General Medical Council

04 April 2024

Dr Richard Marks FRCA

Anaesthetists United

Sent by email

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Chair
Professor Dame Carrie MacEwen

Chief Executive and Registrar
Charlie Massey

Dear Dr Marks,

Thank you for your letter of 26 March 2024 sent on behalf of Anaesthetists United regarding our approach to the regulation of physician associates (PAs) and anaesthesia associates (AAs). I appreciate your taking the time to write to me and our Chair, Professor Dame Carrie MacEwen, about the use of certain terminology in *Good medical practice* and the future design of our public-facing registers.

I think it's fair to say that we share a common goal - to promote patient safety and to ensure public confidence in those delivering care. I am confident that the regulation of PAs and AAs by the GMC at the end of this year will make a significant contribution to both.

I thought it would be helpful to respond to each of your points in turn, as well as to the proposals you make regarding the format of *Good medical practice* and our public-facing registers once PAs and AAs are regulated.

Promoting and maintaining public confidence

We agree that patients must always be clear about who is treating them and every healthcare professional has a duty to clearly explain their role. PAs and AAs are two relatively new professional groups in healthcare so it is even more important that they are always clear about their roles and responsibilities with the patients they treat. They do not have the same knowledge, skills and expertise as doctors. They are not doctors, and they can't replace them.

I think professional regulation will be helpful in this context. Our professional standards say that PAs and AAs will have a responsibility to clearly communicate who they are and their role in the team, just as doctors must do now. Regulation will also mean that we are able to take action in the event that an

individual registered with us falls below the standards we set, including any instances in which they are not open and transparent about their role or qualifications.

The Faculty of Physician Associates also has guidance on 'titles and introduction' which provides a standardised way of using the PA title and highlights the importance of explaining it to patients and colleagues.

Use of terminology

I appreciate your concerns around the use of the terms 'medical professions' and 'medical professionals' in *Good medical practice* and the fact that PAs and AAs will be required to follow a set of core standards that contains the words 'medical practice' in its title.

As you'll know, the term 'medical associate professions', which includes PAs AAs, has been used for many years now by organisations across the UK including employers, statutory education bodies and the Department of Health and Social Care. This is in recognition that there are professionals in addition to doctors that are trained in, and work to, the medical model.

Our legislation sets out the legally protected title that only registered and licensed doctors can use. That term is 'registered medical practitioner'. Anyone holding themselves out to be a 'registered medical practitioner' when they are not is committing a criminal offence and may be liable to prosecution. Once regulation of PAs and AAs begins, the protected titles for them in law will be 'physician associate' and 'anaesthesia associate' respectively. Again, anyone using these titles when they are not GMC registered PAs or AAs will also be committing a criminal offence. The use of any other terminology is a linguistic rather than a legal issue but language is always important in terms of being clear about roles and responsibilities.

On occasion we use 'medical professionals' as an umbrella term to collectively describe all the professionals we will regulate in future. This is in preference to always separately listing out each individual role. The alternative term we considered was 'registrants', which we felt was cold and impersonal. And we will only use the term 'medical professionals' sparingly and when appropriate to the circumstances, for example when referring to the collective professionals we regulate. The professional titles of medical practitioners, physician associates and anaesthesia associates will continue to be separate and distinct, as well as protected in law.

The terms 'in practice', 'practise' and 'practising' are used in relation to all healthcare professionals as well as many other professional groupings outside of healthcare such as solicitors and barristers. The term 'fitness to practise' is widely used in legislation covering all healthcare professionals, teachers, lawyers and other regulated professions to describe the processes that regulators use to investigate

the conduct and competence of their registrants. These terms are not exclusive to doctors and their regulation.

I have also asked our lawyers to look at references to the terms 'registered medical professional' and 'responsible medical professional' in *The Abortion (Northern Ireland) (No. 2) Regulations 2020* and the *Armed Forces Act 2011* respectively. We do not agree that there is a contradiction of definitions in legislation. These terms are defined for those specific pieces of legislation and only for the purpose of those pieces of legislation, meaning only professions listed within these definitions are legally entitled to undertake activities specified in the legislation. The interpretation section in each of these pieces of legislation makes clear that both terms are used to mean 'registered medical practitioner' – the protected title for doctors as described in the Medical Act. There is no reference to PA or AAs within these definitions. Occasionally referring to doctors, PAs and AAs under the umbrella term of 'medical professionals' does not mean that PAs and AA could undertake any of these activities given that the interpretation section in both pieces of legislation clearly define these terms as referring exclusively to doctors who are registered and licensed by the GMC.

Good medical practice and the proposal to create two separate sets of core standards

Where professional regulators set standards of professional behaviour for more than one group of registrants, they generally do this through shared standards. For example:

- The General Dental Council (GDC) publish a single set of professional standards for all dental professionals (dentists; dental nurses; dental hygienists; dental therapists; orthodontic therapists; dental technicians; and clinical dental technicians).
- The Nursing and Midwifery Council (NMC) publishes The Code, professional standards of practice and behaviour for nurses, midwives and nursing associates.
- The Health and Care Professions Council (HCPC) publishes a single set of standards of conduct, performance and ethics for the 15 professions it regulates.

