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Physician associates: an updated position statement from the RCP Trainees Committee

Executive summary

> There is a need for clarity on the role of physician associates (PAs) and how that role should integrate with that of doctors of all grades. In the absence of clarity around roles, scope of practice and medicolegal responsibilities, both patients and trainees are put at risk.

> Advanced 'scope', including 'ceiling' of practice, must be nationally defined on a specialty-by-specialty basis following multi-stakeholder participation.

> The Royal College of Physicians' Trainees Committee (RCP TC) supports all five outcomes from the 2024 extraordinary general meeting (EGM) and calls for a slow-down in the expansion of the PA workforce until the above concerns are adequately addressed.

> While the debate around the role of the PA workforce is important, it has often been heated and damaging to those affected. We unequivocally denounce attacks or abuse directed at individuals, including PAs, doctors and those in senior leadership positions. We recognise the distress that many are experiencing and request that discussions remain respectful.

> PAs are not doctors, yet instances have been reported where they have been placed on doctors' rotas, including in roles requiring senior decision making. We invite the RCP to work with the RCP TC to define what it means to be a 'senior decision maker' and the steps required to practise this role safely. It is the TC's view that completion of medical school, followed by entry to a college-endorsed training programme (eg IMT/HST), or appointment as a post-membership locally employed or SAS doctor, is required to function as a senior decision maker.

> Any evaluation of the impact of PAs must incorporate the impact on training for doctors across a broad range of domains, including educational and clinical supervision. We cannot overstate the importance of consultant-delivered training for the future consultant workforce.

> The evaluation process must also have input from doctors in training, from conception through to analysis and reporting, to ensure that areas of concern are included and findings appropriately shared with trainee members.

> Postgraduate medical education, training and recruitment continue to face significant challenges, and a wider body of work is urgently needed to address this, taking into account lessons learnt from previous attempts. We welcome steps currently underway to bring together key stakeholders to determine strategies to improve the lives of doctors in training.

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Background

Physician associates (PAs) are healthcare professionals who work as part of a multidisciplinary team under the supervision of a named senior doctor. PAs are part of the medical associate professions (MAPs) grouping in the health and care workforce. While PAs have been working within the NHS for the past 20 years, it is only recently that there has been a substantial increase in the recruitment of PAs in line with the NHS Long Term Workforce Plan for England, which expects 10,000 PAs to be employed in the NHS by 2036. In 2015, the RCP TC produced a position statement on the role of the PA, with key requests including:

- statutory regulation of PAs to be addressed urgently
- PAs not to work at a post-membership level of responsibility or under indirect supervision
- the RCP to produce guidance on how any expansion of scope by PAs would be quality assured
- prioritisation of resource and opportunity for doctors in postgraduate training.

The Faculty of Physician Associates (FPA) is a professional membership body for PAs in the UK and has been hosted by the RCP since 2015. The FPA reviews and sets standards for the education and training of PAs, delivers the PA national examination and certification process, and manages the voluntary register.

On Wednesday 13 March 2024, the RCP held an extraordinary general meeting (EGM). This was held following a submission by fellows of the RCP raising concerns about various aspects of the delivery of the PA workforce.

The motions were:

1. **Scope of practice**

   Physician associates are not doctors. They should not be regarded as replacements for doctors and they should never replace a doctor on a rota. They are valued healthcare professionals who participate in patient care in addition to the rest of the wider multidisciplinary team.

2. **Accountability**

   This EGM notes the current legal restrictions on who can prescribe medication or request ionising radiation and reminds all medically qualified membership categories of the RCP that they remain responsible for any such decisions by others that they may be asked to endorse.

3. **Evaluation**

   This EGM calls on the RCP to contribute actively to generating an evidence base and evaluation framework around the introduction of PAs, addressing (for example) clinical outcomes, cost effectiveness, safety, the patient experience, staff wellbeing and interrelationships, and implications for the healthcare workforce.

4. **Training opportunities**

   This EGM calls on the RCP to explore, document and address the impact on training opportunities of doctors resulting from the introduction of PAs.

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5. **Caution in pace and scale of roll-out**

   In the initial request for this EGM, fellows called on the RCP to pause the roll-out of PA roles. A pause is clearly not feasible given recent legislation. This EGM therefore calls on the RCP to limit the pace and scale of the roll-out until the medicolegal issues of regulation, standards and scope of practice are addressed.

All five motions were passed.

Ahead of this EGM, the RCP distributed a survey to members to inform the EGM and voting fellows. The results can be found here.

