IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

CASE NO: AC-2024-LON-002308

BETWEEN:

THE KING (on the application of
BRITISH MEDICAL ASSOCIATION)

Claimant

-and-

GENERAL MEDICAL COUNCIL

Defendant

-and-

(1) FACULTY OF PHYSICIAN ASSOCIATES
(2) ASSOCIATION OF ANAESTHESIA ASSOCIATES
(3) ROYAL COLLEGE OF PHYSICIANS
(4) ROYAL COLLEGE OF ANAESTHETISTS
(5) ANAESTHETISTS UNITED
(6) NHS ENGLAND
(7) SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

Interested Parties

SKELETON ARGUMENT ON BEHALF OF THE CLAIMANT
Rolled-up hearing: 12-13 February 2025

References are to the Core Bundle and Supplementary Bundles in the form [CB/page number] and [SB/page number]

A. INTRODUCTION AND SUMMARY

1. This skeleton argument is filed on behalf of the British Medical Association ("**BMA**"), a registered trade union and professional body for doctors and medical students in the UK. The BMA challenges decisions taken by the General Medical Council ("**GMC**") in relation to its role as regulator of Anaesthesia Associates ("**AAs**") and Physician Associates ("**PAs**")[1] in the UK. The GMC became the regulator of the Associate professions on 13 December 2024, when the Anaesthesia Associates and Physician Associates Order 2024 ("t**he AAPA Order**") came into force.

[1] Together referred to here as "**Associates**" or "**the Associate professions**".

2. The BMA challenges:
    a. The GMC's decision to apply its core guidance document for doctors – *Good Medical Practice* – to Associates/its failure to produce distinct and appropriately tailored guidance for Associates.
    b. The GMC's decision to characterise doctors and Associates alike as "medical professionals", both in *Good Medical Practice* and more generally.

3. The BMA submits that the GMC's approach is unlawful because it is inconsistent with the applicable statutory framework, unlawful for want of appropriate regard being given to patient safety and confidence in the professions, as required by the GMC's statutory objectives, and irrational. The GMC's decisions pose significant concerns for public understanding of, and confidence in, the medical profession and the Associate professions, and give rise to real patient safety concerns. These become particularly acute when considered in combination with the lack of any nationally agreed standards or guidance as to the ambit of the work that Associates may undertake (referred to here and in the evidence as "scope of practice").[2]

4. The BMA's claim for judicial review was brought against the version of *Good Medical Practice* which was published on 22 August 2023 and came into effect for doctors on 30 January 2024. The GMC subsequently made further changes to *Good Medical Practice* in December 2024 ("the December update"). As explained in its Reply to the GMC's Detailed Grounds of Resistance ("DGR"), the BMA submits that these recent amendments have no material effect on the grounds it has advanced. The BMA's claim should be treated as a challenge both to the version of *Good Medical Practice* which came into effect on 30 January 2024 and the December update, as the GMC has done in its DGR.

5. The BMA recognises that it may require an extension of time to bring this claim, an issue addressed further below.

[2] By way of background, the BMA observes that the extent and depth of the concerns that have been expressed from multiple sources, regarding the regulation of Associates are apparent from (i) the judicial review claim brought by Anaesthetists United which relates to different aspects of the GMC's approach to regulation, but is founded on similar public safety concerns, and (ii) the review of the Associate professions which has been commissioned by the Secretary of State for Health and Social Care (see Daniel McAlonan's third witness statement, §§30-31 and §§34-35 [CB/265-266]).

B. FACTUAL BACKGROUND

6. Because there have been a range of different consultations and decision-making processes regarding various aspects of regulation of Associates, and because there is not a single document within the hearing bundle in which the factual background (insofar as relevant to this claim) is clearly described, this skeleton argument seeks below to draw together in chronological sequence the principal materials referred to in the pleadings and witness statements.

7. AAs and PAs are not doctors. They are not medically qualified. They are recognised as providing support to doctors and anaesthetists as part of a multi-disciplinary team. The GMC has decided not to regulate Associates' scope of practice and there is no nationally agreed guidance on how they work. As a result, what Associates do is itself contentious [CB/158/§13]. Although PAs and AAs have been working in small numbers within the NHS since 2003 and 2004, their roles are not well known to the public [CB/156-158/§§8-12].

Initial steps towards statutory regulation of Associates

8. In October 2017, the Department for Health and Social Care ("**DHSC**") published a consultation entitled *"The regulation of medical associate professions in the UK"* [SB/320-360]. This consultation, through which the DHSC sought views on the principle of statutory regulation and initial views on the most appropriate healthcare regulator, suggested that patient safety was the key determinant for whether a profession should be subject to statutory regulation. The DHSC identified the GMC and the Health and Care Professions Council **("the HCPC")** as the most suitable potential regulators. In its December 2017 response [SB/361-364], the BMA confirmed its support for the principle of statutory regulation but expressed its concern about the use of the professional title of physician associate.[3]

9. In February 2019, the DHSC published its consultation response: *"The Regulation of Medical Associate Professionals in the UK"* [SB/365-412]. This recorded that it had been persuaded that statutory regulation of PAs and AAs should be introduced (§§1.6-1.7), and that further scoping work was being undertaken to decide which body should regulate the two professions (§1.12). In July 2019 the DHSC announced that it had asked the GMC to regulate PAs and AAs when statutory regulation was introduced [SB/413-414].

[3] It explained: "*Concerns remain within the medical profession that the term can too easily be confused with doctors working as associate specialists*".

10. Following this, an External Advisory Group on Medical Associate Professions ("the EAG") was set up by the GMC to advise it on its regulatory framework for PAs and AAs. The EAG's first meeting took place on 26 November 2019 [SB/613-615]. Members included the DHSC, the devolved governments, the BMA and other key stakeholders.[4]

11. In December 2019, the GMC established an online "community of interest" to provide information to and engage with people interested in its work preparing for the regulation of Associates (Mark Swindells §19). The community was made up of individuals, rather than institutions or representative bodies such as the BMA.

12. At a 6 February 2020 meeting [SB/659-662], the EAG discussed that expanding the number of Associates presented both an opportunity and a risk, with the risks including "*a question about how well patients and carers understand the different roles.*" [SB/661].[5] In March 2020, the GMC held an interactive workshop at its patient forum on the regulations of Associates.[6]

13. In June 2020, the GMC distributed a survey to the community of interest. Mark Swindells, in a statement on behalf of the GMC, has described the analysis of its results as "*key to the GMC's eventual decision that GMP 2024 would apply to PAs and AAs, as well as doctors.*" (§21). The survey did not address the terminology which should be used to describe PAs, AAs and doctors collectively, nor did it use the term "medical professionals".

14. The GMC's internal report on this survey[7] recorded that 64% of respondents disagreed or strongly disagreed with the statement "*The PA/AA role is well understood by patients*" [SB/1799]. 90% agreed with the question "*Do you think it is appropriate that PAs/AAs adhere to the same professional standards as doctors in the four broad areas discussed above*" [SB/1808-1812].[8] However, the comments provided by respondents demonstrate a more nuanced set of views than suggested by this headline figure. The GMC's report explained that the comments left to support "yes" answers could be divided into two main groups: "*Those who believed that all healthcare professionals should follow the same high standards*" and

[4] For an overview of the EAG and its considerations see §§37-38 of Daniel McAlonan's first witness statement [CB/165-166].
[5] The EAG held a further meeting on 4 May 2020 [SB/692-697].
[6] Mark Swindells' statement (§§31-32) [CB/214] summarises the GMC's conclusions from the roundtable but does not exhibit any contemporaneous documents recording the discussions.
[7] The GMC's index accompanying disclosure of this document states that it was prepared in August 2020.
[8] The preamble to question described the "*four broad areas*" and summarised the role of *Good Medical Practice* [SB/1813-1814].

"*Those who agreed with the above sentiment but also recognised the need to be specific about different roles and reflect this somehow using separate documentation…*" [SB/1809-1810].[9]

15. While the survey responses were being analysed by the GMC, the EAG continued to consider the potential for patient confusion between doctors and Associates. The minutes of its 27 July 2020 meeting [SB/757-760] record that the "*group felt we should engage with patients to assess their understanding of the difference between the professions.*" [SB/759]. In a paper prepared for the EAG meeting on 21 October 2020 [SB/786-789],[10] the GMC recommended that the EAG *"note the support for the proposal that PAs and AAs should continue to uphold the same (appropriately tailored) professional standards as doctors across the four broad domains of Good medical practice.*" (emphasis added) [SB/766].

16. On 11 December 2020, the GMC published a report on the community of interest survey, summarising its results [SB/1902-1914]. In December 2020 and January 2021, it held focus groups with doctors, PAs and AAs (Mark Swindells §26, exhibiting the GMC's slide packs [SB/1915-1964] and facilitator packs [SB/1965-2014]).

First use of "medical professionals"

17. In November 2020, the GMC published its corporate strategy for 2021-2025, in which it introduced the term "medical professionals" to cover Associates as well as doctors [SB/2788-2810]. The BMA objected to this in December 2020, when responding to the publication of the strategy. In an email sent on behalf of the BMA's Professional Regulation Committee, Daniel McAlonan noted that "*In advance of publication … we advised that the BMA was strongly opposed to the use of this wording*" [SB/2859-2860]. He added:

    "We very much believe that PAs and AAs must be distinguished from medically qualified professionals (those with a primary medical qualification). We believe it's inappropriate to refer to both groups as an interchangeable entity – doctors, PAs and AAs have very different roles and responsibilities and these should not be confused, even if this makes GMC communications easier. In addition to the term being an incorrect collective description, we also believe its use will add to existing confusion and misunderstanding by patients around the training and qualifications of the professionals providing their care."

