HCSA – the hospital doctors' union

General Medical Council
Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards and guidance

Response submitted 20th May 2024

Section 1: Education and training

1. **To what extent do you agree or disagree that the standards set out within the *Standards for PA and AA curricula* describe the essential criteria that must be met for each AA and PA curriculum to be approved?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

Before providing our response, and since there is not an appropriate section of this consultation to provide feedback, HCSA would like to place on record our view that the format and content of this consultation is prohibitive in gaining reliable, valid and representative responses. Much of the consultation is unwieldy with supporting documents to cross-reference and a great deal of background knowledge required. This makes it inaccessible for stakeholders, not least for individual respondents such as our own members. There are experienced medical professionals who have insight that would be useful to the GMC, yet tell us do not have the time to engage with the content despite their desire to do so. Moreover, the questions are overly restrictive and narrow, preventing respondents from expressing relevant views. The result in our case is that there are several questions where our responses may not be an exact fit for the questions asked, and others where we felt unable to respond at all.

In terms of this question, HCSA firmly holds the view that there should be a universally agreed scope of practice for PAs and AAs with limits for work. Setting educational standards is clearly problematic when the purpose of the role is ambiguous. It is not sufficient to have separate Royal Colleges and employers producing varying codes of practice. The role must be commonly understood and defined so as to make clear that MAPs work in support of doctors, but are not doctors.

HCSA's view is that without regulatory responsibility for the scope of practice, we are giving a blank cheque for implementation which is apparent within the Standards for PA and AA curricula. While the learning requirements are presumably drafted such that they are intentionally high level, without the grounding of an agreed scope, the result is that they appear insubstantial and ineffective. This gives

cause for concern at their implementation. For example, CR3.1 states: "CR3.1 Identify the learning outcomes that are the expected knowledge, skills, capabilities, levels of performance and experience, learners must demonstrate to complete their course." It is not clear what the expected knowledge is in this case.

HCSA believes that setting curriculum standards before there is an agreed scope is producing an inverted process that is unlikely to be effective in protecting associate professionals, doctors nor patients. There is a role for the regulator to benchmark the standard and identify where supervision is required, with the input of the medical profession.

2. To what extent do you agree or disagree that the standards set out within the *Standards for the delivery of PA and AA pre-qualification education* describe the essential criteria that must be met for an AA and PA course to be approved?

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer

The standards document must be redrafted to make clear the principle that PA/AAs are dependent practitioners working in assistance to doctors, rather than fully autonomous. It is crucial that this is universally understood, including to PA/AAs themselves. It is important that PA/AAs feel pride in holding a new role that has its own sense of purpose and responsibilities. Regrettably, these principles are not upheld to date with use of unclear language. HCSA opposes the terminology 'physician's associate' and notes that until 2013, the role had been labelled 'physician's assistant'. HCSA supports reversion to this terminology which sends a far clearer signal to employers and the public of the nature of the role. We note that a key driver of the name change had been to support the regulation of the role, and would argue that this no longer applies, with a consensus across the board that regulation is appropriate for patient safety. Given that the majority of patient consent encounters involve assumed consent, it is important that patients have clarity. 'Assistant' is an internationally recognised term that we see no need for the UK to deviate from.

The standards also use the umbrella term 'medical professionals', as introduced by Good medical practice, to refer to both doctors and PA/AAs. HCSA strongly opposes this repurposing of language that is synonymous with 'doctor'. It will undoubtedly create further confusion that impacts on patient safety. HCSA has made its position clear on several occasions that PA/AAs should be regulated by a separate regulator and fall under a separate code of practice, to maintain the safety boundaries between doctors and associate professionals.

Without any explicit statement on the dependent nature of the PA/AA role, the standards underplay the importance of a PA/AA understanding their role within the team, which will in turn limit the ability of any course to prepare a PA/AA for safe working practices.

The standards document refers to the requirement that learners on placement have an 'appropriate level of clinical supervision'. HCSA has great concerns about the impact for doctors of this new duty, and the risk to doctors of being held responsible for the work of PA/AAs when the scope of the role is not defined, such as in the case of Dr Zaw in 2017, where a junior doctor was found to be responsible for the errors of a PA under his supervision. HCSA is firmly of the view that only a suitably senior

doctor i.e. of Consultant or SAS level should be responsible for supervision of a PA/AA, and this must be agreed as part of a Job Planning process then appropriately remunerated.

