

BMA suggestions for completing the GMC consultation on proposed rules, standards and guidance for physician associates (PAs) and anaesthesia associates (AAs)

Background

PAs and AAs are currently working in the NHS in a variety of roles across primary and secondary care.¹ They complete only a two-year postgraduate course (1,600 hours of clinical experience and teaching²) but are increasingly being employed in the NHS in roles that had previously been reserved for doctors, and in many cases as direct and apparently permanent substitutions for doctors, working on doctors' rotas. There have been recent high-profile cases of harm occurring to patients seen by MAPs, sadly including several deaths.³ In a recent BMA survey, 87% of more than 18,000 doctors expressed concerns that how MAPs were currently employed in the NHS was 'sometimes' or 'always' a risk to patient safety.⁴ The BMA has called for a halt in recruitment to these roles while their regulation and scope of practice can be reconsidered.⁵

The General Medical Council (GMC) has been chosen to regulate PAs and AAs. The BMA opposes regulation with the GMC, as it will further blur the lines between doctors and MAPs, and states the Health and Care Professions Council is more appropriate.⁶

The failure to appropriately set scope limits for PAs and AAs and the danger of placing PAs and AAs on the same register, blurs boundaries and risks patients assuming that PAs and AAs are somehow the same as doctors. They are not. They do not have a medical degree and must always be supervised by a doctor as dependent practitioners.

The GMC has opened this public consultation on its rules, standards, and guidance for PAs and AAs. We have produced this guide to provide important policy context for any doctors or patients who intend to respond to this consultation.

How you can help

The GMC's latest consultation is a technical consultation with many sections about the required rules and guidance needed to regulate PAs and AAs, and at first glance may seem overwhelming. However, you can help by answering as many questions and parts as you can, giving voice to your concerns, and sharing the consultation with others who may wish to respond.

We have outlined below some broad concerns and themes that can be used to fill in the free text sections in the consultation. While our suggestions don't cover every question, they highlight the areas we believe the GMC needs to take into consideration as the regulator and to fulfil its duty by keeping patients safe and not allowing people to practise medicine without a medical degree.

Please be aware that it is possible that any answers that stray from the questions asked won't be counted by the GMC.

* PAs have completed a previous undergraduate degree in the majority of cases, but this is not specific medical training. A limited number of PA courses are a combined undergraduate degree (2 years) with the PA masters (2 years), which is also not equivalent to a primary medical qualification



The deadline for responding is 11:59pm on 20th May 2024

Consultation documents can be found [here](#)

Key concepts of the BMA safe scope parameters⁷

- 1) A PA or AA follows medical directives. They do not give medical directives. That is, a PA or AA acts upon the medical decisions of a doctor. A PA or AA must not make independent management decisions for patients nor be responsible for initial assessments of patients and diagnosis.
- 2) PAs and AAs must never work on doctors' rotas, or as substitutes for doctors in any way.
- 3) PAs and AAs must not see any undifferentiated patients.
- 4) National standards for supervision must be set and adhered to, including that supervision is voluntary and must be consented to by consultants, autonomously-practising SAS doctors, and GPs in writing. Employers must not discriminate in any way against those who choose not to supervise.
- 5) Doctors must have 'first right of refusal' for all clinical and training opportunities. This means that within a department, any procedure, senior doctor teaching, clinic opportunity, or other learning event must be offered to the doctors first. Only after all doctors have refused this opportunity, can it be offered to non-doctor staff. This does not mean that a senior doctor is required to consult all doctors before imparting ad hoc knowledge or instruction to a MAP.
- 6) PAs and AAs must make it clear in all communication to patients and to other staff members that they are not doctors and be clear about their specific assistant role at all times.
- 7) The public must be able to tell the difference between a doctor and a PA or AA and their levels of training.

Key concerns with the proposed GMC's method of regulation and registration

- 1) Registration with the GMC blurs boundaries with doctors, and the GMC is an inappropriate choice for regulator of PAs and AAs.
- 2) Registering PAs and AAs without clear, nationally-agreed scope parameters is a risk to patient safety and will undermine public confidence in both the GMC and the medical profession.
- 3) The registration of the "physician associate" and "anaesthesia associate" titles will protect these profoundly misleading titles in law. "Physician" is already a protected title describing doctors. One of the GMC's key roles is to prevent patients from being misled into believing that they are being treated by a medically qualified doctor when they are not. The titles must be changed to allow patients to understand that the role is an assistant role and to protect patients from mistakenly thinking they have seen a doctor and not seeking further medical help if necessary.
- 4) There must be completely separate registers for PAs and AAs that are in no way linked to that of doctors. We would suggest developing a second register for them and having a completely different website/or page from the website so that there is no public confusion. Having similar numbers and format of registration numbers is also inappropriate and will create confusion. PAs and AAs must have a prefix and a different alphanumeric format to that of doctors' GMC numbers. For example, MAP01AA123 and MAP01PA123.
- 5) It must be abundantly clear to the public, to doctors, and the PAs and AAs themselves that they are not doctors and cannot do the work of doctors. There must not be any conflation of the two professions. As such, it is inappropriate to refer to PAs and AAs as medical professionals. We do not think that PAs and AAs should be adhering to the *Good Medical Practice* (GMP) guidance that was developed for doctors and would urge the GMC to write a version of GMC particularly for PAs and AAs. This should clearly outline the expectations of a dependent practitioner in an assistant role. For clarity, it should have a separate name that refers to the separate profession. Something like *Standards of PA and AA Practice* may be appropriate.

