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By email and post

Direct tel +44 (0)7920 591584 Date 21 June 2024
Email Nicola.Mead-Batten@tlt.com; Simon.Ramsden@tlt.com

Dear Sirs

Judicial Review Pre-Action Protocol: R (British Medical Association) v General Medical Council

Proposed Claimant

1. The Proposed Claimant is a registered trade union and professional body for doctors and medical students in the UK. The British Medical Association (**BMA**) has more than 193,000 members across the UK. Its role is to represent and support UK doctors and medical students on issues impacting the medical profession and to act as a leading voice nationally in advocating for outstanding health care. The BMA has been found to have standing to bring judicial review proceedings in multiple cases relating to doctors' training, qualifications, and other work-related issues that engage questions of public law and therefore fall within the scope of judicial review in line with *R v Berkshire Area Health Authority ex parte Walsh* [1984] 3 All ER 425.

2. The BMA's address is BMA House, Tavistock Square, London WC1H 9JP.

3. Please confirm urgently by return if you have any objection to the BMA on standing grounds.

Proposed Defendant

4. The General Medical Council (**GMC**) is the independent regulator of doctors in the UK. It maintains the official register of medical practitioners in the UK.

5. Per the Anaesthesia Associates and Physician Associates Order 2024 (**AAPAO**), which was made in exercise of powers conferred by sections 60(1)(b) and 62(4) and (4A) of, and Schedule 3 to, the Health Act 1999, on 13 March 2024, the GMC is to be the statutory regulator of Anaesthesia associates (**AAs**) and Physician associates (**PAs**) from 13 December 2024.

For what comes next

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Claimant's legal representatives

6. The BMA is represented by TLT LLP, 1 Redcliff St, Redcliffe, Bristol BS1 6TP, FAO Nicola Mead-Batten, Partner and Simon Ramsden, Legal Director (email addresses above, file reference 119994/000016).

Details of the matter being challenged

7. The BMA seeks to challenge the GMC's decision to apply its long-established central guidance for doctors – *Good Medical Practice* (**GMP**) (the most recent version of which was published on 22 August 2023 and came into effect on 30 January 2024) – equally to PAs/AAs once they are regulated by the GMC as of 13 December 2024.

8. The BMA also challenges the continued use of the term "medical professionals" by the GMC in this context as a collective description for doctors and PAs/ AAs – and, specifically, repeatedly within the GMP text - on the basis that inclusion of PAs and AAs within the term "medical professionals" is liable to confuse patients and the broader public and blur the important distinction between medical practitioners (i.e. doctors) and associate professionals which, in turn, gives rise to serious public protection concerns.

9. Both of these issues are particularly concerning against the backdrop of: a continued absence of any nationally agreed *scope of practice* guidance for PAs/AAs; continuing public safety concerns connected with the same; and the broad nature of the standards for education and training for PAs/ AAs drawn up by the GMC in its latest consultation launched on 26 March 2024 *Regulating anaesthesia associates and physician associates – consultation on our proposed rules, standards and guidance*.

Details of any interested parties

10. We are copying this proposed challenge to those persons we have identified as being directly affected by the issues raised in this letter. Namely:

    a. The Faculty of Physician Associates within the Royal College of Physicians (FPA@rcp.ac.uk, FPARegulation@rcp.ac.uk).

    b. Association of Anaesthesia Associates, the representative body of the AA role in the UK (info@anaesthsiaassociates.org).

    c. The Royal College of Anaesthetists, which states on its website that its role in relation to AAs is to provide leadership and guidance on their education, training and professional development (info@rcoa.ac.uk).

    d. Anaesthetists United (**AU**) (team@AnaesthetistsUnited.com), described on its website as *"an informal group of consultants and SAS Anaesthetists from all over the UK. We came together because we felt our leaders were not adequately representing our views"*. AU published on its website an open letter to the GMC, dated 26 March 2024, referring to similar issues as are expounded in this letter. The GMC's response was sent to AU on 4 April 2024.

    e. NHS England (NHSE.newproceedings@nhs.net).

    f. The Government Legal Department on behalf of the Secretary of State for Health and Social Care, who is ultimately responsible for the NHS (thetreasurysolicitor@governmentlegal.gov.uk).

