General Medical Council

05 February 2026

Regent's Place
350 Euston Road
London NW1 3JN

Email: gmc@gmc-uk.org
Telephone: 0161 923 6602

gmc-uk.org

Chair
Professor Dame Carrie MacEwen

Chief Executive and Registrar
Charlie Massey

Layla Moran MP
Chair, Health and Social Care Select Committee
House of Commons
London
SW1A 0AA

Sent by email to hsccom@parliament.uk

Dear Layla,

Thank you for the opportunity to attend the meeting of the Health and Social Care Select Committee on 21 January as you considered the work of the GMC. As requested on the day, I am pleased to be able to provide further information.

Consideration of the regulation of Physician Associates (PA) and Anaesthesia Associates (AA)

You requested to see papers from the time of when the GMC considered taking on the regulation of PAs and AAs. Formal government consultation to bring different types of medical associate professionals into regulation began in 2017. I have attached two sets of Council papers which illustrate some of the prevailing issues from around the time of the Government's 2017 *Consultation on the regulation of Medical Associate Professions in the UK* and how these were considered. Additionally, I have included the Council's consideration in 2019 of how the GMC would begin to bring PAs and AAs into regulation, following the Government's invitation in July of that year to take on the regulation of the two roles.

Good medical practice and our response to the Leng Review

I can reiterate the confirmation I provided in the meeting that *Good medical practice* (GMP) will continue to apply to registered PAs and AAs alongside doctors. GMP sets out the principles, values and standards of professional behaviour doctors, PAs and AAs are expected to meet in areas including candour, consent and confidentiality, for example. It is not a 'scope of practice' setting out the different roles doctors or PAs have across the health and care sector.

We consulted specifically on the proposal to apply GMP to PAs and AAs alongside doctors in the development of the current version of GMP. The majority of respondents, including doctors and doctor representative bodies, supported it. This was subsequently tested at the High Court which ruled clearly in our favour BMA v GMC [AC-2024-LON-002308] - Approved Judgment.

We agree with Professor Leng that more should be done to clearly differentiate professional groups and are considering the changes we can make on our website to support patients' and the public's understanding about the roles of doctors, AAs and PAs. We expect to implement these during the course of 2026, with completion date in line with the introduction of new professional titles.

On the change of titles, as I noted during the meeting, we have no difficulty with the recommendations made by Professor Leng, but felt that adopting new names right now which would not align with the titles set in legislation could cause considerable confusion. I should also highlight that our regulatory responsibilities for PAs and AAs are UK-wide. As a UK wide regulator, we continue to urge as much consistency as possible across all four countries of the UK for the benefit of patients and all those affected by the review. We look forward to the DHSC's consultation on reformed GMC legislation, which we expect to put into law the change of professional title. We will be ready, once that has happened, to make changes accordingly in all of our materials.

Countries that do not reciprocate proactive notifications of doctors subject to regulatory action

I was grateful for the opportunity at the Committee to set out how we have responded to the issues raised by recent media coverage of doctors with overseas sanctions. We worked at pace to review each of the cases highlighted, and took action in a number of cases, including referral to an Interim Orders Tribunal (IOT) where necessary and contacting the doctors' responsible officers.

When we assess an application for registration, we carry out several checks to ensure the doctor is qualified and fit to practise safely in the UK. We are also exploring the viability of technological solutions to further protect the integrity of our register. In the meantime, we have written to various partners including the International Association of Medical Regulatory Authorities (IAMRA), European regulators, and the UK Government to push for better international information sharing.

Information sharing with European regulators, in particular, has been a significant challenge since the UK's withdrawal from the European Union due to our inability to access the European Commission's Internal Market Information system. We will continue to work with the Department of Health and Social Care, the Department of Business and Trade, and our partners to address these barriers and would welcome any assistance the Committee might be able to provide.

Regulators that do not share information with us

The committee asked for a list of countries that do not share information with us. I am afraid that due to the significant number of regulators across the world and the differences in how regulation is set up across different jurisdiction we are not in position to share a comprehensive list with you in that way.

We can however share the names of regulators that do proactively share information with us on a regular basis. They are: the Medical Council of Ireland; the Norwegian Board of Health Supervision; the College of Physicians and Surgeons of Ontario, Canada; the College of Physicians and Surgeons of Alberta, Canada; the Medical Council of New Zealand; and the Singapore Medical Council. The 71 licensing bodies in the US provide proactive information through the Federation of State Medical Boards' (FSMB) Physician Data Centre (PDC).

Existing information sharing networks

In addition to direct communications, we receive information from overseas regulators both directly and via the Physician Information Exchange (PIE) which has been developed by IAMRA and we helped to establish and promote. However, not all IAMRA members post on PIE and those that do are not always sharing information consistently.

We are also now able to undertake additional checks when we register a doctor via the PDC. This has only become an option recently following FSMB's relaunch of PDC with a revamped user experience.

Reasons for lack of proactive information sharing

Not every overseas regulator responded to our requests to share information with us. Of those that responded, we received an explicit decline from Finland. Romania, Germany and Sweden have indicated they want to explore how to share information proactively.

GMC proactive information sharing

Despite the lack of reciprocation, I noted at the meeting that we proactively share details with other regulators of fitness to practise (FtP) sanctions imposed in the UK. We issue a decisions circular each month to a range of UK and overseas organisations. This contains all investigation stage and hearing decisions in the preceding month and includes sanctions imposed on a doctor's registration, undertakings, interim orders, warnings and cases where a doctor has been granted voluntary erasure or has been administratively erased if at the time of their erasure there were outstanding FtP concerns. We also have an outgoing notification process. A notification is issued to an overseas regulator when a doctor first receives an action on their registration.

GMC funding and headcount

The Committee expressed interest in our funding and the expansion of the GMC workforce since 2010. We are funded by our registrants and within this time our Council has kept registration fee uplifts at or below the level of inflation each year. Registration and full licence to practise for a doctor currently stands at £463, an increase from £420 in 2010. In 2010, the GMC employed 553 people. Our latest headcount stands at 1,779. Over this 16-year period, the number of doctors on the GMC register has increased from 239,260 to 410,529.

Since 2010, in addition to managing the increase in registrants, the GMC's role has expanded to cover: the regulation of PAs and AAs in addition to doctors (as of 22 January 2026, there are 4,008 PAs, and 186 AAs on our register); new powers to oversee postgraduate medical education and training; the design and delivery of revalidation for doctors; and the introduction of the Medical Licensing Assessment.

Over the last decade we have seen significant growth in the number of international medical graduates applying for registration with us. For context, in 2015 we saw 6,513 doctors who qualified outside the UK applying for registration for the first time, which then increased each year to its recent peak of 20,848 applications in 2024.

This increase was largely driven by demand to sit our PLAB registration exam, which is the main route through which internationally qualified doctors seek registration. In 2015 we saw 2,719 doctors sitting part 1 of the exam and 2,257 doctors sitting part 2, increasing rapidly in each subsequent year to a peak of 21,916 part 1 candidates and 15,702 part 2 candidates in 2023.

While these changes have driven significant increases in resourcing, they are overall self-financing. The number of places offered is driven solely by demand and the cost of delivering PLAB is met through applicant fees so that UK-registered doctors are not asked to subsidise the system through their own registration fees. Those fees are therefore set to recover costs only – not to generate profit.

Interim Orders data

During out hearing the Committee asked about IOTs. At any point during our investigations, we can refer a doctor to an IOT at the Medical Practitioners Tribunal Service (MPTS). On average we seek approximately 300 new interim orders per year. We do this where the allegations against the doctor are serious enough that, if proven, would mean the doctor poses a threat to patients or the public. At this stage there have been no facts found proved against the registrant. Interim orders can only be imposed by an IOT for a maximum of 18 months. After this time the High Court can agree an extension.

At the time of writing, there are 523 doctors with active interim orders (from an open caseload of 1,661). We assess whether we need to seek an interim order continually throughout the life of a case, and as evidence is gathered our assessment may change as to whether an order is required.

Our annual FtP statistics reports show the number of concerns we receive, where they come from and what happens to them at each stage of our processes. Each report covers a full calendar year from 1 January to 31 December. The 2024 report includes a snapshot over the past five years. It is important to note that the data reflects decisions made at each stage of our processes and does not

track a doctor through the entire process. This means a doctor may appear in the data more than once if their case moves through the stages within the year, or if they have more than one case started.

Data on third party involvement

The Committee raised a question about the number of open FtP cases that are over 12 months old. These numbers are published by the Professional Standards Authority. In their 2025 GMC Performance Report they show the latest published figures Q2 2024-25, with 760 cases currently over 12 months old. Although the PSA report notes that the number of open old cases has increased throughout the report's review period, it highlights that these are within range of recent years. It also notes that overall, the "GMC's performance in terms of end-to-end timeliness has improved this year and the time from receipt to consideration by the Investigating Committee (IC) or Case Examiners (CEs), and from IC/CEs to final hearing has remained consistent with previous years".

Several factors contribute to cases remaining open for more than 12 months. One key reason is when we are unable to progress matters due to an ongoing process by another body (primarily the police and Courts). Of the 760 cases over 12 months, 408 are currently or have previously been unable to be progressed due to another investigatory process.

