Royal College of General Practitioners position paper on physician associates working in general practice

October 2017

Executive Summary

This paper sets out the RCGP position on the role of physician associates in general practice. It frames the current situation and explores the key challenges that need to be resolved in order to support physician associates to work most effectively and safely in general practice.

The RCGP is committed to working with governments across the UK, the Faculty of Physician Associates and our membership, to ensure that physician associates in general practice are safely and effectively integrated into the multidisciplinary team. Physician associates are new members of the clinical team, complementary to GPs rather than a substitute, who assist GPs and their teams to provide, high-quality, integrated patient care.

Physician associates can fulfil an enabling role for general practice, taking on certain areas of workload, helping to free GPs to be able focus on the more complex patient cases, and other staff such as nurses to focus on their areas of competency. They can also free up GPs to carry out other important activities, such as training, Continuing Professional Development (CPD) and research.

One of the key aims of integrating physician associates is to ensure GPs can continue to lead multi-disciplinary teams to adapt to the evolving healthcare needs of patients, in response to a growing and ageing population. This does not mitigate the need to urgently address the shortage of GPs, who supervise their work, nor does it reduce the need for other practice staff. Instead, physician associates can help to broaden the capacity of the GP role and skill mix within the practice team to enhance patient care.

The next steps for integrating physician associates into general practice should include:

- Commitments in the GP Forward View relating to physician associates need to be met. These sit alongside commitments to increase the number of GPs
- Professional regulation needs to be established as a matter of urgency
- Once regulated, consideration needs to be given to enabling physician associates to acquire appropriate prescribing rights
- The level of exposure to general practice during physician associate courses needs to be evaluated and potentially extended
- Resources for training placements in general practice must be increased accordingly; the training of GPs and other staff must not be affected
- Clearer guidance and support needs to be produced on effective supervision of physician associates, e.g. in out of hours settings
- Funding should be provided to practices to support physician associate’s transition into employment, e.g. for preceptorships
• Further research is needed on the cost, impact and geographical distribution of physician associates
• Measures should be taken to raise public awareness and understanding of the physician associate role in general practice

Background – the current ‘state of play’ for physician associates in general practice

1. Physician associates are healthcare professionals with a generalist medical education who work under the supervision of doctors providing medical care to patients. They are dependent practitioners who work with a doctor as a named supervisor, but are able to work with some autonomy with appropriate support.

2. The Department of Health defines a physician associate as:

   A new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision (Department of Health, 2012).

3. Physician associates are still relatively new to the NHS. New UK physician associate courses have only produced graduates since 2007 (Drennan, et al., 2015). The Faculty of Physician Associates believes there are up to 450 physician associates in the UK working throughout the NHS. In a recent survey conducted on behalf of the UK and Ireland University Board for Physician Associate Education (UKIUBPAE) and Health Education England (HEE), which had a 100% response rate from universities that conduct physician associate courses, there were 1,210 physician associate students in the UK (Parle. J, 2016). As of 4th August 2017 there were 366 registered as physician associates on the Managed Voluntary Register with the Faculty of Physician Associates (Faculty of Physician Associates, 2017b).

4. The first physician associates were trained in the USA where they are known as physician assistants. Here, physician associates are a well-established and regulated profession. Around 100,000 work across the USA, of whom around 30% work in primary care (Anadalo, 2016). There are approximately 40 physician associates working in the UK who trained in the USA (Parle. J, 2016).

5. Governments across the UK are at different stages of developing and implementing the role of the physician associate in general practice:
   • In England, the General Practice Forward View (GPFV) commits to investment by HEE in the training of 1,000 physician associates to support general practice by 2020
   • In Scotland, the Government has not taken a stance on physician associates in general practice although it has been very supportive of enhancing the multidisciplinary team
   • In Wales, the Government has established a Physician Associate Workforce Development Group. In 2016, government began funding the first year of the physician associate course in Swansea and Wrexham
   • In Northern Ireland, the Department of Health has been supportive of the physician associate concept
6. While anecdotal feedback from GPs working with physician associates has generally been positive, discussions have highlighted some concerns among doctors about the role of physician associates, including:
   - Lack of professional regulation
   - Lack of clarity among doctors, patients and the public about physician associates and their roles
   - Concerns about the impact of PAs on doctors’ training
   - Lack of clarity about supervision
   - Suitability of physician associates to different care settings
   - Physician associates as a quick and cheap substitute for fully qualified doctors (British Medical Association, 2017)

7. Understanding patient views of physician associates is critical for this discussion. The views of the RCGP’s Patient Groups across the UK were sought via a survey and have been incorporated into this paper. Members of the RCGP’s Patient and Carers Partnership Group were also consulted in the development of the paper.