11. If you are aware of any other interested parties, please respond urgently by return and provide relevant details.

Background

PAs and AAs

12. Physician associates and anaesthesia associates are healthcare professionals who work under the supervision of a medically qualified doctor or anaesthetist[1].

13. PAs and AAs have been working, in relatively small numbers, in the NHS since 2002 and 2004 respectively. When they were first introduced, they were respectively known as physician assistants and physicians' assistants (anaesthesia). The terminology for PAs has since changed to 'physician associate' and 'anaesthesia associate'. As of June 2023, NHS workforce data showed that there were 93 full-time equivalent (**FTE**) qualified AAs and 1,508 FTE qualified PAs working in NHS trusts and other core organisations in England, and a further 1,707 FTE qualified PAs working in GP practices and primary care networks. The government has indicated plans to expand this number considerably – per the NHS long term workforce plan published in June 2023.

14. In the past two decades since their introduction, PAs/AAs have not been subject to statutory regulation. This will change as a result of the AAPAO with effect from 13 December 2024, when they will come within the GMC's regulatory framework. The BMA is, as the GMC is aware, strongly supportive of statutory regulation but considers that the appropriate regulator for the roles of PAs/AAs would be the Health and Care Professions Council, which regulates 15 relevant professions in the UK. That is not, however, the issue raised by this challenge. The BMA also considers that it would be significantly less confusing for patients and the public if the description "physician assistants" and "anaesthesia assistants" were employed, rather than physician and anaesthesia associates, but recognises that these terms have now been enshrined in secondary legislation.

15. However, these two factors – the fact of regulation by the GMC rather than the HCPC and a professional description which has the potential to mislead patients and the public as to the nature and extent of the qualifications and experience of PAs and AAs – reinforce the absolute importance of ensuring that the distinction between medical practitioners, on the one hand, and associate professionals, on the other hand, is made absolutely clear by all relevant public bodies, and in particular by the statutory regulator, the GMC.

16. The BMA recognises that PAs and AAs can have a role to play within the NHS, but considers that it is absolutely essential that there is no possibility whatsoever for confusion among patients, other healthcare professionals/staff and the public. The BMA is seriously concerned about issues from a public protection standpoint, including:

    a. There is and remains, remarkably given the less than six months out from their becoming regulated professionals (and in circumstances where the NHS plans to significantly expand this workforce), no clarity around a nationally agreed *scope of practice* for PAs/AAs, and limited guidance for the roles that sets out that which PAs/AAs can and should be permitted to do and that which they should not be doing[2]. As the intended regulator for PAs/AAs under AAPAO, the GMC has not sufficiently engaged with this, and/or the potential implications for the relevant professionals and their patients.

    b. It is clear that lay people struggle to grapple with the semantics and technicalities associated with PAs/AAs; who they are, what they do (and don't do), and the differences between them and registered medical professionals, i.e. doctors. (A 2023

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[1] Physician and Anaesthesia Associate roles in the NHS fact sheet, 3 November 2023 Physician and Anaesthesia Associate roles in the NHS – fact sheet – Department of Health and Social Care Media Centre (blog.gov.uk)

[2] See for example: PA and AA generic and shared learning outcomes - GMC (gmc-uk.org); PA registration assessment content map - GMC (gmc-uk.org)

survey by the BMA revealed that 25% of a representative sample of 2,009 people erroneously believed that a physician associate was a doctor, while a fifth made the same mistake about "physician assistants".)