18. Replying in January 2021, the GMC defended the use of the term "medical professionals" in

[9] It also recorded that "*A number of responses, despite voting no, went to comment along the lines of the broad principles being appropriate, but that these needed to be presented separately for PAs and AAs to avoid confusion and unintended consequences such as negative impact on public perceptions around professional reputations.*" [SB/1811].
[10] The paper is undated but its contents indicate that it was prepared for the October 2020 meeting.

its strategy (*"we felt the term 'medical professionals' was the best option; suitably simple to help with clarity, while being broad enough to cover the three professions we'll be regulating in the near future"*) but added: *"We agree that doctors, Physician Associates (PAs) and Anaesthesia Associates (AAs) have very different roles and responsibilities that shouldn't be confused; but we don't believe the umbrella term will do that. We'll only use it where appropriate to the circumstances. The majority of our communications will be tailored to refer to each profession individually"* [SB/2859] (emphasis added).

Reviewing *Good Medical Practice*: preliminary research

19. On 29 January 2021, the GMC published research into the approach taken by different regulators to setting standards [SB/2015-2047]. This was undertaken to inform the GMC's review of *Good Medical Practice*, which would cover a wide range of issues. The research included consideration of standard-setting for multiple professions. The GMC identified four regulators which regulate more than one profession (one of which was Australian), though it is apparent from the research that each of the UK regulators had different overall approaches to that adopted by the GMC for the regulation of multiple professions [SB/2031-2032].[11]

Proposed interim standards for AAs and PAs, pre-consultation survey and delays to legislation

20. At this stage, the DHSC's intention was to make changes to the legislative framework regulating doctors and to introduce statutory regulation of Associates simultaneously. However, in early 2021, delays began to appear in the legislative timetable. In a report for the EAG dated 27 January 2021, the GMC noted that DHSC colleagues had previously "*indicated they hoped to begin consultation on the necessary changes to the Medical Act before the end of 2020, so as to be able to lay legislation in parliament before the summer recess*" [SB/791]. The timetable had slipped, and the earliest possible start date for regulation was January 2022 [SB/791]. The report further recorded that the GMC intended "*that Good medical practice should form the core professional standards for PAs and AAs*", while noting that a number of questions remained to be resolved [SB/793].

[11] The research recorded that: "*the HCPC and the NMC have an overarching set of principles or code that focuses on values and behaviour which applies to all the professions they regulate and then a separate standard of proficiency for each profession, which focuses on knowledge, skills and specific competencies*." (emphasis added) [SB/2031]. As for the GDC, it explained that "*its model is slightly different in that it has one set of principles and standards that apply to **all** the professions they regulate. However, alongside this the GDC also publish a pared-back 'scope of practice' for each separate profession which lists the skills and abilities each registrant group should have and can exercise.*" [SB/2031]. It was noted that the GDC's single publication was very long, and that as *"the standards need to apply to all the professional groups, the GDC has found that there needs to be a certain level of detail included to adequately cover all professions*."

21. In early 2021, the GMC also considered the question of interim standards for Associates, to cover the period in which it carried out its broader review of *Good Medical Practice*. On 23 February 2021, an internal MAPS[12] programme board considered three options for these interim standards: a) annotating the doctor version of *Good Medical Practice*, accessed on the same webpages used by doctors; b) amending *Good Medical Practice* with separate MAPs branding, accessed separately to the guidance for doctors; and c) adopting option b), but with a "*support package of selected tailored guidance and resources*" [SB/2054]. The option proposed to and adopted by the programme board was b) with elements of c). One of its benefits was said to be the "*Clarity that comes from having branded, tailored single piece of core guidance that MAPs held to account against.*" [SB/2057].

22. The GMC set out its proposed approach to interim standards in a paper for a 21 April 2021 meeting of the EAG, explaining that it intended to share draft guidance later in the year [SB/807-814].[13] A GMC paper for a further EAG meeting on 28 July 2021 [SB/877-881] noted that a first draft of the interim guidance had been emailed directly to EAG members for comment by 30 July 2021 [SB/851/§11] and explained that the document would be "*badged as interim guidance with the intention of merging with guidance for doctors following the wider review of Gmp due to complete in 2023".* Daniel McAlonan provided comments on the draft guidance on behalf of the BMA [SB/2133-2139]. He explains the BMA's approach to these comments in his third witness statement [CB/264/§27].

23. In July 2021, the GMC sent a pre-consultation survey – relating to its review of *Good Medical Practice* – to key stakeholders [SB/1574-1581]. The BMA responded in August 2021 [SB/1582-1584]. Mr McAlonan explains the BMA's approach to its response to this survey in his third witness statement, including why it did not answer a question on whether the same core professional standards should apply to doctors, PA and AAs [CB/264/§28].

24. The GMC produced a short report analysing the results of this survey in August 2021 [SB/2168-2169]. Out of 24 respondents, 21 agreed with the question "*Should the same core professional standards apply to all our registrants?*". However, as with the earlier community of interest survey, the comments provided by respondents demonstrate a more nuanced view. The report described two themes arising out of these comments: "*Caution to ensure differences*

[12] I.e. Medical Associate Professions, a collective term for PAs, AAs and Surgical Care Practitioners.
[13] The minutes summarise the EAG's discussions on this issue [SB/846-847].

between roles are appropriately reflected" and "*Clarity for patients*".[14]

25. During this period, the GMC set up a further group which met for the first time on 8 September 2021: the Good Medical Practice Advisory Forum ("**the Advisory Forum**"). Members of the Advisory Forum participated in a personal capacity and the BMA was not formally represented (though its members included a GP trainee who was the Co-Chair of the BMA Welsh Junior Doctors Committee). As can be seen from its title – and as demonstrated from a review of its meeting minutes – the Advisory Forum was created to advise on a much wider range of issues relevant to the review of *Good Medical Practice* than those which might relate to the regulation of Associates.

26. During the Advisory Forum's first meeting on 8 September 2021 [SB/2175-2179], a GMC attendee described the responses the GMC had recently received to its stakeholder survey (§4). She reported that the GMC's stakeholders "*had expressed strong support for high-level overarching principles to apply to all professional groups we regulate. However, respondents had said we need a flexible approach to recognise multi-disciplinary team working and differences between roles*" (§17). The minutes further record that "*No objections to shared standards were made in discussion*", though different perspectives were expressed (§18).[15] The meeting does not appear to have discussed the GMC's proposed separate interim standards for Associates.[16]

27. On 21 October 2021 the GMC published the interim guidance for PAs and AAs ("*Good Medical Practice: Interim Standards for Physician Associates and Anaesthesia Associates"* [SB/1129-1159] ("**the Associate Interim Guidance**")).[17] The Associate Interim Guidance stated that it "*Comes into effect at the start of regulation for physician associates and anaesthesia associates. This guidance is interim and will remain in effect until the full review of Good Medical Practice is complete"* [SB/1131]. Importantly for the purposes of this claim,

[14] As an example, the Medical Protection Society "*broadly supported the principle of shared core professional standards and that the 'general tenor' of guidance for registrants should be the same. However they believed it unlikely an 'identical document' could be applied to doctors, physician associates and anaesthesia associates.*" [SB/2169].
[15] A *"lay member said it should be clear that we were not diluting standards for doctors*" and a "*medical member asked whether we were sure that, by creating shared standards, we would not be imposing obligations on AAs and PAs that they may not have been trained to meet*" (§18).
[16] The Advisory Forum's second meeting on 14 October 2021 addressed various issues relating to Good Medical Practice, which did not include the proposed interim standards for Associates, whether and how to implement shared standards, or the use of terminology to describe Associates and doctors collectively [SB/2180-2188].
[17] The following year, in September 2022, the GMC published *Achieving good medical practice: interim guidance for physician associate and anaesthesia associate students* [SB/1160-1197]. Its purpose was to show how the interim standards for PAs and AAs described above applied to students.

it differed from *Good Medical Practice*: it was specifically targeted toward Associates (noting that patients need *"good healthcare professionals"* [SB/1134] and referring in terms to PAs and AAs) and was tailored to the roles and responsibilities of the Associate professions, particularly in making references to appraisal and supervision by clinicians. It did not use the term "medical professionals".

Wider DHSC consultation

28. Alongside these developments, the DHSC was undertaking broader work on the regulation of healthcare professionals. On 24 March 2021, it began a consultation on reforming the systems for the regulation of healthcare professionals: "*Regulating healthcare professionals, protecting the public*" [SB/415-524]. This was largely concerned with wider issues of regulatory reform, but touched on the regulation of PAs and AAs, suggesting that "*Regulation by the GMC will give the regulator responsibility and oversight of all three professions, allowing it to take a holistic approach to the education, training and standards of the roles*" (§371), whilst noting that "*There will, however, be some differences between PAs and AAs and doctors in the way they are regulated by the GMC to reflect the contexts in which each role practises and the risks posed*" (§376). In its response [SB/525-540], the BMA re-iterated its view that the HCPC was better placed than the GMC to regulate the Associate professions and urged the DHSC to reconsider its position.[18]

Further developments on regulation of Associates and review of *Good Medical Practice*

29. In late 2021 and early 2022, the GMC continued its two parallel and related workstreams: preparing for its proposed new role as statutory regulator of Associates, and carrying out a review of *Good Medical Practice*. In a paper prepared in place of an EAG meeting scheduled for 8 February 2022 [SB/910-913], the GMC explained that it continued "*to work closely with DHSC on the draft legislation that will form the basis of our new regulatory framework*" (§1), reflecting a continued intention simultaneously to change the legislative framework for the regulation of doctors and to introduce statutory regulation of Associates.

30. The product of this legislative work appears to have been the draft Medical Professions Order 2022 ("the draft MPO") [SB/2542-2576], described in the index of documents disclosed with the GMC's DGR as having been provided to it on 1 April 2022. The draft MPO was

[18] The DHSC published its response to this consultation in February 2023 [SB/2963-2976].

accompanied by explanatory commentary [SB/2577-2613].[19] Its contents are addressed further below; for present purposes, it should be noted that it proposed to define "medical professionals" to include medical practitioners (i.e. doctors), PAs and AAs (in contrast to the approach eventually adopted in the AAPA Order) but was never enacted.