In many cases we receive additional allegations from different employers whilst an investigation is ongoing. This elongates the process but allows us to build a more complete picture of a doctor's FtP. When this happens, we would gather medical records and a further expert report before progressing the case. It is not unusual for this to happen on multiple occasions during the life of a case.

Another reason why a case may become protracted is where a doctor is unwell (in the most serious cases they may have been sanctioned under the mental health act) and is unable to engage with us whilst they seek treatment. In these cases, we would pause our investigation until the doctor is well enough to engage with our investigations.

We have a robust review process for all cases, with reviews undertaken throughout the life of each case, and an additional review for any that reach the 12-month point. We always try to progress cases where we are able and look for opportunities to improve efficiency.

While we met all of the 18 Standards of Good Regulation in our 2025 Performance Review by the PSA, we are not complacent. We remain focused on continued improvements to how we support the professions we regulate, so patients receive safe, high-quality care.

I hope this information is of interest to the Committee. I would like to thank you once again for your interest in the work of the GMC. Should you have any further questions, please do not hesitate to contact me.

Yours sincerely

Charlie Massey
Chief Executive and Registrar

General Medical Council

Agenda item:	**CS4**
Report title:	**Regulation of Physician Associates**
Report by:	**Richard Marchant**, Assistant Director Regulation Policy, Strategy and Communication, richard.marchant@gmc-uk.org, 020 7189 5024
Action:	**To consider**

Executive summary

The GMC regulates doctors. Over the last year we have been approached several times about taking on the regulation of physician associates (PAs). We have stated publicly that we think PAs should be subject to statutory regulation but have not said who we think should do it. However, following an approach from the Scottish Government in 2015 we said that if the governments of the four countries of the UK, and the profession, felt we should have a role we would be prepared to give the matter serious consideration.

During 2016 we undertook some preliminary scoping work to help us better understand the role of PAs and the possible models for their future regulation so that we would be in a position to offer a considered response if the UK governments invited us to take on their regulation. This scoping work attempted to address three questions:

- Is there a persuasive case for statutory regulation of PAs?
- If so, is the GMC the appropriate body to regulate PAs?
- If the GMC is the appropriate body, what would be the regulatory model?

Since that work was completed, the Government has announced its intention to consult on the future regulation of PAs. We do not yet know when the consultation will be published. However, we anticipate that it will raise the question of whether PAs should be regulated by the GMC.

Recommendations

Council is asked to:

a Note the outcome of the scoping work on the future regulation of Physician Associates.

b Agree that, if requested by Government, it would in principle be appropriate for the GMC to take on the regulation of Physician Associates, subject to certain conditions being met.

What are physician associates?

1 A physician associate (PA) is:

> '…a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.'*

A brief account of the PA role in a hospital setting can be seen in the information video made by Health Education West Midlands, *A Day in the Life of a Physician Associate.* (https://www.youtube.com/watch?v=KnMyYRJrdCE). PAs also work in general practice.

Physician associates and the changing shape of regulation

2 As pressures on the health services grow, ways are being sought to maintain the service for patients. This includes improving the flexibility of the workforce, maximising the potential of different roles, bearing down on costs and allowing doctors to focus on those activities which require their particular level of expertise, while more routine tasks are undertaken by other members of the healthcare team.

3 This is driving an increase in the number PAs. There are currently 16 UK universities providing education and training leading to the award of a PA qualification recognised by the UK and Ireland Universities Board for PA Education and the PA Faculty at the Royal College of Physicians (London). The Secretary of State has called for 1,000 PAs in general practice by 2020 and projections suggest there will be >3000 overall by 2020.† There is also pressure to expand other roles, such as physician assistants (anaesthesia) (PA(A)s), surgical care practitioners and advanced critical care practitioners. While decisions about the future shape of the workforce are not for us, we are hearing calls for the expansion of our regulatory responsibilities to cover more than just PAs. Some have argued for regulating these new groups under a single umbrella title of 'Medical Associate'.‡ This is being actively explored by Health Education England (HEE).

4 The Government's work on the future shape of healthcare professional regulation points strongly towards a re-configuration of the largely uni-professional model we have today. The expectation has been that some of the existing regulators will be

* The Department of Health Competence and Curriculum Framework for the Physician Assistant (now Physician Associate).
† Personal communication, J Parle, Chair of the UK and Ireland Universities Board for PA Education
‡ GMC stakeholder workshop on the future regulation of PAs and PA(A)s May 2016.

abolished or merged, and criteria will be developed to provide the basis for bringing new groups into regulation. Seen in this light, the calls for the GMC to take on PAs reflect a different way of thinking about how professional regulation should be organised which could require us to re-appraise our role as a regulator exclusively of doctors. The UK's decision to leave the EU will almost certainly put the brakes on the pace of change. Even though a consultation on the future shape of professional regulation is understood to be imminent, we are not optimistic that this will result in fundamental legislative reform in the near future.

5 More limited reforms, however, such as PA regulation are on the agenda. A Department of Health (DH) stakeholder event is expected shortly, followed by public consultation. The possibility of the GMC regulating PAs will undoubtedly be raised. It is, therefore, timely that we consider and make clear our position.

Is there a persuasive case for statutory regulation of physician associates?

6 We have spoken with a wide range of stakeholders in the UK and overseas. This culminated in a workshop in May 2016 chaired jointly by the GMC and Health and Care Professions Council (HCPC) where there was a clear consensus supporting the statutory regulation of PAs.

7 To aid our own thinking we have developed criteria for bringing new groups into regulation, drawing extensively on work by HCPC, PSA* and NMC. The criteria are generic and could be applied to any emerging group of health professionals aspiring to statutory regulation, not just PAs. The proposed criteria are reproduced at Annex A, together with a preliminary assessment of how PAs meet the criteria.

8 We have concluded that, as currently organised, PAs represent a clearly identifiable group of professionals with a defined body of knowledge, skills and expected professional standards. Although every PA works under the overall supervision of a named doctor, there is a high degree of complexity and autonomy associated with the role, coupled with significant potential risk to patients. Indeed, many of the tasks they undertake are those which would otherwise be undertaken by licensed doctors. It is estimated that at the moment around 40% of PAs practising in the UK are not even subject to the safeguards of voluntary regulation. If the profession expands in line with Government ambitions, the risk to patients in the absence of regulation will increase.

* PSA has since developed its own matrix which brings together an assessment of risk, vulnerability of the patient group and the setting in which care is provided. Although constructed differently from our model, many of the same considerations are present.

9 A further consideration is that in order to maximise the potential of the role PAs need to be able to prescribe and to order ionising radiation for patients (requesting x-rays). They are unlikely to be able to do this without regulation. It was reported in the workshop that this is inhibiting the expansion of the role. Voluntary regulation, even if accredited by PSA, would not address this need.

Is the GMC the appropriate body to regulate physician associates?

10 It is not only the Scottish Government that has requested the GMC regulate PAs. The new Faculty of PAs at the Royal College of Physicians (currently providing voluntary regulation of PAs) sees the GMC as the preferred regulator. Several other bodies have expressed similar views. We do not know the views of doctors or the other departments of health.

11 HCPC was specifically constituted to regulate new professional groups.* It has the track record and the systems in place to be able to regulate PAs cost effectively and would be prepared to do so if asked by government. While we also have a proven track record of efficient and effective regulation, our regulation of PAs would require a compelling regulatory logic to justify a change from the status quo.

12 It is useful to look at the precedents of the USA, Canada and Netherlands, where PAs and doctors are regulated by the same bodies. This makes sense because PAs work as dependent practitioners. That is to say, their scope of practice is directly linked to that of their supervising doctor. A similar model of dependent PA practice exists in the UK.

13 Turning to UK regulatory models, recent years have seen General Dental Council (GDC) take on regulation of the wider dental team, General Pharmaceutical Council (GPhC) regulating pharmacy technicians as well as pharmacists, and the General Optical Council (GOC) regulating other members of the optical team. The uni-professional model of professional regulation is, therefore, already being replaced by new configurations which take account of the wider healthcare team and the relationship between professional roles. It is not about whether one group has longer training, more expertise or higher status than another; regulation is being organised around how groups of professionals work together.

14 UK PAs train and work to a medical model, their scope of practice is linked to that of their supervising doctor, and their ethical code issued by the Faculty of PAs is based upon *Good Medical Practice* (GMP). PAs are not doctors, but where they undertake

* We should note, however, that a new regulatory body (separate from HCPC) is being established for the regulation of social workers.

the same tasks they should be expected to meet the same standards and work within the same ethical framework as doctors. It is not difficult to see that having PAs and doctors overseen by the same regulator would provide a professional and regulatory coherence which would be in the interests of patients and the professions involved. But it would be for Government to weigh its priorities in deciding whether HCPC or GMC (or indeed some other model) provided the best regulatory fit.