c. This was tragically underscored by the case of Emily Chesterton; a thirty-year-old woman who died in November 2022 after suffering a pulmonary embolism. A pain in Ms Chesterton's calf was misdiagnosed by a PA (on two occasions) as a sprain. Ms Chesterton's parents said that Emily believed the person diagnosing her was a GP. This issue was highlighted by Ms Chesterton's parents' MP Barbara Keeley in Parliament session on 6 July 2023:

> *Physician associates are expected to be under the supervision of a designated medical practitioner, but that does not appear to have been the case with the lack of supervision that occurred in the case of Emily Chesterton. When qualified medical professionals such as GPs are already stretched, it is easy to see how tasks such as checking the notes and work of a physician associate could be missed.*
>
> *There is also the problem of the title of the role, which Marion Chesterton told me sounds "extremely grand, even grander than a General Practitioner". She suggested that the name should change to "doctors apprentice", "learner doctor" or "probationary doctor" to avoid confusion, and it should be made very clear who patients are seeing.*
>
> *Marion Chesterton also told me: "We only discovered that the medic treating Emily was not a doctor the week before the inquest. This caused us extreme distress." She asks: "Could something be put into place to keep families fully aware earlier on in the process?"*

d. There is even evidence of a current lack of understanding within the NHS, as illustrated by the recent marketing campaign *"It's a GP Practice Thing"* by one NHS Integrated Care Board apparently designed to help the public understand PAs, which advanced *"Your **Physician** will see you now"* in reference to and containing a picture of a Physician Associate (see below). The use of the professional title *"Physician"* is amongst those protected by section 49(1) of the Medical Act 1983 (the **1983 Act**), and its misuse can constitute a criminal offence (per s. 49A).

A related poster referred to a “Cancer Specialist” (above) and another (see below) misleadingly portrayed health professionals supporting GP practices as part of a “specialist team” including a “Physician”, dressed in a white coat and stethoscope and described as carrying out examination and diagnosis associated with the work of a qualified doctor, and referred to consultation, treatment and referral by “mental health experts”.

You’ll be seen quicker by a member of our specialist team.

It’s a GP practice thing.

NHS

Physician

Work with GPs to support patients by diagnosing illness or injuries and performing physical examinations.

Pharmacist

Provide information and advice about the safe and effective use of medications as well as monitoring progress.

Physiotherapist

Diagnose, assess and treat problems with muscles, bones and joints. Improve problems by exercising and stretching.

Social Prescriber

Look at how illness affects all parts of your life and helps you get the support you need with day to day challenges.

Care Navigator

Trained to assess and direct you to speak to the right person. Might ask you questions to make sure you get the right care.

Health Visitor

Identify health needs of 0-5 year olds and improve wellbeing by promoting health and reducing inequalities.

Practice Nurse

Treat wounds, apply dressings and provide emergency first aid as well as taking swabs, smears and samples.

Care Coordinator

Provide support for patients with complex needs and help you learn how to manage your own health.

Advanced Care Practitioner

Assess, diagnose and monitor complex conditions through examinations, testing and prescribing medicines.

Lifestyle Practitioner

Find out what works best to help you stay healthy or improve your health through personlised care plans.

Nurse Practitioner

Diagnose and treat illnesses and ailments often focussing on minor illness or new conditions and prescribing medicines.

Mental Health Worker

Fully trained mental health experts can offer a consultation, treatment, peer support, or a referral to hospital teams.

Not everyone needs to see a doctor.
Your GP practice will make sure you get the right care as quickly as possible.

Find out more

Scan the QR code for further information about your team. Remember, you can ask to see one of your GP team if you have a particular question about your health.

These materials were adopted by more than one body. Following complaints via various channels including the Royal College of Physicians and the BMA the mistakes and errors have been acknowledged and apologised for with the relevant posters recently removed from the Bradford District and Craven Health and Care Partnership and Integrated Care Board websites with steps taken to remove and amend material used by others elsewhere. An internal review into how these mistakes took place has been started by the Integrated Care Board.