Geographical distribution

8. In the UK, physician associates are currently predominantly based in England. The table below gives a breakdown of the results of the census by the Faculty of Physician Associates (Ritsema T. S., 2016). It should be noted that the census response rate was 58.2% and there are likely to have been developments since the census last year; for example, anecdotal evidence indicates that a few physician associates are starting to gain employment in Wales.

<table>
<thead>
<tr>
<th>Percentage of physician associates employed in each nation of the UK</th>
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<tbody>
<tr>
<td>England</td>
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<tr>
<td>Scotland</td>
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<td>Wales</td>
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<td>Northern Ireland</td>
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Physician associates in general practice

9. Data published on 22nd August 2017 by NHS Digital indicates that there were 48 FTE (58 headcount) Physician Associates working specifically in general practice as of March 2017 (NHS Digital, 2017).

The role of a physician associate in general practice

10. Physician associates are in patient-facing roles and in general practice they see patients in their own appointments. As physician associates are dependent practitioners, they are supervised by a GP, and they cannot currently prescribe. The scope of practice for any particular physician associate will therefore develop over time at the discretion of their named supervising GP, who has overall responsibility for the physician associate. As with other roles, the named supervising GP does not have to be present at all times that the physician associate is working; their day to day work can be overseen by any GP that is present at the time. This can be structured in different ways, but anecdotal examples include lunchtime meetings with
a GP and sometimes the wider team, ad hoc advice where appropriate for urgent complex referrals, and meetings at structured points in the day for GPs to sign prescription requests.

11. The Faculty of Physician Associates states that:

In a GP surgery, physician associates see patients of all ages for acute and chronic medical care. Physician associates can refer patients to consultants, the Emergency Assessment Unit (EAU) or to A&E when clinically appropriate. Other duties include home visits, prescription reauthorisation, review of incoming post and laboratory results. Physician associates are an additional health care team member to help the practice reach Quality Outcome Framework targets (Faculty of Physician Associates).

12. Perhaps unsurprisingly given the relatively small numbers working in UK general practice, there is currently limited research on the safety and effectiveness of physician associates in general practice. One study by Drennan, et al. (2015) compared aspects of physician associate consultations with those of GPs. The study found that the processes and outcomes of physician associate and GP consultations for same-day minor illness patients were similar, while the cost of a physician associate consultation was lower. Anecdotal evidence from GPs working with physician associates suggests that physician associates can contribute to reducing GP workload and freeing up GP time to care for more complex patients.

13. Physician associates do not have the same degree of expertise in medical generalism as GPs. They can only have supportive and complementary roles to GPs and cannot act as a substitute for GPs, with their unique skill sets in areas such as diagnosing undifferentiated symptoms, managing uncertainty and the treatment of multiple conditions. GPs remain the only professional that can take a holistic medical diagnosis of the whole person, combining physical, psychological and social aspects of care, for all patients, including those with the most complex needs.

14. A study in Scotland looked at an example of a scope of practice for a physician associate working in general practice. It included the following tasks:
   - Elicit a comprehensive history
   - Elicit a problem-oriented history
   - Perform a complete and directed physical examination
   - Formulate a differential diagnosis
   - Formulate a patient-focused management plan of care
   - Order appropriate tests and interpret test results
   - Prepare prescriptions for signature
   - Educate and counsel patients and families
   - Arrange for follow-up care and/or referrals to specialists
   - Perform injections, aspirations, basic phlebotomy, dipstick urinalysis, collection and preparation of cultures, fluorescein exam, minor surgery, diagnostic tests, take vital signs
   - House calls for nursing and homebound patients (Farmer, Currie, West, Hyman, & Arnott, 2009)

**Multidisciplinary team working**

15. Physician associates are trained to work as part of a multidisciplinary team in general practice. Their exact role will depend on the make-up of the wider team, which can
vary widely. In addition to being supervised by and working with GPs, physician associates may work with:

- General practice nurses including Advanced Nurse Practitioners
- Healthcare assistants
- Clinical pharmacists
- Paramedics
- Mental health therapists
- Physiotherapists
- Practice managers
- Reception and clerical staff

16. A study in Scotland found that team members working with physician associates found they brought additional complementary skills and attitudes to teams but should not be regarded as a potential direct substitute for a nurse or a doctor (Farmer, Currie, West, Hyman, & Arnott, 2009).

