The Royal College of Radiologists

Scope of Practice for Physician Assistants working in Interventional Radiology

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1. Introduction and purpose

At the time of writing, fewer than ten Physician Assistants (PAs; formerly known as Physician Associates)[1] are in post in interventional radiology (IR) services in the UK. However, in line with requirements arising from the Leng Review, this document has been produced to define the scope within which such roles must operate. Where PAs are already in employment, it defines the boundaries, safeguards and exclusions required to ensure patient safety and prioritise training of IR resident doctors.

This scope of practice document is intended as a framework to support services that have already chosen to employ PAs within IR departments. The guidance it contains is designed to ensure that any deployment of PAs is justified, deliberate, safe and integrated appropriately within the multidisciplinary team. Employing organisations may wish to seek legal advice on any decisions they make with regard to their existing PA workforce.

Background to this work

This document has been informed by the views and experiences of those on the advisory group that was established to define the scope of practice for PAs working in IR. The group's membership included representation from the RCR's Interventional Radiology Committee, the British Society of Interventional Radiology, the Society of Radiographers, the Royal College of Nursing, and a Physician Associate currently working in IR, as well as interventional radiologists appointed to the group in an individual capacity. The group took account of the results of a survey of members of the British Society of Interventional Radiology in 2023, as well as a survey of PAs currently working in IR undertaken in early 2026. Input was also sought from the RCR's Clinical Radiology Faculty Board, Professional Practice Board and Interventional Radiology Committee.

[1] We are using the term 'Physician Assistant' for the purposes of the work of this group in line with the recommendations made by the Leng Review, for which the RCR has expressed its support. The scope of practice for Physician Assistants will apply equally to those in Physician Associate roles.

[Placeholder text: we will comment here in due course on the nature of the public consultation process and the volume of comments received from individuals and organisations through that process]

2. Definitions

Interventional Radiology

An interventional radiology procedure is any minimally invasive, image-guided intervention performed with diagnostic and/or therapeutic intent. Such procedures are performed by an appropriately trained interventional radiologist, or under their guidance. The interventional radiologist holds responsibility for procedural safety and for the patient's clinical care before, during and after the intervention.

Physician Assistant

PAs are a dependent profession, meaning that they must work under the direction and supervision of a named consultant, specialty, associate specialist or specialist (SAS) doctor (see Section 6: Supervision of PAs working in interventional radiology). They are not doctors. They work as part of the multidisciplinary clinical team and contribute to safe and effective care for patients by undertaking a range of clinical and administrative tasks. Clear differentiation of roles within the multidisciplinary team is vital to support effective teamwork and ensure patients understand who is involved in their care. PAs remain professionally accountable for their own actions while working under supervision.

Further information on the initial education and training that PAs undertake, and the registration requirements that apply to them, is provided in Appendix 1.

3. Undifferentiated patients

PAs should not see undifferentiated patients. An undifferentiated patient is defined as *a patient with new signs or symptoms who has not yet had an initial clinical assessment*[2].

All patients coming to the IR department are considered to be differentiated because they have either been:

a) pre-assessed, i.e. have been given a diagnosis or differential diagnosis and are on a clear treatment pathway; or
b) fully assessed and ready to be put on an operating list [interventional procedural list] and given a 'to come in' date.[3]

[2] Department of Health and Social Care (2026). *A clinical protocol for physician assistants, their supervisors, team members and employers: Teamworking and undifferentiated patients. Draft document for targeted stakeholder consultation.* This RCR consultation draft has been prepared in advance of publication of the final national clinical protocol, which, at the time of writing is subject to targeted stakeholder consultation. The College will review and consider the final published version once it is available. The final content of this document will therefore remain subject to any changes considered necessary following publication of the national clinical protocol, a process over which the College has no direct control.

[3] Getting It Right First Time (GIRFT), Preoperative Assessment Services Guidance.