This is plainly relevant context for the potential grounds for the BMA's present complaint.

Statutory framework

17. Section 1(1A) of the 1983 Act provides that the over-arching objective of the GMC in exercising its functions is the protection of the public. Section 1(1B) explains that this involves 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."* (underlining added). The term medical profession within the 1983 Act can only refer to medical practitioners i.e. medically qualified doctors – that is the profession to which the section refers.

18. Section 2(1) of the 1983 Act provides that there shall continue to be kept by the Registrar of the GMC *"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"*. Section 2(2) provides that this register is *"the register of medical practitioners"*. Multiple other provisions in the Act refer to *"medical practitioners"*, including Part IV which addresses the information to be included within the registers.

19. Section 60(1)(a) of the Health Act 1999 permits the King by Order in Council to make provision modifying the regulation of any profession to which subsection (2) applies; section 60(1)(b) permits an Order in Council to be made regulating *"any other profession"* which appears to be *"concerned (wholly or partly) with the physical or mental health of individuals"*. Schedule 3, para 1, to the 1999 Act provides that an Order may make provision, *"in relation to any profession"*, for any of the following matters: (a) the establishment and continuance of a regulatory body; (b) keeping a register of members admitted to practice; (c) education and training before and after admission to practice; (d) privileges of members admitted to practice; (e) standards of conduct and performance; (f) discipline and fitness to practise; (g) investigation and enforcement by or on behalf of a regulator body; (h) appeals. Para 10 of the schedule defines a medical practitioner as *"a registered medical practitioner as defined by Schedule 1 to the Interpretation Act 1978"* which, 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"*.

20. The AAPAO was made in March 2024 under the powers conferred by the 1999 Act. Most of its provisions will have effect from 13 December 2024. Article 3(1) AAPAO imposes a duty on the GMC to *"determine standards applicable to associates"* and provides that these standards must relate to: education and training; knowledge and skills; experience and performance; conduct and ethics; proficiency in the English language; and *"such other matters as the Regulator may prescribe in rules made under paragraph 2(2)(a) of Schedule 4"*. Before determining a standard, the GMC must consult such persons as it considers appropriate: article 3(3).

21. The AAPAO uses the terminology of *"the anaesthesia associate and physician associate professions"*: thus, para 3 of schedule 1 states 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"*. Para 3

also requires the GMC to discharge its functions under the AAPAO in a way that is transparent, accountable, proportionate and consistent.

22. It is plain from the statutory framework that the term "medical profession" and "medical practitioner" relates to medically qualified doctors only. It is equally plain from the statutory framework that PAs and AAs are to be regarded and described as members of *associate professions* (i.e the anaesthesia associate and physician associate professions) and not as members of the medical profession.

GMC consultation on proposed rules, standards and guidance

23. The GMC's *Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards and guidance* was launched on 26 March 2024. It stated that the consultation concerned the following:

    a. Draft rules, course standards and curriculum standards relating to the education and training of AAs and PAs, so as to enable them to qualify as an AA or PA.

    b. Draft rules regarding entry onto the register, removal and re-entry.

    c. Draft fitness to practise rules.

    d. Draft fitness to practise principles to "inform the content of fitness to practise decision-making guidance that will apply to doctors as well as to PAs and AAs from December 2024".

    e. Draft rules on the process for revising GMC decisions and for appeals.

    f. Draft rules relating to fees.