Current state of postgraduate medical training

It is important to acknowledge the wider context in which the discussion about the role of PAs is being held. There have been increasing concerns about the state of postgraduate medical training over the past decade. These include a perception that service delivery is being prioritised over training, restrictions on national training numbers leading to bottlenecks in training pathways, and rigid and/or variable application of guidance leading to negative impacts on individuals' personal lives and wellbeing (for example, excessive numbers of rotations with subsequent disruption to family life and support networks, as well as long and potentially dangerous commutes over which trainees have little to no control). These concerns, combined with an increasingly pressured NHS, are having significant consequences on trainee morale and welfare.

RCP Trainees Committee Position

The RCP Trainees Committee (RCP TC) consists of doctors in postgraduate training within physician specialties who are elected to represent regions within the UK. RCP TC chairs (elected by the TC membership) sit on RCP Council and have voting rights.

In recent years, issues surrounding the expansion of the MAP workforce have again been brought to the attention of the RCP TC through its constituent members, and the growing concerns featured on both social and mainstream media platforms. The RCP TC has been formally discussing these concerns and considering the response to them since July 2023.

The RCP TC supports and endorses all five motions that were passed during the EGM.

1. Scope of practice

Background

While it is self-evident that PAs are not doctors, there have been numerous, now published, examples of PAs having taken the place of doctors on formal medical rotas, used in place of doctors to cover ad hoc shifts, and providing senior advice or procedural expertise.

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While the GMC has now published guidance on scope of practice at point of qualification: ‘Physician associate and anaesthetic associate generic and shared learning outcomes’, with which the FPA curriculum is aligned, there has to date been no national guidance to clearly define a scope of practice for PAs post-qualification. Instead, this has been delegated to local employers to determine, and in many instances advanced scope of practice has been actively encouraged. This has led to considerable variation in practice.

In the absence of national guidance, the BMA has published guidance for the safe scope of practice of MAPs. These recommendations, however, were not developed collaboratively and remain a subject of dispute.

RCP TC position

In contrast to PAs, doctors in postgraduate training are regulated and subject to rigorous training standards. They follow a quality-assured training programme that requires continuous assessment, independent verification, and multiple postgraduate membership examinations, to advance scope of practice.

Trainees undertake such rigorous training at enormous personal cost. The outputs of this training are senior decision makers who have broad and deep knowledge built on theoretical and experiential learning. While competent at individual tasks and procedures, the sum is greater than the parts and it is the entirety of their training that enables trainees to take on advanced roles and to practise safely as a senior decision maker.

It is therefore not appropriate, equitable or safe for PAs to practise at advanced levels in the absence of a nationally defined postgraduate curricula and competency framework. It is for specialist societies and royal colleges to determine ‘scope’ and ‘ceiling’ of practice through multi-stakeholder participation, which must include the trainee voice. The RCP, which sets internationally reputable and recognised standards of training and practice for doctors in the UK, should not advocate for delegation of such standards for PAs to local employers.

We invite the RCP to work with the TC to define what it means to be a ‘senior decision maker’ and the steps and qualifications required to reach this position. It is the TC’s view that completion of medical school, followed by entry to a college-endorsed training programme (eg IMT/HST), or appointment as a post-membership locally employed or SAS doctor is required to practise medicine within physician specialties at an advanced level (ie functioning as senior decision maker). Not to do so undermines the purpose for which the RCP was created.

2. Accountability

Background

Though we strongly welcome the regulation of PAs, we are concerned that expansion was promoted ahead of regulation. This has led to uncertainty around working practices for trainees. Clarity around

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legal responsibilities for prescriptions and requests for ionising radiation made on behalf of PAs, and liabilities around receiving and making specialty referrals to and from PAs, is urgently needed and must precede any expansion in the PA workforce. The RCP's survey highlighted concerns around lack of consultant supervision of the PA workforce, with many trainees expected to shoulder this responsibility instead.

RCP TC position

As dependent practitioners, PAs must practise under the supervision of a senior doctor, and it is therefore the strong view of the RCP TC that supervision should not be delegated to doctors in training. While non-senior doctors may provide clinical advice to PAs, this does not constitute supervision. By default, therefore, requests for prescriptions and ionising radiation requests should be managed by the senior supervising clinician, rather than by doctors in training, which is the current model being practised in many organisations. In contrast to reducing the burden of work and increasing capacity, as was the intention behind the introduction of PAs, for many doctors in training working with PAs has entailed an extra burden of both workload and supervisory responsibility. We welcome recent guidance from the FPA on clinical supervision for the PA role, but suggest that further clarification on these matters is required from bodies including the RCP and the GMC.

3. Evaluation

Background

The expansion of the PA workforce is a novel intervention within the healthcare sector. As we would expect for any new therapy or model of care, rigorous evaluation is imperative in order to ensure patient safety.