Employers must be required to assess and identify capacity for supervising PA/AAs within the senior doctor workforce, ahead of beginning the associate practitioner recruitment process. Where there is no adequate and willing resource available, then an MAP cannot be appointed. There should also be clear limits on how many individuals a doctor can reasonably supervise and reasonable time for this activity ringfenced. The GMC must work with medical indemnity associations to define the level of responsibility registered doctors supervising PAs are culpable for with agreed safeguards before any further expansion. The current ambiguity could create a situation where an employer appoints a PA and expects them to carry out infinite medical duties, with a supervisor appointed who is not suitably senior, nor clear on what the supervision entails. This supervisor could in theory be automatically referred in any case where the PA is accused of malpractice. This is an unfair and potentially dangerous position to place a doctor in. Indeed, junior doctor members tell us at times they have been on a ward with a PA yet unaware who the supervisor is and unclear if they personally are responsible for the work of the PA. The regulations must give clarity on this and who has responsibility on a day-today basis – for example, what happens when the named supervisor is on annual leave. The PA must always be aware of who their supervisor is and required to give this information when asked. In all likelihood, employers will struggle to find doctors willing to undertake this additional responsibility unless these changes are made.

Again, we are concerned that the standards are not specific enough. We note that PAs were originally introduced into the NHS workforce to expand access to care for patients and support the workforce, which in turn would free up doctors' time to fulfil their training requirements. Unfortunately, we hear from doctors who feel that their training has been negatively impacted by the presence of PAs. The standards document provides no safeguards or requirements that the training is to be focussed on workforce and service provision. This must be considered along with ensuring safeguarding of training opportunities, for both doctors and PA/AAs.

HCSA's view is that a defined scope should then lead to deeper consideration of the specifics on the training required for PA/AAs. We would expect, for example, that an AA/PA would require less training of an interventional/procedural nature than a junior doctor. Whilst a junior doctor has spent 5 - 6 years at medical school studying basic sciences including detailed anatomy and physiology, a PA/AA will not have this grounding. Therefore, it is not appropriate for their training to involve more invasive procedures, procedures requiring ultrasound localisation of anatomical structures and endoscopic and endovascular practice. Instead, the role should be restricted to the level required to perform basic skills as part of the team e.g. neurovascular supply of the arm for bloods and cannula, urinary tract for catheters and upper airway and stomach for NG tubes. This level of specificity within the standards would give far greater clarity on the limits of the role and enable training opportunities to be directed appropriately. Should allied staff wish to increase their knowledge and understanding to allow them to provide safe care beyond this restriction, the established route of obtaining a medical degree with graduate entry programmes would allow them to do so in a regulated manner.

It is apparent that the evolution of the PA/AA role has created many different interpretations already that vary across employers with individuals developing different competencies. Junior doctors are required to submit practice outcomes for procedures to National Registrars and then go on to specialist registration with defined competencies. A means of recording PA/AA competencies is necessary for safe registration. We would propose that National Registrars, overseen and audited by the same standards as applied to doctors are created for PA/AAs. Practice without submitting data should be prohibited and subject to censure and submission rites should be based on the

competency level assessment for doctors. This is required in addition to establishing a common scope of practice and would give some independent reassurance to supervising doctors.

3. **To what extent do you agree or disagree with our proposed approach to approving education and training, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

The rules do not make clear who the educator is, who sets the standards and who will be scoring the summative OSCEs. HCSA strongly opposes the unsafe practice of self-regulation by Royal Colleges, as seen in ACPs.

As MAPs are dependent practitioners (working under supervising doctors), it is only right that doctors should be involved in the assessment process. Appropriate benchmarking must also be used.

4. **To what extent do you agree or disagree with our proposed approach to monitoring and quality assuring education and training, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

HCSA is concerned by the absence of information on how medical education will be protected during the introduction of PA/AA courses. Theme 4 'Supporting educators' should be amended to include protections for medical resources. Our members report struggling to access simulation time, unavailability of clinical laboratory rooms and worn-out resources that need updating.