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Patients may display new signs or symptoms whilst under the care of the IR team, requiring further assessment and treatment. An initial clinical assessment, investigation or differential diagnosis does not in itself mean that a patient is differentiated where significant diagnostic uncertainty remains. The service is responsible for ensuring that all assessments undertaken by PAs are carried out under clear supervision arrangements, with appropriate supervisory capacity, clinical protocols and governance arrangements in place to support both assessment and escalation where necessary, protecting both patients and PAs.

Following initial assessment, if the presentation is not clearly consistent with the patient's established diagnosis or treatment, falls outside the relevant clinical protocol, gives rise to diagnostic uncertainty, or if the patient is acutely deteriorating, the PA must escalate the patient for assessment by an appropriately competent member of the multidisciplinary team, via their day-to-day supervisor (see Section 6: Supervision of PAs working in interventional radiology).

4. Scope of practice for PAs working in interventional radiology

Where PAs are already employed in IR services, their role must be limited to a range of protocol-led, non-decision-making tasks, performed under supervision. The list below provides examples of the range of protocol-led activities (those that are supported by a Standard Operating Procedure) that PAs working in the IR suite or in ward settings may undertake under direction and supervision and should not be interpreted as defining a substantive or expanding clinical role. They are intended to be illustrative rather than exhaustive and all treatment decisions should be discussed with the day-to-day supervisor (see Section 6: Supervision of PAs working in interventional radiology), ensuring patient safety and adherence to established pathways whilst making the most appropriate use of skills mix to provide good patient care. Once the need has been identified by the Clinical Lead (or equivalent), specific arrangements must be supported by the employer's governance processes and authorisation of individuals, along with allocation of adequate time within the job plans of consultant and SAS interventional radiologists who are to provide supervision.

General

- Work under the supervision of a day-to-day supervisor (see Section 6: Supervision of PAs working in interventional radiology).
- Work collaboratively with the IR team (including consultants and SAS doctors, resident doctors, nurses, radiographers) and the wider multidisciplinary team.
- Support the IR team with routine clinical tasks.
- Act as liaison between clinical teams/wards and the IR team.
- Relay relevant patient information to their day-to-day supervisor (see section 6: Supervision of PAs working in interventional radiology) to inform or reassess care plans.
- Provide information to patients and relatives regarding agreed management plans, addressing basic queries, and escalating concerns where necessary.
- Support general clinical administration, including coordination of IR pre- and post-procedural clinics in accordance with agreed management plans and under direction of the day-to-day supervisor, and preparation of patients for multidisciplinary team (MDT) review, either in the MDT meeting setting or in the ward setting, in discussion with their day-to-day supervisor.
- PAs must not undertake activities requiring independent clinical judgement, responsibility for IR procedures or decision-making within IR pathways.

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Triage and referral management

- Co-ordinate and review incoming referrals, flagging to day-to-day supervisor for vetting.
- Discuss cases with day-to-day supervisor and update patient/procedural lists to reflect priorities as directed by the supervisor.
- Ensure required investigations (e.g. blood tests, imaging), are available and have been reviewed by clinicians, contacting relevant clinical teams to arrange tests/review results, if not.
- Verify that specific pre-procedural requirements are met (e.g. fasting status, allergy status, coagulation status).
- Communicate with referring teams regarding IR procedure timing, reasons for delays and changes of plan.

Pre-procedural patient care and optimisation

- Conduct basic clinical assessments (observations, history and examination) for patients attending prior to their IR procedure.
- Assist with consent[4]/assent processes including first-stage discussions of risks and benefits and preparing consent documentation (with final confirmation by the operator).
- Assist with preparation of patients for IR procedures, including patient positioning, baseline monitoring, and intravenous access.
- Facilitate completion of required pre-procedure documentation (request forms, consent) and checklists.
- Assist with equipment preparation (e.g. gathering equipment from stock cupboards, preparing trolleys).
- Escalate any concerns regarding patient fitness for procedure to the day-to-day supervisor.
- Contribute to the efficient running of the Day Case Unit.

