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BMA

Richard Marchant
Associate Director – Regulation Policy
General Medical Council

20th May 2024

By email

Dear Richard,

Re: Regulating anaesthesia associates and physician associates: consultation on proposed rules, standards and guidance.

The British Medical Association is a professional association and trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We welcome the opportunity to respond to the consultation on proposed rules, standards, and guidance to regulate Anaesthesia Associates (AAs) and Physician Associates (PAs), and on fitness to practise decision-making principles that will apply to doctors.

Our position on the statutory regulation of PAs and AAs has been clearly stated. We continue to believe their statutory regulation is best undertaken by the Health and Care Professions Council and that their professional titles should revert to Physician Assistants and Anaesthesia Assistants respectively. We also strongly oppose NHS England's (and devolved nations') plans to expand the PA and AA workforce, calling for these to be halted until there is clarity around scope of practice and adequacy of supervision, and material assurances have been provided on patient safety. We have also called for an urgent investigation into hospital Trusts replacing doctors with PAs on medical rotas, and published landmark guidance on the safe scope of practice for both AAs and PAs.

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.

As will be understood from our responses to government consultations on regulatory reform and on the introduction of the AA and PA Order 2024, we have been strong supporters of a revised fitness to practise framework. Compared to the current fitness to practise approach for doctors, the legislative provisions set out in the AA and PA Order 2024 and the GMC's proposed rules, standards and guidance offer an approach which is less adversarial, will result in earlier resolutions, be less prescriptive and will be more responsive to the clinical landscape in which PAs and AAs will operate. It is therefore

hugely frustrating that the regulatory framework for medical practitioners will not benefit from these improvements for some time, due to a lack of prioritisation by government.

As noted in the consultation document, the draft rules, standards and guidance will provide a future template for doctors. We are therefore responding to the consultation with both the associate professions and the medical profession in mind. We will also respond fully to the future consultation on draft legislation covering medical practitioners and the GMC rules that will follow.

Our responses to specific sections of the consultation are set out below, but in summary we have concerns regarding the stated ownership of the PA curriculum, the lack of recognition of a primary medical qualification as an approved associate qualification, the constitution of tribunal panels considering associate fitness to practise, the need to ensure impartiality on the part of case examiners, the potential for doctors to be pressured into accepting a proposed outcome, the lack of registrant choice on fitness to practise representation, and the referral to tribunal of doctors following a conviction that has resulted in a custodial sentence.

You will be aware that the medical profession has been concerned for some time that the GMC's fitness to practise processes lack fairness, and that many ethnic minority doctors fear that they will suffer discrimination in the process of GMC referral and notification of an investigation. In February 2023 we called for anonymisation of personal information and protected characteristics following receipt of a referral, before the case is allocated to a decision maker to consider whether the current Rule 4 threshold test is met. We ask again that the introduction of anonymisation into the GMC's processes is prioritised to help allay these concerns.

We also ask again that the GMC adopts an 'opt in' notification of complaints system, which allows doctors to choose if they wish to be notified each time the GMC receives a concern or complaint about them – something we have called for since March 2022 and which the GMC said would receive careful consideration as part of its regulatory reform change programme.

We would be very happy to discuss the concerns we have outlined while consultation feedback is being analysed and would welcome further engagement before any amended rules are approved by GMC Council later this year. If you require further information, please do not hesitate to contact Laura Russell, Head of Regulation, Education and Training at LRussell@bma.org.uk.

Yours sincerely,

Dr Tom Kane
Chair, Professional Regulation Committee

BMA

Regulating AAs and PAs: consultation on proposed rules, standards and guidance – detailed comments:

Education and training

1. The consultation document states that there will be one curriculum for PAs owned by the Faculty of Physician Associates (FPA), which will retain ongoing responsibility for designing and developing each curriculum in a way that meets GMC standards and be referred to 'the curriculum developer'.

2. 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.

3. 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.

4. 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.

5. Course providers must be able to demonstrate that educators have sufficient time to complete supervision and assessments, and importantly this role must not be undertaken at the expense of educators' oversight of undergraduate or postgraduate medical training. The learning environment and culture standard and theme proposals must include a specific requirement to this effect – that organisations cannot educate and train PAs and AAs at the expense of medical students and doctors in postgraduate training.

6. The GMC's quality assurance monitoring and quality assurance must take into account the views of educators. The quality assurance process must ensure that medical education and postgraduate training is not impeded by the education and training of PAs and AAs in the workplace.

7. We agree with the proposed PA and AA pre-qualification education requirement that organisations must have the capacity, resources and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners as required by their curriculum or training programme. We also agree with the

requirement that education organisations provide the required educational supervision and support. In addition, we agree that it is important that organisations must make sure educators are given adequate time and resources to complete the expected assessments. We support the proposed standard that educators receive the support, resources and time to meet their education responsibilities, and that educators must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.