Training

17. The first Competence and Curriculum Framework for the ‘Physician Assistant’ (later changed to Physician Associate), was developed in 2006 by the Department of Health in partnership with RCGP and the Royal College of Physicians (RCP). The initial framework drew from the American model which had been established for over 40 years (Department of Health, 2006). This helped to form the basis for the Department of Health’s revised curriculum framework for physician associates in 2012.

18. The current curriculum framework specifies that physician associates will complete a Masters level 1 academic programme of no less than 90 weeks leading to a Postgraduate Diploma in Physician Associate Studies. It also recommends that newly qualified physician associates undergo a period of preceptorship, during which they receive additional training in relation to the clinical field in which they are working as well as consolidating their common core learning and providing a clinical service (Department of Health, 2012). Some regions are developing general rotations which are somewhat similar to foundation years, e.g. 16 month periods with three 4 month placements in hospitals and one in general practice. Other regions are focusing specifically on ‘first contact’ services. In these areas Trust A&E departments are working with general practice provider organisations to provide a period of experience in both areas. Preceptorships such as these are seen as potential ways of attracting qualified physician associates to work in a particular region.

19. In England, there were 28 physician associate courses as of August 2017 (across 26 institutions: see Appendix 1 for the full list). In Scotland, there is a physician associate course at the University of Aberdeen. Physician associate courses have recently started in Wales at Bangor and Swansea Universities, and in Northern Ireland at Ulster University. Physician associate students usually have an undergraduate qualification in a life science field, although some physician associates have experience as nurses, healthcare assistants or paramedics (Faculty of Physician Associates).

20. Physician associates have to pass a national exit exam developed and administered by the Faculty of Physician Associates which includes a written assessment (a Single Best Answer, multiple choice paper) and a practical component (an OSCE examination of consulting, examination and procedural skills). Physician associates do not undergo revalidation in the same way that GPs do, but instead have to pass
the written component of this exit exam every six years to remain on the voluntary register. They are also required to have yearly appraisals by their employer. In addition, physician associates are required to complete 50 hours of CPD per year to remain on the voluntary register and it is recommended that they have an annual appraisal with a GP.

21. UKIUBPAE provides a network for Higher Education Institutions which supports and enables them to meet, share best practice and review the training, assessment and standards for physician associate education in the UK.

Funding for physician associate education

22. Across the UK, most students on physician associate courses largely self-fund their tuition costs. However, government funding across England has been inequitable with some programmes and students receiving tuition, bursaries and placement funds and others receiving placement funding only; some programmes receiving no funding. This is being currently being addressed by HEE and further details are anticipated in the near future.

23. HEE’s funding for physician associate programmes in England is separate to its budget for GP training; HEE has reassured RCGP that it will have no impact on the latter, nor other practice staff training funds. However, if physician associates gain more of their training experience in general practice, training capacity will need to be increased to ensure GP training, and training of other established practice roles, is not impacted. This will require additional investment.

Pay and indemnity

24. A newly qualified physician associate has been evaluated under Agenda for Change at Band 7 (around £31,000-£41,000). Higher level physician associates (usually requiring a minimum of five years experience) have been banded at 8a (around £40,000-£48,000). The vast majority of physician associates currently working in the UK are on Band 7, with only a few very experienced ones on Band 8.

25. Physician associates usually obtain their own indemnity from the medical defense organisations. For a salaried physician associate this may be paid for by the practice or by the physician associate.

Challenges – issues to be resolved for physician associates in general practice

26. There are a number of challenging regulatory and wider policy issues that must be addressed in order for physician associates in general practice to work most effectively (Jackson, Schofield and Marshall 2016). The RCGP will work with governments across the UK, the Faculty of Physician Associates and our members to address these issues.

Regulation and revalidation of physician associates

27. Physician associates currently have no statutory regulation as a profession. However, in October 2017 the Department of Health published a consultation on whether physician associates should be regulated. RCGP has in the past called for regulation for this profession, and therefore welcomes the consultation.
28. Currently, there is a voluntary register of physician associates held by the Faculty of Physician Associates. The Faculty and all relevant experts advise very strongly that GPs should require the physician associates they employ to be on the register. This assures them that the individual is either a UK or USA-trained physician associate, has passed the national examination, maintained their CPD, passed the re-certification exam if appropriate (required every six years) and has not, at least to the knowledge of the Faculty, had any significant professional behavior issues raised.