Consultation on *Good Medical Practice* and legislative developments

31. Between 27 April 2022 and 20 July 2022, the GMC ran a consultation on its updated draft of *Good Medical Practice*. In the main consultation survey [SB/1585-1628], under the heading 'Style and application', it said that it proposed to "*have one set of core professional guidance for all medical professionals registered with us: in future this will include physician associates (PAs) and anaesthesia associates (AAs)"* and that it had *"…adopted the term medical professionals to describe all the professional groups we regulate. This is also the term that will be used in the legislation to bring PAs and AAs into regulation.*" [SB/1592].

32. While this consultation was taking place, the EAG held a further meeting on 5 May 2022 [SB/949-953]. It was informed that the DHSC's draft order was almost complete and that the DHSC hoped to consult on it in autumn 2022, with the intention of the legislation coming into effect in summer 2023 [SB/950].

33. When the EAG met again on 14 July 2022, a significant update on the approach to legislative reform was given [SB/997-1003]. It was explained that DHSC had been "*looking at ways to reduce the risks of any further delays*", and that Ministers had "*decided to proceed with a PA/AA-only order, with reforms for doctors commencing later*" [SB/998]. The DHSC expected to consult on a new draft order (applying only to Associates) in the autumn of 2022 and to lay the order in Parliament in the second half of 2023, with the GMC beginning to regulate Associates around autumn 2024.[20] The minutes also record that Dr Matthew Tuck, attending on behalf of the BMA, "*commended the GMC for the recent publication of regulation FAQs aimed at doctors, describing these as 'excellent'*" (emphasis added) [SB/1003].

34. On 20 July 2022, the BMA responded to the GMC's consultation on *Good Medical Practice*

[19] §81 of Mark Swindells' statement [CB/230] describes this as commentary on the "*full draft AAPA Order*", but that would appear to be a mistake: it is clear from the face of the commentary that it relates to the draft MPO, rather than the latter AAPA Order.

[20] A representative of the Faculty of Physician Associates "*asked what had changed to enable this decision as the FPA had previously been told that de-coupling the legislation was impossible*." [SB/999]. The answer on was that "*decoupling is "a practical solution to a sequencing challenge" caused by the complexity of the legislation.*"

through a letter [SB/1255-1257], a table of commentary [SB/1258-1275] and answers to a survey [SB/1654-1660]. Mr McAlonan's third statement explains the relationship between the approach taken to the BMA's consultation response and the issues raised in this claim.

GMC analysis of consultation responses

35. Following the conclusion of the *Good Medical Practice* consultation, the GMC undertook an analysis of the responses it had received. It has disclosed part of an internal report, on the topic of "*Structure, style and application, and tone*" [SB/1629-1653].[21] This recorded that 73 respondents had commented on the use of the term "medical professionals", of which 35[22] had responded negatively [SB/1641-1642]. It noted that "*One of the main objections to using the term was that it would confuse patients*", before quoting a number of responses to that effect. 26 respondents were described as having spoken positively about using the term. The report recorded that, in asking this question, the GMC had "*explained this term would be used in the legislation*". 53 respondents had commented on whether *Good Medical Practice* should apply to all of the GMC's registrants, of which 35 had responded positively and 9 negatively [SB/1642-1644]. The negative comments included that the proposed approach would "*further blur the lines and make it impossible for the public to differentiate between doctors and assistants*".[23]

36. The EAG met again on 3 October 2022. By this time, the GMC had received a draft AAPA order. A representative from the Scottish Government noted the reference in the GMC's communications strategy "*to PAs and AAs being part of the 'medical' workforce and questioned whether 'multi-disciplinary' would be a better term.*" [SB/1039/§11]. A GMC representative explained that "*we use individual profession names in our communications wherever possible and only employ collective terms where needed. We understand that 'medical professionals' will be the term used to describe our three registrant groups in the GMC's future legislation and it's also one we use in the GMC's corporate strategy.*"

37. The Advisory Forum met for a further time on 18 October 2022 [SB/2212-2220]. A GMC paper prepared for the meeting summarised and commented on consultation responses on the

[21] The extract is undated. The GMC index accompanying its disclosure suggests it was completed on 25 July 2022 (i.e. five days after the consultation closed), while Mark Swindells' statement records that the GMC undertook its analysis of consultation responses in August-September 2022 (§75).
[22] This number is described in Mark Swindells' statement as "*a minority*" (§§77 and 111(e)), rather than "almost half".
[23] A patient safety charity – Action against Medical Accidents – was noted as having raised "*a patient safety argument for having a separate GMP for MAPs*" [SB/1644].

topic of "*Structure, style and tone*" [SB/2614-2622], and addressed the use of "medical professionals" under the heading "*Terminology*" [SB/2619-2620]. The paper stated: "*Perhaps inevitably the majority of comments focused on the one issue that is not in our gift to change: the use of the term* ***medical professionals*** *to describe doctors, PAs and AAs.*" (§29, underlining added, bold in original). It was noted that "*Doctors in particular warned that this would be confusing for patients.*" (§30). The paper later explained: "*We'll continue to use the term 'medical professional' because it is DHSC's preferred collective name for the GMC's three registrant groups and so is likely to feature in future legislation relating to the GMC.*" (§34). It noted that the GMC "*might wish to consider whether there is a form of words we can use … which distinguishes between the three professional groups.*" (§35).[24] As for shared standards, the report commented: "*Having one set of core standards for the three professional groups drew responses in a similar vein* [to those on terminology], *but some respondents added note* [sic] *of caution about a potential impact this could have on patient safety.*" (§32).

Further DHSC consultation

38. On 17 February 2023, the DHSC published a consultation ("*Regulating anaesthesia associates and physician associates"*) on its proposed regulation of the Associate professions, alongside a draft AAPA order [SB/541-595]. This described the overarching purpose of the regulation of healthcare professionals as public protection [SB/549]. On the question of guidance, it explained that the GMC had "*published an interim set of standards that provides a framework for decision-making that is designed to keep patients safe. It is based on the current version of Good medical practice and has been tailored to reflect the role of AAs and PAs.*" [SB/553].

39. The BMA responded to this consultation on 16 May 2023 [SB/596-602]. It repeated its view that the HCPC would be the more appropriate regulator of the Associate professions, having regard to the 15 other professions that it regulated in the UK under the Health Professions Order 2001, rather than the GMC.[25] Further EAG meetings were held on 16 March [SB/1058-1061] and 6 June 2023 [SB/1096-1099], with updates on the DHSC's consultation.

[24] The Advisory Forum held two further meetings – on 24 November 2022 [SB/2221-2230] and 30 January 2023 [SB/2231-2240] – neither of which considered issues directly relevant to this claim.

[25] The BMA is not in these proceedings challenging the decision by the DHSC to appoint the GMC as the regulator of Associates. It does, however, rely upon the identity of the GMC as the regulator of Associate professions as giving rise, prima facie, to the potential for confusion or false assumption on the part of the public that Associates are, in some way, medically qualified. Further details on the issues of public confusion as to the role of Associates and whether or not they are medically qualified, including the influence that the identity of the GMC as their regulator is likely to play in that confusion, are set out in the first witness statement of Daniel McAlonan [CB/154-193]. This confusion is not restricted to lay members of the public and has even been demonstrated across the NHS: see paragraph 74 of Daniel McAlonan's first witness statement at [CB/178-179].

Publication of *Good Medical Practice*

40. The GMC published the new version of *Good Medical Practice*, which came into effect on 30 January 2024 for doctors, on 22 August 2023 [SB/1276-1305]. This version of *Good Medical Practice* stated: "*We use the term 'medical professionals' to describe all our registrants who we address directly (as 'you') throughout this guidance"*, with the footnote reading: "*At the time of publication we regulate doctors. We are preparing to regulate Physician Associates and Anaesthesia Associates in the future, at which point this guidance will also apply to them*" [SB/1280].[26]

41. On 17 October 2023, the EAG held a further meeting [SB/1110-1113]. The minutes demonstrate that the issue of blurred boundaries between doctors and Associates remained live: "*Clarity is required on the role of a doctors, a PA and AA is, and who can practise medicine.*" (§14).

42. On 24 October 2023, the GMC published online "*More information on PAs and AAs*" [SB/1451-1463] in which it said that "*PAs and AAs are distinct professions. They are not doctors …"* and that *"PAs and AAs should never be referred to as 'medical practitioners' because that term is used specifically in legislation to mean doctors."* At the same time, however, it said that *"When writing about or addressing PAs, AAs and doctors, we use the three distinct names of each profession, except on rare occasions when it makes sense to use a single umbrella term. For example, for ease of reading, we use the term 'medical professionals' in the updated Good medical practice, because the professional standards will apply to all three groups once regulation begins."* (emphasis added) [SB/1458].

43. On 3 November 2023 the DHSC published a fact sheet[27] that "*sets out* [its] *position on the Physician and Anaesthesia Associate roles in the NHS"* [SB/313-316]. It described PAs and AAs as *"healthcare professionals, trained to the medical model"*: PAs *"can work autonomously, but always under the supervision of a fully trained and experienced doctor".* The fact sheet recorded the Government's plan to expand the number of PA and AAs in the NHS

[26] In a document describing *How we developed the updated professional standards* for *Good Medical Practice 2024*, also dated August 2023 [SB/1306-1332], the GMC stated that *"Good medical practice will apply to PAs and AAs when regulation begins in the future"*. The GMC also noted that this was *"the first time we've updated the guidance with a forward look at the future regulation of physician associates and anaesthesia associates, subject to new legislation being introduced by the UK government"* [SB/1315].

[27] The fact sheet was updated on 21 December 2023 https://healthmedia.blog.gov.uk/2023/11/03/physician- and-anaesthesia-associate-roles-in-the-nhs-fact-sheet/

(as was also set out in NHS' England's Long Term Workforce Plan, dated June 2023[28]). The fact sheet further suggested that the GMC's responsibility for, and oversight of, doctors, PAs and AAs will help to embed associates in the work force "*by making it easier for employers, patients and the public to understand the relationship between these roles and doctors*".