15 We have developed some generic principles setting out the basis upon which the GMC might consider taking on the regulation of a new group such as PAs (Annex B). There is no doubt that PAs would meet most of the specified conditions. There are, however, political and practical issues that would also need to be addressed before making any commitment. For example, we would need fundamental change to our legislation; we would need a dowry from Government to cover transition costs – as happened when we took on the regulation of postgraduate medical education in 2010 (and officials recognise that doctors could not be expected to pay for bringing PAs into regulation); the change must be broadly supported by both doctors and PAs; and there must be support from the governments of all four UK countries. Above all, our operating model for regulating PAs following transition would need to be financially sustainable in the long term. On the other hand, our willingness to take this on would underline both our relevance and our wish to contribute positively to ensuring the sustainability of the NHS and to relieving pressures on doctors.

What would be the regulatory model?

16 The strength of our regulatory model for doctors comes in large part from the integration of our education, registration, revalidation, professional standards and fitness to practise functions.

17 At a more operational level, however, we may want PA regulation to look very different in some areas to ensure proportionality of approach, cost-effectiveness and sustainability. This paper does not detail all of the options that we have considered. That would be premature until we have taken a decision on the principles and the Government's intentions are clear. However, for illustrative purposes we might note the following four broad areas:

Education

18 Once they have graduated, PAs must pass the national qualifying examination before they are eligible for registration with the Faculty of PAs. We could take the view that the existence of the national examination would enable us to take a more selective and targeted approach to quality assurance of PA education than we currently do for doctors. Indeed, we are deploying similar arguments in support of the Medical Licensing Assessment (MLA).

Registration and revalidation

19 Our model will need to cover the ongoing costs of PA regulation. PAs registered with the Faculty of PAs already pay an initial registration fee of £200 and the same amount as their ARF. We will want to avoid cross-subsidisation of PAs by doctors. One option would be for doctors and PAs to pay the same registration and ARF fees. Alternatively (and more defensibly), we could set fees which reflect the relative cost of regulating the two groups. For example, our most significant regulatory cost comes from fitness to practise. The evidence from USA, and the albeit limited evidence from the UK, is that PAs are less likely than their supervising doctors to be subject to fitness to practise proceedings. Their regulatory cost is therefore likely to be lower.

20 The Continuing Professional Developing (CPD) requirements for PAs are broadly similar to the expectations of doctors (50 hours a year). They also undergo annual appraisal. However, to retain their registration PAs must re-certify every six years by re-taking their national qualifying examination. Part of the justification for this is that PAs are generalists and should be expected to maintain the same breadth of capabilities throughout their career which provides flexibility for them and for the NHS. We may consider that this is an entirely appropriate revalidation model for PAs.

Fitness to practise

21 There is little evidence to suggest that regulating PAs would lead to a material increase in our fitness to practise work, although this could change as numbers of PAs in the health services increase. However, given the context in which they work we may also consider that, save in the most serious cases, we should only consider complaints or referrals which have already been through a local process. This would reflect the more flexible direction of travel we wish to move to for doctors' fitness to practise but where the legislative constraints we need to overcome are considerable.

Transition

22 If it was agreed in principle that we should take on PA regulation we would undertake more detailed due diligence into how PAs could be incorporated into our business model. Our provisional view is that we would seek the sort of 'lift and shift' approach that we followed when merging Postgraduate Medical Education and Training Board (PMETB) into the GMC. As far as possible, we would initially adopt existing practices developed by the Faculty of PAs and look to develop the model over time – it will however, be critically important that the legislation establishing PAs as a regulated profession is future-proofed so far as possible around, for example, the relative responsibilities of the employer and the GMC in dealing with fitness to practise.

Next steps

23 This paper has proposed some principles for the extension of our role beyond the regulation of doctors to include PAs. It has also made the case for GMC regulation of PAs based on those principles and provided some initial scoping for what the regulatory model might look like.

24 We are seeking agreement in principle to the extension of our role, subject to the conditions set out in this paper. This would enable us to put our position on public record in advance of the planned DH stakeholder event should we wish to do so. More detailed operational and financial modelling would be held back to a second phase of work once Government intentions are clear. At that stage Council may also find it helpful to have a further seminar discussion involving the Faculty of PAs.

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CS4 – Regulation of Physician Associates

CS4 – Annex A

The case for regulation of Physician Associates

1 Physician Associates (PA) are currently an unregulated profession; all PAs are however strongly encouraged to join the Physician Associate Managed Voluntary Register (PA MVR) on completion of an accredited training programme and after passing the national assessment. The PA MVR is currently managed by the Faculty of Physician Associates (FPA) at the Royal College of Physicians (London).

2 A number of our key stakeholders, including other professional regulators, medical royal colleges and representatives from PA organisations consider statutory regulation of PAs necessary to ensure sufficient patient protection and that the profession continues to be developed in a way that is beneficial and valuable in delivering services within the NHS.

3 To determine whether a new professional group should be brought into regulation a principled and evidenced case for regulation must be made. To explore this we have developed the following criteria:

- **a** The professional group must have a defined body of knowledge and standards.
- **b** The profession must be a clearly definable and differentiated group and have a clear role.
- **c** Statutory regulation is necessary to perform functions associated with the role (for example prescribing).
- **d** There is a high level of complexity associated with the role.
- **e** There is a high level of risk associated with activities necessary to fulfil the role and therefore a need for accountability.
- **f** Professionals have a significant degree of autonomy.
- **g** Regulation is necessary to be able to command public confidence.

h Regulation is necessary to provide assurance of quality and reliability to other professional groups or agencies using the services of the profession.

i Statutory regulation must be supported by the proposed professional group and other key stakeholders.

j The professional group must be of sufficient size and maturity to be able to support the requirements of regulation (for example, an established educational and professional infrastructure and professional standards. This might be demonstrated through voluntary regulation)

4 Each of the above criteria would need to be met in order for a new professional group to become regulated, but some may carry more weight than others, for example level of risk associated with the activity and public confidence in the profession. What follows is a discussion of whether the profession of Physician Associate meets each of the above criteria for regulation.

Criteria for bringing a new profession into regulation

Defined body of knowledge and standards

Yes.

5 The Faculty of Physician Associates launched in July 2015 after collaboration between UK Association of Physician Associates (UKAPA) and the Royal College of Physicians. UKAPA was founded in July 2005 by American physician associates employed in the United Kingdom in an effort to support and promote the development of the PA profession in the UK.

The Faculty is responsible for:

a Managing the voluntary register.

b Accrediting PA training programmes.

c Quality Assurance of PA programmes.

d National Assessment and re-certification.

e Developing standards for CPD.

f Investigating concerns about PAs.

6 A *Competence and Curriculum Framework* was developed in 2006 by a Department of Health convened committee jointly chaired by Royal College of Physicians (RCP) and Royal College of General Practitioners (RCGP) and subsequently updated in 2012. The framework is now held by the Physician Assistant Managed Voluntary Register (PA

MVR) and there is a *Code of Conduct* (developed in 2009) which all PAs are required to adhere to.

7 The PA MVR was jointly established in November 2010 by the UKAPA in conjunction with the UK and Ireland Universities Board for Physician Associate Education (UKIUBPAE). The Faculty ensures that no one is placed on the register or allowed to remain on the register without evidence of fitness to practise. They have a mechanism for periodic checks to ensure that standards continue to be met. Currently 75% of existing PAs working in the UK are on the register.

Clearly definable profession with a clear role

Yes.

8 The Department of Health's Competence and Curriculum Framework for the Physician Associate defines the physician associate as:

…a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.

9 The new Faculty of Physician Associates at the Royal College of Physicians has defined physician associates (PAs) as:

…collaborative healthcare professionals with a generalist medical education, who work alongside doctors, GPs and surgeons providing medical care as an integral part of the multidisciplinary team. Physician associates are dependent practitioners working with a dedicated supervisor, but are able to work independently with appropriate support[1]*.*

10 The Faculty's website highlights in detail the variety of settings in which PAs work as well as the range of activities they undertake in each of the different settings. The *Competence and Curriculum Framework* also sets out in detail the role of a PA and the core procedural skills that PAs are expected to be able to perform on completion of the educational programme.

11 Although it is argued that PAs perform a similar function to a number of other professionals such as nurses, surgical care practitioners (SCP) and Physician Assistants (Anaesthesia) (PA(A)s), the role of PAs is easily distinguishable from these other professions. PAs, unlike advanced nurse practitioners, SCPs and PA(A)s are trained in general medicine, and are able to work across a number of disciplines as opposed to being focussed in a specialty area.

[1] Faculty of Physician Associates – *What is a Physician Associate?* - http://www.fparcp.co.uk/faqs/

Requirement for statutory regulation

Yes.

12 PAs' training includes activities that they are currently unable to undertake such as prescribing or ordering ionising radiation. Prescribing medication is a reserved activity under the Prescription Only Medicines (Human Use) Order 1997. The use of ionising radiation has been subject to specific legislation since 1988 in order to protect patients from unintended, excessive or incorrect medical exposure. The 2006 amendments to the Ionising Radiation (Medical Exposure) Regulations 2000 set out that only registered healthcare professionals are able to order ionising radiation (request x-rays).

13 PAs' inability to prescribe and order ionising radiation hinders effective service delivery by restricting the scope of their practice. The *2009 Evaluation of Physician Assistants pilot programme in Scotland*, highlighted that inability to prescribe was a particular hindrance in primary care settings and out of hours clinics, which '*represented an erosion of PAs' efficiency in the out of hours clinic'*. The evaluation concluded that PAs need to be able to prescribe to be most productive and enhance the role of the profession.