24. It also specified what the consultation was not about. It said it was not about the principle of statutory regulation, or whether AAs or PAs should be regulated by the GMC. It was not about the content of the AAPAO, including the professional titles of PA/AAs. Most pertinently for present purposes, the GMC also said that:

    > *"it isn't the role of the regulator to determine what tasks individual professionals can safely carry out once they are registered with us, because that depends on their individual skills and competence, which develop over time. We won't determine scope of practice for AAs and PAs beyond initial qualification competencies, just as we don't determine it for doctors. We know that NHS England, employer bodies and royal colleges have begun looking at how AA and PA scope of practice may develop over time. We welcome those developments and encourage involvement of the AA and PA professions in them also."*

25. The BMA responded to the consultation on 20 May 2024. As well as (re-)stating various points it has raised previously in the wider context of PAs/AAs including issues with the titles and regulation by the GMC (cf. HCPC), and the BMA's concerns about plans to expand the PA/AA workforce, calling for these to be halted *"until there is clarity around scope of practice"*; the response also explained that the term "medical professionals" should only be used to describe medical practitioners and not members of associate professions, adding:

    > *"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."*

26. The BMA also made various representations regarding the GMC's planned approach to *Education and training* including:

" Given the decision by the Royal College of Physicians, London to transition the FPA into an independent faculty by April 2024, it is wholly inappropriate for a dependent profession that works under the supervision of doctors to set its own curricula, not least for a profession where, for too long, the role and remit has been blurred with that of fully trained and qualified medical practitioners. We oppose any arrangement where the approval of curricula for physician assistants is not owned and directly overseen by an appropriate body of medical practitioners.

While the GMC is on course to be the regulator, we agree that the GMC should set the standards that course providers must meet to deliver and award AA and PA qualifications, approve AA and PA courses, and carry out quality assurance checks to make sure that education organisations are meeting the standards. In undertaking this work it must be clear from the outset that PAs and AAs are learning the skills to be supportive, dependent professionals who will have a role in assisting doctors. PA and AA courses must be clearly distinguished from medical schools and should never be referred to as such.

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 multi-disciplinary 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."

27. The GMC's planned approach to PA/AA training and curricula - namely setting a high level and broad set of standards for education and training, without setting out in sufficient detail the knowledge, skills and capabilities expected of these associates - is in marked contrast to the GMC's current approach to the training of doctors which has become much more prescriptive through the introduction of the Medical Licensing Assessment.

28. The Regulatory PA/ AAs consultation has now closed, and the GMC says it is considering responses; it will *"publish a report with the conclusions of the consultation and summarise any changes we have made to our rules, standards, and guidance based on the feedback we have received."*[3]

The issues

Good medical practice (GMP)

29. *GMP* has been published by the GMC, and directed to doctors, since 1995. Whilst the GMC publishes numerous pieces of guidance, *GMP* has a particular and key status: it is the guidance which brings together what the GMC regards as the fundamental standards for doctors, and it is almost invariably the standards set out in *GMP* that doctors' fitness to practise is assessed against.

30. The GMC now intends that *GMP* should apply to PAs and AAs as it does doctors (per the statement on its website: *"These standards will also apply to physician associates and anaesthesia associates in the future, once they're regulated by us"*). The Consultation document stated: *"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"*

31. The latest version of the *GMP* published on 22 August 2023 with effect from January 2024 states in Footnote 1: *"At the time of publication we regulate doctors. We are preparing to*

[3] https://www.gmc-uk.org/pa-and-aa-regulation-hub/regulating-aas-and-pas-consultation

regulate Physician Associates and Anaesthesia Associates in the future, at which point this guidance will also apply to them". The footnote which is in small print on page 4 and repeated in a footnote list at the end is, as far as we are aware, the first unequivocal indication of intention in this regard. There are no other references currently in the substantive text to PAs/ AAs.

32. There had been previous references in GMC documents and meeting minutes to (our emphasis) "**interim** versions" of *GMP "**amended** to reflect the roles and responsibilities of PAs and AAs…"* (27 July 2020 Meeting of MAPs regulation programme external advisory group, which has BMA attendees), notes of the *"support for the proposal that PAs and AAs should consider to uphold the same (**appropriately tailored**) professional standards as doctors across the four broad domains of Good medical practice…"* and *"different options for presenting this guidance. For example, will we **annotate** the existing version of GMP, or develop **separately branded** versions for each group or something in between" "…GMP clearly is linked to the professional identity of doctors"* (report for the October 2020 meeting of the same group by Emily Phillips). Other papers for the same meeting note that the question was asked whether PAs/AAs should adhere to the same professional standards as doctors in the 4 GMP domains. The answer was that there was: *"Broad support, with some highlighting the need for **separate standards to make clear differences** in level and nature of roles"*.

