Royal College of Physicians

Physician associates

Interim guidance on scope of practice (general internal medicine)

December 2024

Introduction

This document sets out a safe and appropriate scope of practice for physician associates (PAs) working in general internal medicine (GIM) 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.

This guidance should be reviewed in collaboration with stakeholders following the publication of the report of the independent review of physician associate and anaesthesia associate professions (the Leng review) and when the General Medical Council becomes the regulator of the medical associate professions. The examples included are not intended to be exhaustive.

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 Scope of practice for PAs in a ward setting

In a general medical and ward setting, PAs can assist with basic clinical and administrative tasks. This includes:

- assisting the supervising clinician (SC) during ward rounds
- completing tasks defined in this guidance, and identified by the SC to be appropriate
- relaying information about the patient's care, including investigation results, to the SC
- working in collaboration with resident doctors and the wider MDT to ensure that patient lists are well maintained and that hospital discharges are expedited effectively.

Under the direction of the SC, a PA may provide routine updates to patients and relatives regarding ongoing treatment plans that have been defined by the SC. PAs may contribute to, but not lead, all aspects of multidisciplinary care.

PAs may perform core procedures, as defined in the PA curriculum (Box 1).

Some core procedures from the PA curriculum (eg administering intravenous medication) would require additional local competency assessment and national specialty guidance, and have therefore been excluded from the interim scope of practice.

All medical procedures inherently carry some degree of risk. In addition to technical competency, undertaking medical procedures requires a thorough understanding of the clinical situation. Complex decision making may be required in real time as the procedure is being undertaken. This is particularly true of invasive interventions with therapeutic intent, with a range of possible outcomes depending on the clinical circumstances, and these procedures (eg intercostal chest drain insertion) are beyond the ceiling of practice for a PA working in GIM.

A PA must never function as a senior decision maker. They should not make independent assessments of deteriorating patients or define discharge plans, nor should they do so by proxy via resident doctors and the MDT, nor be asked or expected to do so by others. A PA should follow local governance processes and speak to their SC if they have concerns about what is being asked of them.

Box 1: PA core procedures

- Baseline observations
- Perform cardiopulmonary resuscitation to the level expected in Immediate Life Support training
- Venepuncture
- Cannulation
- Take blood cultures
- Measure capillary glucose
- Peak flow measurements
- Urinalysis
- ECG
- Urinary catheterisation
- Inhaler technique

3 Scope of practice for PAs on the acute medical take

PAs who contribute to the acute medical take require specific further supervision and support, due to the high volume, rapid turnover and undifferentiated nature of patients presenting in this setting. All PAs should be able to contribute to the post-take ward round with the SC. Furthermore, they may assist with tasks that have been generated by the clerking medical team (provided they are included within this document) and identified by the SC to be appropriate.

A PA may be able to assess a patient presenting to the hospital, but only if this is followed by prompt in-person review by the SC to define the diagnosis and management plan. A PA should not be able to decide whether a patient is admitted or discharged from hospital. Under supervision, a PA may be able to action specific tasks defined by the SC. In this way, the PA contributes to patient care, but is not an independent diagnostic opinion provider or senior medical decision maker in secondary care GIM.

4 Scope of practice for PAs in outpatient care

In a medical outpatient care setting, there is a limited role for PAs (eg sitting in with the SC to assist with administration or carry out tasks at their discretion). A PA could assess a patient as part of a follow-up appointment, but only if this is followed by in-person review by the SC. A PA should never undertake outpatient clinics independently. They must not undertake outpatient clinics alongside resident doctors or other healthcare professionals without the SC in the clinic.

Physician associates: interim guidance on scope of practice (general internal medicine) was developed by resident doctors, with input from 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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