



High level principles concerning physician associates (PAs)

Academy consensus statement

Healthcare in the twenty-first century is often delivered by multi-professional teams with different specialist skills and capabilities. These teams are varied and constantly evolving to meet the needs of the population, enabling patients to access the care they need, delivered by a trained professional, in a timely fashion. The medical profession has a proven track record of successfully integrating new roles into existing teams while maintaining patient safety since the inception of the NHS.

The Academy is clear that physician associates [PAs] are not doctors and cannot and should not be used as a substitute for doctors. The role of PAs is to support the work of doctors and work collaboratively within the wider healthcare team. This view is explicitly agreed by [NHS England](#) and, as clarified by the Minister of State for Health, Andrew Stephenson, the [Government](#).

Multi-professional teams comprise members from many different backgrounds and levels of experience, such as advanced care practitioners [ACPs]. It may be, after consideration, that certain specialties will have no defined role for PAs as the tasks they might undertake are already being delivered by the current multi-professional team.

The NHS [Long Term Workforce Plan for England](#) commits to doubling the number of medical school places, rising to 15,000 entrants from the academic year 2031/32. This will translate, by 2035, to a minimum of 60,000 extra doctors on the GMC register [in 2022 there were 296,182 doctors on the register with a license to practise]. These medical students will, in time, be accommodated by an expansion of post-graduate training places.

The medical workforce expansion sits alongside the plan's commitment to increase the PA workforce to a total of 10,000 by 2036/37. These twin commitments, and the wider plan, reflect the increased demand for healthcare due to changing demographics,

epidemiology, medical research and advances in pharmaceuticals and technology. The other nations of the UK already have or are developing their own such plans. These drivers and challenges are common to all healthcare systems internationally.

This document outlines some practical and high-level principles that doctors and healthcare teams should use to determine whether and how to integrate PAs into existing teams. Given that PAs will join more varied and diverse teams than anaesthesia associates [AAs], these principles are directed at the PA workforce. It is important that the debate around PAs always remains inclusive, professional, evidence-based and respectful in tone and content.

Medical royal colleges [MRCs] are key in the delivery of post-graduate medical curricula and developing professional standards across all specialties and healthcare delivery settings. Individually they are ideally placed to determine whether PAs are required and how best to utilise them to safely support excellent patient care.

High level principles concerning PAs

- 1. Role definition** — Physician associates [PAs] should be deployed only where there is a defined role and workforce need for them within the team. The role for the PA should be identified and agreed within the healthcare team, prior to recruitment being undertaken, taking into account any relevant nationally agreed scope of practice. An agreed understanding of the PA's role should be shared and promoted emphasising PAs are not doctors and cannot be used as a substitute for them.
- 2. Onboarding PAs** — PAs, like any professionals, work best in teams that welcome them, support them, teach them, work alongside them and defend their value to others. Positive professional behaviour to all colleagues is a major determinant of positive patient outcomes and enhanced patient safety. Not all teams will have PAs working within them, so a shared understanding of their value to the team needs to be understood and promoted.
- 3. Training opportunities** — Medical training has benefitted from being structured and this requires defined time for trainees to learn as well as time within job plans to deliver the high quality training required. Training opportunities for doctors in training need to be prioritised and protected so that no one's training and development is compromised.
- 4. Pre-qualification supervision** — PAs must have a designated medical supervisor during their training who will support them and facilitate their meeting curriculum outcomes. The supervisor will require training, time and other resources to deliver this role, which must be enabled by the employer and not detract from the training of other staff groups.

5. **Post-qualification supervision** — A PA must have a named supervisor, who must be a senior doctor. A PA must, in addition, have suitable supervision identified for the duration of every clinical shift.
6. **Day to day management** — Each team should agree shared levels of entrustment so that the PA does not have to prove their capability on numerous separate occasions. These capabilities will likely develop with time. The capability levels should be defined, recorded and accessible to all, including the PA.
7. **Familiarity with the working environment** — PAs may work in many, varied and different environments. They will develop skills closely related to the environment in which they work. A perceived value of the role of a PA is to provide location-specific stability and continuity. They should not be moved routinely between significantly different environments to fill short-term workforce gaps as their training is not designed to support this.
8. **Specialty-specific guidance** — Each specialty should consider developing a national capability framework for the PAs in their particular environment, potentially taking into account the experience and skills of established specialty-specific PAs. This will range from initial tasks which may be undertaken by newly qualified PAs/those new to that particular healthcare setting, to capabilities which may be developed as specific agreed training and local needs dictate. This may include specifying a narrow range of conditions that can be managed according to clear protocols. Where doctors in training have a capability/training framework to acquire new skills to support advanced practice, the training and capability assessment of PAs should not be demonstrably quicker, easier or less onerous. The scope of practice, training and supervision of PAs will be highly specialty and place-specific and needs to be agreed, understood and owned by the entire team, including the supervisor and employer, taking into account any nationally agreed frameworks.
9. **Employer governance responsibilities** — PAs should be firmly embedded in the existing governance framework of their employer, including but not limited to incident reporting reviews and morbidity and mortality meetings. The PA should have the same time in their job plan to take part in governance activities as all other members of the healthcare delivery team. It is the employer's responsibility to ensure sufficient time to train and supervise all learners is present within clinical job plans.
10. **Pastoral care** — Good employer and team-based support is vital for all members of the workforce, PAs included, to enable them to perform their jobs as safely as possible, and retain them and their skills, experience and expertise within the workforce to support patient care.

11. **Team working** — All members of the team should share their capabilities freely with their colleagues, regardless of professional group, as well as with students and other learners attached to the team. This is an explicit part of Good Medical Practice, which applies equally to doctors and PAs, once regulation has occurred. No one, including PAs, should be asked to work beyond their capabilities. All members of the healthcare delivery team should understand the limits of their capabilities and when to ask for senior support and review. It is the employer's responsibility to ensure senior support and review is available in a timely fashion to all members of the team. There are defined mechanisms in every employing organisation whereby concerns over these issues can and should be raised.
12. **Exploring scope of practice** — Skills and knowledge increase with time so a PA's scope of practice can be explored locally once it is deemed right and safe to do so, taking account of nationally defined scope of practice (where it exists), as well as the views of all members of the team. Governance arrangements should be put in place to support this and must include defined supervision and time to deliver this, a transparent service and workforce need, a defined training plan and a robust employer governance framework.

This statement is supported by 23 of the 24 medical royal colleges and faculties. The Royal College of General Practitioners has deferred its decision on this until its next Council meeting (March 2024).