Intra-procedural responsibilities

- Assist the lead IR clinician during procedures when required, either scrubbed or circulating, if this does not reduce training opportunities for resident doctors or other relevant members of the multidisciplinary team.

Post-procedural patient care and follow-up

- Support routine post-procedural recovery activities.
- Facilitate safe handover to clinical teams/wards.
- Contribute to post-procedural ward rounds (e.g. reviewing clinical status and access sites).
- Identify early complications (e.g. haematoma, haemodynamic instability, pain) and escalate appropriately.
- Assist with ongoing aftercare under direction from day-to-day supervisor.
- Co-ordinate discharge planning, including preparing discharge summaries and facilitating the arrangement of follow-up investigations and appointments.

IR service development

- Participate in local audit, service development and quality improvement initiatives.
- Participate in research studies as appropriate and under supervision where required.

[4] General Medical Council, Decision making and consent.

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- Contribute procedural data to clinical registries in accordance with governance and data quality requirements.

5. Exclusions

PAs work under the supervision of a doctor within multidisciplinary teams.

The following activities are outside their scope of practice and PAs **must not**:

- Make independent clinical decisions regarding patient management within IR pathways.
- Directly manage any complications arising from interventional procedures.

Medicines management

PAs gain an understanding of medicines management as a core element of their initial education and training. Their understanding of medicines management within IR, supported through appropriate additional education and ongoing supervision, should be sufficient to enable them to discuss a patient's treatment plan with colleagues.

In line with current UK law (the Human Medicines Regulations 2012), PAs are not allowed to prescribe medicines and cannot supply or administer Prescription-Only Medicines (POMs) using a Patient Group Direction (PGD)[5]. This includes medications relevant for IR procedures such as local anaesthetics, sedation (midazolam/fentanyl), and contrast media. Legislative change is required before a profession can gain prescribing rights and undertake non-medical prescriber training.

Imaging referrals

PAs should not currently refer patients for imaging investigations within IR pathways. Any involvement in imaging requests should be administrative only and be undertaken within clearly defined protocols and with appropriate supervisory oversight (including supervision and review of both requests and results).

Given the cross-specialty implications of imaging referral practice by PAs, the RCR considers that this is not an area that should be determined through scope of practice guidance produced by individual specialties. A consistent, national and multiprofessional approach is required to ensure clarity, equity, patient safety and alignment across clinical settings.

6. Supervision of PAs working in interventional radiology

PAs will always remain under the supervision of a doctor who retains overall responsibility for the safety and management of the patient. They should expect supervision that is supportive, proportionate and developmental, working as dependent practitioners within a restricted and clearly defined scope of practice. Supervision of PAs must not compromise the quality of supervision or training of resident doctors (or autonomous practitioners working within the multidisciplinary team).

[5] Specialist Pharmacy Service, Supply and administration of medicines by staff group.

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Further information on the different types of supervision that should be in place to support PAs' professional practice is provided below[6]. Supervision is intended to promote safe, effective patient care while supporting professional practice, confidence and team integration. It is not solely a mechanism of oversight, but a process that enables PAs to practise within their scope, ask questions, reflect, and learn in an open and psychologically safe environment. Supervision should be responsive to the PA's level of experience, competence and clinical context, with additional support (including some direct supervision) available when undertaking new or more complex tasks.

Supervisory capacity

IR teams will support a variety of learners at any given time, and given the potential additional demand on limited supervisory resources that will necessarily arise through the supervision of additional dependent practitioners, will need to take appropriate steps to ensure that:

- They have sufficient capacity to support supervision of PAs in the team.
- The allocation of work to PAs, in line with the scope of practice outlined in this document:
  - Does not negatively impact on the provision of training opportunities for, or supervision of, resident doctors.
  - Does not negatively impact on the recruitment of nurses or radiographers, or on the provision of professional development opportunities for those autonomous practitioners seeking to progress to enhanced or advanced practice roles[7] within the multidisciplinary team.
- Where capacity to support learning across the service is temporarily compromised, specialty training for resident doctors should take priority, to develop the IR workforce and the clinical supervisors of the future.
- Named supervisors and day-to-day supervisors are trained and are allocated appropriate job-planned time to enable them to effectively carry out their supervisory roles and responsibilities, which should be agreed in accordance with their employer's governance processes and be subject to appropriate indemnity cover.

