Royal College of Physicians

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Ref: 2025-0107

22 April 2025

Royal College of Physicians response to Regulation 28 report to prevent future deaths

Dear Dr Henderson,

The Royal College of Physicians (RCP) notes with concern the content of the Regulation 28 report for the prevention of future deaths related to the death of Pamela Anne Marking.

We send our sincere condolences to the family of Mrs Marking.

The Regulation 28 report is addressed to the RCP, but we wanted to note that whilst the Faculty of Physician Associates (FPA) was part of the RCP at the time of the inquest, it was dissolved on 31 December 2024. Additionally, effective 13 December 2024, the GMC began regulation of Physician Associates (PAs).

This letter has also been addressed to recipients with expertise in anaesthesia, who may be best placed to respond to concerns 6, 7 and 8.

Many of our fellows and members have significant concerns about the safe deployment of PAs, especially concerning regulation, scope of practice and supervision. We have now delivered the results of a working group on PA and have submitted our findings to the Leng review alongside a submission from our resident doctors. To ensure that the PA workforce is able to contribute to patient care actively and safely, the RCP believes that considerable changes need to be made. This will require time, commitment, coordination, transparency - and above all - collaboration between the NHS, patient groups, royal colleges, the GMC, and medical associate professionals, including PAs.

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Matters of concern and the RCP response

1. **The term 'physician associate' is misleading to the public**

We agree there is significant risk of confusion for the public, particularly noting patients and families are often in vulnerable situations when they seek healthcare advice. We also note that the lack of understanding around the term 'physician associate' is not the fault of the PA. We believe the term 'assistant' is much clearer and in line with the competence of the PA, and have recommended a change in name in our submission to the Leng review. We also note the need for clear and specific introductions from the PA when introducing themselves to patients and their families and suggest not using phrases such as 'I am on your clinical / medical team.' The RCP published interim guidance on titles and introductions for PAs in December 2024, in which we were clear that 'PAs must clearly explain their role to patients, their families and carers, as well as colleagues and supervisors, and provide details of their educational and clinical supervision when required.

2. **Lack of public understanding of the role of physician associate**

We agree that, for both patients and the wider healthcare system, the role of the PA is confusing. 'Medical professional' is another term used for a PA and, again, we believe that for the public and wider healthcare system this does not provide adequate clarification in the differences in roles, training and competency between doctors and PAs.

3. **The right of patients and family to seek a second opinion**

This would be addressed at a local level, but we fully support the implementation of Martha's Rule to enable families to ask for a second opinion when they are worried about a relative's acute deterioration. In addition, we are clear that PAs should not be making decisions independently, particularly around discharge in patients in an emergency or undifferentiated setting.

4. **Lack of local and national guidelines and regulation of the scope of practice for a physician associate**

The RCP believes that PAs should be working to nationally-agreed guidelines and relying on local guidelines only risks inconsistency, or at worst no agreed guidelines at all. The GMC is now responsible for regulation, but our understanding is that regulation will need to be supported by national guidelines to provide a clear framework for assessment. We would also welcome clarity of PA clinical competency at qualification; we note passing the PA exit exam is not synonymous with competency and ability in a clinical setting.

5. **Lack of guidelines for direct supervision and consideration of an appropriate level of autonomy for physician associates**

We agree with this and the RCP has written published interim guidance for physician associates working in the medical specialties.

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The FPA closed in December 2024. The initial transfer of PA Managed Voluntary Register (PAMVR) data from the RCP to the GMC began on 31 October 2024, and was deleted on 31 March 2025. The GMC register opened on 13 December 2024 and will be voluntary until December 2026.

The RCP is clear that PAs are not doctors but workforce pressures are very high, particularly in acute care, and this leads to risk of workforce substitution and lack of adequate capacity for supervision and training. At worst, this risks assessment of patients in inappropriate spaces and pressure to rapidly discharge without ability to observe and review. Elderly frail patients with dementia or confusion are particularly at risk in our current overcrowded systems. The RCP also supports the need for the development and distribution of clear guidance for the consultant who is supervising the work of the PA to ensure standardised, adequate oversight.

A comprehensive, national, safe and clear scope of clinical practice for PAs is essential. However, we note the following:

- There is insufficient central coordination, or agreement, within the NHS and amongst employers on how a national scope of practice should be developed and by whom.
- There is limited awareness of what a PA can safely do in a clinical setting upon completion of PA studies and no agreed mechanism for extended clinical practice.
- PAs are employed in a very wide range of clinical settings and specialties, and within both the NHS and private healthcare settings.

System leaders, including the GMC, should take a leading role in developing and overseeing a national scope of practice and supervision of PAs. Multi-disciplinary working must be supported by full regulation and competency assessment. A national framework for the employment and deployment of PAs is needed. National policy and guidance must be clearly understood and delivered locally, supported by good governance structures.

Working with our fellows and members, the RCP will continue to actively campaign to limit the pace and scale of roll-out of PAs in the NHS until we are reassured that there are safe systems in place for PA deployment. We have repeatedly made clear that PAs are not doctors, and they cannot and must not replace doctors. We have also called on the UK government and the NHS to develop and publish an evidence-base and evaluation framework around the introduction of PAs. This should be a priority, and we are working with the RCP Patient Safety Committee to consider what more we can do to support this agenda.

Yours sincerely,

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Clinical Vice President, Royal College of Physicians