14 An article in the *Clinical Medicine Journal*[2] also commented that the ability to prescribe and order ionising radiation would enhance the contribution that PAs could make to the care of patients in the hospital service.

High level of complexity associated with the role

Yes.

15 The PA training programme operates at the level of post-graduate study. Most PAs will hold at least bachelor's degree, usually in a life science field. Most PA programmes require at least a 2:1 honours degree for entry into the Postgraduate Diploma course along with some prior health or social care experience.

16 PAs work in a variety of settings and undertake numerous complex medical tasks and procedures ranging from taking medical histories to skin biopsy to nerve blocks to IUD fitting and removal.

High level of risk and need for accountability

Yes.

17 PAs work in a range of environments within primary and secondary care and although supervised by a consultant physician or GP they often enjoy a significant degree of

[2] A new kid on the block, H.Hodgson, Clinical Medicine 2014 Vol 14 No: 3 219 – 20
http://livelink/A_New_Kid_on_the_Block_Hodgson_2014_Clin_Med.pdf?

autonomy. PAs directly interact with large numbers of patients and the public on a daily basis and can undertake numerous tasks autonomously (though this is dependent on their level of experience).

18 PAs undertake invasive and intimate procedures, lumbar punctures and cervical smears with a high level of risk to the patient. With no statutory standards to provide a boundary of competence there is minimal protection to the public if a PA does not realise the limitations of their competence.

19 The PA role is expanding in numbers, breadth of specialties and depth of clinical competence, more and more PAs are working in different areas of medicine and have acquired increasing levels of autonomy. Health Education England announced last year that it will commission 205 PA training posts, representing a 754% increase from 2013 and Jeremy Hunt announced in June 2015 that there will be 1,000 PAs working in general practice by 2020. Overall projections are for >3000 PAs by 2020.

20 There has only been one fitness to practise case so far that has come to the attention of the managed voluntary register, which involved an alleged false declaration. This may reflect the small numbers of PAs and the 'dependent/supervised' nature of their role. As the profession expands, so do the numbers of patients being treated, and the chance of an adverse incident or harm.

21 There are a number of risks associated with the current arrangement of voluntary registration for PAs, which were identified by NHS Scotland, NHS Grampian and the University of Aberdeen in their draft paper *An evidence base to support statutory registration for physician assistants*:

a An individual with a medical/nursing degree from anywhere in the world could apply to be a physician assistant[3] here in the UK as there are no standards of entry or education. Potential risks relating to intimate and invasive procedures being administered inappropriately.

A physician assistant with poor standards of competence, conduct and ethics could move around the UK seeking employment in different locations.

There are no statutory standards of education and training to determine the baseline of appropriate competence for physician assistants. Different hospitals could have different interpretations of the competence level required for equivalent posts. Therefore, there is the possibility of inadvertently accepting a poorer standard of patient care given no baseline of competence.

[3] 'Physician associates were referred to as 'physician assistants' in the UK until a change of title in 2015.

A Code of Conduct and ethics provides a culture for a profession to operate in, yet voluntary registration does not define the culture and ethics for the entire profession. Therefore inappropriate behaviours are harder to challenge in such a framework.

b There is no requirement to register with the voluntary register and only 60% of the profession currently do.

22 The level of accountability provided by existing structures and the voluntary register is not proportionate to the level of risk described in the preceding paragraphs, as patients at present can be treated by PAs who may not have completed an accredited training programme. Statutory regulation enhances patient and public protection by providing appropriate safeguards, such as mandatory registration for employment as a healthcare professional, national standards for education and training and statutory procedures for dealing with concerns about a professional's practice.

23 Stakeholders have argued that statutory regulation is needed to ensure effective protection of vulnerable patients, those in a hospital or primary care environment with significant trauma or illness e.g. domestic abuse, psychiatric illness, stress, or aggravated injury. All of these patient groups could potentially meet PAs at the start of the patient journey. It is essential to provide confidence for vulnerable patients that the first point of contact is with a profession that has set standards of entry, conduct and ethics.

Significant degree of autonomy

Yes.

24 PAs undertake a variety of tasks across a number of settings. Within primary care PAs see patients of all ages for acute and chronic medical care, their responsibilities include:

a Referring patients to consultants, to Emergency Assessment Units or to A & E when clinically appropriate.

b Initial consultation (first contact) with patients in both primary and secondary care, conducting home visits, prescription reauthorisation.

c Reviewing laboratory results and determining management plans.

d Helping their practice setting reach Quality Outcome Framework targets.

25 Within secondary care PAs are able see the full spectrum of patients that enter the hospital; they see patients with minor and major injuries as well as resuscitation and

post resuscitation, trauma, mental health, paediatric, obstetrics and gynaecology cases. Their responsibilities include:

a Obtaining medical histories.

b Conducting the physical exams.

c Requesting investigations.

d Referring both to in-house specialities as well as arranging for outpatient appointments or GP reviews.

e Discharging or admitting patients and can arrange for intermediate care or community services.

26 Though PAs are described as dependent health care professionals, they work with varying degrees of autonomy, depending on the level of experience they have. A newly qualified PA is likely to be very closely supervised by a consultant physician or GP, whereas a PA with several years of experience may only need minimal supervision within their scope of practise. Some experienced PAs also help with teaching for PAs and medical students as well as Foundation Years 1 and 2. However, a PA as a dependent practitioner will always be able to identify their supervising doctor.

Command public confidence

Yes.

27 The existence of the voluntary register ensures public confidence to an extent, as patients can feel confident that any PA on the register has gone through an accredited training programme, but it does not assure the public that all PAs who are practising in the UK are safe, as PAs may be practising in the UK who have not graduated from an accredited programme or have not maintained their CPD. Further, as matters stand, it is possible for a doctor erased by the GMC to re-invent themselves as an unregulated PA.

28 PAs currently inspire confidence in those they treat and work with and The evaluation of the PA Pilot Programme in Scotland is a useful illustration of patients' opinions of PAs, how they communicated, how they treated patients and how they added value to the medical team. Patients commented that PAs explained things clearly and expressed appreciation of the service they had received from PAs. They also felt that on occasions the involvement of PAs sped up the service received and patients were grateful that PAs encouraged questions; they felt less intimidated in asking a PA a question in comparison with a doctor. Additionally PAs were generally viewed by their colleagues to be effective communicators, friendly, approachable and well received by patients.

29 A number of pilot studies and articles have also highlighted the opinions of doctors in relation to the role of PAs. The article in the Clinical Medicine journal – *Doctor satisfaction with Physician Associates*[4] outlined that doctors felt PAs have good clinical and communication skills and that they improve team flexibility and the continuity of care provided to patients. Doctors also reported that their patients also expressed satisfaction with the PA role.

30 Although there is plenty of evidence to suggest that patients who have encountered PAs are happy with the service they receive, the voluntary register only goes some way to providing assurance to the public that those on the register are competent and safe to work as a PA as only 75% of PAs in the UK are actually registered. Further assurance is needed in terms of clinical competence of PAs, i.e. setting national standards for education and training and creating a statutory register for all PAs wanting to work in the UK.

Confidence of other professional groups and agencies using the services of the professional group

Yes.

31 Currently, other professional groups can be assured of the quality of services provided by PAs in the following ways:

a Managed Voluntary Register – all PAs are encouraged to register with the PA MVR and only those who have completed an accredited training programme and passed the national assessment, are eligible to apply. Currently there are no equivalence routes for PAs practising overseas and in the EU (other than the US) so EU and overseas PAs are not able to register on the PA MVR.

b PAs are required to complete 50 hours of CPD each year and are subject to annual appraisals and a re-certification every six years to ensure they remain up to date and fit to practise.

c Code of Conduct exists which all PAs are required to follow.

d The Faculty of Physician Associates quality assures and accredits PA training programmes, but at present there is nothing to stop a university from setting up and running its own PA programme without accreditation from the Faculty.

32 Yet the lack of statutory regulation means that it is difficult for doctors to ensure that they are effectively fulfilling their responsibilities in relation to delegation, as set out in *Good Medical Practice*. The medical profession also need to be assured of the skills and

[4] Doctor satisfaction with Physician Associates, L.E.Williams, T.S.Ritnsema, Clin Med 2014 - http://livelink/Doctor_satisfaction_with_Physician_Associates_Scanned_2014.pdf?

competencies of PAs when delegating tasks. We have already begun to receive queries about doctor's responsibilities in relation to delegating tasks to PAs and recently the Academy of Medical Royal Colleges has also raised this issue with the GMC.

33 Statutory regulation would enable doctors to feel assured when delegating to PAs that they have met national standards and achieved the level of competence required to practise as a PA.

Support from both the proposed professional group and other key stakeholders

Yes, to an extent.

34 Members of the profession have continually expressed the need for statutory regulation. The Royal College of Physicians in particular has been campaigning for regulation of PAs since 2005.

35 In a joint statement in 2014, the Royal College of Physicians and UKAPA said that statutory regulation would allow physician associates to make a "*more effective contribution to the health service and the health economy as well as offering better protection to the public*."