29. The Faculty of Physician Associates estimates that approximately 80% of Physician Associates are currently on the voluntary register.

30. Regulation of physician associates is necessary to maintain high standards of professionalism and quality and to ensure that GPs and patients can have confidence in physician associates. This would also provide a framework within which extending physician associate competencies could be considered and the benefits and risks evaluated, for instance, to encompass prescribing rights.

31. Support for the professional regulation of physician associates has been indicated by numerous Royal Colleges (including RCGP and RCP), Health Education England (HEE), the General Medical Council (GMC), the Health and Care Professions Council (HCPC) and other stakeholders.

32. As part of a new regulatory framework for physician associates a framework for revalidation should be introduced. At present physician associates retake the written component of their exit exam every six years. While this approach ensures they maintain a current level of medical knowledge, adopting a revalidation model once professional regulation has been established would help to ensure they are continuing to work safely and effectively.

**Funding and support for the rollout of physician associates in general practice**

33. The profession is already growing rapidly; for example, over the past four years the number of physician associate courses has grown from 2 to 28. However, even with this growth, the target for England of 1,000 physician associates working in general practice by 2020/21 is unlikely to be achieved without significant intervention that goes beyond supporting the training of physician associates and supports their transition to employment as well.

34. Governments could support the rollout of physician associates in general practice through a programme to provide funding and support to practices looking to employ a physician associate. This would allow for a consistent and supported approach. The government could evaluate support for the integration of the role into general practice over time.

35. There may also be a role for the RCGP, in partnership with the Faculty of Physician Associates, to develop practical guidance for GPs looking to employ a physician associate. The Faculty of Physician Associates have recently published An Employers Guide to Physician Associates (PA) (Faculty of Physician Associates, 2017a). The guide is for both primary and secondary care, including some specific guidance for general practice as well as outlining the current limitations of the role and supervision requirements. This could be built upon to provide additional specific information for general practice, such as exemplar job descriptions. The RCGP has partnered with colleagues to develop similar resources for pharmacists, physiotherapists and paramedics.
What supervision means in general practice

36. One of the obvious challenges for effectively integrating physician associates into the general practice workforce is to fully understand what supervision arrangements might look like in a general practice context where physician associates have their own consultations with patients. The recently published Faculty of Physician Associates employer guidance may be useful for this, but further support could be developed. The relationship is likely to be similar to supervision of other advanced clinical practitioners who are seeing face-to-face patients.

37. A further challenge is ensuring affordable and sufficient indemnity cover if available for supervisors of physician associates and practices employing these staff.

CASE STUDY
An approach to supervision for a physician associate

Ria Agarwal, who has been a physician associate in general practice for four years generally sees a minimum of 27 patients per day. Ria has three, ten minute appointment slots in a row, and at the end of those slots has a ten minute break for administration and including having prescriptions signed by a GP. Supervision is shared between the doctors working in the practice. If she requires an urgent opinion she can ask the on call doctor to review a patient. On average this might happen once every two-three months. There is an opportunity for Ria to discuss any non-urgent concerns or queries about specific patients during a ten minute debrief with an on call doctor which takes place every 2-3 weeks. Ria and the doctors in the practice also aim to have a daily lunch meeting when they can discuss complicated cases as a team. Other healthcare professionals such as Health Visitors are also invited to join where appropriate.

Ria Agarwal, Physician Associate

Ensuring equality of access to GPs

38. Some concerns have been voiced that if physician associates are mainly employed in areas with severe shortages of GPs, they may end up clustered in deprived and/or rural areas. While patients in these areas would benefit from enhanced access to services within the practice, over time this could contribute to a variation in access to GPs across different parts of the UK. It will be important to monitor any geographical inequalities that might develop in any evaluation of the impact of physician associates in general practice. Physician associates should not be considered a replacement for GPs within workforce planning in general practice.

39. However, the role of physician associates may help to improve access for patients to general practice through helping to extend the availability of appointments to see a member of the practice team for ailments within the framework of physician associate competencies.

Considering patient preferences

40. It is important that patient preferences are understood and acknowledged as physician associates are rolled out in general practice. A survey of the members of the RCGP’s Patient Groups across the UK found that, after the role of a physician associate was explained, patients were broadly comfortable with the idea of having a consultation with a physician associate in general practice. In particular, many of the patients would choose to have an appointment with a physician associate quickly, rather than wait for an appointment with a GP. This is consistent with evidence that
for same day appointments in general practice there were no significant differences in re-consultation rates nor diagnostic or prescribing activity between physician associate and GP appointments and the vast majority of patients were happy to see physician associates again for similar problems (Drennan, et al., 2015), (Farmer, Currie, West, Hyman, & Arnott, 2009), (Jackson, Schofield & Marshall, 2017).

