be a consultant physician, associate specialist or specialist doctor. They must retain clinical and professional responsibility for patients and have adequate clinical time in their job plan for supervising PAs.

3 Newly qualified PAs or those in new roles will require direct supervision (as opposed to indirect supervision). Supervision levels must be reviewed regularly to ensure that the level of supervision remains appropriate.

Working in a team with a PA

4 Resident doctors are not, and must not be expected or asked to be, responsible for the clinical supervision of PAs.

5 SCs are responsible for prescribing, making informed decisions based on PA input and requesting ionising radiation for PA-seen patients.

6 In emergency situations, PAs should escalate to the most senior available doctor.

7 PAs are accountable for their practice and must follow GMC *Good medical practice* guidance.

8 PAs must explain their role clearly to patients, colleagues and supervisors.

Employing PAs

9 Employers must provide sufficient resource and support for SCs and ESs, align PA recruitment with team and service needs, and ensure that HR teams are equipped to oversee the employment of PAs.

10 Work schedules for PAs should clearly define duties, work hours and development opportunities, include regular supervisory contact time, and ensure annual appraisals with the ES for development review.

11 PA roles must not compromise the training experience of doctors. PAs must not replace doctors in any role, including the on-call rota.

12 Employers should monitor the impact of the PA role on patient outcomes and training for doctors.

13 Employers must establish governance processes for PA roles, ensuring oversight by the medical director / chief medical officer / responsible officer, implement policies on clinical system access, role limitations and adherence to national guidance, and be aware of GMC personal indemnity requirements.

Introduction

This document sets out interim guidance for the safe and effective supervision, employment and deployment of physician associates (PAs) at the point of qualification. This guidance applies to PAs working in the medical specialties (also known as the physician specialties).

To ensure patient safety, PAs must be supported with supervision, professional regulation, and a nationally agreed scope of practice. PAs must support – not replace – doctors, have a nationally defined ceiling of practice, and have a clearly defined role in the multidisciplinary team (MDT). They should only be supervised by consultants, specialist or associate specialist doctors.

At the time of publication, healthcare professionals working as PAs face an uncertain future. This interim guidance should be reviewed in collaboration with stakeholders as scope of practice is developed across the medical specialties, and following the publication of the report of the independent review of physician associate and anaesthesia associate professions (the Leng review) that has been commissioned by the secretary of state for health and social care (or similar reviews in the devolved nations). In the meantime, this guidance should be used to support physicians and their teams.

1 What is a PA?

A PA carries out basic clinical and administrative tasks at the direction, and under the supervision, of a consultant physician / associate specialist / specialist doctor. In this way, they work as part of the clinical team and contribute to safe and effective care for patients. PAs are not doctors. They should not be regarded as replacements for doctors, and they should never replace a doctor on a rota.

As part of their education and training, PAs gain a focused understanding of the diagnosis and initial management of common medical conditions. This permits their incorporation into the medical team and supervised provision of continuity of care. PAs are not trained to undertake definitive, independent diagnosis and management of patients in secondary care settings or to provide a general or specialist medical opinion.

PAs are trained to recognise – but not manage – complexity, risk and uncertainty. They will therefore always remain a dependent practitioner. Overall clinical responsibility for patient care will always remain with the supervising consultant physician / associate specialist / specialist doctor.

2 Patient safety

Patient safety is of the utmost importance in healthcare and must be the foremost consideration during the development, deployment and supervision of PA roles. PAs are not able to prescribe medications or request ionising radiation (see sections 5.1 and 5.2).

While PAs are responsible for their own practice, they must always work under the supervision of a consultant physician / associate specialist / specialist doctor. The senior supervising doctor retains clinical and professional responsibility for patients treated under their care.

It is important that patients understand who is providing their care. PAs must clearly explain their role to patients, their families and carers, as well as colleagues and supervisors (in line with RCP interim guidance on titles and introductions for PAs working in the medical specialties), and provide details of their educational and clinical supervision when required.

3 Scope of practice

PAs should have a nationally defined ceiling of practice and a clearly defined role in the MDT. These should be defined by the specialist societies.