Growing concerns around Associates

44. As explained at §83 of Mr McAlonan's first witness statement [CB/181], since September 2023 there have been an increasing number of concerns expressed by key stakeholders[29] as to the patient safety dangers of the proposed roll out and regulation of PAs and AAs, with a particular focus on (i) the role of the GMC further blurring the lines between medical practitioners and Associates, (ii) the decision by the GMC to adopt terminology that further confuses patients, and (iii) the lack of any defined and agreed scope of practice for Associates, exacerbating patient safety concerns. In November 2023, against a backdrop of growing concerns among doctors and reports of patient deaths following misdiagnoses by PAs (as set out at §76 of Mr McAlonan's first witness statement [CB/179]), the BMA called for an immediate pause on recruitment of PAs and AAs on the grounds of patient safety [SB/1505-1507].

45. In December 2023 the DHSC published its "*Consultation response to regulating anaesthesia associates and physician associates"* [SB/2977-3057]. This stated that regulation under the GMC would *"make it easier for employers, patients and the public to understand the relationship between the roles. The GMC will be key to ensuring that the roles complement doctors and other professionals within the wider NHS to support quality and safety in patient care"* [SB/2980]. The response acknowledged that there were *"wider concerns raised through consultation responses about the scope of practise* [sic] *of associates, their use in the healthcare system and the public's perception and understanding of the role of AA and PAs."* [SB/3022].

[28] https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-termworkforce-plan-v1.2.pdf. It also stated: "*Their role and clinical duties are very different to those of a doctor. Like Allied Health Professionals, Advanced Clinical Practitioners, Health Care Scientists, and other healthcare roles, PAs and AAs deliver specific aspects of patient care, increasing the capacity of clinical teams and reducing the workload of other clinicians, including doctors - increasing the capacity of the medical team to deliver care to patients*".

[29] These include but are not limited to: the Royal College of Anaesthetists; the Royal College of Physicians; the Royal College of Physicians in Edinburgh; the Royal College of General Practitioners; the Royal College of Surgeons England; the Academy of Medical Royal Colleges; the Doctors' Association UK; the Association of Anaesthetists; Anaesthetists United; the National Association of Sessional GPs.

46. A further meeting of the EAG took place on 6 February 2024, when updates were provided on the progress of the AAPA Order through Parliament and an upcoming GMC consultation. [SB/1127-1128]. The minutes also record: "*BMA reported they have recently published a survey which has raised concerns about how MAPS are working. Concerns also remain around the GMC acting as a multi-professional regulator. The BMA is looking to gain more clarity on PA/AA scope of practice.*" (§8).

2024 GMC consultation

47. Further to the AAPA Order having been made on 13 March 2024, the GMC published a consultation on 26 March 2024 entitled *'Regulating Anaesthesia Associates and Physician Associates: Consultation on Our Proposed Rules, Standards and Guidance'* [SB/1348-1424]. The GMC stated that it was seeking views *"on the draft rules and standards that are required to implement the legal duties and powers within the AAPO, and bring AAs and PAs into statutory regulation later this year"* [SB/1351]. Responses were required by 20 May 2024.

48. The specific rules, standards and guidance that were the subject of this consultation were grouped by the GMC by regulatory function, and covered the following: education and training for AAs and PAs; the form and keeping of the register of AAs and PAs; entering and re-entering the register of AAs and PAs; removal from the register of AAs and PAs; fitness to practise proceedings for AAs and PAs; the process for revising specified decisions and for internal appeals against decisions; fees. These areas were described as *"the ones that we need to have in place for the start of AA and PA regulation"* [SB/1357]. The guidance and standards consulted on did not include the standards of conduct and ethics that are set out in *Good Medical Practice*.[30]

49. The consultation document explained that *"Anaesthesia associates and physician associates work with doctors. They each belong to a defined professional group and hold complementary skill sets to doctors."* [SB/1354]. It described PAs as forming *"part of the multidisciplinary team, which consists of different healthcare professions …"*. Regulation was described as helping *"assure patients, colleagues and employers that AAs and PAs are appropriately educated and qualified, can contribute safely and appropriately to the care of patients and can be held to account if serious concerns are raised. This is the underlying purpose of regulation,*

[30] Instead the consultation document explained that *"When AAs and PAs come into regulation, they'll be expected to meet our standards of patient care and professional behaviour, which already apply to doctors: Good Medical Practice"* [SB/1360].

for doctors, for other healthcare professionals and, in the future, for AAs and PAs too." The AAPA Order was described as enabling the GMC to, inter alia, *"set professional standards for AAs and PAs".* [SB/1355]. Elsewhere in the consultation document, the GMC referred to doctors as *"the medical profession"* [SB/1357].

50. The BMA responded to the GMC's consultation on 20 May 2024 [SB/1425-1431]. Its covering letter said [SB/1425]:

"We firmly believe that the term 'medical professionals' should only be used to describe medical practitioners and not members of associate professions. It therefore follows that Good Medical Practice should pertain only to doctors, with standalone guidance produced to define good associate practice. The continued use of 'medical professionals' to refer to all three distinct professions only adds to existing confusion and risks blurring the lines between clinicians with very different qualifications and training."

51. The BMA went on to make references to established public confusion regarding the titles of PA and AA, and to the need for the standards and requirements to address how their roles are differentiated from medical practitioners.[31]

<u>GMC's continued use of "medical professionals"</u>

52. On 26 March 2024, an organisation representing anaesthetists (Anaesthetists United) wrote to the GMC setting out a number of concerns, including a concern regarding the adoption of the term "medical professionals" by the GMC [SB/1284-1294]. The GMC responded on 4 April 2024 [SB/1295-1300]. It began by recognising the differences between doctors and Associates.[32] However, the letter went on to confirm that the GMC had decided to continue its use of the umbrella term of "medical professionals" to encompass not just doctors, but PAs and AAs:

"*On occasion we use 'medical professionals' as an umbrella term to collectively describe all the professionals we will regulate in future. This is in preference to always separately listing out each individual role. The alternative term we considered was 'registrants', which we felt*

[31] It said: "*The consultation standards and requirements for PA and AA curricula must go further than simply requiring a stated and clear purpose based on practice within a multidisciplinary team, service, and patient and population needs. How these roles are differentiated from medical practitioners should be included in the standards and requirements. Given the inappropriate blurring of roles noted above, the standards and requirements should not only describe the knowledge, skills and capabilities expected of a PA or AA graduate, but set out that these capabilities cannot be seen as equating to the unique skills and capabilities of doctors.*" [SB/1427/§4].

[32] It said: "*We agree that patients must always be clear about who is treating them and every healthcare professional has a duty to clearly explain their role. PAs and AAs are two relatively new professional groups in healthcare so it is even more important that they are always clear about their roles and responsibilities with the patients they treat. They do not have the same knowledge, skills and expertise as doctors. They are not doctors, and they can't replace them*."

was cold and impersonal. And we will only use the term 'medical professionals' sparingly and when appropriate to the circumstances, for example when referring to the collective professionals we regulate. The professional titles of medical practitioners, physician associates and anaesthesia associates will continue to be separate and distinct, as well as protected in law."

53. The letter also said, in relation to the GMC's website and its presentation of information regarding the registers, that "*We worked to two key principles in developing this prototype – that we should reflect the needs of users now and in the future and that it should be abundantly clear to users of our public information whether a particular registrant is a doctor, a PA or an AA.*" [SB/1299]. The BMA submits that this is an acknowledgement that it is imperative that the public are aware of the distinctions between the different professions and queries why the same distinction is not made abundantly clear in *Good Medical Practice*.

December 2024 updates to *Good Medical Practice*

54. In December 2024, the GMC made a small number of further amendments to *Good Medical Practice*. The updated version is dated 13 December 2024 [SB/2268-2299], though the GMC has explained that it was published on 16 December 2024 and the amendments were approved by its Council on 7 November 2024 (Mark Swindells §66 [CB/226]). The GMC has provided a version of the December update tracking the amendments [SB/2300-2323]. The changes include replacing some uses of the term "medical professionals" with alternatives (such as "doctors, PAs and AAs" or "individual"); and adding new duties in relation to practising under an appropriate level of supervision[33] and to how registrants should introduce themselves to patients[34]. However, the structure and approach adopted in the December update remains the same as previously; and it continues to use the term "medical professionals" to describe all of the GMC's registrants [SB/2300]. In its DGR (§43), the GMC states that it made these changes – described as "*clarificatory amendments*" – as a result of a number of respondents to its March-May 2024 consultation raising concerns.

[33] "*You must only practice under the level of supervision appropriate to your role, knowledge, skills and training, and the task you're carrying out.*" [SB/2304].
[34] "*You should introduce yourself to patients and explain your role in their care.*" [SB/2320].

C. THE LEGAL FRAMEWORK

The Medical Act 1983 and the GMC

55. The Medical Act 1983 ("**the 1983 Act**"), which is concerned, *inter alia*, with the registration, training and fitness to practise of medical practitioners, also governs the purpose and functions of the GMC. By section 1A, the "*over-arching objective of the General Council*[35] *in exercising their functions is the protection of the public*." Section 1B defines the pursuit of this overarching objective as involving the pursuit of the following objectives:

    "*(a) to protect, promote and maintain the health, safety and well-being of the public,*

    (b) to promote and maintain public confidence in the medical profession, and

    (c) to promote and maintain proper professional standards and conduct for members of that profession..." (Emphasis added)

56. §9A to Schedule 1 of the 1983 Act specifies a number of matters to which the GMC must have regard when exercising its functions. These include that it must have "*proper regard*" for "*the interests of persons using or needing the services of provisionally or fully registered medical practitioners in the United Kingdom*" (§9A(1)(a)).