36 A number of organisations, including the Royal College of Physicians, *Clinical Medicine journal* and NHS Scotland, as well as physician associates themselves, have on numerous occasions argued for statutory regulation of PAs. The following are some examples of those arguments:

a A New Kid on the Block H. Hodgson Clinical Medicine Journal 2014[5] – highlighting lack of statutory regulation brings limitations to the fulfilment of the role and if expansion of the role is being urged the profession should be registered and regulated.

b Physician associate: new role within mental health teams[6] – outlining the value added by PAs in mental health services, PAs remain in post longer than doctors in training, who rotate frequently, and therefore PAs are able to help with improving service provision and providing continuity of care for patients. Statutory registration will help overcome obstacles that may hinder their role.

[5] A New Kid on the Block, H.Hodgson, Clinical Medicine 2014 Vol 14 No: 3 219 – 20
[6] Physician associate: new role within mental health teams, G.Kaybinder, S.Kauser, K.Khattack F.Hynes, The Journal of Mental Health training, education and practice 2014 VOL. 9 NO. 2.

c Evaluation of Physician Associates to NHS Scotland: Final report 2009[7] – highlighting the success of the PA Pilot Programme in Scotland.

37 PAs have made it clear that they wish to be a regulated profession and have expressed their desire for the GMC to regulate the profession, with 80% of Faculty members of the view that the GMC is best placed to take on regulation of PAs. The other 20% view the HCPC as being best placed to regulate PAs.

38 Approximately 40 Trusts across the UK currently employ PAs. This indicates that a number of employing organisations view PAs as adding value to the system, but we are yet to gain a clear view from employers as to whether they support the need for statutory regulation, or whether they consider appropriate safeguards are already in place to protect the public.

39 A survey in 2014[8] highlighted that 90% of doctors surveyed felt that statutory regulation was important, with the majority of doctors commenting that current legal restrictions that prohibit PAs from prescribing limits their effectiveness. Anecdotal evidence gathered by Regional Liaison Service suggests that in some parts of the country the lack of PA regulation is making GPs reluctant to use them.

Readiness

Yes.

PAs have an established educational and professional infrastructure including:

a PA MVR - the Faculty of Physician Associates currently manage the voluntary register for PAs and have processes for removing and restoring entries in the register.

b PAs are required to follow the *Code of Conduct* and a *Competence and Curriculum Framework* is in place for PAs.

c Processes and procedures for quality assuring PA accredited programmes.

d National Assessment – all PAs must pass in order to be eligible for registration.

e PAs are required to complete 50 hours of CPD per year, as well as providing evidence that they remain fit to practise at annual appraisals.

[7] Evaluation of Physician Associates to NHS Scotland: Final report 2009, J. Farmer, M.Currie, C.West, J. Hyman, N. Arnott,
[8] Doctor satisfaction with Physician Associates, L.E.Williams, T.S.Ritnsema, Clin Med 2014 - http://livelink/Doctor_satisfaction_with_Physician_Associates_Scanned_2014.pdf?

f PAs are required to sit the re-certification examination every six years in order to remain on the register.

g Investigating concerns about the fitness to practise of PAs – the Faculty is responsible for investigating concerns. A Fitness to Practice Committee may hold hearings and can issue sanctions to individuals, either suspension of practice or removal from the register. An appeals process also exists for PAs.

40 Some of the structures in place, in particular fitness to practise procedures and processes for removing and restoring entries to the register, are fairly basic and would need to be developed if statutory regulation was introduced for the profession. Though the lack of complexity in current procedures is reflective of the frequency of their use which is low.

Council closed session , 23 February 2017

General Medical Council

CS4 – Regulation of Physician Associates

CS4 – Annex B

Regulatory principles for taking on a new profession

1 The following principles are intended to guide us when thinking about whether it would be appropriate to for the GMC to regulate a new professional group, such as PAs.

2 Regulation by the GMC should only be considered if the following principles are achieved:

- GMC regulation is likely to lead to greater public protection than would be afforded elsewhere.
- The group is educated and trained to a medical (or similar) model.
- The proposed group practises to the same values and within the same (or similar) ethical framework as doctors.
- The nature of practice of the proposed group brings similar types and levels of regulatory risk as medical practice.
- There is significant overlap in areas of practice between the proposed group and doctors and/or:
- There exists a practising relationship between the new group and doctors (for example, part of the same team or supervisory/dependant relationship).
- GMC regulation of the new group is likely to achieve greater efficiencies and economies of scale than would be seen with separate regulation.
- GMC regulation would contribute to greater consistency of outcomes than would be seen with separate regulation.
- GMC regulation commands the support of doctors and the new group.
- GMC regulation is supported by the governments of all four UK countries.
- Transition costs for bringing the new group into GMC regulation are covered by Government and not borne by doctors.
- The operating model for regulation following transition is financially sustainable in the longer term.

26 April 2017

General Medical Council

Council closed session

CS1

Draft as of: 7 April 2017

To approve

Minutes of the Closed Session on 23 February 2017 - Extract

Members present

Terence Stephenson, Chair

Steven Burnett
Shree Datta
Christine Eames
Michael Farthing
Anthony Harnden
Helene Hayman
Paul Knight
Suzi Leather
Denise Platt
Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Chief Operating Officer
Paul Buckley, Director of Strategy and Communication
Una Lane, Director of Registration and Revalidation
Colin Melville, Director of Education and Standards
Patricia Morrissey, Council Secretary
Anthony Omo, General Counsel and Director of Fitness to Practise

Update on Department of Health (DH) consultation on legislative reform and the future of Professional Regulation

9 Council received an oral update on the DH consultation on legislative reform and the future of professional regulation.

10 During discussion, Council noted that:

a Discussions with ministers about fundamental legislative reform have been ongoing since the Law Commissions published their proposals in 2014. Although ministers decided not to proceed with the Law Commissions' Bill, a Government consultation on alternative reform proposals had been expected during the last quarter of 2016. However, that was now unlikely to take place until after the outcome of Northern Ireland elections was known. Even then, the prospects of the consultation leading to fundamental legislative reform in the near future were unlikely due to Brexit and the pressures of exiting the EU on parliamentary time.

b The GMC would continue to discuss with Department of Health officials opportunities to deliver some GMC legislative priorities through Section 60 Orders, and would continue to work with other regulators to explore opportunities for non-legislative reforms, for example through better collaboration.

Regulation of Physician Associates

11 Council considered a report on the possible future Regulation of Physician Associates (PAs).

12 Council:

a Noted the outcome of the scoping work on the future regulation of Physician Associates.

b Agreed that, if requested by Government, it would in principle be appropriate for the GMC to take on the regulation of Physician Associates, subject to certain conditions being met and following appropriate due diligence.

13 During discussion, Council noted:

a That the GMC was sensitive to the anticipated concerns of registrants regarding the use of the Annual Retention Fee (ARF) to subsidise the regulation of another profession. The expectation was that the DH should provide the resources required to deliver PA regulation and the GMC should press for this.

b That given the close working relationship between doctors and PAs, the expectations of patients, the role of doctors in training and the shape of the future

workforce the GMC was an appropriate body to regulate PAs. However it would be a significant step with the potential to impact across all areas of the GMC's business.

c That it would be for the Government to decide which regulator was best placed to take on the regulation of PAs. While the GMC was in principle supportive of taking on the regulation of PAs, it would not proactively campaign to regulate this profession.

d It would be important to consider the matter in the wider context of the Government's work on the future shape of healthcare professional regulation. However, the UK's decision to leave the EU was likely to affect the speed of changes.

General Medical Council

Agenda item:	**CS3**
Report title:	**Department of Health Consultation on the Regulation of Medical Associate Professions in the UK**
Report by:	**Richard Marchant**, Assistant Director, Strategy and Communication, richard.marchant@gmc-uk.org, 0207 189 5024
Action:	**For consideration**

Executive summary

At its meeting on 23 February 2017 Council considered the results of a scoping exercise on the possible future regulation of physician associates (PAs). Council agreed that, if requested by Government, it would in principle be appropriate for the GMC to take on the regulation of PAs, subject to certain conditions being met.

On 12 October 2017, Department of Health (England) published a consultation on the regulation of Medical Associate Professions in the UK. These include PAs, physician assistants (anaesthesia) (PA(A)s), surgical care practitioners (SCPs) and advanced critical care practitioners (ACCPs). Of these four groups, the consultation proposes that only PAs should be subject to statutory regulation at the present time. The GMC and The Health and Care Professions Council (HCPC) are both identified as bodies that could take on this role. Respondents are asked to state which it should be. This paper sets out the key points we should make in response to the consultation.

Recommendations

Council is asked to:

- **a** Re-affirm strongly our view that PAs should be regulated.
- **b** Re-affirm its preliminary view from February 2017 that, subject to certain practical and operational considerations being satisfied, the GMC would be prepared to take on regulation of PAs.
- **c** Note the key considerations and due diligence that should guide any future negotiations with the Department over PA regulation by the GMC.
- **d** Agree the points we should make in responding to the consultation.