The proposed approach greatly overlooks the impact on doctors, both of those in training and educators. Without addressing this, the GMC will fail to fulfil its' obligations to safeguard training for doctors. We cannot have yet another missed opportunity upon decades of under-resourced medical training.

5. **To what extent do you agree or disagree with our proposed approach to attaching conditions to or withdrawing our approval of education and training, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

As above, more preparatory work on setting a defined scope of practice of PA/AAs must urgently be undertaken before the process for attaching conditions to or withdrawing education can be reflected on meaningfully.

Section 2: Establishing a register of AAs and PAs

6. **To what extent do you agree or disagree with our proposed approach to the form and keeping of the register, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

We reiterate our view that it is not safe to establish a register without the introduction of a single recognised scope of practice for the PA/AA role. Professional regulation is a key component in ensuring patient safety, but must come after the role is defined - otherwise it gives employers a go ahead to utilise the role as they see fit, beyond the scope that the majority of stakeholders would be comfortable with.

HCSA also firmly opposes the expansion of the remit of Good Medical Practice to cover doctors and PA/AAs as their code of practice, which interfaces with their registration. There must be a separate code of practice drafted to cover the scope of the PA/AA role. This would also send a clear message that the two groups are distinct.

The proposed approach is to create a separate register from the medical register, with associate practitioners differentiated from doctors with tweaked reference number. HCSA feels this does not go far enough in maintaining a distinction. We have made our view clear at every opportunity that the GMC is not the correct regulator for PA/AAs, and that a different regulator holding a separate register is by far our preference. However, if the GMC is to be the regulator, at minimum we recommend clearer labelling and the establishment of a separate department within the GMC for non-medical practitioners to prevent blurring of roles.

Supervision of PA/AAs is a key component of registration. As dependent practitioners, they cannot work fully autonomously. We believe this needs reflected in their registration status since they cannot work in active practice without a supervisor. A solution would be to have a field which references whether their registration is 'active' with the named supervisor on the record, or 'inactive'.

Section 3: Gaining entry to and removal from the AA and PA register

7. **To what extent do you agree or disagree with our proposed approach to registration, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

Our response to this section is covered by our response to question 6.

8. **To what extent do you agree or disagree with our proposed approach to re-entry, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

9. **To what extent do you agree or disagree with our proposed approach to removal, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

10. **To what extent do you agree or disagree with our proposed approach to handling requests for removal (including where there may be outstanding fitness to practise concerns), as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for you answer.

11. **To what extent do you agree or disagree with our proposals for when decisions to remove an entry from the register will take effect?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for you answer.

Section 4: Fitness to practise proceedings and decision-making principles

12. **To what extent do you agree or disagree with our proposed approach to initial assessment, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

  Please provide a reason for your answer.

  Rules and decision-making principles around FTP must make clear that it is unacceptable and a matter for investigation for an MAP to mislead a patient by describing themselves as a doctor, either in correspondence, on social media when related to healthcare matters or in person. This should be unacceptable for use with patients in any situation regardless of whether this language could be technically accurate such as in cases where they have

gained the title via a non-medical route such as a PhD.

13. **To what extent do you agree or disagree with our proposed approach to interim measures and interim measure reviews, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

14. **To what extent do you agree or disagree with our proposed approach to accepted outcomes, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

15. **To what extent do you agree or disagree with our proposed approach to adjudication, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

HCSA entirely opposes the plans for composition of tribunal panels; that of 3 proposed members there must be one who is either a current or former PA/AA, or current doctor. Inclusion of any associates on the panel amounts to self-regulation which is a dangerous practice. AA/PAs are dependent practitioners and therefore it follows that every panel should include a doctor.

16. **To what extent do you agree or disagree with our proposed approach to final measure reviews, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

17. **To what extent do you agree or disagree with our proposed approach for accepted outcome decisions to be made by a single case examiner, selected from a team of case examiners?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

We would caution that there need to be appropriate checks and balances built in where decisions of a serious nature regarding fitness to practice are made. Having a single case examiner hold this responsibility is problematic as individual analysis can vary greatly.