57. Section 2(1) of the 1983 Act requires the GMC to keep "*a register of medical practitioners registered under this Act containing the names of those registered and the qualifications they are entitled to have registered under this Act*. The meaning of the "*register of medical practitioners*" and the identity of those who are registered medical practitioners under the 1983 Act is defined further in sections 2(2)-(3).

58. Whilst the terms "medical practitioner" and "medical profession" are not defined by the 1983 Act, it is plain from both an objective reading of the 1983 Act and the context in which those terms are used (in reserving the right to be registered as a medical practitioner, and thus to practise medicine, to those who are suitably qualified in medicine and/or surgery[36]) that the practitioners and profession referred to can **only** be references to medically qualified doctors.[37]

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[35] I.e. the GMC.

[36] Section 4 of the 1983 Act provides for the GMC to maintain a list of qualifying examinations that result in degrees of bachelor of medicine or surgery, licentiate of the Royal Colleges of Physicians and Surgeons, or licentiate in medicine and surgery of the Society of Apothecaries of London. Section 3 provides for entitlement to registration as a fully registered medical practitioner of those who hold the appropriate qualifications and who have completed "an acceptable programme for provisionally registered doctors"

[37] See also section 10A, which provides for the recognition of acceptable programmes for "provisionally registered doctors".

59. "Medical practitioner" is, however, defined in paragraph 10 of schedule 3 to the Health Act 1999 ("**the 1999 Act**") as *"a registered medical practitioner as defined by Schedule 1 to the Interpretation Act 1978"*. Schedule 1 to the Interpretation Act 1978 in turn uses the definition of a *"fully registered person within the meaning of the Medical Act 1983 who holds a licence to practise under that Act",* and section 5 of the Interpretation Act provides that in any Act the words and expressions listed in Schedule 1 *"are to be construed according to that Schedule"* unless the contrary intention appears.

60. Part IIIA of the 1983 Act provides for the grant, by the licensing authority[38], of licences to practise to medical practitioners. Part IV contains various provisions concerning the registers of medical practitioners to be maintained by the GMC. Part 4A includes the requirement for the GMC to keep a register of general practitioners and a register of specialist medical practitioners. Part V is concerned with fitness to practise and medical ethics and contains the framework for the investigation and determination of allegations that the fitness to practise of a fully registered or provisionally registered person is impaired.

61. Section 35, which falls within Part V, empowers the GMC to provide, in such manner as it thinks fit, *"advice for members of the medical profession on (a) standards of professional conduct; (b) standards of professional performance; or (c) medical ethics"*. Members of the medical profession plainly means medical practitioners, i.e. medically qualified doctors.

62. Part VI of the 1983 Act concerns the "privileges of registered practitioners", and in particular section 47 provides for the holding of appointments "*as physician, surgeon or other medical officer"* only by a person who is fully registered and holds a licence to practice. In recognition of the importance of the reserved rights of medical practice to medically qualified doctors, section 49(1) makes it a criminal offence if any person wilfully and falsely pretends to be registered under the 1983 Act, including the use of a protected title or (importantly) otherwise seeking to describe oneself in a way that implies that s/he is registered under the 1983 Act. This includes the use of the term "physician":

"(1) Any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine

[38] The licensing authority means the Registrar, a Registrational Panel or such other committee or officer of the GMC as may be prescribed.

or an apothecary, shall be liable on summary conviction to a fine not exceeding level 5 on the standard scale." (Emphasis added)

63. Section 49A penalises those who do not hold a licence to practise but hold themselves out as having one or engage in conduct calculated to suggest that they have one.

64. §9B of Schedule 3 to the 1983 Act provides that *"For the purposes of ensuring that registered medical practitioners and the public are informed about the General Council and the exercise by them of their functions, the Council shall publish or provide in such manner as they think fit information about the Council and the exercise of their functions."*

Orders under the Health Act 1999

65. Section 60 of the 1999 Act provides for a power to make orders in council for the purpose of regulating "*health professions*" and social workers. Section 60(1)(a) gives a power in respect of professions already regulated by the primary and secondary legislation under section 60(2) – which includes the medical profession as regulated by the 1983 Act[39] – whereas section 60(1)(b) gives a power in respect of other professions which are not already regulated, concerned wholly or partly with physical or mental health, and which are deemed to require regulation.

66. A non-exhaustive list of the matters that may be provided for in an order made under section 60 are set out in §1 of Schedule 3 to the 1999 Act. §11 of Schedule 3 clarifies that the powers conferred by section 60 of the 1999 Act enable professions that are not already regulated to be regulated, including "*the regulation of activities carried on by persons who are not members of the profession but which are carried on in connection with the practice of the profession"* (emphasis added, see sub-paragraphs 1 and 2(b)). Schedule 3 also addresses the procedure to be followed by the Secretary of State before making an order under section 60(1).[40]

The Anaesthesia Associates and Physician Associates Order 2024

67. The AAPA Order was made on 13 March 2024 pursuant to section 60(1)(b) of the 1999 Act, thus introducing regulation of professions (referred to within the Order as *"the anaesthesia*

[39] The full list of legislation under section 60(2) is as follows: (a) the Medical Act 1983; (b) the Dentists Act 1984; (c) the Opticians Act 1989; (d) the Osteopaths Act 1993; (e) the Chiropractors Act 1994; (f) the Nursing and Midwifery Order 2001; (g) the Health Professions Order 2001; (h) the Pharmacy Order 2010 and the Pharmacy (Northern Ireland) Order 1976; (i) any other Order in Council made under section 60 of the 1999 Act.

[40] This includes publishing a draft of the order and inviting representations from "*persons appearing to him appropriate to represent any profession… to be regulated, persons appearing to him appropriate to represent those provided with services by any profession… to be regulated and any other persons appearing to him appropriate to consult…*" (sub-paragraph 1).

associate and physician associate professions") that were not already regulated under the 1983 Act or any other legislation. Save for one provision, the AAPA Order came into force on 13 December 2024.[41]

68. Article 3 of the AAPA Order places a mandatory obligation upon the GMC[42] to determine standards that are "applicable to associates". The standards must relate to a number of areas, including knowledge and skills, experience and performance, and conduct and ethics.

69. A Registrar appointed by the GMC[43] must maintain a single register of associates who meet the requisite standards set by the GMC and comply with other requirements concerning the provision of information or other requirements made under the AAPA Order or set by the Registrar ("**the Associate Register**"): Articles 5 and 6 AAPA Order. The Associate Register must be divided into two parts, one for AAs and the other for PAs (Article 5(2) AAPA Order).

70. In addition to the objectives and duties contained within the Medical Act 1983, §3 of Schedule 1 to the AAPA Order imposes additional objectives and duties on the GMC as the regulator of Associates. These include that the GMC "*has the objective of promoting and maintaining – (i) public confidence in, and (ii) proper professional standards and conduct for members of, the anaesthesia associate and physician associate professions*" (§3(1)(a)); and that, when exercising its functions under the AAPA Order, that it must have regard to certain matters, including "*the interests of persons using or needing the services of associates in the United Kingdom*" (§3(b)).

71. The legislative framework thus itself draws a distinction between **"the medical profession"** as identified in and governed by the 1983 Act and **"the anaesthesia associate and physician associate professions"**. This same distinction is maintained within the explanatory memorandum to the AAPA Order (at paragraph 7.53), which also adopts the umbrella term of **"healthcare professionals"**, consistently with the 1999 Act.

<u>The draft Medical Professions Order 2022</u>

72. The draft MPO was intended to cover the regulation of both doctors and Associates. It defined "medical professional" for the purposes of the Order as meaning, other than for one draft

[41] Article 19(1)(b), which makes the use of the title physician associate or anaesthesia associate without appropriate registration a criminal offence where there is an intent to deceive, comes into force on 13 December 2026. All other articles of the AAPA Order came into force on 13 December 2024: see Article 1 AAPA Order.
[42] Article 2(1) defines "the Regulator" for the purposes of the Order as the GMC.
[43] See §1 of Schedule 1 AAPA Order.

provision, "*(a) medical practitioner, (b) anaesthesia associate, or (c) physician associate*" and provided that "*medical professions*" was to be construed accordingly [SB/2544]. The explanatory commentary explained as follows [SB/2577]:

"*'Medical professional' covers the professions that will be regulated by the GMC within the MPO. An equivalent definition will need to be included in each regulators' legislation for the profession/professions that they will regulate. We note that further work may be required around the definition of medical professional. We intend to undertake a legal review of the full order to consider the consistency and accuracy of when the terms 'medical professional', 'medical practitioners' and 'person' have been used.*"

The draft MPO was ultimately not introduced.

D. SUBMISSIONS

73. Whilst the factual background to this challenge is lengthy and relatively complex, the core of the BMA's case is straightforward. The BMA submits that, notwithstanding a clear statutory distinction between doctors and Associates, the GMC has acted contrary to the legislative framework, failed in its statutory duties towards the public, doctors and the Associate professions, and acted irrationally by: (i) failing to produce an appropriately altered or distinct version of *Good Medical Practice* for the Associate professions, and (ii) conflating the roles of Associates with medical practitioners through the application of the umbrella term "medical professionals." These decisions are of particular concern when considered in the relevant factual context, which includes known public confusion as to the roles of Associates, and the lack of any nationally agreed scope of practice for them.

74. The GMC seeks to dismiss the BMA's challenge to the use of the term "medical professionals" as not being amenable to judicial review on the basis that it relates merely to a drafting style (e.g. DGR §58). On the contrary, the very premise of the BMA's objection and challenge is that the GMC's intended use of 'medical professionals' as an umbrella term is not just unhelpful or poor drafting, but that it is a deliberate decision which conflates the distinct professions – contrary to the statutory framework – and actively increases the risks in relation to patient safety and confusion as between the respective professions and their qualifications and experience. That, in turn, undermines the public's confidence in both the medical profession and the associate professions. The fact that the GMC does not want to acknowledge that it has made a "decision" in respect of the use of the term does not alter the fact that there has

incontrovertibly been a decision; this should be understood as a matter of substance, not form.[44]

Ground 1: Conflict/inconsistency with the legislative framework

75. The legislative framework of the 1983 Act and of the AAPA Order creates a clear and firm distinction between, on the one hand, *"the medical profession"*, whose members are *"medical practitioners"* (i.e. medically qualified doctors), and, on the other hand, *"the anaesthesia associate and physician associate professions"*, whose members are *"anaesthesia associates"* and *"physician associates"*. These are statutory terms that bear distinct meanings derived from their statutory context.

