Royal College of General Practitioners

RCGP response to General Medical Council (GMC) consultation on **regulating Anaesthesia Associates and Physician Associates**, and **Fitness to Practise**: proposed rules, standards and guidance

Prepared by the Royal College of General Practitioners (RCGP) – May 2024

Preface:
The Royal College of General Practitioners (RCGP) has responded to the General Medical Council's (GMC) recent consultation on the regulation of Physician Associates (PAs) and Anaesthesia Associates (AAs), and Fitness to Practise (FtP) proposed rules, standards and guidance. As this was an extensive consultation covering many technical areas, the RCGP response focused on reflecting key messages and concerns on behalf of general practice. This document summarises our response which was submitted according to the questionnaire format required by the GMC.

Submission:
It is the Royal College of General Practitioners' (RCGP) position that it would be more appropriate for a regulatory body other than the General Medical Council (GMC) to regulate Physician Associates (PAs), to prevent confusion amongst patients about the differences between doctors and PAs.
However, we recognise that the processes are well advanced for GMC regulation of PAs, and therefore it is important that all efforts are made to ensure there is clarity over the differences in these roles. This should be considered in all decisions around how regulation decisions are implemented and how guidance documents are produced.

a. The RCGP calls for an addendum to be added to the GMC's Good medical practice 2024 (GMP) to specifically address the variations in these roles, e.g. including formally adopting the FPA guidance on titles and introductions and clearly stipulating that PAs must always work under supervision, must work within the limits of their own competence, and be held accountable for their own actions. Furthermore, employers must ensure that appropriate supervision structures are in place for the PAs they decide to employ.
b. If regulation is to proceed under the GMC, the RCGP strongly advise that the prefix used ahead of registration numbers be assigned as 'PA' for PAs, as opposed to 'A' as currently proposed by the GMC. Unpublished results from a recent RCGP member survey suggest that only a very small proportion of over 5,111 respondents think that the proposed prefix ('A') should be used, and the majority thought that 'PA' for PAs (and 'AA' for AAs) should be used.

We note that the GMC does not intend to determine the scope of practice for AAs and PAs beyond initial qualification competencies, as it does not determine it for doctors. This scope of practice needs to be urgently developed and agreed on a uniform basis by the major stakeholders and the RCGP will have a significant role to play in regard to the way that PAs work in general practice.

a. Education and Training

a. Careful consideration must be granted to the time and resource demands on trainers, supervisors, and GP leaders.
b. As stipulated in the RCGP red lines on PAs, the training and retention of GPs must be prioritised and the responsibilities and skills required by GPs to supervise PAs must be recognised and resourced.
c. At a time of significant GP workforce challenges, funding allocations, resources and learning opportunities within general practice must be prioritised for the training and retention of GPs.
d. At this point in time, it is difficult to approve a list of essential criteria, based on a lack of clarity regarding a defined scope and remit of PAs working in general practice.

b. Registration

a. The RCGP strongly advise that the prefix used ahead of registration numbers be assigned as ‘PA’ for PAs, as opposed to 'A' as currently proposed by the GMC. Unpublished results from a recent RCGP member survey suggest that only a very small proportion of over 5,111 respondents think that the proposed prefix ('A') should be used, and the majority thought that ‘PA’ for PAs (and ‘AA’ for AAs) should be used.
b. The GMC should be resoundingly clear regarding the use of protected titles**, and emphasise across all of its rules, guidance documents and standards that it is** illegal to falsely use protected titles.
    a. The RCGP acknowledge that the title Doctor on its own is not a protected title, although it insists that the GMC firmly stipulate that PAs or AAs who hold an accredited and recognised level 8 equivalent doctorate degree (PhD) do not use the title of 'Doctor' (or any synonymous terms), when working in a clinical setting.
    b. Furthermore, the RCGP requests that the GMC clearly states that PAs using the title of 'Doctor' or prefix ‘Dr’ in an academic setting must also use their postnominal qualification to clearly identify their qualification, in line with FPA Physician associate title and introduction guidance for PAs, supervisors, employers and organisations.

c. The RCGP highlight the need for clear distinction between roles, and standards.
d. The RCGP is seeking clarity on whether PA and AA registers will be made public so that the public and profession can check registration online, and if so, what steps the GMC will take to clearly distinguish these roles for the public.