Background

1 The scoping work that we undertook in 2016 sought to answer three questions: should physician associates (PAs) be subject to statutory regulation; if so, would the GMC be the appropriate body to regulate PAs; and, if so, what would the regulatory model look like? Our conclusion, set out in our paper to Council in February 2017 was that PAs should be subject to statutory regulation. Furthermore, the way PAs are trained and work to a medical model meant that there was a strong case for their regulation and professional standards to be overseen by the GMC, provided that practical issues, such as transitional and operating costs, could be satisfactorily addressed. We acknowledged, however, that any decision on PA regulation would be a matter for Government. We should not lobby to take on this role, but should signal our readiness to assist if Government felt that we had a role to play.

2 Although our February 2017 paper focused on the regulation of PAs, we noted the possibility that there might also be pressure to bring other groups, physician assistants (anaesthesia) (PA(A)s, surgical care practitioners (SCPs) and advanced critical care practitioners (ACCPs), into regulation. Any decision to extend the GMC's remit to include PAs could lead to calls for us to take on other groups as well. In the event, the DH consultation paper looks at the case for regulating each of the four groups (collectively referred to as medical associate professions (MAPs). It proposes that only PAs require statutory regulation at the present time. However, we should recognise that the position of the other three groups could change in future.

3 In the following paragraphs we set out the key points of our proposed response to the consultation. If these are agreed by Council we aim to finalise our consultation response by the beginning of December. The consultation closes on 22 December 2017.

Proposed response

Consultation Questions 1-4: What level of professional assurance do you think is appropriate for PAs, PA(A)s, SCPs and ACCPs?: voluntary registration, accredited voluntary registration [by Professional Standards Authority (PSA)], statutory regulation, other.

4 Our 2017 scoping paper set out some suggested criteria for bringing new professional groups into statutory regulation and considered how these were met by PAs. Using a risk assessment matrix adopted from PSA the DH consultation shares our conclusion that PAs should be subject to statutory regulation. Our consultation response would set out our rationale in relation to PAs. For the other three MAPs groups, our response may need to be more nuanced.

5 In the case of PA(A)s, the nature of the interventions they undertake leads DH to assess them as having the potential for a high risk of harm to patients. However,

because of uncertainties about their scope of practice and level of autonomy DH is seeking further evidence before taking a view. We may also note that the number of PA(A)s currently practising is low (165) and therefore unlike PAs, where the projected growth of the profession is significant, statutory regulation may be disproportionate. On the other hand, it can be argued that lack of regulation serves as a brake on the expansion of this group.

6 The consultation concludes that neither SCPs nor ACCPs require statutory regulation. In both cases the number of practitioners is small. Further, since entry to training for these professions requires individuals to be already registered as a health professional with one of the other UK regulators, the public protection value of dual registration as an SCP or ACCP would be limited. We do not, for example, require oral and maxillo-facial surgeons to be registered with both the GMC and the General Dental Council (GDC). By extension, it might be disproportionate to insist on a Nursing and Midwifery Council registered nurse also having additional statutory regulation to work as an ACCP. On the other hand, it seems likely that if SCPs and ACCPs were regulated in their own right there would be no need for the current pre-condition that those entering these new professions should already be members of another regulated profession.

7 Our consultation response for these three MAPs groups should, therefore, be informed by broader strategic considerations that go beyond the immediate merits of each individual case. The future of regulation will not be uni-professional and our readiness to take on the regulation of PAs accepts the principle that it may be appropriate for the GMC to regulate other professional groups. In the short term, if asked, it would be unrealistic for us to attempt to absorb all four professional groups in one go. In the longer term we need to contemplate the possibility that we could be asked at some point to take them on and to position ourselves accordingly. In those circumstances, a consultation response today, that we do not think the remaining three MAPs professions should be regulated, may be unhelpful.

8 If that conclusion is correct, in relation to PA(A)s, SCPs and ACCPs, our response would say that while we do not think that the DH consultation makes a sufficient case for their statutory regulation at the present time, this should not be ruled out in the future. In the meantime, voluntary regulation or voluntary accredited registers under PSA would contribute to providing greater public assurance and help prepare those groups for the professional responsibilities flowing from possible statutory regulation in future.

Question 5: In the future, do you think that the expansion of medicines supply, administration mechanisms and/or prescribing responsibilities to any or all of the four MAPs roles should be considered?

9 One of the arguments for bringing PAs into statutory regulation is that it will help maximize the potential of the role by enabling them to prescribe and order ionising radiation (requesting x-rays) as they can in other jurisdictions. Since we have concluded that there are not, at present, sufficient grounds for regulating the other three MAP groups, it follows that prescribing responsibilities should not be considered at the present time. We will reserve our position on what might be appropriate in the future were they to be regulated.

Question 6: Which healthcare regulator should have responsibility for the regulation of any or all of the four MAP roles? GMC, HCPC, Other, Don't Mind

10 Our February 2017 paper for Council examined the reasons why it would be a good regulatory fit for PAs to be overseen by the GMC. They train and work to a medical model and they are 'dependent practitioners' whose scope of practice is determined by their supervising medical practitioner. It therefore makes sense for there to be close alignment between the professional standards governing both doctors and PAs. This is best achieved if they are regulated by the same body. In other jurisdictions, such as USA and Canada, PAs are overseen by medical regulators.

11 Regulation by the GMC may also help to mitigate some of the concerns being expressed by doctors about the expansion of PAs. For example, fears that doctors' training opportunities will be lost to PAs (and vice versa) are more easily tackled if the standards for education and training of both groups, and the quality assurance of how that training is delivered, are overseen by one body.

12 However, the decision is ultimately one for Government. If it was felt that we were the appropriate body to regulate PAs, we would be ready to do so subject to agreement about transitional costs, the operating model and supporting legislation. In particular, doctors could not be expected to bear the cost of regulating PAs and the legislation must be proportionate and future proofed. It would be unacceptable simply to extend the existing provisions of the Medical Act 1983 to PAs.

Question 7: Invites respondents to consider the costs and benefits of the different types of regulation described in the document (voluntary registration, accredited voluntary registration [by PSA] and statutory regulation)

13 In relation to the cost of statutory regulation, the consultation notes the range of fees charged by the different regulators: HCPC (£90pa); GMC (£425pa for doctors); GDC (£890pa for dentists). Whilst we will not want to commit to a particular fee level for PAs at this stage, we should note that if we were asked to take on the regulation of

PAs we would consider the registration fee levels that would be appropriate. We would not use doctors' fees to cross-subsidise PA regulation. Nor should it be assumed that the same fee would apply for both doctors and PAs. Our preliminary scoping work suggests a registration fee for PAs of around £200pa. This would match the fee currently charged by the Faculty of PAs for voluntary registration. Depending on the regulatory model we adopt, this could fall as the number of PAs increases.

14 Second, while the consultation lists various benefits associated with statutory regulation it makes no mention of the ability of regulation to support professionals in delivering good practice and helping to drive up both education and practice standards. This key role of regulation is at the heart of our new corporate strategy.

15 Oddly perhaps, the document cites one of the benefits of both voluntary regulation and PSA accredited voluntary registers as being the ability of individuals to practise a profession without being registered or having to pay the associated registration fee. Arguably, this is less of a benefit for members of the public who risk being treated by unregulated individuals whose training cannot be assured and who are not accountable for their professional standards.

Question 8: Invites respondents to consider the equality considerations of introducing regulation for these groups

16 We are not aware of any adverse or beneficial equality implications for bringing PAs into statutory regulation. As the consultation notes, we are subject to the Public Sector Equality Duty and this would apply to our regulation of PAs as it does to our regulation of doctors.

The views of others

17 In our press release at the time of the consultation launch we said that in considering our response we would wish to take note of the views of our regulatory partners. At the time of preparing this paper, many of them will still be developing their views. From our previous work we understand that the Faculty of PAs, and PAs themselves, are likely to support regulation by the GMC. Similarly, the Academy of Medical Royal Colleges and a number of the individual colleges are thought to want us to take this on. However, the British Medical Association does not want GMC regulation of PAs. As we finalise our response we will seek to understand further the range of views. These will inform, but should not determine, our response.

Conclusion

18 In summary, the key points for our proposed response would be:

a PAs should be subject to statutory regulation.

b The evidence of the consultation document does not demonstrate a sufficient case for statutory regulation of the other three MAPs. However, statutory regulation should not be ruled out for the future. In the meantime, voluntary regulation or voluntary accredited registers under PSA would contribute to providing greater public assurance and help prepare these groups for the professional responsibilities flowing from possible future regulation.

c Once PAs are subject to statutory regulation they should be able to prescribe and order x-rays. This will help to maximise the potential of the role. The position of the other three groups should be considered if and when they are brought into statutory regulation.

d Regulation of PAs by the GMC alongside doctors would provide a good regulatory fit. If Government felt that we were the appropriate body to regulate PAs we would be ready to do so subject to agreement on transitional costs, the operating model and supporting legislation.

e If we were asked to regulate PAs we could not commit to a particular registration fee level at this stage. However, it should not be assumed that the same fees would be appropriate for both doctors and PAs. In addition, doctors could not be expected to bear the costs of bringing PAs into regulation.

f We would note the additional benefits of statutory regulation in driving up standards and supporting professionals in delivering good practice.