76. Medically qualified doctors are the *"medical practitioners"* to which the 1983 Act makes repeated reference, and they alone can properly be said to be in *"medical practice"*. The *"medical profession"* referred to in section 1(1B)(b) is the profession which is regulated by the 1983 Act – namely the profession comprised of medical practitioners: they are the *"members of that profession"* referred to in section 1(1B)(c). By contrast the AAPA Order recognises, as distinct professions, "*the anaesthesia associates and physician associate professions*" and recognises AAs and PAs as distinct associate professionals, described as an "*anaesthesia associate*" and as a "*physician associate*".

77. *Good Medical Practice*, and the GMC's use of what it describes as the *"umbrella term"* of *"medical professionals"*, confuses and conflates these separate and distinct professions in a way which is fundamentally inconsistent with, indeed in conflict with, the statutory framework to which the GMC is subject and pursuant to which it exercises its functions. The very title of *Good Medical Practice* leads the reader to conclude that those to whom it relates are medical practitioners, yet Associates are not and cannot be medical practitioners. So too does the reference to *"medical practice"* within the guidance (see e.g. *"medical practice is a lifelong journey."*). *Good Medical Practice* explicitly describes all those regulated by the GMC as *"medical professionals"* (see, e.g., the section headed "*What is Good medical practice?"*).

78. Whereas section 1(1B) of the 1983 Act refers to *"the medical profession"* – which is plainly, in the context of the Act, a reference to the profession that is comprised of medical practitioners

[44] The suggestion that the GMC may keep matters under review (DG$ §59) and subsequently make a decision to change its approach does not prevent this being a substantive decision: on the contrary the indication of a settled position that may be subject to review is indicative that a decision has been taken.

– *Good Medical Practice* talks (under the heading "*How the professional standards relate to our fitness to practice*" process) of *"promoting and maintaining public confidence in the medical professions"* (i.e. in the plural) and *"promoting and maintaining proper professional standards of conduct for members of those professions"* [SB/273], thus telling patients, the public *and* Associates that Associates are members of medical professions – which they are demonstrably not, either under the 1983 Act (where the medical profession is plainly only that of the medically qualified doctor – the medical practitioner) or under the AAPA Order (which scrupulously avoids the conflation of the professions, by characterising PAs and AAs as members, not of the medical profession or professions, but of the anaesthesia associate and physician associate professions). There are then repeated references throughout *Good Medical Practice* to *"the medical professional"* and *"medical professionals"* (e.g. SB/275, 276 and 279) – references which are utterly unobjectionable insofar as *Good Medical Practice* is directed at doctors (as it has been since 1995), but which, insofar as it applies to Associates, characterises Associates as members of the medical profession in a way which is fundamentally irreconcilable with the statutory framework of both the 1983 Act and the AAPA Order.

79. The GMC accepts that the 1983 Act refers to "the medical profession" in relation to doctors (DGR §51). It argues that there is no illegality in its use of "medical professionals" because it has omitted a prefix of "the" and added an "s" to make the phrase plural. This contention does not withstand scrutiny. "Medical professionals" is a term which derives from "the medical profession" and cannot – as a matter of construction or ordinary language – be separated from it. The potential for – and strong likelihood of – confusion arising from the public use of the phrase "medical professionals" by the GMC (even without considering existing confusion regarding the differing professions) is patent.

80. The GMC also seeks to defend its approach on the basis that the term "medical professionals" is not itself a protected title or statutorily defined (DGR §67(b)). This fails to engage with the purpose and breadth of the protection given in the 1983 Act to the terminology used to define the medical profession. The purpose of s.49 of the 1983 Act is not merely to preserve specific phrases as precisely formulated in statute, as if the protected titles were a trademark. Instead, s.49 is much broader: it recognises, and seeks to prevent, the significant harm that can be done by a patient being led to believe that they are engaging with, and being treated by, a member of the medical profession who is registered under the 1983 Act. Thus, s.49 not only protects the terms 'physician' and 'doctor of medicine' (*inter alia*) but makes it a criminal offence for

an individual to describe themself in a way that either expressly or implicitly suggests that they are a member of the medical profession.

81. Other aspects of the GMC's defence demonstrate the illogical nature of its attempts to justify the term. It is explicit in s.49 of the 1983 Act that it is an offence to hold oneself out wilfully and falsely as "*a practitioner in medicine*". Yet the GMC seeks to justify its decision to use the term by arguing that an Associate's "*practice relates to medicine*" (DGR §74(b)(iii)), and that it would be appropriate to describe an Associate as "*being in practice*" (DGR §74(b)(x)). It would follow that if Associates are "*in practice*", they can describe themselves as being a "*practitioner*". Furthermore, "*the*" practice of a "*medical professional*" can only sensibly be understood as being the practice of medicine (as the title *Good Medical Practice* only serves to reinforce, if there were any doubt) by a doctor registered under the 1983 Act.

82. The GMC also argues (DGR §67(e)) that it has *"simply followed the practice of other multi-profession healthcare regulators"*. This ignores the fact that the GMC is subject to the specific statutory framework of the 1983 Act and the AAPA Order; that other regulators have different statutory frameworks and approaches to setting standards[45]; and that there is not the wealth of evidence and concern regarding confusion between the different professions regulated by other regulators.

83. The GMC's witness evidence refers to a number of other factors which are said to have influenced its decision to adopt the term "medical professionals" in *Good Medical Practice* (Mark Swindells §111 [CB/242-243]). To the extent that these factors are not recorded in the contemporaneous documentation, they should be scrutinised with care.[46] Evidence elucidating reasons originally given may be admissible; evidence contradicting those originally given or providing wholly new reasons generally is not. Further, reasons proffered after the commencement of proceedings must be treated especially carefully, because "*there is a natural tendency to seek to defend and bolster a decision that is under challenge*" (Chamberlain J in ***Inclusion Housing v Regulator of Social Housing*** [2020] EWHC 346 (Admin) at §78, summarising long-established principles). The documents establish that the key reason for the GMC's decision was in fact its belief that "medical professionals" would be used in legislation

[45] For example, and as reflected in the January 2021 GMC research described above, the General Dental Council has (in contrast to the GMC) issued guidance which describes and specifies the tasks which each separate dental profession can (and cannot) properly undertake.

[46] The same point applies to Mark Swindells' summary of the factors relevant to the GMC's decision to apply shared core standards to doctors and Associates (§110 [CB/239-242]).

introduced by the DHSC, and that as a result it was bound to use the term. That belief was wrong. Moreover, the DHSC's use of the term (as in the draft MPO) was dependent on and resulted from its proposal to introduce statutory regulation of Associates and to reform the legislative basis for regulating doctors simultaneously. In the absence of such reform, the GMC's use of the term was (and remains) unlawful.

84. Thus, when considered objectively and holistically, the GMC's use of the term "medical professionals" (both in *Good Medical Practice* and more broadly as the regulator of the Associate professions) approves and encourages an Associate professional to use terminology that is likely to be unlawful and could even result in them committing a criminal offence under s.49 of the 1983 Act. The GMC's use of the term "medical professionals" falls foul of the first limb of the test set out in ***R (A) v SSHD*** [2021] UKSC 37, [2021] 1 WLR 3931.[47] The GMC also falls foul of the third type of case identified in §46 of ***A v SSHD***: where "*read as a whole, the policy presents a misleading picture of the true legal position.*"

85. The terminology used to describe doctors on the one hand and Associates on the other is a fundamental component of the statutory framework governing their regulation. The GMC's use of the term "*medical professionals*" to describe the group as a whole is a positive statement of the law which is wrong, and which will or may induce those who follow it to act in breach of the legislative framework. Further, the GMC's suggestion (DGR §70(a)) that the December 2024 updates to *Good Medical Practice* – requiring Associates to be honest about experience, qualifications and their current role, and to introduce themselves to patients and explain their role – might cure this illegality is misguided. Unless the statutory framework is changed, *Good Medical Practice* will be unlawful as long as it authorises or approves the use of the term "medical professionals" for Associates as well as doctors.

86. Fundamentally, however, the central issue in this ground of challenge does not turn on the broad typology of cases identified in ***R (A)***. If, as the BMA submits, the use of "medical professionals" in *Good Medical Practice* contradicts or is inconsistent with the legislative framework, it will be unlawful. The BMA does not understand the GMC to demur from that matter of principle, which is consistent with and confirmed by ***R (A)***.

[47] As was put by Lord Sales and Lord Burnett at §38: "…*the court will intervene when a public authority has, by issuing a policy, positively authorised or approved unlawful conduct by others… In this limited but important sense, public authorities have a general duty not to induce violations of the law by others*".