41. The responses of the members of the Patient Groups are summarised below:

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<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be comfortable having an appointment with a physician associate in general practice</td>
<td>0%</td>
<td>0%</td>
<td>21.43%</td>
<td>57.14%</td>
<td>21.45%</td>
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<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>I would prefer to have an appointment with a physician associate quickly rather than wait a long time for an appointment with a GP</td>
<td>0%</td>
<td>11.11%</td>
<td>16.67%</td>
<td>55.56%</td>
<td>16.67%</td>
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<tr>
<td></td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>3</td>
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</table>

42. While members of the Patient Groups were broadly comfortable with the idea of an appointment with a physician associate, this was not true for all medical issues. Patients tended to report that they would be comfortable having an appointment with a physician associate for issues including blood pressure checks, sore throat and management of a single long-term condition, but not for the management of complex multiple long-term conditions and or for receiving bad news such as a cancer diagnosis.

Q8 Would you be comfortable to have an appointment with a physician associate in general practice for any of the below (select all that apply)?

Answered: 29  Skipped: 1

- Sore throat
- Ear ache
- Cough
- Chest infection
- Blood pressure check
- Management of long term:
- Management of complex
- Delivering bad news e.g. a cancer diagnosis
- None of the above

9
43. Patient opinion may well further change over time as exposure to physician associates increases. Proactive measures to raise public awareness and understanding of the role will also be necessary in order to fully integrate physician associates into the general practice team on a wider scale.

**CASE STUDY**
An RCGP’s Patient Group member’s view on physician associates

“Whether or not I felt comfortable having an appointment with a PA would depend on my symptoms and the degree of urgency I felt was necessary for a preliminary diagnosis. Overall I think they will make a useful contribution to the NHS and are to be welcomed. More details about their training and qualifications would be reassuring.” – Patient in England.

Training physician associates for general practice settings

44. Physician associate courses vary greatly in terms of the time that physician associate students spend in general practice, although the national curriculum specifies a minimum of 180 hours, i.e. 5 weeks. There is strong evidence that spending time in general practice enhances students’ opinions of general practice and leads to more students choosing to work in general practice (Wass, 2016) (Alberti, 2017). The same is likely to be true for physician associates. In order to ensure that a significant proportion of physician associates choose to work in general practice after graduation, and that they have appropriate experience, more exposure to general practice is likely to be needed.

45. Achieving more and longer placements in general practice will be a challenge. General practices may already be hosting medical students and student nurses (and exposure to general practice will be important for these professions). In order to achieve more placements in general practice, more funding will need to be made available to support practices in hosting physician associate students. There will also need to be significant investment in training general practice trainers.

Discussion and next steps

The relationship between the RCGP and the Faculty of Physician Associates

46. The Faculty of Physician Associates is hosted by the RCP which received funding from HEE to host the new faculty from 2015. There is scope for the RCGP to work more closely with the Faculty of Physician Associates in the future to support physician associates working in general practice, and the Faculty have stated that they are keen to develop a closer relationship with the RCGP.

Engaging with the regulatory and policy process

47. RCGP will respond to the consultation on the regulation of physician associates during the consultation period which ends 22 December 2017. RCGP will continue to engage with governments across the UK, the Faculty of Physician Associates and with the universities providing courses through the UK and UKIUBPAE, as physician associates are rolled out in general practice, as well as with HEE and its Medical Associate Professions Oversight Board.

Supporting our members
48. The issues around the new role of physician associates are indicative of a wider challenge facing general practice, namely, how to effectively integrate a range of roles into the practice team. There is a consensus that one of the solutions for freeing up GP time to focus on the most complex patients in primary care is to make use of allied healthcare professionals and other practice staff to handle simpler cases and much of the administrative burden. GPs will nevertheless require support to recruit, manage, supervise and make best use of these expanded practice teams.

49. The College is well placed to help to provide support and expertise in this area, working with the relevant professional bodies such as the Faculty of Physician Associates. For instance, an online toolkit could be developed to provide practical support to members such as guides to employing different members of a practice team and job descriptions explaining the capabilities and limitations of various roles. It could also help to provide resources for continuing professional development.