12 December 2017

General Medical Council

Council closed session

CS1

To approve

Minutes of the Closed Session on 7 November 2017 - Extract

Members present

Terence Stephenson, Chair

Steven Burnett
Shree Datta
Christine Eames
Michael Farthing
Anthony Harnden
Helene Hayman
Deirdre Kelly
Paul Knight
Suzi Leather
Denise Platt
Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Chief Operating Officer
Paul Buckley, Director of Strategy and Communication
Una Lane, Director of Registration and Revalidation
Colin Melville, Director of Education and Standards
Patricia Morrissey, Council Secretary
Anthony Omo, General Counsel and Director of Fitness to Practise
Neil Roberts, Director of Resources and Quality Assurance

Department of Health Consultation on the Regulation of Medical Associate Professions in the UK

7 Council considered the proposed GMC response to the Department of Health consultation issued on behalf of the four UK health departments, on the regulation of Medical Associate Professions (MAPS) in the UK, including Physician Associates (PAs), physician assistants (anaesthesia) (PA(A)s), surgical care practitioners (SCPs) and advanced critical care practitioners (ACCPs).

8 Council:

a Strongly re-affirmed the view that PAs should be regulated.

b Re-affirmed its preliminary view from February 2017 that, subject to certain practical and operational considerations being satisfied, the GMC would be prepared to take on regulation of PAs.

c Noted the key considerations and due diligence that should guide any future negotiations with the Department over PA regulation by the GMC, including the necessity of having a modern legal framework for regulating PAs that was substantively different from the prescriptive model set out in the Medical Act.

d Agreed the points to be made in the response to the consultation as set out in the paper, with the exception that all the roles referred to in the consultation as MAPS should be considered for regulation as four groups within one profession. There would be economies of scale in a single regulator developing a framework that could absorb the four groups.

e Agreed that the Chair and Chief Executive would approve the GMC's consultation response prior to submission.

9 During discussion, Council noted:

a The potential benefits for workforce planning of bringing all four groups within the scope of one regulatory body, as these roles could provide an alternative route to becoming a doctor.

b The views of stakeholders including PAs.

c The reassurance that the GMC had sufficient capacity to integrate regulation of PAs, and the other medical associated professions, subject to due diligence and appropriate arrangements agreed with Government, including set up costs and ensuring that the GMC registrants did not subsidise the regulation of PAs.

d The plan for handling discussions with the Department of Health on regulation of PAs, and in particular how we might leverage this opportunity to seek the wider legislative reform that we require to become a modern regulator.

General Medical Council

September 2019 - Council Meeting

MEETING
26 September 2019 09:00

PUBLISHED
18 September 2019

Working with doctors Working for patients

General Medical Council

Council Meeting
Meeting Room 2.07/8
350 Euston Road,
London, NW1 3JN

Agenda

Thursday 26 September 2019

09:00 - 13:00

Meeting

		Meeting part 1
09:00 - 09:03 *3 mins*	**C1**	Chair's business
09:03 - 09:05 *2 mins*	**C2**	Minutes of the Confidential session on 12 June 2019
09:05 - 09:25 *20 mins*	**C3**	Review of corporate risk
09:25 - 09:45 *20 mins*	**C4**	The SoMEP workforce report
09:45 – 09:55 *10 mins*	**C5**	Any other business – for sensitive items
09:55 – 10:00 *5 mins*		**Short adjournment**
		Meeting part 2
10:00 – 10:03 *3 mins*	**M1**	Chair's business

10:03 – 10:05 *2 mins*	**M2**	Minutes of the meeting on 12 June 2019
10:05 – 10:25 *20 mins*	**M3**	Chief Executive's Report
10:25 – 10:45 *20 mins*	**M4**	Section 40A appeals update
10:45 - 11:00 *15 mins*		**Break**
11:00 - 11:25 *25 mins*	**M5**	Update on regulation of Physician Associates and Anaesthesia Associates
11:25 - 11:50 *25 mins*	**M6**	Update on implementing the current Corporate Strategy
11:50 - 12:15 *25 mins*	**M7**	Pension valuation
12:15 – 12:45 *30 mins*	**M8**	Update on the Staff Survey
12:45 - 12:55 *10 mins*	**M9**	Any other business

M10	Annual report of GMC Group Personal Pension Plan governance
M11	The Professional Standards Authority (PSA) Annual Review of our Performance 2017/18
M12	Council members' register of interests
M13	Update to the Governance Handbook

General Medical Council

Agenda item:	**M5**
Report title:	**Update on regulation of Physician Associates and Anaesthesia Associates**
Report by:	**Richard Marchant, Assistant Director, Strategy and Policy,** richard.marchant@gmc-uk.org, 020 7189 5024
Action:	**To consider**

Executive summary

In July 2019 the Government invited the GMC to take on the regulation of two additional professions; physician associates (PAs) and anaesthesia associates (AAs). We have confirmed our readiness to regulate both groups, subject to the Government providing set up and transitional funding to cover the cost of bringing them into regulation and the development of appropriate, future-proofed legislation.

This paper outlines our initial thinking about how we will approach the work ahead and the regulatory model needed.

Recommendations

Council is invited to:

- **a** Consider the overarching principles that should govern our approach to regulating PAs and AAs.
- **b** Note our initial plans for scoping the work ahead.

Background

1 The GMC regulates doctors. Since 2015 we have been approached on a number of occasions about taking on the regulation of physician associates. In 2016 we undertook preliminary scoping work to help us better understand the role of PAs, whether they should be regulated and, if so, whether the GMC was the appropriate body to do so. In February 2017 Council agreed that, if requested by Government, we should be prepared to regulate PAs subject to certain conditions being met. The conditions included stakeholder support for us taking this on, provision of transitional funding from Government, a financially sustainable regulatory model and legislation that is fit for purpose in supporting the model.

2 In October 2017 the Government consulted on the future regulation of four professions: PAs, AAs, surgical care practitioners (SCPs) and advanced critical care practitioners (ACCPs). These discrete groups were collectively described as medical associate professions (MAPs). In our response of December 2017 we said that all four MAPs professions should be regulated and that we would be prepared to take this on, provided our conditions were met.

3 The Government's initial response was published in February 2019. It stated that only PAs and AAs from the four MAPs professions were to be brought into regulation and that further work was needed to decide who the regulator should be; GMC or HCPC. In July 2019 it was announced that GMC was the preferred regulator for both PAs and AAs.

PAs and AAs: some basics

Physician Associates

4 PAs are:

> '…healthcare professionals with a generalist medical education, who work alongside doctors, physicians, GPs and surgeons providing medical care as an integral part of the multidisciplinary team. Physician associates are dependent practitioners working with a dedicated supervisor, but are able to work autonomously with appropriate support.'*

5 There are 1,181 PAs on the Faculty of Physician Associates Voluntary Register.† We think this represents approximately 70% of the practising PAs in the UK.

* https://www.fparcp.co.uk/about-fpa/faqs

†† As at 20 August 2019.

6 There are approximately 1,600 PA students in training* spread across 37 training programmes.

7 The Government has committed to having 1,000 PAs available to work in primary care in England by 2020. The *Interim NHS People Plan* estimates the total number of PAs will increase to 2,800 by the end of 2020, rising to over 5,900 by the end of 2023.

Anaesthesia Associates

8 AAs:

'…perform duties delegated to them by their medical anaesthetic supervisor. These will include pre and post-operative patient assessment and care, maintenance anaesthesia and (under direct supervision) conduct the induction and emergence from anaesthesia. AAs will also deputise for anaesthetists in a variety of situations where their airway and venous cannulation skills will assist in patient care and where medically qualified anaesthetists cannot be available.'†

9 As at December 2018, there were approximately 189 qualified AAs in the UK.‡ The Royal College of Anaesthetists runs a 27-month training programme with a national assessment based at the University of Birmingham leading to a Postgraduate Diploma in Anaesthetic Practice.

Developing our regulatory approach

10 During our preliminary scoping work in 2016 we identified some broad principles that should govern our approach to the regulation of new professions. It is right that these should now be tested:

Parity of regulatory esteem

11 We are the General Medical Council but are about to become a multi-professional regulator. We cannot regard ourselves as principally the regulator of doctors, with PAs and AAs as supplementary groups of lesser regulatory significance. Our case for taking on PAs and AAs alongside doctors was based upon the coherence of regulating

* Figures provided by Department of Health and Social Care

† https://www.rcoa.ac.uk/careers-training/anaesthesia-related-professionals/physicians-assistant-anaesthesia/faqs

‡ Figures provided by Department of Health and Social Care

them as part of the medical team. All three professions must therefore be afforded parity of esteem in our regulatory approach.

Proportionality

12 Notwithstanding the parity of esteem principle, our operating model should reflect the differences in the education and practice of the different professions, and the regulatory risks involved. For example, although we will wish to be satisfied about the standards for education and training of PAs and AAs, and that they remain up to date and fit to practise, it does not follow that our operational arrangements for education quality assurance or revalidation must be identical to those for doctors. It is worth noting that PAs currently re-certify every six years by taking the Faculty of Physician Associates (FPA) national examination. That may be an entirely appropriate revalidation model for a profession whose practice is based around generalist skills. Similarly, it does not necessarily follow that the two-tier system of registration and licensing we have for doctors must be replicated for PAs and AAs.