8. We agree with the proposal to approve individual AA and PA courses, rather than entire education and training institutions in order to take proportionate and targeted action more suited to the needs of that course, rather than taking action that will affect all courses run by that organisation.

Establishing a register of AAs and PAs

9. In December 2023 the GMC announced the reference numbers for AAs and PAs would have a prefix to differentiate it from the reference number for doctors, that the A-prefix will be the same for both PAs and AAs, and that there will be no change to doctors' GMC reference numbers, which will remain a seven-digit number without a prefix. However, PAs and AAs even being able to note that they hold a "General Medical Council reference number" will lead to confusion and false equivalence. We therefore suggest a greater alphanumeric mix for registration numbers, such as MAP01AA123 and MAP01PA123.

10. The GMC has already described how public facing registers will look once regulation of PAs and AAs begins. In addition to enabling searching specifically within one or more profession(s) or across all registrants, having registrants' professions clearly visible within a list of search results, and making a registrant's profession clearly visible within their own record, further patient safety steps are required. Given the established public confusion regarding the title physician associate and anaesthesia associate, all PA and AA registrants' entries should include a clear statement that *'This registrant is not a doctor*' – in a way similar to the approach taken for doctors who are not on the GP or Specialist register and whose entries on the medical register currently state '*This doctor is not on the GP Register*' or '*This doctor is not on the Specialist Register'*.

11. We agree that publishing information is an important aspect of being an open and transparent regulator, and believe that the public and those who employ or contract with registrants rightly expect to be able to rely on any information made available by the regulator. The AA and PA Order sets out clearly what must be published and what the GMC can choose to publish. However, the regulator should be driven not by a concern to satisfy public demand for more information but by a concern to protect the public through the provision of useful and reliable information about a registrant's professional practice. The GMC will recall that the medical profession made its view clear in 2016 when it robustly rejected plans to expand the range of information publicly available.

Gaining entry to and removal from the AA and PA register

12. The rules state that a person is eligible to apply for registration as a PA or AA only where they hold a relevant qualification. There are no aspects of a PA or AA qualification not included in a primary medical qualification. It would therefore be inconceivable for a GMC recognised primary medical qualification not to be automatically recognised as a relevant PA or AA qualification. As we advised the GMC in February 2022, a holder of a GMC recognised medical degree should be entitled to register with the GMC as a PA or

AA and subsequently apply for any PA or AA post following registration. Although it is unlikely that a qualified medical practitioner would seek registration as a PA or AA, a doctor's freedom to choose alternative health service employment should not be curtailed by its regulator.

Fitness to practise proceedings

13. Regarding the constitution of tribunals, current rules for doctors rightly require panels to have a medically qualified registrant member, and we would object strongly to a future change that proposed a non-medically qualified registrant sitting on panels. In a mature regulatory system it would be understandable why some would argue for a similar approach to be taken towards AAs and PAs, but due to the considerable concerns of the medical profession over scope creep and medical substitution, until the regulated associate professions have matured and become settled into the healthcare workforce we would not accept associate registrants sitting on associate panels and insist that all associate panels continue to have medically qualified registrant members.

14. It is important to expedite fitness to practise cases where possible. There is a clear recognition that delay undermines justice and fairness for all participants and that robust and effective steps are required to achieve a far greater level of expedition. To this end, we believe that time limits should be stipulated for each stage of the process. For registrants, the imposition of realistic time limits will provide certainty on how their case will progress. This will assist in limiting the distress inherent in fitness to practise proceedings. For particularly complex cases, we recognise that time limits may need to be extended. While the AA and PA Order 2024 does not contain time limits, we believe rules stipulating time limits should be introduced, while providing a case management discretion for these limits to be extended where the interests of justice and fairness require it.

15. As discussed in the above letter, it is essential that measures are put in place to ensure impartiality on the part of case examiners and that registrants do not feel pressured into accepting a proposed measure under the accepted outcomes process. The rules should include a formal mechanism established to ensure impartiality and reduce the risk of bias. Engagement with the medical profession and associate professions should take place following the consultation period to determine an agreed mechanism.

16. The draft rules regarding the notification of the Terms of the Proposed Outcome stipulate that the associate's agreement or rejection must be received by the case examiner within a period of 28 days, beginning with the day on which the notification is served. Although a further rule notes that case examiners may extend this period, we would suggest that 28 days is likely to prove, in the majority of cases, insufficient for registrants to source legal and professional advice on the terms proposed – a decision which may have career ramifications for them.

17. Given any acceptance of the proposed outcome at the case examiner stage would result in significant time and resource savings for the registrant and the GMC, consideration should be given to extending the 28 day period. This would assist those registrants who have been unrepresented, but who may wish to seek and secure legal or professional advice at this stage of proceedings.