In regard to revalidation:

a. The RCGP look forward to engaging in consultations in due course when the GMC begins to develop their revalidation model (subject to consultation in 2025, for implementation 2026).
b. We are reassured to see that the GMC have said: 'as for doctors, our revalidation model will not routinely require PAs or AAs to sit an exam as part of the process'.

c. Fitness to Practise Rules & Decision-making Principles

a. The RCGP support a Fitness to Practise (FtP) model that promotes reflection and learning to effectively deliver the three limbs of public protection. The correct balance should allow for appropriate accountability without driving anxiety and fear of blame, as this has been shown to be detrimental to retention, workforce performance, and patient outcomes.
b. The inclusion of supportive measures and cultural competency principles can mitigate negative experiences and impacts on practitioner wellbeing, encouraging continued professional development and appropriate return to practice.
c. We are pleased to see that the GMC has stated that PAs and AAs must always work under some form of supervision, and they are accountable for their own actions and must work within the limits of their own competence. We support the GMC's statement that Doctors are not accountable for the actions of PAs and AAs provided they have delegated in line with GMC guidance. However, the RCGP feel that greater clarity is required as to how the level of risk and responsibility held by GPs, as supervisors and leaders of MDTs in primary care, will be approached by the GMC in relation to Fitness to Practise of PAs, including complaints and other investigations.
d. We are pleased to hear that Physician associates working in general practice are indemnified under the same state-backed clinical negligence indemnity as general practice colleagues.
   (i) However, we advise that variations in the provisions for state-backed indemnity across the UK, such as in Northern Ireland are carefully considered. Physician associates working in general practice have different indemnity arrangements across the four nations. In England and Wales there is similar cover under the

same state-backed clinical negligence indemnity as general practice colleagues.

(ii) For example, in Northern Ireland no state-backed scheme exists for GPs. Current GP costs for indemnity are being partially offset in this financial year as an interim solution agreed with the Department of Health through reimbursement to practices. While a recurrent and formal solution is being sought, there is no guarantee this will be achieved for next year. Until such a state-backed solution is found, PAs working in NI general practices need to seek personal indemnity.

e. The case examiner and accepted outcomes model appears fitting and appropriate for cases that are straightforward, with clear facts that are understood and uncontested by all parties, and which may be supported or guided by historical precedent. However, in cases where multiple complex and interrelated factors such as bias, a significant elapse of time, numerous respondents with differing statements, systemic implications, and cultural differences are implicated in the nature of the referral/investigation, the FtP review process must be equitable and robust.

(i) Such highly complex cases should be referred for a panel hearing, where it is important to have a range of views heard, fairly test insight, and give the registrant a platform to defend their position, in the presence of a panel offering diverse backgrounds, experiences and perspectives.

(ii) In complex cases where bias or cultural differences may be at play, and/or if a registrant continues to defend their position or cannot come to an agreement with the case examiner through accepted outcomes, the case should be referred for a panel hearing. If this occurs, appropriate support and guidance should be provided to the registrant throughout the process.

(iii) It is crucial to ensure that the FtP proceedings are fair and equitable for all registrants, regardless of their professional background. Doctors and PAs will have varying levels of experience and training, in addition to differences in their roles and responsibilities.

(iv) These imbalances could lead to disparities in understandings of context and navigation of the proceedings, for both registrants and those involved in decision-making. Therefore, it is essential that the GMC provide clear, accessible, and comprehensive guidance to all individuals involved in FtP proceedings and outcomes, to ensure that the decision-making consistent and fair for all registrants.

f. Case Examiners should be provided with robust training (including Equality, Diversity, and Inclusion (EDI)) and support to be able to

identify and appropriately refer cases to a panel hearing in the event of complex elements and/or disagreement over details.

g. It may be suitable for healthcare professionals engaged in regulatory roles, including undertaking decision-making work, to have access to experienced guidance and structured support. If not already in place, a 'Regulators' Support Group' may promote inter-regulator discussions and collaboration. Inter-regulator discussions should be promoted, in a timely and collaborative manner, to promote consistent application of the three limbs of public and support shared learning from mistakes, reflection on problem cases, and provide a professional network for regulators across the sector.