Flexibility

13 Although at present the Government only intends to bring PAs and AAs into regulation, it has not ruled out regulating SCPs and ACCPs at a future date. Our operating model (including our IT systems), should therefore be designed to accommodate the future development of MAPs as a whole.

Lift and shift

14 Having signalled our willingness to regulate PAs and AAs, we will be under pressure to deliver as quickly as possible. To some extent the implementation timetable is beyond our control because it depends upon the Government delivering legislation that is fit for purpose. The Department of Health and Social Care (DHSC) estimates that it will take between 18 and 24 months to develop and lay the necessary legislation. As matters stand, and given the uncertain political climate, it seems unlikely that any legislation could be ready before 2021 at the earliest.

15 However, to minimize delay our preliminary thinking is that we should, where possible, initially adopt the mechanisms put in place by the FPA and Royal College of Anaesthetists to support their existing voluntary registers. The advantage of this lift and shift approach is that it would allow us to introduce a basic level of statutory regulation at the earliest opportunity in the interests of patient safety. The disadvantage is that this may expose us to some regulatory risk in the short term if the adopted mechanisms are not initially as robust as those we are used to for doctors. Further work with the FPA and the College to understand their existing systems will enable us to assess the potential risk and decide whether this is the correct approach.

Legislative model

16 How we regulate PAs and AAs will depend upon the legislative model. When the Government introduced regulation for nursing associates it did so essentially by inserting the term 'nursing associate' into the Nursing and Midwifery Order alongside the terms 'nurse' and 'midwife'. If this approach were to be replicated for PAs and AAs it would simply impose on them all the shortcomings that we know exist in the Medical Act for regulating doctors.

17 We should, therefore, insist on a regulatory model for PAs and AAs which reflects the aspirations for legislative reform set out in the Government's proposals *Promoting Professionalism: Reforming Regulation.* There is a real opportunity for PAs and AAs to be early adopters of the more flexible legislative model that we, and the Government, are seeking for all professions.

No cross subsidisation

18 We made clear in our offer to Government that doctors must not be expected to fund the transitional cost of bringing new professions into regulation. This principle has been accepted by DHSC officials. It is now a matter of agreeing the sum required. Our initial estimate of transitional costs was between £3.5m and £4.5m, but this will be tested through our proposed scoping work (see paragraph 24 below). The final figure may be higher or lower depending on our more detailed analysis.

19 However, the ongoing costs for regulating PAs and AAs once the transition is complete must be borne by the GMC. Again, doctors should not be expected to carry the cost of PA and AA regulation through an increased annual retention fee (ARF). The cost of PA and AA regulation must be borne by those professions. Our aim is that their fees should initially be no higher than those paid for inclusion in their respective voluntary registers. The scoping work ahead will provide clarity on costs. Our expectation is that costs will reduce as the number of PAs and AAs increases and we are able to benefit from economies of scale. We will want to discuss with DHSC transitional funding to cover the period until the numbers are sufficient to become self-funding.

20 However, the principle that doctors must not bear the cost of regulating new professions does not mean regulatory separation with different processes and systems individually costed for each profession. It seems probable that there would be greater coherence and efficiency if regulatory functions and activities can be aligned. For example, a single education quality assurance visit might reasonably look at the education and training provisions for both doctors and PAs in the same location.

21 We will apply these principles to the scoping work ahead.

Scoping

22 Although we undertook some initial scoping in 2016 looking at the feasibility of regulating PAs, we now need to carry out full due diligence for both PAs and AAs. Una Lane (Director of Registration and Revalidation) will lead the programme of work on bringing PAs and AAs into regulation. She is currently putting together a team to support her in taking this work forward and is working closely with Neil Roberts (Director of Resources) and other colleagues in focusing initially on scoping out what that programme might look like and, in particular, the likely costs.

23 Una Lane, Director of Registration and Revalidation, will establish and chair an internal programme board. Details are being finalised but, at present, we expect to have a small core team working on the project full time. It will probably comprise an Assistant Director (AD) lead, a programme manager, and additional administrative support. There will be a number of work streams to support the programme and these will report into the board. The work streams will include policy/legislation, education and assessment, operations, resource and IS, communications and engagement. Individual work streams will be supported by staff from across the business working on the project for a percentage of their time. We expect DHSC to cover the backfill costs. We are also planning to establish an external advisory group involving all key stakeholders to support the work.

24 On 2 September 2019 we met DHSC officials for preliminary discussions about how to take the work forward and the funding arrangements needed to support the work. DHSC has agreed in principle to fund the set up and implementation costs. We will now prepare a business case detailing our anticipated costs for the initial set up and scoping phase of the project. This scoping should enable us to reach a shared view of our legislative requirements, the set up and transitional funding needed for implementation and the provisional timetable. The scoping will need to cover, among other things:

- Legislative requirements (including the need for PAs and AAs to be able to prescribe)
- Grandfathering arrangements for PAs and AAs not already on their respective voluntary registers
- IT systems requirements
- Staffing and resources
- GMC governance and the implications for the size and shape of Council
- Registration and annual retention fees

- Development of regulatory functions: education, standards, registration, revalidation/re-certification and fitness to practise
- Operating model and internal organisation
- Implementation and phasing
- Set up, transitional and ongoing costs of regulation.

25 Over a longer timescale, particularly as these professions develop, there will be wider implications for our regulatory model. These will include, but not be limited to, such issues as the relationship between PAs, AAs and doctors in the clinical team; the need for the sort of educational and system infrastructure upon which we depend for regulating doctors, and the arrangements for registering international graduates.

Communications

26 During the scoping phase of the work, effective communication and engagement will be crucial. We will establish a stakeholder reference group to enable us to test our thinking. One to one meetings with key individuals and organisations have already begun.

27 Most of the stakeholder groups who responded to the consultation and the Government announcement have welcomed the GMC as the preferred choice of regulator. Those who support the decision include PAs and AAs, the devolved administrations, the Academy of Medical Royal Colleges, a number of individual colleges and Health Education England. Both students and practising PAs and AAs have already been in touch for information about how the GMC intends to regulate them.

28 However, the British Medical Association (BMA) and medical trainees have said that they are 'fundamentally opposed' to the decision. The BMA is concerned that the GMC will lose its focus on doctors. Medical trainees are concerned, among other things, about the impact on their own training opportunities. This highlights the need for our communication and engagement work to cover both doctors and PAs/AAs as our regulatory responsibilities expand. In doing so it will be a priority to listen to and address the concerns that have been raised by the medical profession. There is also learning to be taken from the experience of the Nursing and Midwifery Council, General Dental Council and General Pharmaceutical Council in bringing new professions into the regulated team.

Next steps

29 The immediate next step is to submit our formal business case to DHSC officials so that they can, we hope to agree and release the funding necessary for the initial set up and scoping work required, from which more detailed implementation plans will be developed.

30 We will update Council on progress before the end of the year.

General Medical Council

Council

Draft as of: 24 October 2019

To approve

Minutes of the meeting on 26 September 2019 - Extract

Members present

Clare Marx, Chair

Steven Burnett
Christine Eames
Anthony Harnden
Philip Hunt
Deirdre Kelly
Paul Knight
Suzi Leather
Denise Platt
Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Paul Buckley, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Anthony Omo, Director of Fitness to Practise and General Counsel
Neil Roberts, Director of Resources
Colin Melville, Medical Director and Director of Education and Standards
Paul Reynolds, Director of Strategic Communications and Engagement
Melanie Wilson, Council Secretary

Chief Executive's report (agenda item M3)

4 Council considered the Chief Executive's Report, noting that:

a We are continuing to work closely on the regulatory reform agenda with other regulators, particularly with the Nursing and Midwifery Council, on regulatory alignment.

Update on regulation of Physician Associates and Anaesthesia Associates (agenda item M5)

9 Council received a paper providing an update following the Government's decision in July 2019 to invite the GMC to take on the regulation of physician associates (PAs) and anaesthesia associates (AAs).

10 Council noted that:

a It will likely take between 18 and 24 months to develop and lay the necessary legislation, with the potential for the uncertain political climate to extend that period further.

b The Government has accepted that it needs to fund both the scoping phase and a costed implementation phase and we are working on agreeing the initial sum.

c Communications planning was needed to address the concerns expressed, including by the British Medical Association and medical trainees; to ensure that devolved administrations are kept updated; and to manage the expectations of PAs and AAs about how long the new arrangements will take to put in place.

d In particular we need to be clear that the GMC's role is about developing an effective regulatory framework for PAs and AAs, whereas wider issues pertaining to PAs and AAs such as their roles, numbers and training pathways are matters for the wider health system.

e Recruitment is already underway to manage five workstreams of activity to prepare for the changes.

11 Council noted the overarching principles that should govern the GMC's approach to the regulation of PAs and AAs and the GMC's initial plans for scoping the work ahead.

12 During discussion, Council noted that, following reference to the issue at the Labour Party Conference, any views on regulation of PAs/AAs of other political parties would be ascertained.