All PA students must graduate from their university course before they sit the physician associate registration assessment (PARA). Passing the PARA is a mandatory requirement for entry onto the General Medical Council (GMC) PA register. The exam sets the standard for PAs across the UK, and is designed, developed and administered by the Royal College of Physicians (RCP) Assessment Unit.

Two key documents published by the GMC outline the educational and assessment requirements for PAs:

- Physician associate and anaesthesia associate generic and shared learning outcomes
- Physician associate registration assessment (PARA) content map

4 Supervision

To support doctors, the GMC has published advice for doctors who supervise PAs. These principles are mapped to *Good medical practice*.

Supervision must be time, situation and individual specific. Throughout this section we use the term 'supervising doctor', the requirements for which are set out below. There are two types of supervising doctor, the educational supervisor (ES) and the supervising clinician (SC). An ES requires on average 1 hour per week (0.25 SPA) in their job plan to supervise a PA.

4.1 Educational supervisor (ES)

Each individual PA must have an ES. The role of the ES is to oversee the long-term clinical, educational and professional development of the PA, providing guidance and managing any concerns that arise. An ES is a skilled and important role, and they must have undertaken and maintained formal training on educational supervision. Good communication between the ES and the supervising clinician(s) is essential for quality of supervision.

The **educational supervisor** is responsible for:

- establishing and agreeing an individual work schedule with the PA
- ensuring that an individual PA's work schedule and development are in line with national guidance from medical royal colleges and specialist societies
- meeting the PA at least twice a year to review their portfolio. For newly graduated PAs, those moving into a new medical specialty or those changing ES, there should be an initial meeting, followed by meetings at 3 months, 6 months and 1 year
- performing an annual appraisal
- providing pastoral support.

4.2 Supervising clinician (SC)

The SC of the PA must be the consultant physician/ associate specialist / specialist doctor who retains clinical and professional responsibility for patients treated under their care. The SC can change from day to day, but there must be an SC available and contactable for real-time, in-person advice.

With correct supervision, and with robust delegation arrangements in place, PAs are responsible and accountable for their own practice. The SC will remain responsible for the overall management of the patient, any decisions around transfer of care, and the processes in place to ensure patient safety.

The SC requires adequate direct clinical care (DCC) time in their job plan to facilitate clinical supervision of PAs. The time required will vary according to the experience and competency of the individual PA and the tasks being undertaken.

4.3 Levels of supervision

The level of clinical supervision required will change based on the experience of the PA. There are two levels of clinical supervision for a qualified PA:

Direct: The PA's supervising clinician is immediately available in the same clinical environment to provide advice to the PA and, if required, an immediate in-person review of a patient.

Indirect: The PA's supervising clinician is available to provide advice to the PA and, if required, an in-person review of a patient within a reasonable timeframe.

A newly qualified PA, or a PA moving into a new or unfamiliar role, will require **direct** supervision initially. Supervision levels must be regularly reviewed to ensure that they are appropriate and proportionate.

5 Working in a team with a PA

Supervising doctors have been defined above. The following guidance is for other members of the medical team who are working with PAs. **Resident doctors are not, and must not be expected or asked to be, responsible for the clinical supervision of PAs**.

5.1 Prescribing

PAs cannot prescribe medications regardless of any prior healthcare background (eg those with non-medical prescribing qualifications from previous roles) while working as a PA.

Responsibility for prescribing for patients who have been seen by a PA lies with the SC.

Prescribers must never prescribe unquestioningly at the request of any other clinician, but should weigh up the information that they have from a range of sources to make an appropriate prescribing decision. This is outlined in the GMC's *Good practice in prescribing and managing medicines*.

5.2 Ionising radiation

PAs cannot request ionising radiation (eg CT scans or X-rays). Responsibility for requesting ionising radiation for patients who have been seen by a PA lies with the SC.

5.3 Seeking advice and guidance

In situations where a delay in seeking guidance from the SC might lead to patient deterioration and/or clinical harm, PAs must seek guidance from the most senior doctor immediately available.

In this situation, the doctor is not supervising the PA, but they should respond as they would to anyone informing them about any acutely deteriorating patient.