33. We are also aware of a document titled *"Good medical practice: interim standards for physician associates and anaesthesia associates"*[4]. Although this is marked "Not yet in effect" we understand from statements by the GMC Council that this standards document was brought into effect in 2022[5]. This document collectively refers to PAs/AAs as "healthcare professionals", and notes the following in respect of explanatory guidance within GMP: "*Although the current suite of explanatory guidance is addressed to doctors for the time being, we encourage physician associates and anaesthesia associates to consult the explanatory guidance to support understanding of the expected standards"*.

34. Furthermore, "*Achieving good medical practice: interim guidance for physician associate and anaesthesia associate students*"[6] was published on 29 September 2022 – this document refers to the prospect of student PAs/ AAs becoming "future medical professionals" and states on its face that it is intended to "outline the standards expected…" and show "how the principles and values of the GMC's core guidance for PAs and AAs, Good medical practice: interim standards for physician associates and anaesthesia associates, apply to you as a student…". It states "We want to give students, as well as their educators and those who work with them, an opportunity to understand what it will mean to join a regulated profession. It will be updated once the full review of Good medical practice is complete."[7].

35. The BMA's position, as expounded in its consultation response, is that this muddled history is illustrative of some of the patient safety issues caused by confused professional standards. *GMP* should relate to doctors (medical practitioners) alone, and separate guidance should be produced for PAs/ AAs. Whilst a number of the professional standards (such as the

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[4] Good medical practice for MAPs (gmc-uk.org)

[5] Minutes of GMC Council meeting on 24 February 2022 (published 28 February 2022) states (p.86) "We published *Good medical practice (GMP) for PAs and AAs* in October 2021 together with accompanying case studies. These standards will operate from the start of regulation until we publish new ethical guidance for all registrants emerging from the wider GMP review. Publishing interim standards gives PAs and AAs, students and educators, time to prepare for our expectations, and we know from feedback that this has been appreciated. We're currently considering how our Outreach teams can support future/new registrants both before and after regulation.": council-meeting---24-february-2022---agenda-and-papers--updated_pdf-105935292.pdf (gmc-uk.org); The Council paper entitled *Progress on MAPS* dated 24 February 2022 states (p.8): "Interim Good medical practice standards for [Medical Associate Practitioners] are now in place": council-meeting---28-april-2022--agenda-and-papers-new_pdf-96552803.pdf (gmc-uk.org)

[6] Achieving GMP for PAs and AAs (gmc-uk.org)

[7] *About this Guidance* (p.5)

requirements relating to honesty and integrity) may appropriately be common to both sets of professions, treating medical practitioners and associate professionals as one and the same is fundamentally wrong, inconsistent with the statutory framework as set out above, and irrational. It is also inconsistent with the statutory overarching objective in the 1983 Act imposed on the GMC. There are three core concerns which underscore this:

a. as a matter of principle, having the same guidance applying without distinction to the different professions blurs the distinctions between doctors and PAs/AAs 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;

b. if applied without distinction, parts of the specific content of *GMP* risk confusing and conflating the separate roles and responsibilities of doctors, on the one hand, and associates on the other. Whilst there are, obviously, large parts of *GMP* that can properly apply to both sets of professionals (e.g., the requirement to act with honesty and integrity), there are other parts which were plainly drafted with doctors in mind and which should not be read across to associates. For example (and please note that these are examples only):

   i. The very title of *GMP*, referring as it does to *"medical practice"*, might lead readers to conclude that the professionals to whom *GMP* applies are medical practitioners.

