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Professional Standards Authority for Health and Social Care
16-18 New Bridge Street
London
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Our R [redacted]
JH

Date: 6 February 2026

By email only to: [redacted]

Dear [redacted]

The General Medical Council ('GMC') failure to comply with the Professional Standards Authority for Health and Social Care ('PSA') Standards of Good Regulation

1. We are instructed by Anaesthetists United ('**A**U'), a group of doctors who campaign for effective GMC regulation of Physician Associates and Anaesthesia Associates ('**PAs'** and **'AAs**'). The GMC is one of the 10 health profession regulators over which the PSA has regulatory oversight, as you know. The PSA therefore imposes its 18 Standards of Good Regulation ('**the standards**') on the GMC, monitors, periodically reports on its performance against them and has arrangements in place to escalate serious concerns when necessary. At present, the PSA is reviewing the standards, discussing draft revisions with stakeholders (presumably including the GMC) and will at some future, unannounced date produce revised ones. In the meantime, the current standards apply and, in the December 2025 report about the latest performance review covering the period of 2024/25 ('**the December 2025 report'**), the PSA found the GMC had met all of them.

2. AU has serious concerns about all of these matters. It has evidence that the GMC is not complying with at least six of the current 18 standards in relation to its new role of regulating PAs and AAs (Standards 1, 2, 4, 5, 6 and 7). AU has also concluded that the PSA has not properly tested the GMC's compliance with the standards in this particular respect. Further, the fact the PSA has found the GMC is in compliance with the current standards calls into question their fitness for purpose. We explain why AU says all this below.

3. AU therefore requests that the PSA:

   (1) formally reviews the GMC's compliance with its standards in the light of the information in this letter and the evidence dossier you will shortly receive significant parts of which emerged during the judicial review (*R (on the Application of Anaesthetists United Limited and Others) v General Medical Council* [2025]

EWHC 2270 (Admin)) that AU brought as a limited company along with Emily Chesterton's parents, Marion and Brendan Chesterton;

(2) consider whether to withdraw the December 2025 report and rewrite it;

(3) takes this information into account as part of its review of the standards and gives specific consideration to amending the draft revised standards to require regulators to specifically and adequately address the risks to the public presented by healthcare associates and assistants[1], in particular PAs and AAs, including by obliging regulators to enforce limits on associates' and assistants' practice (regardless of who sets those limits);

(4) provides AU with any internal discussion or policy papers produced by the PSA on the regulation of PAs and AAs since the Leng Review report; and

(5) provides AU with a copy of the draft revised standards in order that it can comment further before they are finalised;

('**AU's requests**').

4. Please acknowledge this letter by return. AU would like a considered response to its requests within 28 days unless any decisions are to be made on the draft revised standards within the next 42 days. If such decisions are about to be made, please say when that will be when acknowledging receipt of this letter and address requests (3) and (4) sufficiently quickly to allow AU at least 14 days to comment on the draft revised standards before they are finalised.

Background to AU's requests

The PSA's special statutory role in protection of the public

5. The PSA's responsibility for oversight of the GMC arises under the National Health Service Reform and Health Care Professions Act 2002, as amended. Section 25(A) explains that "the over-arching objective of the Authority in exercising its functions under subsection (2)(b) to (d) is the protection of the public." Those functions span promoting the interests of the users of healthcare, promoting best practice, formulating principles relating to good professional self-regulation, encouraging regulatory bodies to conform with them and promoting cooperation between regulatory bodies. As mentioned above, the PSA has various arrangements in place to these ends, including standard setting, registration, assessment, monitoring, reporting and concern escalation.

6. Parliament's intention of promoting patient safety by creating and then giving further powers to the PSA is clear, for example, from the debates about the Health and Social Care (Safety and Quality) Bill in 2014 and 2015 where it was explained that the various forms of regulation then in place were considered insufficient. This is echoed in the PSA's most recent Annual Report, that for 2024/25 which stresses that the authority "protects the public by raising standards of regulation and registration of people working in health care". When the report was published, the PSA's press release indicated that it was "playing [its] part to improve quality standards and prioritise patient safety", a task that had become "ever more important, and we will continue to promote good practice in the year ahead to protect the public".

[1] The Leng Review recommended the use of this word rather than 'associates' to help address public misunderstanding about the roles.

The PSA's interest in the regulation of PAs and AAs

7. No doubt with its statutory functions in mind, the PSA has taken some interest in the debate about GMC regulation of PAs and AAs.

8. For instance, in a significant March 2025 submission to the Leng Review, 'Background Paper on Scopes of Practice' ('**the Background Paper**'), it "set out considerations in relation to scope the practice of health and care professionals" an issue that the PSA considered "central to the debates about the safety of the physician associates (PA) and anaesthesia associates (AA) roles."