18. The draft rules describe what the Terms of the Proposed Outcome must include, such as the case examiner's findings on the case, their conclusion on impairment, and details of the Final Measure proposed by the case examiner, including the period during which the Final Measure is to apply. The registrant may choose to accept, reject,

or not respond to the Terms of the Proposed Outcome, but there is no proposed facility for them to suggest an alternative outcome that may address any patient safety concerns to the same degree.

19. We suggest that a registrant should be able to explain why a proposed condition may have the same practical effect as suspension from the register, for example due to the inability of employers to accommodate or implement specific conditions. Case examiners may well lack practical experience of working in healthcare settings or understand the realities of working in an under-resourced, under-staffed NHS.

20. Registrants should therefore be afforded the opportunity to make submissions to case examiners on such matters while the proposed outcome is being considered, and be able to propose alternatives that would achieve the same patient safety and regulatory aims in a way which is practicable and workable. Therefore, we propose that the rules should incorporate a process that allows case examiners to receive registrant comments and submissions as part of the Proposed Outcome process.

21. Where the registrant fails to agree to or reject the terms of the Proposed Outcome, the case examiner must decide whether to impose the Final Measure specified in the Terms of the Proposed Outcome, or refer the case to an Associates Tribunal. It is unclear if any consideration has been given to achieving consistency in decision making, and what advice or guidance will be provided to help them reach a decision. The draft rules also state that reasons for the imposition of a final decision have to be provided. Such reasons should also set out why a decision was not made to refer the case on to a tribunal, so these can be reviewed and assessed to ensure appropriate decisions are being made and learnings are shared.

22. The current rules for doctors require the Registrar to refer an allegation falling within section 35C(2)(c) of the Medical Act relating to a criminal conviction resulting in the imposition of a custodial sentence, whether immediate or suspended, directly for consideration by a medical tribunal. We welcome the absence of such a direction in the proposed rules, which will allow the regulator to apply discretion when it comes to considering convictions or custodial sentences that will not pose a risk to patients, past or future (for example, for those with a conviction or custodial sentence for taking part in a legitimately peaceful protest on climate change).

23. Regarding part five of the fitness to practise rules (adjudication), paragraph 34 addresses representation and states that an associate may be represented by a solicitor or counsel or, at the discretion of a case manager or the tribunal, an individual whom the case manager or tribunal allows to represent the associate (including, but not limited to, a representative of a professional organisation of which the associate is a member). We strongly believe that decisions regarding representation should not be at the discretion of the regulator or independent tribunal. Given what is at stake, it should be for each registrant to determine who represents them, not the GMC or tribunal.

24. Regarding representation at an oral appeal hearing, the draft rules state that an appellant may be represented by a solicitor or counsel or, at the discretion of an Internal Appeal Manager or the Appeal Panel, an individual whom the Internal Appeal Manager or Appeal Panel allows to represent the appellant (including, but not limited to, a representative of a professional organisation of which the appellant is a member). Again, we strongly believe that decisions regarding representation should not be at discretion of the regulator. It should be for each registrant to determine who represents them, not an Appeal Manager or Appeal Panel.

25. In relation to the 'starting points for assessing seriousness' in the draft 'principles to inform impairment guidance', we believe any claims by a PA or AA that they are like doctors, working as doctors, or falsely identifying as a doctor in other ways would be a significant departure from the standards expected and indicate a high level of seriousness. This behaviour should be specifically listed in the examples provided of behaviour that constitutes a high level of seriousness.

26. Regarding the 'draft principles to inform guidance on warnings', reference is made to 'unlawful discrimination in relation to protected characteristics' and we note that tribunals have no jurisdiction to determine whether a registrant has engaged in 'lawful discrimination'. Such jurisdiction is reserved exclusively to employment tribunals and the civil courts. As such, the guidance could be reframed so as to refer to conduct of a kind which would amount to an act of discrimination, as defined by the Equality Act 2010.

27. Regarding the 'Principles to inform impairment guidance', under the heading of 'Underlining Collaborative Working', reference is made to whistleblowing and that 'raising concerns in good faith, in compliance with a registrant's professional duty, should not be treated as an indication of a lack of collaborative working'. However, the whistleblowing scheme under Part IVA of the Employment Rights Act 1996, which gives effect to the protections of the Public Interest Disclosure Act, has dispensed with a requirement of 'good faith' and instead stipulates that the disclosure must be 'in the public interest'. The reference to 'good faith' in the GMC's proposed guidance is therefore out of step and inconsistent with the revised statutory requirements for whistleblower protection.

Fees

28. In relation to fees, the consultation document states that the 'when developing these rules and the level of the annual fee, our over-arching financial principle is that associates and doctors should pay for the cost of their own regulation'. However, the overarching principles proposed in the rules fail to explicitly state that the regulator must ensure no cross subsidy occurs through the fees collected for the registration of medical practitioners. The rules should therefore be expanded to include this key principle.