Since 2019 we have engaged a range of stakeholders - including the BMA, medical royal colleges, doctors and patients - to help us settle on our terminology and approach to regulation, including through our recent extensive and wide-ranging consultation on the review of *Good medical practice*. Throughout there has been strong agreement that PAs and AAs should be held to the same high professional standards as doctors.

There has also been no significant objection to the terminology used in *Good medical practice* until very recently. Indeed, it was not mentioned at all by our key stakeholders (including the British Medical Association) either in response to our pre-consultation engagement survey on *Good medical practice* in 2021, or in response to our public consultation in 2022.

We do not accept that shared standards of conduct between professions implies conflation of those professions. Shared standards do, however, imply equivalence in terms of standards of care and professional behaviour, and we think this equivalence is in the interests of both patients and professionals. Having shared professional standards means that patients and professionals can have confidence that all registrants are working to the same expectations in terms of their conduct. It also means that, when concerns are raised about the conduct of doctors, PAs or AAs, those concerns will be considered against the same set of expectations.

Given the extensive engagement already undertaken prior to the publication of *Good medical practice* 2024, and the departure from multi-profession regulatory norms that this would represent, I do not agree that creating two separate sets of standards is the right answer. I do agree, however, that we should ensure that any guidance published on our website in future makes it as clear as possible that it applies to three distinct professions.

Applicability of the standards to all professions

In your letter you also suggest that the formulation of 'you must' in the professional standards paints a false and clear impression that PAs and AAs are doctors, or equivalent to doctors. You mention as examples the standards in relation to prescribing and having a licence to practise.

The professional standards are (and always have been) necessarily high level to apply to all doctors, in all specialities, in the four countries of the UK. This means that not every standard in the guidance is equally relevant to all doctors. For example, paragraph 9 which starts "You must provide safe and effective clinical care" has no relevance to a doctor who is not in clinical practice.

In the introduction to *Good medical practice,* we say "You must use your professional judgement to apply the standards in *Good medical practice* to your day-to-day practice. This means working out which of the professional standards are relevant to the specific circumstances you are facing, and using your knowledge, skills and experience to follow them in that context."

The position is no different for PAs and AAs – the standards will apply to the extent they are relevant. Specifically in relation to prescribing, we added the word 'propose' in paragraph 7d in recognition of the fact that PAs and AAs won't be legally entitled to prescribe when regulation starts.

Format of our public-facing registers

When discussing our public-facing registers it is important to be clear that the information we publish is a subset of the information we hold. Our online registers are a search function that allows registrants, employers, Responsible Officers, HR departments, patients and others to search for a particular registrant and view their registration status, qualifications, training and designated body. The registers that we hold internally sit behind this search function. The current legal position is that

we hold three registers – the general register, the specialist register and the GP register. The new legislation covering PAs and AAs provides that we will hold a fourth register once regulation of PAs and AAs begin.

It is not always well understood that this published information is not everything we record on "the registers" as defined in legislation; rather it is a limited selection of information that we are either required, or choose, to publish via an online interface. The way in which we describe and display our published information about registrants is not prescribed by legislation.

The images we shared in March were prototypes designed to demonstrate that we'll ensure the prominent labelling of profession type on our online registers to ensure that when anyone conducts a search in future it will be very clear whether an individual is a doctor, a PA or an AA. The sharing of these images also accompanied our announcement that PA and AA reference numbers will include the alphabetical prefix 'A' to further ensure there is clear differentiation.

We worked to two key principles in developing this prototype – that we should reflect the needs of users now and in the future and that it should be abundantly clear to users of our public information whether a particular registrant is a doctor, a PA or an AA. Creating two or more separate search facilities would add a significant burden for users who want to check the professional status of an individual or those making multiple simultaneous searches – such as employers. We believe that creating separate online search facilities could add to confusion for our users and the clear labelling of profession on our online search facility should help to clarify status without adding additional complexity and additional searches for users. We have had very positive feedback from our stakeholders about the proposals, both in terms of the prefix to the GMC reference number for associates and the clarity of the online search facility covering all four registers and we are now working to further develop and finalise the changes we intend to make based on the prototype we published.

Conclusion

Thank you again for taking the time to write to myself and our Chair setting out your concerns so comprehensively. I hope that my responding to each of your concerns in some detail gives you greater confidence that the work we have been doing internally and with stakeholders is sensible and proportionate and will help ensure that patients can be as clear as possible about the role and professional status of the people providing their care.

I welcome the opportunity to work together to achieve our shared goal – to promote and protect the high-quality standards of care that patients deserve.

Yours sincerely,

Charlie Massey