The Royal College of Radiologists

Scope of Practice for Physician Assistants working in Clinical Oncology

DRAFT FOR CONSULTATION

1. Introduction and purpose

This document sets out a safe and appropriate scope of practice for Physician Assistants (PAs; formerly known as Physician Associates)[1] working in clinical oncology, and the safeguards that should be in place to ensure that PAs are able to contribute to teams delivering safe and effective cancer care. It has been produced primarily to support members and Fellows of the Royal College of Radiologists (RCR) to understand the role of PAs within clinical oncology services. It is intended to provide clarity for PAs, supervisors, and the wider multidisciplinary team, and to set out the conditions under which PA roles in clinical oncology services can be supported. The document has been structured to ensure patient safety; clear, planned supervision; and robust governance.

Services must make informed decisions regarding the establishment of and recruitment into PA roles based on the existing resources and skill mix they have available, the specific gaps they need to address, and their capacity to provide the required levels of training and supervision.

This scope of practice document is intended as a framework to support services that, having justified a clear service need beyond their existing skill mix, choose to employ PAs. The guidance it contains is designed to ensure that any deployment of PAs is 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.

[1] We are using the term 'Physician Assistant' for the purposes of the work of this group, in line with the recommendations made in 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.

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 clinical oncology. The group's membership included representation from the UK Acute Oncology Society, the UK Society for Medical Oncology, the Society of Radiographers, the Royal College of Nursing, and a Physician Associate currently working in clinical oncology, as well as clinical and medical oncologists appointed to the group in an individual capacity. The group also took account of feedback from the RCR's Clinical Oncology Faculty Board and Professional Practice Board.

[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. What is a 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 clinical oncology). 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.

PAs working in clinical oncology

It is not appropriate for newly-qualified PAs to work in oncology immediately post-qualification, given their limited exposure to oncology during their initial training. PAs should gain significant prior experience – normally a minimum of two years – working in general/acute medicine before progressing to roles in clinical oncology. Such prior experience will facilitate development and consolidation of the skills needed to work with patients presenting with a wide range of general medical symptoms and conditions. In exceptional circumstances, applicants to PA roles who demonstrate sufficient competencies or a particularly relevant professional background may be accepted, even where their experience has been gained over a shorter time frame.

Following entry to the specialty, PAs working in CO must receive additional education and training appropriate to their anticipated scope of practice. This should be delivered through recognised and validated oncology-specific postgraduate educational provision, with locally structured training, supervision, and competency assessment that ensures safe practice within a locally-defined scope. Training provided locally should also support PAs to understand the service of which they are a part and the specific roles they may undertake.

DRAFT FOR CONSULTATION

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 oncology department are considered to be differentiated because they have a cancer diagnosis and are on a cancer treatment pathway. Where a patient with an established cancer diagnosis who is on a cancer treatment pathway develops a new presentation, PA involvement should be limited to clearly defined presentations arising from that cancer or its treatment, where assessment and management can take place within an agreed clinical protocol and appropriate medical supervision is readily available. This includes patients who are presenting with:

a. signs and symptoms of expected toxicities of the treatment that they are receiving, e.g. neutropenic fever;
b. worsening symptoms consistent with progressive disease; and/or
c. symptoms relating to their cancer, e.g. pain.

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 such assessments undertaken by PAs must be 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 clinical oncology).

4. Scope of practice for PAs working in clinical oncology

The sections below provide illustrative examples of the range of protocol-led activities (those that are supported by a Standard Operating Procedure) that PAs working in ward and clinic settings may undertake under direction and supervision. They are intended to be illustrative rather than exhaustive and all treatment decisions should be discussed with a day-to-day supervisor, ensuring patient safety and adherence to established pathways whilst making the most appropriate use of skills mix to provide good patient care. Specific arrangements must be supported by the employer's governance processes and authorisation of individuals.

[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.

DRAFT FOR CONSULTATION

PAs working in ward settings

In a ward setting, PAs can assist with a range of protocol-led clinical and administrative tasks. Ward settings include ambulatory oncology units and emergency treatment settings such as Same Day Emergency Care (SDEC) services.

Illustrative tasks that PAs working in ward settings may perform include:

- Clerking patients on admissions units, including taking a clinical history of the patient's presenting problem(s), confirming the patient's current medication list, undertaking structured clinical assessment and examination, and formulating a preliminary plan for investigation and management.
- Undertaking routine post-treatment toxicity assessments.
- Reviewing results from any available investigations and requesting non-radiological investigations where required (e.g. bloods, urine, ECGs).
- Making protocol-based recommendations on the basis of the assessment and investigations, to enable the supervisor to formulate or reassess the plan for the patient's care.
- Answering patient queries, appropriate to the PA's individual competencies, and escalating to an appropriately competent colleague where required.
- Providing routine updates to patients and relatives regarding ongoing treatment plans that have been defined by the day-to-day supervisor.
- Supporting resident doctors with routine tasks and core procedures, as defined in the PA training curriculum (see table 1).
- Preparing patients for multidisciplinary team review and discussion, either in the multidisciplinary team (MDT) meeting setting or in the ward setting, in discussion with their day-to-day supervisor.
- Working in collaboration with resident doctors and the wider clinical team to ensure that patient lists are well maintained and hospital discharges are expedited effectively.
- Participating in relevant research, audit and quality improvement initiatives.