   ii. The first of the 4 domains into which *GMP* 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, or that PAs and AAs are not medical practitioners.

   iii. 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 para 6), para 7 sets out what a professional must do in providing clinical care (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"*) in a way which does not distinguish in any respect between that which a doctor may do and that which an associate may do.

   iv. The second domain is entitled *Patients, partnership and communication* and provides at para 18 that *"you must recognise a patient's right to choose whether to accept your advice, and respect their right to seek a second opinion"*, whilst para 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 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. This would be wrong.

c. The use of the term "medical professionals" as applicable to both doctors and PAs/AAs – this is picked up more particularly in paragraphs 36-38 below.

<u>'Medical professionals'</u>

36. "Good medical practice" is clearly intended to outline principles of "medical practice" which are "good". "Medical practitioners" are in "medical practice"; PAs/AAs are not in "medical practice". As set out in more detail in the section of this letter headed 'Statutory Framework' above, "Medical practitioner" is a specific term used in the 1983 Act to describe doctors.

37. *GMP* repeatedly refers to the document setting out the standards of care and behaviour expected *"of all medical professionals"*; *"We use the term 'medical professionals' to describe all our registrants* [footnote one per paragraph 31 above] *who we address directly (as 'you') throughout this guidance…"* There are 14 references to 'medical professionals' in total in *GMP*. Section 1(1A) of the 1983 Act refers to *"the medical profession"* and *"members of that profession"* and it is plain from the broader context of the Act that these references can only be to doctors. Thus, using the term "medical professional" to describe or include associates runs the risk of confusing the public (and/or professionals) as to the roles, skills and competencies of PA/AAs, and/or of blurring the important distinctions between doctors and associates. Set against the wider context of already existing confusion as to the roles of PAs/AAs and the lack of any detailed curricula or scope of practice, this is deeply troubling.

38. The GMC's reference to its intention to apply *GMP* to PAs/AAs (initially in the Consultation document and now confirmed in footnote 1 within *GMP*) confirms there is no intention to demarcate the relevant contents in any way, contrary to previous indications that such demarcation would take place (as set out at paragraph 32 above).

The BMA's case

39. The BMA's case is that (i) the application of *GMP* in equivalent manner (as standards set) for PAs/AAs as for doctors without demarcation or amendment and (ii) the continued use of 'medical professionals' as a collective term applicable to doctors and PAs/AAs:

    a. Constitutes a failure by the GMC to act in accordance with its statutory objectives per the 1983 Act including protection of the public, promotion and maintenance of confidence in the <u>medical profession</u>, and promotion of proper standards and conduct for members of the profession (ss. 1(1)(A) and (1)(B). [For the same reasons, the GMC is also failing in its parallel objectives in respect of PAs/AAs per para 3 of schedule 1 AAPAO.]

    b. Is irrational and/or fails to have regard to relevant factors (including the importance of clear articulation of the differences applicable in the regulation of PAs/AAs *cf.* doctors) in its intention to simply apply *GMP* to PAs/AAs *as is* from the commencement of its regulation of PAs/AAs in December 2024, and in its continued use of "medical professionals" as a term which encompasses doctors and PAs/AAs in this context.

<u>Anaesthetists United</u>

40. The BMA is aware that Anaesthetists United raised certain issues which are similar to the BMA's proposed grounds of challenge in its letter to the GMC dated 26 March 2024, to which the GMC responded on 4 April 2024.

41. In its response to Anaesthetists United, the GMC underlined its intentions:

    "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 was cold and impersonal. And we will only use the term 'medical professionals' sparingly…*
>
> *We do not accept that shared standards of conduct between professions implies conflation of those professions. Shared standards do, however, imply equivalence in terms of standards of care and professional behaviour, and we think this equivalence is in the interests of both patients and professionals. Having shared professional standards means that patients and professionals can have confidence that all registrants are working to the same expectations in terms of their conduct. It also means that, when concerns are raised about the conduct of doctors, PAs or AAs, those concerns will be considered against the same set of expectations."*

42. The BMA disagrees with these explanations and considers that the GMC's decision in this regard needs to be carefully revisited against the concerns set out in this letter as a matter of urgency.