RCP TC position

We urge leaders to consider the impact on training for doctors across a broad range of domains, alongside wider evaluation of the PA workforce. PAs practise across a wide range of specialties, and the majority currently work in primary care. Therefore, any evaluation process requires input from all the royal colleges, specialty societies and their respective trainee committees, alongside other key stakeholders.

4. Training opportunities

Background

The findings from the RCP members' survey clearly demonstrated that the introduction of PAs into the workforce has negatively impacted training opportunities for many. This must not be overlooked or trivialised.

Issues with UK medical training are multifactorial and the introduction of PAs is only one facet, but initial claims that the expansion of PA roles would improve training opportunities have clearly not materialised. The RCP TC recognises that while the volume of work in healthcare is expanding, educationally valuable activities, consultant-delivered training and supervisory capacity are finite.

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Where PAs have fulfilled roles beyond their initially intended scope of practice, these resources have been stretched further.

RCP TC position
PAs should not be given protected opportunities to advance scope of practice and undertake educationally valuable work if trainees, SAS and locally employed doctors at the same organisations are then left to deliver less educationally valuable work and are unable to appropriately advance their scope of practice, in line with their training programme requirements or wider educational goals. Where there are positive examples of PAs improving access for doctors to training opportunities, these should be shared for wider system learning.

The introduction of PAs into the workforce must not result in our next generation of senior decision makers receiving less supervision and training than is required for completion of their respective training programmes, or according to their individualised personal development plans. Organisations who employ PAs must consider the impact on supervisor resource and on training opportunities for doctors, particularly when employing PAs, and when considering an expanded scope of PA practice. There must be local and regional mechanisms in place to continuously evaluate this, and to redress issues at pace.

It has been suggested that appropriately trained PAs may deliver training to postgraduate doctors. While some parts of physician training could feasibly be delivered by PAs – as some aspects currently are by wider multiprofessional team members, skilled within different domains – it is important to remember that doctors in training are the consultants and supervisors of the future. We cannot overstate the importance of consultant-delivered training for our future consultant workforce and for a sustainable model of supervision to be established and protected.

5. Caution in pace and scale of roll-out

RCP TC position
Given the concerns outlined, we agree with the motion to slow the roll-out of PAs until regulation is in place, and wider concerns about expanding the PA workforce have been adequately addressed.

We recommend that the RCP issues a clear statement confirming to members and relevant stakeholders that limiting the pace and scale of the roll-out is now RCP policy.

While we recognise that it is not directly within the gift of the RCP to limit the expansion of PAs, we recommend publishing an explanation of who this sits with, and how and when the RCP will contact them to ensure that they are aware of their new stance.

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A way forward

Trainees work at the coalface and provide valuable insights into the running of the NHS. The TC is willing and ready to work with all relevant stakeholders on the issues raised.

We welcome the recent announcement that, moving forwards, the FPA will be managed as an independent faculty, separate from the RCP.

The TC recognises the immense toll that recent events have had on those caught up in the discourse. We unequivocally denounce attacks or abuse directed at individuals, including PAs, doctors and those in senior leadership positions. We do not lay blame at the feet of individual PAs for loss of training opportunities. We continue to support multiprofessional working, but we do need clarity on the role of the PA and how this should integrate with that of doctors of all grades.

The TC is committed to assisting the various workstreams now required to support all five motions.

Suggested actions:

- Advanced 'scope', including 'ceiling' of practice, must be nationally defined on a specialty-by-specialty basis following multi-stakeholder participation. The absence of such definitions is directly leading to unwarranted local and regional variation and poses an ongoing threat to patient safety.
- Clear guidance for doctors in training on supervisory roles and relationships, and the medicolegal implications for prescribing, ordering ionising radiation and receiving and making referrals to PAs. It should not by default fall to doctors in training to oversee prescription management or scan requests on behalf of PAs.
- Evaluation of the impact of the PA workforce on training, with inclusion of specific questions on this topic within existing national training surveys. Real-time analysis through exception reporting mechanisms should be encouraged. Equally, where there are examples of PAs improving access for doctors to training opportunities, these should be shared for wider adoption.
- Defining what it means to be a 'senior decision maker' and the steps and qualifications required to reach this position. It is the TC's view that completion of medical school, followed by entry to a college-endorsed training programme (eg IMT/HST), or appointment as a post-membership locally employed or SAS doctor, is required to practise medicine within physician specialties at an advanced level (ie functioning as senior decision maker).
- A wider evaluation of the state of postgraduate medical training is warranted. While issues surrounding the introduction of PAs would merit concern in any context, trainee frustrations are exacerbated by the prioritisation of service delivery over training in recent years. This evaluation must also consider physician specialty recruitment and the restrictions on national training numbers, including a plan to expand specialty training places in line with the increase in medical student numbers proposed in the NHS Long Term Workforce Plan.

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