Table 1: Core procedures defined in the PA curriculum:

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

PAs working in clinic settings

In an outpatient clinic setting, PAs can assist with a more limited range of protocol-led clinical and administrative tasks. They should never undertake outpatient clinics independently and may only see patients where the day-to-day supervisor is immediately available in the same clinical environment to provide advice and review (i.e. able to provide direct supervision). Illustrative tasks they may undertake include:

- Seeing stable, follow-up patients in outpatient clinics under direct supervision.
- Assessing the patient's performance status and whether they are fit enough for treatment.

DRAFT FOR CONSULTATION

- Assessing and documenting treatment-related toxicities or side effects for patients undergoing radiotherapy or systemic anti-cancer therapies.
- Ensuring all required blood tests are done before starting treatment.
- Assessing whether further investigation is necessary and requesting non-radiological investigations where required (e.g. bloods, urine, ECGs).
- Answering patient queries, appropriate to the PA's individual competencies, and escalating to an appropriately competent colleague where appropriate.
- Ensuring the treatment plan, as agreed by the day-to-day supervisor, is updated and includes a record of shared decision-making with the patient, documentation of risks, benefits and alternatives discussed, and consent confirmation if treatment intent or modality changes (note: PAs are not permitted to seek consent from patients except under direct supervision).
- Providing patients with advice on managing the side effects of their treatment at home, and recording the advice given.
- Actioning referral requests agreed by the day-to-day supervisor (e.g. to palliative care, dietetics, physiotherapy, psychology).
- Documenting treatment summaries and follow up plans.
- Preparing end-of-treatment clinic letters, confirming the planned surveillance schedule and late effects monitoring plan.
- Participating in relevant research, audit and quality improvement initiatives.

5. Exclusions

PAs work under the supervision of a doctor within multidisciplinary teams. What an individual can safely do will vary according to their skills and competence, both of which develop over time.

In considering the roles that PAs take within multidisciplinary teams in clinical oncology, it is important to clarify that PAs **do not**:

- Design, plan, deliver, or evaluate radiotherapy.
- Prescribe or administer systemic anti-cancer therapies.

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 clinical oncology, 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)[3]. 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 clinical oncology pathways. Any involvement in imaging requests should be administrative only and be undertaken within clearly

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

DRAFT FOR CONSULTATION

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 clinical oncology

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, recognising their role as valued members of the multidisciplinary team.

Further information on the different types of supervision that should be in place is provided below[4]. 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, more complex or higher-risk tasks.

Supervisory capacity

Oncology 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 introduction of additional dependent practitioners into any team, will need to take appropriate steps to ensure that:

- They have sufficient capacity to support the introduction of PAs into 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[5].
- Where capacity to support learning across the service is temporarily compromised, specialty training for resident doctors should take priority, to develop the clinical oncology 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.

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

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

DRAFT FOR CONSULTATION

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 supervisor who 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 clinical or medical oncologist or may be shared with an appropriately qualified medical colleague (e.g. who has responsibility for all PAs across an organisation).

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

In clinical oncology, day-to-day supervision is normally undertaken by the doctor with responsibility for ward cover or, particularly in the outpatient context, the patient's named consultant. 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 in the event that 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 clinical oncology 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.

DRAFT FOR CONSULTATION

In line with the requirements of Good Medical Practice[6], 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.

7. Potential contributions of PAs to training

Appropriately experienced PAs may positively contribute to the education and training of resident doctors in clinical oncology 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 clinical oncology should support, not substitute, the core training delivered by consultants, other senior clinicians, or 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.

8. Future role extension

This document sets out the scope of practice for PAs working in clinical oncology from the point of initial appointment within an oncology service. Definition of a comprehensive extended scope of practice for PAs working in clinical oncology is beyond the remit of this document, and will be dependent upon a range of factors that are specific to the service in which the PA is working, and to the individual PA.

It is expected that PAs will be supported to develop in their roles through engagement with professional development activities appropriate to their intended scope of practice. Any extended role for PAs should be clearly defined, protocol-led (in line with clearly defined local standard operating procedures), and supported by appropriate governance. Skill development is expected to be facilitated largely through structured workplace-based learning, with ongoing supervision, and support and guidance from the wider multidisciplinary team. Educational input may include a combination of locally delivered training, accredited short courses or education modules, or professionally endorsed programmes where available. PAs may also progress to non-clinical leadership roles.

There is no national post-registration education or career development framework for PAs (though this may change). Whilst PAs may learn to undertake additional, more complex tasks under supervision, their level of practice does not change. This is different from radiographers and nurses,

[6] General Medical Council, Good Medical Practice.

DRAFT FOR CONSULTATION

who already have established national frameworks for enhanced and advanced practice[7, 8], enabling them to work autonomously, make high-level decisions in complex and uncertain situations, and be accountable for managing complete episodes of care as part of the multidisciplinary team. Until a national framework exists for PAs, any extension of their roles must be managed locally, through clear accountability and strong governance.

Extension of PA roles in clinical oncology may be considered by the service to support delivery of timely and effective patient care, where:

- there is evidence of need (including a lack of residents, nurses or other healthcare professionals);
- a robust, funded business case has been considered at an appropriately senior (e.g. board) level to enable an organisational rather than local decision to be taken and to ensure that appropriate risk management, governance and indemnity is in place;
- appropriate training and competency assessment relevant to the extended role can be clearly defined and provided, normally by a consultant clinical oncologist, with capacity available to do so; and
- direct supervision is in place to support the PA in safely undertaking any new, complex or high-risk tasks.

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

DRAFT FOR CONSULTATION

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

[8] Society of Radiographers, Education and Career Framework for the Radiography Workforce (4th edition)

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.

DRAFT FOR CONSULTATION

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.

DRAFT FOR CONSULTATION

[13] General Medical Council, Good Medical Practice.