Intention to apply to extend time

43. The BMA recognises that it may be argued that the claim has not been made in time. However, the history to this matter is convoluted. The terminology used by various stakeholders over the years has fluctuated. The picture on the intended regulation (or otherwise) of PAs/AAs is still evolving, 20 years plus since their inception. The matters which form the basis for this challenge on one level appears to have been set months ago (albeit via a minor introduction of a footnote to a long-standing document, the *GMP*), but the issues raised in the latest Consultation are live, responses to the Consultation are still being considered by the GMC, and we are now only six months away from the new regulatory regime being set.

44. As far as we are aware, the earliest date at which the matters which are the subject of this challenge might be said to have been determined by the GMC is via the *GMP* footnote, and therefore on 22 August 2023. However, it is plainly (at least) arguable that such intentions were not cemented and finally determined until more recently in the form of the March consultation and/or correspondence with Anaesthetists United.

45. Taking the earliest date of 22 August 2023, the BMA would be out of time to launch this claim in ordinary circumstances, but the issues raised here are too important (viewed from the perspective of patient safety and the wider public interest) not to be aired and so, insofar as is necessary, it intends to apply to the Court for an extension of time at the same time as filing the claim. Furthermore, it is the BMA's position that these issues do not fall to be viewed in isolation, but in the context of:

    (i) a continuing absence of any scope of practice guidance from the NHS and/or the GMC and/or the royal colleges (such that the BMA has been compelled to provide its own guidance – but is aware that others do not agree with that guidance);

    (ii) the absence, in the materials on which the GMC is currently consulting, of any clear guidance as to the differing and respective roles of medical practitioners and associate professionals;

    (iii) the continuing lack of clarity within the NHS itself as to the distinctions between these roles (see the examples referred to above); and

    (iv) the real, ongoing and serious risk that the public may be misled or confused and the consequential impact on patient safety.

46. For the reasons set out in this letter (and particularly expounded in paragraphs 16, 27 and 35-38 above), it is essential and squarely in the public's interest that these core aspects of

the GMC's now determined approach to regulation of PAs/AAs are tested before the Administrative Court. We do not consider there will be any prejudice to the GMC in any such application given that statutory regulation does not commence until December 2024, but if there is any prejudice that can no doubt be ameliorated by seeking to expedite (i) the court's consideration of the application for permission, (ii) any substantive hearing (including perhaps by agreement between the parties that there could be an expedited and rolled-up permission and substantive hearing).

Action(s) that the Defendant is expected to take

47. To consider the above matters and (i) to agree to amend GMP such that it is clear that it only refers to medical practitioners (i.e. doctors), (ii) to agree to produce a new version of standards for PAs/AAs (which may be based on *GMP* but not the same as it), which is appropriate, in line with its statutory objectives per the 1983 Act (and the AAPAO); and (iii) to cease using the term "medical professionals" in its publications as a term encompassing both medical practitioners (i.e. doctors) and PAs/AAs.

ADR Proposals

48. In light of the above matters, we are not convinced that ADR is appropriate in this case, but if you wish us to consider it, please contact us urgently.

Proposed reply date

49. Given the points made above particularly around timing, we consider an abridged timeframe for response (compared to the standard) of one week from receipt of this letter via email, i.e., by **4 p.m. on Friday 28 June 2024**, to be appropriate. Please let us know by immediate return if this causes any issues. We look forward to your response.

Yours faithfully

TLT LLP

TLT LLP

Cc: The Faculty of Physician Associates within the Royal College of Physicians; Association of Anaesthia Associates; The Royal College of Anaesthetists; Anaesthetists United; NHS England; Government Legal Department.