h. Lay-person representation:
    1. Lay-person representation in fitness to practise decisions and hearings for medical professionals in the UK is crucial because it ensures that the concerns and perspectives of patients and the broader public are considered, and adds validity to the process.
    2. Lay representatives can provide valuable insights into the impact of conduct or competency on patients, communities, and wider society. This inclusion helps maintain transparency, accountability, and fairness in the regulatory process, ultimately strengthening the quality of care provided by regulated healthcare practitioners in the UK. It would be prudent for lay representatives to receive commensurate training as case examiners, particularly EDI training.

d. Revision and Appeals

a. PAs must not be self-regulating, thus, appeal panels must appropriately reflect the team in which PAs work and should include representation by at least one doctor.

b. As previously stipulated, the RCGP believe that lay-person representation in fitness to practise decisions and hearings (including revisions & appeals) for medical professionals in the UK is crucial because it ensures that the concerns and perspectives of patients and the broader public are considered, and adds validity to the process. Lay representatives can provide valuable insights into the impact of conduct or competency on patients, communities, and wider society. This inclusion helps maintain transparency, accountability, and fairness in the regulatory process, ultimately strengthening the quality of care provided by regulated healthcare practitioners in the UK. It would be prudent for lay representatives to receive commensurate training as case examiners, particularly EDI training.

e. Fees

a. As stipulated in RCGP red lines: *Regardless of the regulatory body, as previously stated, it is also important that any costs of the regulation of PAs must not be transferred to doctors.*

f. Equality and Diversity

a. As has been highlighted in the PSA review of Social Work England's process for 'accepted outcomes' in Fitness to Practise (FtP) cases, the RCGP is concerned about the risk of more serious outcomes being accepted by a registrant in the absence of a panel, particularly by those who may already face disproportionate outcomes.
b. We acknowledge ongoing work by the General Medical Council (GMC) to address fairness in its FtP process. However, the movement away from a panel structure towards a case examiner (or a single decision maker) model raises concerns surrounding the transparency and reliability of decision-making, support and representation for registrants, and the mitigation of human factors such as bias and experience in these systems.
    (1) It will be very important for the GMC to clearly demonstrate how case examiners reach their decisions, following a clear algorithm or decision-making process.
        a. This should be accompanied by a GMC commitment to independent auditing and monitoring of their FtP processes and governance structures, with transparent publishing of results and analysis of findings.
    (2) There will also need to be quality control of this process and consideration of how artificial intelligence and machine-generated learning could be implicated and managed in these matters.
    (3) Case examiners, panellists, expert witnesses, lay-people, registrants, service users, and all others involved with proceedings should be provided open and clear pathways to provide feedback. They should be supported and protected to speak openly, and treated consistently if they decide to do so, and as part of this, a regulator-specific whistleblowing policy may be fitting (if not already in place)
c. It has been established that Black, Asian and Minority Ethnic (BAME) doctors and internationally trained medical graduates (IMGs) are overrepresented in FtP and performance concern referrals, and face harsher scrutiny in investigations. (Source: NHS, An exploration of the experiences of ethnic minority practitioners and International Medical Graduates of the management of concerns about their medical practice (March 2024)., General Medical Council, Reviewing how we approach fairness and bias: Actions for 2023 (February 2023)., General Medical Council, Fair to Refer? Reducing disproportionality in fitness to practise concerns reported to the GMC (June 2019)).
d. Case examiners will need regular Equality, Diversity, and Inclusion (EDI) training and analysis of the outcomes of their cases to ensure there is no inadvertent bias in their decisions.
e. The RCGP has heard anecdotally that these groups, and those with other protected characteristics such as disabilities, are at a higher risk of being poorly represented by medical defence organisations, meaning they may

feel unsupported, limited in their options, and are at a higher risk of accepting more severe outcomes.

f. There is concern that the deployment of PAs in deprived areas, which often struggle to hire or retain GPs, could lead to inequalities in patient care and outcomes. While PAs may support patient access to care in these areas, it is important to note that they are not a replacement for GPs. The quality of care provided by PAs, and the impact PA roles may have on patient outcomes and the general practice environment (particularly in deprived areas), are critical issues that need further investigation.
g. While the regulation of AAs and PAs is a significant step forward, it is essential to address potential inequalities and ensure that GMC regulation and the implementation of the AAPAO do not compromise the quality of patient care or exacerbate existing healthcare inequalities.

ENDS.