18. **To what extent do you agree or disagree with our proposed decision-making principles for impairment guidance?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

19. **To what extent do you agree or disagree with our proposed decision-making principles for guidance on what restrictive action is required?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

20. **To what extent do you agree or disagree with our proposed decision-making principles for guidance on warnings?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

Section 5: Revisions and appeals

21. **To what extent do you agree or disagree with our proposed approach to revisions, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

Timelines for decision revision requests should follow current rules which allow 2 years. Reducing this to 3 months, in the case of case examiner decisions could limit likelihood of reaching a fair outcome.

22. **To what extent do you agree or disagree with our proposed approach to internal appeals, as described within our rules?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

There should be no exceptions to the right of appeal to the registrant at all stages. This is an essential component of a just regulatory system.

The composition of appeal panels is also a concern. Inclusion of any associates on the panel amounts to self-regulation which is a dangerous practice. AA/PAs are dependent practitioners and therefore it follows that every panel should include a doctor.

Section 6: Fees

23. **To what extent do you agree or disagree with our proposed approach to setting and charging fees, as described within our rules?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

The consultation document lays out that regulation will be subsidised initially due to low PA/AA numbers limiting contributions. However, regulation of PA/AAs must not be funded from doctor's registration fees, and the two funding strands kept entirely separate. Whilst this consultation doesn't include fee amounts, associates start on band 7 which is beyond the income of a foundation doctor so fees should be set appropriately to reflect this and not lower than medical fees.

24. **To what extent do you agree or disagree with our proposed principles for setting and varying fees in future?**

- Agree
- Disagree
- **Neither agree nor disagree or don't know**

Please provide a reason for your answer.

Section 7: Equalities & Welsh language obligations

25. **Referring to our separate EQIA, to what extent do you agree or disagree that we have identified all relevant impacts (for AAs, PAs and members of the public) for our proposed rules / guidance / standards as currently drafted?**

- Agree
- **Disagree**
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

We are extremely concerned about access to training opportunities for junior doctors, and especially those who may find it more difficult to advocate for themselves such as ethnic minority doctors. There are already problems locally in some employers with assigning learning opportunities appropriately to those who require them, and this will only be exacerbated by the expansion in MAP numbers.

Additionally, the expansion of PA/AAs will lead to a requirement for more supervisors and educators. We are concerned that many doctors will find themselves pressured into taking on this extra responsibility. We know that IMG doctors find it more challenging to advocate for themselves. This could be compounded by the change in arrangement for Consultant pay, which will now require Consultants to demonstrate the work undertaken in order to receive pay uplifts. For these reasons, we have advocated strongly elsewhere in this response for employers to demonstrate they have resources available for supervision before recruiting MAPs, and for supervision to be agreed only through a Job Planning process with appropriate remuneration and additional ringfenced time attached.

Finally, whilst lack of clarity on MAP roles will risk patient safety of all patients, we can foresee an even greater risk for individuals who don't have English as a first language, as well as for individuals who do not have a great understanding of the NHS and its workings. The current title of the roles, lack of clarity on scope and ambiguity on supervision make it very easy for MAPs to be mistaken for doctors and misunderstandings to arise around the level of skill and experience that the professional carry out the treatment or procedure has. In turn, this prevents patients from giving informed consent. We have identified ethnic minorities, disabled people and those from low socioeconomic backgrounds as at particular risk.

26. **In your opinion, could the proposals have either positive or negative effects on opportunities for people to use the Welsh language and on treating it as no less favourable than English?**

- **Agree**
- Disagree
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

As above, we are particularly concerned about the impact on those for whom English is a second language.

27. **Could the proposals be revised in any way to increase opportunities for people to use the Welsh language and to help treat it as no less favourable than English?**

- **Agree**
- Disagree
- Neither agree nor disagree or don't know

Please provide a reason for your answer.

As detailed elsewhere, gaining informed consent from patients for whom English is a second language will be challenging until there is clarity on the scope of the MAP role, on lines of supervision and in the title of the roles.