50. Supporting our members as leaders of the wider practice team is likely to be an ongoing area of work. This aligns with the Policy and Campaigns priorities for 2017/18 on workload and the interface between primary and secondary care, which encompasses work around the development of new care models.

Conclusion

The RCGP is committed to working with governments across the UK, the Faculty of Physician Associates and our membership, to ensure that physician associates in general practice are safely and effectively integrated into the multidisciplinary team. Physician associates provide a complementary rather than a substitute role to GPs. Their integration into general practice does not mitigate the need to urgently address the shortage of GPs, nor does it reduce the need for other practice staff. Instead, physician associates can help to broaden the capacity of the GP role and skill mix within the practice team to enhance patient care.

RCGP calls for the following steps to be taken forward to ensure the effective and safe integration of physician associates into general practice:

- Commitments in the GP Forward View relating to physician associates need to be met. These sit alongside commitments to increase the number of GPs
- Professional regulation needs to be established as a matter of urgency
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- Further research is needed on the cost, impact and geographical distribution of physician associates
- Measures should be taken to raise public awareness and understanding of the physician associate role in general practice
## Appendix 1: List of physician associate courses by nation

<table>
<thead>
<tr>
<th>Country</th>
<th>Institutions</th>
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<tbody>
<tr>
<td><strong>England</strong></td>
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<tr>
<td></td>
<td>Anglia Ruskin University: Physician Associate MSc</td>
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<td></td>
<td>University of Birmingham: Physician Associate Studies Diploma; Physician Associate Studies MSc</td>
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<td></td>
<td>University of Bradford: Physician Associate Studies PG Diploma; Physicians Associate Studies MSc</td>
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<tr>
<td></td>
<td>Brighton and Sussex Medical School: Physician Associate Studies Postgraduate Clinical Diploma</td>
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<td></td>
<td>Brunel University: Physician Associate MSc</td>
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<td></td>
<td>Buckinghamshire New University: Physician Associate PG Dip</td>
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<td></td>
<td>Canterbury Christ Church University: Physician Associate Studies PG Dip</td>
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<td></td>
<td>University of Central Lancashire: Physician Associate Studies PG Dip</td>
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<td></td>
<td>University of Chester: Physician Associate MSc</td>
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<td></td>
<td>University of East Anglia: Physician Associate Studies MSc</td>
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<td></td>
<td>Hull York Medical School: Physician Associate Studies MSc</td>
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<tr>
<td></td>
<td>University of Leeds: Physician Associate Studies PG Dip</td>
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<td></td>
<td>University of Liverpool: Physician Associate Studies Postgraduate Diploma</td>
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<tr>
<td></td>
<td>University of Manchester: PG Dip Physician Associate Studies</td>
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<td></td>
<td>Newcastle University: Physician Associate Studies PG Dip</td>
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<td></td>
<td>Plymouth University Peninsula School of Medicine: PG Dip Physician Associate Studies</td>
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<tr>
<td></td>
<td>Queen Mary University of London: Physician Associate Studies MSc</td>
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<td></td>
<td>University of Reading: PG Dip Physician Associate</td>
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<td></td>
<td>Sheffield Hallam University: PgDip Physician Associate Studies</td>
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<td></td>
<td>University of Sheffield: Postgraduate Diploma in Physician Associate Studies</td>
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<td></td>
<td>St George's, University of London: Physician Associate Studies MSc</td>
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<td></td>
<td>University of Surrey: Physician Associate PG Dip</td>
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<td></td>
<td>University of the West of England (UWE Bristol): Physician Associate Studies MSc</td>
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<td>University of Wolverhampton: Postgraduate Diploma Physician Associate Studies</td>
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<td></td>
<td>University of Worcester: Physician Associate MSc</td>
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<td>De Montfort University Leicester: Physician Associate Studies MSc</td>
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<td><strong>Northern Ireland</strong></td>
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<tr>
<td>Ulster University</td>
<td>Physician Associate Studies - PgDip/MSc</td>
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<td><strong>Scotland</strong></td>
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<td></td>
<td>University of Aberdeen: Physician Associate Studies MSc</td>
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<td><strong>Wales</strong></td>
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<td></td>
<td>Bangor University: Physician Associate MSc</td>
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<td></td>
<td>Swansea University: PG Dip Physician Associate Studies</td>
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List of institutions sourced from the Faculty of Physician Associates, accessed 8 August 2017: [www.fparcp.co.uk/pa-students/pa-student-programmes](http://www.fparcp.co.uk/pa-students/pa-student-programmes)
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