Nature of supervision

Two different forms of supervision should be in place for PAs to ensure that they are appropriately supported in their roles to provide safe and effective care to patients as part of the multidisciplinary team.

Named supervisor
The named supervisor (sometimes referred to as the 'educational supervisor') has overall responsibility for the PA's educational and professional development. This includes establishing the PA's individual work schedule in line with their scope of practice; meeting the PA at least every six months (more frequently for newly-qualified PAs or those moving into a new medical specialty) to review their portfolio and identify additional training, support and development that is required; and providing pastoral care. This role may be undertaken in full by a consultant or SAS interventional radiologist or may be shared with an appropriately qualified medical colleague (e.g. who has responsibility for all PAs across an organisation).

[6] The GMC has published good practice advice for doctors who supervise or work with PAs: Supervision of physician associates and anaesthesia associates.

[7] Multi-professional framework for advanced practice 2025 - Advanced Practice.

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Day-to-day supervisor(s)
The day-to-day supervisor (sometimes referred to as the 'clinical supervisor') is responsible for overseeing the clinical work of PAs working in IR, in line with their skills, knowledge and training. The day-to-day supervisor must be a consultant or SAS interventional radiologist, who retains overall responsibility for the safety and management of the patients under their care.

In IR, day-to-day supervision is normally undertaken by the doctor responsible for the list that the PA is working on, and a PA may work with multiple such supervisors across their working week.

The day-to-day supervisor may ask the PA to take responsibility for providing part of the care or treatment to a patient on their behalf, under instruction and in line with the scope of practice outlined in this document. In doing so the day-to-day supervisor must ensure that the PA is clear on how to escalate any concerns, with the specific patient(s) they are working with and/or with the tasks they have been asked to undertake. The day-to-day supervisor should always be contactable by the PA but may not necessarily directly oversee all aspects of PAs' work with individual patients unless agreed in line with the complexity of the task being undertaken. Named alternative points of contact should be proactively identified if the day-to-day supervisor is unreachable.

Effective supervision

Effective supervision is characterised by:

- Approachability and accessibility, particularly where timely advice or escalation is required.
- Mutual respect, recognising the PA's contribution to patient care within their agreed scope of practice.
- Encouragement to ask questions, raise concerns and acknowledge uncertainty.
- Constructive, timely feedback and shared learning, supporting the development of clinical judgement over time.

Additional considerations

Experienced resident doctors undertaking specialty training in IR and other appropriately competent and experienced members of the multidisciplinary team may provide informal education and case-based discussion as part of usual multidisciplinary team working. Overall responsibility for patient care remains with the day-to-day supervisor as outlined above.

In line with the requirements of Good Medical Practice[8], PAs should actively engage in regular audit and reflective review of their practice to support learning, quality improvement and safe patient care. Audit activity and outcomes should be discussed routinely with supervisors, providing opportunities for feedback, shared learning and development. Each PA's practice will also be reviewed as part of the annual appraisal process, enabling evidence of competence, professional development and practice within the agreed scope to be recognised and supported.

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[8] General Medical Council, Good Medical Practice.