6 Employing a PA

Employers must ensure that MDTs have the most appropriate skill mix to provide excellent healthcare to patients.

Careful consideration of the role and remit of a PA and how they might add value to a team/organisation is required before recruitment. Other roles may be more appropriate, depending on the needs of the service.

Clinical leads overseeing service delivery and development should engage in consultation with team members prior to making decisions regarding the establishment of a PA post, and should have researched, discussed and consulted on any proposal with the appropriate stakeholders.

When defining the role that a PA might undertake in a department, the clinical lead should assess the current skill composition of the department and determine how a PA might best integrate into the team.

Time, managerial responsibility and accountability arrangements must be agreed and stated in the job plans of those doctors supervising the PA (this applies to both SCs and ESs). Job plans should allow time for clinical support and supervision, as well as developmental meetings for PAs and other members of the MDT.

Employers should consider how they will measure the impact of PAs in terms of patient-reported experience and outcomes, and monitor for any impact on training for doctors.

6.1 Work schedules

A work schedule should be developed to allow both the employer and the PA to understand what is expected of them. The work schedule should indicate hours of work, opportunities for development and required duties. It must ensure that the requirements of the post are within the general competencies and scope of practice of the PA role.

PA work schedules should allow for ongoing professional development and encourage retention, while ensuring that the role supports patient care and the needs of resident doctors, the wider MDT and students within their clinical area. Work schedules should be reviewed regularly to ensure that there is continuity of supervision and a balance between patient care, meeting the needs of the service, supporting the training requirements of doctors, and development opportunities for the PA.

6.2 Appraisal

All PAs should have an annual appraisal with the ES who has oversight of their development (see section 4).

6.3 Impact on service and training

Where there is a plan to introduce a PA role into a service, there should be a good understanding of the current training opportunities available to doctors in this service – including foundation doctors, resident doctors in internal medicine training, higher specialty resident doctors, specialist, associate specialist and specialty (SAS) doctors and locally employed doctors – and the expected impact of employing a PA on the training opportunities of resident doctors. Implementation must be done in a way that enhances and improves training for doctors in the service and must not have a negative impact. It is recommended that departmental leads work closely with educational leads to ensure oversight in this regard.

6.4 Employment governance and organisational policies

Organisations must have clear governance processes that provide oversight of the PA role. Organisational policies must define the approved role and remit for PAs, ensuring alignment with regulatory requirements and clear reporting structures. These policies must be based on national guidance developed by medical royal colleges, specialist societies and statutory bodies, and be reviewed regularly. Policies must also set out the processes for monitoring of key patient safety indicators, experience and outcome measures in relation to the work of PAs.

Senior leaders in healthcare trusts, health boards and primary care networks must engage with requirements for revalidation for PAs.

The professional accountability of PAs should be overseen by the medical director / chief medical officer / responsible officer. More information in relation to effective clinical governance supporting revalidation that is inclusive of PAs has been published by the GMC:

GMC. Effective clinical governance to support revalidation, 2024

Clinical IT systems must restrict access for PAs from requesting ionising radiation and prescribing medications.

6.5 Indemnity

Employers and PAs should be aware of GMC requirements for personal indemnity.

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Glossary

AA	Anaesthesia associate
SC	Supervising clinician
DCC	Direct clinical care
ES	Educational supervisor
GMC	General Medical Council
HR	Human resources
MDT	Multidisciplinary team
PA	Physician associate
PARA	Physician associate registration assessment
RCP	Royal College of Physicians
SAS	Specialist, associate specialist and specialty doctors
SPA	Supporting professional activity

Physician associates: Interim guidance on supervision and employment in the medical specialties was developed by a short life writing group made up of resident doctors and consultant physicians. It was reviewed by the RCP oversight group for activity related to PAs (PA oversight group, or PAOG) and signed off by RCP Council in December 2024.

Published as interim guidance that should be reviewed in collaboration with stakeholders, including RCP fellows and members, following the publication of the report of the Leng review.

For more information, please contact **PAOG@rcp.ac.uk**.

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