General Medical Council

5 June 2024

Sent by email

Dear colleagues

An update: preparing for regulation of physician associates and anaesthesia associates

As you will be aware, discussions about the roles that physician associates (PAs) and anaesthesia associates (AAs) play in the UK's health services are continuing online and in workplace settings. It's incumbent on all of us across the health system to respond to these discussions and provide assurance for patients, doctors, PAs and AAs about the way ahead.

For our part, we continue to finalise the policies and processes required for regulation to begin. Regulation will help to assure patients, colleagues and employers that PAs and AAs are safe to practise and can be held to account if serious concerns are raised. As always, patient safety remains our absolute focus and priority.

Below, I have provided an update on our approach to regulation and next steps. I've also summarised some key points from our existing guidance to assist you in your own work.

Future regulation of PAs and AAs

The UK and Scottish parliaments have approved legislation which sets out a legal duty for us to regulate PAs and AAs from December 2024. We have consulted on the rules, standards and guidance needed to implement this legislation and we're now considering the responses so that we can finalise our approach. We'll ensure you have the most up to date information on our plans and next steps.

As a multi-professional regulator, we will recognise and regulate doctors, PAs and AAs as three distinct professions. PAs and AAs don't have the same knowledge, skills and expertise as doctors. They are not doctors, and they can't replace them. It's clear that they can, and do, play important roles within multidisciplinary teams when appropriate and effective clinical governance and supervision are in place.

We will:

- set the standards of patient care and professional behaviours PAs and AAs need to meet
- set the outcomes and standards that students qualifying from PA and AA courses must meet to achieve registration, and approve the curricula that courses must deliver
- check who is eligible to work as a PA or AA in the UK and that they continue to meet the professional standards we set throughout their careers
- give guidance and advice to help PAs and AAs understand what's expected of them
- investigate where there are concerns that patient safety, or the public's confidence in PAs and AAs, may be at risk, and take action if needed

Working within competence

We'll regulate PA and AA pre-qualification education. Our framework sets out the knowledge, behaviour and skills that will be expected of newly qualified PAs and AAs. Like doctors, PAs and AAs will be required to work within their competence once they register with us to ensure safe patient care.

The professional standards that will apply to PAs and AAs say:

- You must be competent in all aspects of your work including, where applicable, formal leadership or management roles, research and teaching
- You must recognise and work within the limits of your competence

Like many other professional healthcare regulators, we don't set a defined post-qualification scope of practice that determines what tasks registrants can safely carry out, as this depends on their individual skills and competence which develop over time.

We support the work that individual colleges, and the Academy of Medical Royal Colleges, are currently leading to further consider issues of scope of practice.

Supervision of PAs and AAs

PAs and AAs have been part of multi-disciplinary teams in health services across the UK for many years. Many doctors already supervise colleagues or lead teams that include PAs and AAs.

Our guidance for doctors is clear that, as with other professionals that they supervise and work alongside, doctors are not accountable for the decisions and actions of PAs and AAs, provided they have delegated responsibility to them in line with the standards and guidance in *Good medical practice*, *Leadership and management for all doctors*, and *Delegation and referral*.

When it comes to good supervision, there isn't a one-size fits all approach because individuals who are being supervised develop their skills, competence, and experience over time. This means that named supervisors should agree a level of supervision appropriate to each individual's skill level, competence, experience, and role, and the nature of the task.

We're aware that issues related to the responsibility and accountability of doctors when supervising

PAs and AAs have come to the fore in recent weeks. In part this is due to online discussions about a Medical Practitioners Tribunal determination from a case in 2017, which has been misrepresented as setting a precedent or policy position. One tribunal determination sets no legally binding precedent on future tribunals.

The case involved significant concerns and allegations about the doctor over a period of time. The primary failure was the doctor's responsibility to urgently and personally review a patient upon admission because of how they presented, which he did not do. While the tribunal found that the doctor failed to adequately supervise a PA's review of that patient, other serious allegations were also found proven which were of an entirely separate nature.

You can read information about the facts of this case below.

Clinical governance

Effective clinical governance systems are vital to ensure that PAs and AAs are properly and safely deployed. In January this year, we published updated guidance for employers on clinical governance of PAs and AAs.

The *Clinical governance handbook* reiterates that PAs and AAs must always work under supervision and that appropriate governance structures must be in place, agreed at a local level.

It also recommends that organisations identify an individual at Board level who is responsible for PAs and AAs, and that local processes are established governing how they are deployed and supervised.

Our Outreach teams across the UK will continue to engage with employers about the importance of having effective and appropriate clinical governance systems in place. Once regulation begins, if we have concerns about local systems, we will escalate these for action.

Working together

Change is not easy. We are listening and responding to the views being shared with us and we will continue to do so. Constructive debate is always to be welcomed but interactions, whether online or in real life, must be respectful and professional at all times. We expect local systems to reiterate this message and support colleagues appropriately in their workplaces.

As we have throughout, we will also continue to engage partners across all four countries of the UK, including employers, patient groups, the royal colleges, trade unions and others, for the benefit of patients, doctors, and the wider multidisciplinary team.

While this is clearly a challenging period, we remain absolutely focused on the steps necessary for regulation to start and our work to promote safe patient care across the UK. Best wishes

<redaction s40(2)>
Chief Executive and Registrar
General Medical Council

Information about the case of <redaction s40(2)>

The case of <redaction s40(2)> was first considered by a Medical Practitioners Tribunal (MPT) in 2017. This followed a series of concerns that had been raised about his performance, communication and leadership. Following an investigation, the GMC then referred him to the Medical Practitioners Tribunal Service in relation to his treatment of four patients. <redaction s40(2)> was found impaired and was suspended for 12 months. He was later erased from the register.

The MPT decision has been misrepresented as setting a precedent or policy position and has caused some concern about the accountability of doctors in terms of the supervision of PAs. It's important to note that this case is one determination of the MPT and sets no legally binding precedent on future tribunals.

The primary failure was <redaction s40(2)> responsibility to urgently and personally review one patient (patient C) upon admission because of how they presented, which he did not do. The MPT also found that <redaction s40(2)> to adequately supervise the PA's review of that patient.

Other serious allegations were also found proven which were of an entirely separate nature. The case also involved significant concerns and allegations about the doctor's conduct in relation to a number of patients over a period of time across two hospital sites. This led to a local investigation of the doctor and, separately, a critical incident report, before the doctor was referred to the GMC.

These other allegations included:

- failing to alert an appropriate consultant of the presence of patient B at St Georges and to make an adequate record.
- failing to review patient C presenting with meningitis, to immediately prescribe IV antibiotics, to organise CT scan and to monitor the patient.
- failing to appreciate the significance of progression of hypoxia in patient D, to arrange appropriate investigations and to escalate for senior review.

<redaction s40(2)> failed to engage or appear at the hearing that took place in 2017 where he was suspended as a result of these significant concerns about his conduct. His failure to attend any review hearings or provide any evidence of insight or remediation ultimately led to his erasure in 2019.