7. Potential contributions of PAs to training

Appropriately experienced PAs may contribute in a limited and supervised capacity to the education and training of resident doctors in IR and other healthcare professionals under the following conditions:

- PAs must be demonstrably competent in and should have substantial experience and recognised expertise in the relevant clinical area in which they are to deliver training.
- Appropriate oversight of all training led or supported by PAs must be in place via the named supervisor, day-to-day supervisor and/or departmental education leads.
- The quality and safety of the training delivered will be subject to established local feedback, quality assurance and governance processes.
- The involvement of PAs in training other healthcare professionals must not compromise the opportunities available to resident doctors and other members of the multidisciplinary team to deliver training. PAs working in IR should support, not substitute, the core training delivered by consultants, other senior clinicians, and resident doctors in specialty training.
- Training contributions should be collaborative, with PAs sharing practical insights, supporting simulation or induction sessions, and facilitating multidisciplinary learning. All contributions should be respectful of professional boundaries and roles.
- PAs must not replace doctors or advanced practitioners in delivering training.

8. Extended PA role

This document does not define or endorse pathways for role expansion or development of IR procedural skills.

IR procedures should only be undertaken by appropriately trained medical practitioners or recognised advanced practitioners working within established professional frameworks in multidisciplinary teams.

Where extended PA roles already exist locally, these should be subject to review to ensure patient safety requirements.

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Date of next review: We expect to review this document three years following publication, or sooner dependent on relevant national developments.

Appendix 1: Education, training and registration requirements for PAs

Initial (pre-registration) education and training requirements for PAs[9,10]

PAs are trained to postgraduate level (Level 7 under the Framework for Higher Education Qualifications), normally delivered as a two-year full-time Diploma or Master's degree, a degree apprenticeship, or a four-year integrated undergraduate and Master's qualification. Entry to PA training typically requires a bioscience-related first degree, although registered healthcare professionals including nurses, midwives and allied healthcare professionals (AHPs) may also apply. Training includes at least 1,400 hours of supervised clinical practice across acute, community and general practice environments.

Preregistration training is designed to equip PAs with the core professional capabilities required to work safely and effectively as part of a multidisciplinary medical team. To complete their training, PAs must demonstrate:

- Foundational medical knowledge, clinical reasoning and the ability to apply these in a variety of care settings: PAs gain an understanding of the initial management of common medical conditions across all body systems and clinical presentations and must demonstrate the practical application of that knowledge during OSCE-based assessment.
- Professional and ethical behaviours, including safeguarding, patient-centred communication, and respect for colleagues and patients: The training curriculum addresses areas including legal responsibilities, consent, mental capacity and personal accountability for safe practice.
- Ability to work collaboratively under medical supervision within multiprofessional teams, including contributing to team-based decision-making, and recognising the limits of professional competence: PAs are trained to recognise – but not manage – complexity, risk and uncertainty.

Registration requirements for PAs[11]

The General Medical Council (GMC) is the registration body for PAs. To be eligible for registration, PAs must:

- Graduate from a GMC-approved PA training programme in the UK; and
- Pass both components of the Physician Associate Registration Assessment (PARA) (formerly the Physician Associate National Examination), i.e. 200-question knowledge-based assessment and 14-station objective structured clinical examination (OSCE).

The PARA is delivered by the Royal College of Physicians (RCP) on behalf of the GMC[12].

[9] The GMC sets out the pre-registration education and training requirements for PAs.

[10] The Royal College of Physicians publishes the PA curriculum.

[11] The GMC sets out the registration requirements for PAs, and provides guidance for employers.

[12] For a more detailed description of the PA training and competencies assessed for GMC registration, please refer to the PARA content map.

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Once registered, PAs must: adhere to Good Medical Practice[13]; maintain an annual appraisal; demonstrate ongoing development and reflective practice; and meet local clinical governance arrangements. This mirrors the revalidation framework in place for doctors.

The GMC opened its PA register in December 2024. From December 2024 to December 2026, a two-year transition period has been in place. During this time, registration with the GMC is strongly encouraged but not yet legally required, allowing existing PAs to continue practising while completing the necessary steps for registration. All practising PAs must be fully registered by December 2026, after which GMC registration becomes a legal requirement.

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[13] General Medical Council, Good Medical Practice.