Ground 2: Contrary to the statutory objectives of regulation and/or failure to have regard to safety and public confidence

87. The GMC's decisions – both in applying *Good Medical Practice* to Associates as well as doctors, without producing an appropriately modified or distinct version, and in using the term "medical professions" for Associates – are contrary to the statutory objectives of regulation and/or fail to have proper regard to safety and public confidence.
    a. *Good Medical Practice* refers to "medical practice" and "clinical care", and to the roles and responsibilities of "medical professionals", without any recognition or qualification to reflect the fact that Associates are not in medical practice, and that there are fundamental differences between their training, skills and responsibilities, and those of medical practitioners (doctors).
    b. Moreover, as a matter of principle, having the same guidance applying to the different professions plainly runs the risk of blurring the distinctions between doctors and Associates in circumstances where there is already significant concern about the potential for the public to be confused, and even misled, as to the roles of Associates and how they interact with doctors.
    c. Whilst some of the standards applicable to medically qualified practitioners are both capable of being applied to Associates, and desirable regulatory standards that the BMA agrees should be applied to Associates (for example, acting with honesty and integrity), a number of the matters set out within *Good Medical Practice* are not applicable to Associates, or are not applicable in the same way and to the same extent as they are to medical practitioners, and without any appropriate amendment or qualification give rise to a very real risk that patients (and Associates) will not be capable of ascertaining without any confusion what a doctor may do that an Associate cannot.
    d. The content of *Good Medical Practice* refers to mandatory obligations upon readers to (*inter alia*) assess, diagnose, treat and prescribe without making it clear that it may not be appropriate for an Associate to undertake any of those activities (or not appropriate to do so without the supervision and authority of their supervising medical practitioner). The concern and confusion that this presents is particularly acute given the wide array of specialisms which an Associate may operate in at any given time and the lack of any nationally agreed scope of practice guidance.

e. The first of the four domains into which *Good Medical Practice* is structured is entitled "*Knowledge, skills and development*". The introduction to the domain talks about *"medical practice"* being a lifelong journey and emphasises how *"good medical professionals"* are competent, keep their knowledge and skills up to date and provide a good standard of practice and care. A reader of this would not understand that the knowledge and skills of doctors, on the one hand, and of PAs/AAs on the other, are fundamentally different.

f. The section in the first domain on the provision of good clinical care talks about the assessment, diagnosis and treatment of patients. Whilst it does not assume that every professional is involved in such work, or involved to the same extent, (see the use of the word *"if"* in §6), §7 sets out what a professional must do in providing clinical care[48] in a way which does not distinguish in any respect between that which a doctor may do and that which an Associate may do.

g. In the second domain, entitled 'Patients, partnership and communication', §18 states "*you must recognise a patient's right to choose whether to accept your advice, and respect their right to seek a second opinion*", whilst §28 is concerned with the provision of information to patients ("*you must give patients the information they want or need in a way they can understand*"), including information about their condition, likely progression, any uncertainties about diagnosis and prognosis, options for managing or treating their condition, the potential benefits, risks of harm, uncertainties about and likelihood of success of each option. This gives the impression that the provision of full advice and information about a patient's condition, diagnosis, prognosis and the obtaining of fully informed consent for treatment is just as much the responsibility of Associates as doctors, which is wrong.

h. *Good Medical Practice* refers its registrants to other items of guidance aimed expressly at doctors and, in doing so, suggests that all registrants are doctors or medical practitioners (see §§8, 41 and 60), or at least blurs the distinctions between doctors and Associates.

[48] For example: *"you must ... adequately assess a patient's condition", "you must ... carry out a physical examination where necessary", "you must promptly provide (or arrange) suitable advice, investigation or treatment where necessary", " you must propose, provide or prescribe drugs or treatment ... only when you have adequate knowledge of the patient's health ...", "you must ... propose, provide or prescribe effective treatment on the best available evidence"*)

88. In issuing guidance (and not just any guidance, but that which sets out core principles) that applies equally to doctors and Associates, without distinguishing between them or between their separate and different training and skills, with the ensuing potential for the public to be unaware of who is and is not a medical practitioner, or unaware of what their different roles and responsibilities are, and in publicly labelling Associates as medical professionals in the same way as doctors, the GMC has failed to act in accordance with the statutory objectives in relation to patient safety and public confidence. Rather than advancing public protection, the GMC's approach exacerbates the already very real risk of confusion as between Associates and doctors, to the detriment of both safety and public confidence. The GMC's approach cannot be reconciled with its overarching objectives, or with the obligation to have proper regard to the interests of persons using or needing the services of medical practitioners.

89. It is particularly difficult to understand the GMC's insistence that there is no room for confusion nor the commission of criminal offences as a result of its use of the term "medical professionals" in circumstances where mistakes in describing the Associate professions have even been made within the NHS[49] and by the GMC's own staff (see the second witness statement of Mr McAlonan dated 1 August 2024). In any event, the GMC's approach must be viewed against the backdrop of significant confusion surrounding the roles, which has given rise to patient safety risks as well as actual incidents of patient detriment.[50]

90. As for the defence advanced by the GMC in its DGR (§§72-75), the BMA additionally submits:
    a. The GMC is wrong to assert that the Court's consideration of this ground of challenge should be based on the ***Wednesbury*** standard (§73). Whether the GMC has breached its statutory duties is for the Court to determine, having regard to the nature of those duties.
    b. The GMC's contention that there was "*strong support*" in the stakeholder engagement and consultation responses "*for having a single set of core professional standards*" (§74(ii)) should be viewed critically and in context. While the GMC's surveys with its community of interest and stakeholders, and the public consultation, suggested support for shared core standards, respondents' comments emphasised the importance of such

[49] See §75 of Mr McAlonan's first statement [CB/179].
[50] See the detail in Mr McAlonan's first statement, in particular, §§63-75 (regarding widespread confusion surrounding the Associate professions); §76 (concerning high-profile cases of patient death or injury further to an Associate failing to clarify that they were not a doctor and that their role and qualifications were different); §§71-75, 83 (evidence from doctors suggesting that the way Associates work is a risk to patient safety). Furthermore, the absence of national scope of practice guidance – and the concerns raised by the bodies on whom the GMC's DGR rely to do so – is a relevant factual backdrop to the grounds of challenge pursued by the BMA.

standards being appropriately tailored. The quantitative headlines must be viewed alongside the qualitative nuance. The same point applies to the consideration given to these issues by the EAG and Advisory Forum, whose recorded discussions must be viewed in their proper context.

c. The duties imposed by *Good Medical Practice* do not provide an answer to the unlawfulness arising from the guidance (§74(a)(iv)). It is the way in which the duties in the guidance have been applied – without any or any adequate differentiation between the distinct professions – which unlawfully blurs boundaries and leads to a significant risk of confusion.

d. As for the suggestion that the lack of clarity and blurred lines are not problematic because the audience is made up of doctors and Associates, and because separate communications for patients have been drafted (§74(b)(ii): (i) this contention is contrary to the GMC's own approach of seeking input from patients and the public on the drafting of *Good Medical Practice*; (ii) patients and the public should not have to seek out separate GMC communications to understand the critical distinctions between doctors and Associates, which should be clear from the text of *Good Medical Practice* itself; and (iii) the GMC's approach requires Associates themselves to attempt to identify and interpret which obligations in the guidance apply to them, which itself risks confusion and error.

e. The GMC's reliance on the GMC having the word "medical" in its name (DGR74(b)(iv) does not support its case. The fact of the GMC being the regulator of Associate professions already gives rise, prima facie, to the potential for confusion or false assumption on the part of the public that Associates are, in some way, medically qualified, which only serves to reinforce the importance of complete clarity in *Good Medical Practice*.

f. The GMC's reliance on AAs and PAs having been referred to historically as "Medical Associate Professionals" (DGR §74(b)(v) is misguided. There are obvious differences, including the explicit reference to "Associate" and that it has never been a term intended to encompass doctors.

g. The GMC is wrong to assert that "*Just over half the responses to the consultation which addressed this matter were supportive of the use of the term "medical professionals"."* (DGR §74(b)(vi)). In fact, of 73 respondents to the 2022 consultation who commented on the use of "medical professional", only 26 spoke positively. By contrast, 35 spoke

negatively. By proceeding on the basis that a majority of respondents to the consultation were supportive of the term "medical professionals", the GMC fell into further error.

h. The assertion that no concerns were raised about the use of "medical professionals" by the EAG and Advisory Forum (DGR §74(b)(vii)) should be viewed with care. Relevant concerns were raised in the EAG – including on the use of the phrase "medical workforce" – and its recorded discussions must be viewed in their proper context (which includes that the initial interim standards considered by the EAG did not use the term). Similar considerations apply to the Advisory Forum, which was also told by the GMC that it was not in its gift to use a different term to "medical professionals".

i. The GMC was wrong to place any material weight on the use of phrases such as "dental professionals" by other regulators (DGR §74(b)(viii)): the legal, regulatory and factual context relevant to the use such terms is different for each regulator.

j. The GMC's submission that the requirements of *Good Medical Practice* do not apply equally and in the same way to all doctors, given their varying roles (DGR §74(c)-(d)), ignores the fundamental distinction between the qualifications, experience and roles of doctors on the one hand and Associates on the other.[51]

k. The GMC's explanation that the other guidance documents which are addressed to doctors and are cross-referred to in *Good Medical Practice* are yet to be updated (DGR §74(e)(iii)) further illustrates the problems arising from its approach.[52]

Ground 3: Irrationality

91. The matters set out above further establish that the GMC has acted irrationally in deciding to apply *Good Medical Practice* without appropriate modification or qualification to Associates and in deciding to refer to doctors and Associates alike as medical professionals.

92. The following points provide further support for this ground:

a. Article 3 of the AAPA Order places a mandatory obligation upon the GMC to "*determine standards"* relating to *"conduct and ethics"* and those standards must be standards *"applicable to associates*". Given the distinction in roles, responsibilities, training, knowledge and skills, and legitimate scope of practice, as between Associates and medical practitioners, the application of *Good Medical Practice* to Associates without

[51] The BMA also notes that the GMC "*accepts that not all requirements of GMP 2024 will apply to the work of all AAs and PAs*" (without specifying which).