- 6) We welcome the regulation of PAs and AAs but we reiterate that, to avoid confusion with “medical practitioners”, who are doctors, it must be done by a regulator other than the GMC. With that caveat, the expectations for a dependent practitioner must be clearly outlined and everyone must be clear that PAs and AAs cannot be substituted for doctors. This should be evident in the training expectations from their course, to the kinds of tasks that they are expected to do at work, to their need for close supervision at all times, and extend to fitness to practise expectations. PAs and AAs should not claim to be like doctors or working as doctors and falsely identifying as a medical doctor at any time should raise concerns about their fitness to practise.
- 7) As senior medical doctors will be supervising PAs and AAs, their concerns and insights about what is required for an assistant role must be listened to by the GMC. The GMC should take on board feedback that all of their guidance and rules must reflect the dependent status of PAs and AAs. This should extend to any fitness to practise hearings where only medical doctors must sit on any committee or tribunal. PAs and AAs cannot be allowed to police themselves and their own practice.

Themes in the consultation

1. Education

- a. This section needs to be amended. It must be key from the outset that PAs and AAs are learning the skills to be a supportive, dependent practitioner who will have a role in assisting doctors. This is not a medical school and should not be referred to as such.
- b. It is obvious that there needs to be clear definitions of what the role and purpose of PAs and AAs is, and that further work needs to be done to ensure that there is no confusion between associates and medically qualified doctors. Scope must be set at a level that keeps patients safe and does not have PAs and AAs working beyond their competence. PA and AA students must be clear that their role is to become an assistant to doctors
- c. Educators also must be given additional time to complete supervision and assessment and this role should not fall on doctors who are not being offered time or pay to do this
- d. Monitoring and QA must take into account the views of educators, and where these educators are medical staff due care must be given to ensure that medical education and postgraduate training is not affected by the addition of PAs and AAs in the workplace.

2. Establishing a register

- a. Registering PAs and AAs without clear, nationally-agreed scope parameters is dangerous and will undermine public confidence on both the GMC and the medical profession
- b. Giving Associates a “General Medical Council reference number”, as this will lead to confusion and false equivalence and this needs to be very explicitly different from a medical doctor’s reference number. We suggest MAP01AA123 and MAP01PA123.
- c. PAs and AAs must have a named supervisor who is a doctor on the GMC register of recognised trainers e.g., Consultants/GPs/Autonomously-practising SAS who has consented in writing to supervise them.
- d. It needs to be made explicit that PAs and AAs must never be put on the GP or speciality registers.
- e. We would support that if a PA or AA falsely claims to be a medical doctor, they can be removed from the register permanently.

3. Fitness to Practise (FTP) and decision-making principles

- a. PAs and AAs should not be self-regulating, and the medically qualified panel member must be a medical doctor and not an associate. In the section ‘*Constitution and appointment of tribunals*’, it is entirely inappropriate that a tribunal may not contain a medical doctor. Aside from the chair and the lay person, the third member must always be a medical doctor.
- b. It must also be made clear that PAs and AAs can never sit on a tribunal for a medical doctor.
- c. High level behaviour leading to FTP procedures includes “where a doctor has deliberately misled patients or others about their licensing status” as an example. This must be modified to include PAs and AAs who falsely claim to be doctors or working as equivalent to doctors in any context.

4. Revisions and appeals

- a. As with the tribunal in the FTP section, a PA or AA must not be self-regulating and therefore requires the presence of doctors. It is entirely inappropriate to not include a minimum of one doctor on an appeal panel.

5. Fees

- a. We welcome the principle that fee income should not exceed its expenses, however we note that AFC band seven pay scale is in excess of many doctors' basic pay and therefore suggest that fees should be at least equal to that of a doctor holding full registration.
- b. No medical doctors' fees should subsidise any PA or AA work by the GMC. If the GMC has underestimated the cost of regulating PAs and AAs and needs to raise fees, this should not be accompanied by any raise in medical doctors' fees.

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BMA

British Medical Association, BMA House,
Tavistock Square, London WC1H 9JP
bma.org.uk

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