[52] The GMC's further assertion that the guidance documents "*set out general principles which are relevant to AAs and PAs as well as doctors*" is unevidenced and should not be accepted.

qualification or appropriate amendment, and without recognising the critical distinctions between the professions, is not a rational exercise of the GMC's functions.

b. As a result of its approach, the GMC is, in effect, asking Associates to re-interpret and re-formulate *Good Medical Practice* in a way that they think ought to apply to them (and to do so in the absence of any nationally agreed or determined scope of practice guidance or framework). This is not a rational exercise of the GMC's functions.

c. Characterising Associates as medical professionals/members of the medical profession runs the risk of Associates referring to themselves in terms that are protected by primary legislation and committing a criminal offence under section 49 of the 1983 Act. Indeed, as set out in the first statement of Daniel McAlonan and above, NHS bodies themselves have held Associates out to be doctors in contravention of the 1983 Act.

d. The entire structure and purpose of the AAPA Order envisages a similar but nonetheless distinct regulation of Associates by the GMC that reflects the distinction between, in the words of the legislation, "*the medical profession*" on the one hand and "*the anaesthesia associate and physician associate professions*" on the other. The failure by the GMC to issue guidance for the differing professions accordingly – alongside its decision to refer to the professions using an umbrella term that is associated in the 1983 Act with medical practitioners only – unlawfully frustrates the purposes of the 1983 Act as well as the purpose of the AAPA Order, contrary to the principle established ***Padfield v Minister of Agriculture, Fisheries and Food*** [1968] AC 997. Accordingly, the GMC's decisions can be regarded as both irrational and in breach of the ***Padfield*** principle.

93. Both the BMA (in its consultation response to the GMC and associated covering letter) and Anaesthetists United (the Fifth Interested Party) have reminded the GMC of the very real and significant consequences for the GMC's statutory objectives of patient safety and patient confidence in the medical profession and Associate professions. The GMC's maintenance of its position, in its letter of 4 April 2024 to Anaesthetists United, explains that it used the term in preference to other terms which were "*felt…cold and impersonal*" and that it would only use the term "*sparingly*" [SB/1562]. Yet the term is used throughout the latest version of *Good Medical Practice*, and a concern about other terms feeling *"cold and impersonal"* (or a choice, as previously set out by the GMC, to use the term *"for ease of reading"*) cannot rationally outweigh the risks of confusion and, consequently, to patient safety and confidence in the respective professions.

94. Furthermore, the GMC's unwillingness to accept that the terms of *Good Medical Practice* give rise to the possibility of confusion for medical practitioners, associate professionals and patients (including in its pre-action response letter [CB/24-32] and defence to this claim) is completely contrary to the (publicly available) evidence of widespread confusion and concern that have been escalating in recent months, as set out in Mr McAlonan's first witness statement. This ongoing refusal to consider well-founded evidence of patient safety concerns from a number of reputable sources – and having been shown to play out in patient deaths – is, of itself, irrational.

95. No reasonable regulator in the position of the GMC – for whom the public's safety and protection ought to be at the heart of its actions – could have made the decisions under challenge. In particular, the decisions by the GMC are unreasonable in that they:
    a. fail to have regard to the concerns now being voiced with increasing urgency by well-informed representative bodies;
    b. fail to have regard to known instances of patient harm caused by the confusion over the Associate profession;
    c. fail to prioritise patient safety in accordance with the GMC's primary statutory objective;
    d. support the impression that Associates can do anything and everything that a doctor can do and thus introduce confusion on the part of patients, doctors and Associates in an environment where confusion can have critical, even fatal, consequences.

96. Finally, the GMC's defence fails to deal with these very pressing patient safety concerns, that are not only at the heart of this challenge but should also be at the heart of its function as a regulator. The GMC does not deny that these patient safety concerns are well-founded, but instead raises the argument that there is no evidence that they have been caused by *Good Medical Practice* (DGR §76(e)). This "wait and see" approach to patient safety and harm is irreconcilable with its statutory objectives as a regulator and perverse. Any reasonable regulator would have regard to well-founded patient safety and public confidence concerns raised by a number of recognised and credible bodies in promulgating guidance and electing how publicly to characterise these fundamentally different professions. It would not, as the GMC does in its DGR (§76(e)), dismiss these as "*without foundation*".

E. EXTENSION OF TIME

97. The BMA recognises that an extension of time to bring its claim may be required, although it notes that regulation of AAs and PAs only commenced in December 2024; that the challenge is concerned with an ongoing policy and ongoing use of key terminology; that, prior to the proceedings being issues, the GMC maintained its position as recently as 4 April 2024; and that, following its 2024 consultation, the GMC made further changes to *Good Medical Practice* in December. Assuming it is required, the BMA asks the Court to grant it an extension of time for bringing this challenge on the basis that there is good reason for doing so. The factors relevant to whether to grant such an extension were addressed by Lord Lloyd-Jones in ***Maharaj v National Energy Corporation of Trinidad and Tobago*** [2019] UKPC 5, [2019] 1 WLR 983 at §38:[53] "*Here it is important to emphasise that the statutory test is not one of good reason for delay but the broader test of good reason for extending time. This will be likely to bring in many considerations beyond those relevant to an objectively good reason for the delay, including the importance of the issues, the prospect of success, the presence or absence of prejudice or detriment to good administration, and the public interest.*

Importance of the issues and the public interest

98. The importance of the issues and the public interest are, the BMA submits, the most significant factors in considering an extension. The fact that patient deaths have occurred and that so many reputable representative bodies have increasingly, and with increasing urgency, expressed their concerns about these issues (which have gone so far as to cause at least one body to withdraw its support for the GMC being the regulator of Associates[54]) demonstrates their significant public importance. There is evidence of ongoing confusion even among professionals and within the NHS as to the appropriate way to describe an Associate in line with their competence and so as not to infringe s.49(1) of the 1983 Act. Any attempt to suggest that the issues raised by this claim are, therefore, settled and not causes for concern is incorrect. The BMA submits that this factor alone would warrant the Court granting an extension of time for this challenge, as has been recognised in a number of authorities.[55]

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[53] The applicability of the test articulated in ***Maharaj*** is reflected in the Administrative Court's Judicial Review Guide 2024 (§6.4.4.2) and has been confirmed in a number of recent authorities: for example, ***R (Dean Dobson) v Secretary of State for Justice*** [2023] EWHC 50 at §31 and ***R (Ingold) v Secretary of State for Work and Pensions*** [2023] EWHC 3207 (Admin) at §128.

[54] The Royal College of General Practitioners did so in a statement on 8 March 2024, as set out at paragraph 83(h) of the first witness statement of Daniel McAlonan.

[55] See, for example, R***. v Secretary of State for the Home Department Ex p. Ruddock*** [1987] 1W.L.R. 1482 at 1485, cited with approval by Rose LJ in ***R. v Secretary of State for Foreign and Commonwealth Affairs Ex p. World Development***

Reasons for delay

99. Whilst *Good Medical Practice* was published on 22 August 2023, to come into effect for doctors on 30 January 2024 (and for PAs and AAs in December 2024), the GMC noted, in its document "*How we developed the updated professional standards*" that it was *"the first time we've updated the guidance with a forward look to the future regulation of physician associates and anaesthesia associates, subject to new legislation being introduced by the UK government"* (emphasis added). That was an important qualification, and it would have been premature for the BMA to bring this claim in advance of the making of the AAPA Order on 13 March 2024: without that Order in Council, there would be no statutory regulation and no power for the GMC to regulate the Associate profession. As set out by Mr McAlonan, the BMA was lobbying the DHSC and Parliament not to make the AAPA Order in the terms that Parliament ultimately did. Had the BMA been successful, there would have been no claim to bring.

100. It was, moreover, reasonable for the BMA to await the publication on 26 March 2024 of the GMC's consultation and its draft standards, rules and guidance, in order to assess whether the GMC might take a different regulatory course – and it could have been said that bringing the claim while the GMC was considering the consultation responses was premature. Before deciding to issue this claim, a step which the BMA did not take lightly, it carefully considered the materials published by the GMC and its position as set out in its letter of 4 April 2024 to Anaesthetists United, as well as the increasing concerns of its own members, the recent voicing of similar, and increasingly urgent, concerns by other representative bodies, and the very recent publication by an NHS body of material which indicated that the central distinctions between the roles of Associates and doctors are not properly understood even within the NHS.

101. Further: (i) when the GMC re-drafted and consulted upon *Good Medical Practice* in 2022, it was not yet the regulator of the Associate professions, and the DHSC had not conducted its own consultation on the standards of regulation for the Associate professions (which it did in February 2023), let alone laid draft secondary legislation before Parliament (as it did in early 2024); (ii) the GMC's earlier work, to which the BMA was privy, indicated that standards applicable to Associates would need to be appropriately amended and tailored (see

Movement Ltd [1995] 1 W.L.R. 386 at 403; ***R. v Secretary of State for Trade and Industry and Others*** [2000] Env. L.R. 221; ***R. (on the application of Robertson) v Wakefield MDC*** [2002] Q.B. 1052; and ***R. (on the application of the Law Society) v Legal Services Commission*** [2010] EWHC 2550 (Admin), [2011] Costs L.R. Online 57.

§§37-50 of Mr McAlonan's first statement); (iii) there was no clear statement that *Good Medical Practice* as drafted (and without further amendment) would be the totality of the standards to which the Associate professions were held by the GMC, nor would that be readily apparent to any objective reader of the draft, given the very limited reference to Associates; (iv) although the GMC describes its recently closed consultation as relating "*to different matters*" (DGR 63(b)), it was the GMC's consultation on the regulation and standards applicable to Associates, hence its title: "*Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards and guidance*". Moreover, on the GMC's own case, this consultation led it to make further amendments to *Good Medical Practice*, on which it now relies in these proceedings.

Prospects of success and detriment

102. The BMA submits that the strength of its case supports the grant of an extension. Further, as explained in Mr McAlonan's third witness statement [CB/266/§§32-33], the BMA's claim, if successful, should not require the GMC to require substantial or unduly burdensome work to remedy the unlawfulness. In any event, any impact on or further work required of the GMC would be decisively outweighed by the public interest and importance of the issues.

F. CONCLUSION

103. For the reasons set out above, the BMA submits that the GMC has – and continues to – act unlawfully by applying *Good Medical Practice* to Associates without producing a distinct or appropriately amended version; and by using the term "medical professionals" to encompass members of the Associate professions. It invites the Court to make declarations to that effect.

JENNI RICHARDS KC
ADAM BOUKRAA

39 Essex Chambers
22 January 2025