9. As discussed in more detail below, the Background Paper included a summary of the PSA's thinking on Right-Touch Regulation which is a sophisticated framework it has developed and published identifying policy problems in healthcare which may call for a regulatory response and then ensuring any necessary response is proportionate. The Background Paper went on to discuss some Right-Touch Regulation considerations in relation to PAs and AAs, particularly regarding identifying problems and risk assessment, along with some possible regulatory approaches that the GMC and others ought to consider. It also identified some potential unintended consequences of regulation which needed to be weighed in the balance. However, at the time the Background Paper was written, the PSA itself had yet to reach firm conclusions on these matters and said as much at paragraph 6.1:

> "optimising flexibility in the workforce is going to be increasingly important in the future, and so we need to think carefully about how to balance this with safety and accountability."

10. Professor Leng's Review report was published in July 2025. Most of the recommendations are public safety-driven and safety issues are cited 143 times. Professor Leng concluded "core evidence on the safety and effectiveness of PAs and AAs was limited and weak." Because of this, she gave significant weight to wider perspectives from patients and the public, clinicians and experts. As far as patients and the public are concerned, she identified concerns about identification, role clarity, progression of care and lack of confidence. Many clinicians raised safety concerns and there was evidence of multiple unsafe incidents provided by the BMA. In primary care there were significant concerns raised by GPs with key issues including supervisory burden, managing complexity and unclear accountability. In both primary and secondary care, there was stark disparity between the views of doctors and PAs about risk. Overconfidence amongst PAs and the mismatch between self-assessment and supervisors' views was identified as a common phenomenon. As regards AAs, the majority of anaesthetists reported use of AAs giving rise to risks to training quality, reduced clinical exposure and supervision pressures. Professor Leng also noted that GMC regulation had "not been widely welcomed by many in the medical profession, with concerns that the approach taken does not help in distinguishing the role of the doctor from those of the PA and AA."

11. The report went on to recommend a recalibration of the PA and AA roles to place patient safety, clarity and accountability at the centre of workforce deployment, concluding that while these roles can add value within multidisciplinary teams, they must operate strictly as dependent practitioners rather than substitutes for doctors. It advised that PAs and AAs should work only within clearly defined national scopes of practice or clinical protocols, should not independently diagnose or manage undifferentiated patients, and must always practise under identifiable medical supervision with ultimate clinical responsibility resting with a named doctor. The recommendations emphasised the need for transparent role titles and communication with patients to avoid confusion, strengthened and standardised supervision arrangements, improved national oversight

of education and deployment, and clearer lines of accountability through professional regulation.

12. The recommendations were welcomed by the Government which committed to implementing all of them. The NHS issued a statement echoing this and a FAQ document noting the recommendations were:

> "far reaching and require cross-system partnership working to consider, plan and deliver these effectively. Moving forward, we will work with the Department of Health and Social Care, Royal Colleges, unions and other relevant organisations to consider implementation of the recommendations."

13. In a July 2025 statement responding to the report, Charlie Massey (the GMC's CEO) said:

> "My thanks to Professor Gillian Leng and her team for their detailed and thoughtful work on this important Review. The Review brings much-needed clarity and offers a timely opportunity for a reset across healthcare.
>
> As the regulator for PAs and AAs we work with them to ensure good, safe patient care. Our regulation has been helping provide assurance to patients, employers - and doctors that PAs and AAs have the right level of education and training, meet the standards that we expect, and that they can be held to account if serious concerns are raised.
>
> 'The findings of the Review will be pivotal to how we work with others and continue to improve our regulatory practices. We look forward to working on the aspects of the report that relate to the GMC and with others where there is a shared responsibility to deliver change.
>
> As always, patient safety remains our absolute focus and priority."

14. It appears that no tangible action whatsoever has been taken since then by the GMC. Its October 2025 meeting noted a CEO report that "We are carefully considering the implications of the Leng review recommendations." The report itself simply said:

> "PA/AA regulation, and the Leng review
>
> Professor Gillian Leng's independent review into the physician associate (PA) and anaesthesia associate (AA) professions in England was published on 16 July 2025. Professor Leng made a number of recommendations for action, including that the professional titles of PAs and AAs should be changed to physician assistant and physician assistant in anaesthesia and there should be restrictions to the tasks these roles carry out in practice (which should in turn be reflected in the curricula). There is a specific recommendation for the GMC that Good medical practice should more clearly distinguish between the three registrant groups to help reinforce and clarify their different roles.
>
> … We continue to carefully consider the implications of the recommendations for us and others across the system. To avoid confusion, for the time being we continue to use the existing professional titles of 'physician associate' and 'anaesthesia associate' (abbreviated to PA and AA) as the titles are set out in the law. We will keep this position under review whilst we gain more detail about the position of the four UK governments on

Professor Leng's recommendations and their plans for implementation and co-ordination."

15. The reasons given for retention of the 'physician associate' and 'anaesthesia associate' titles contrary to Professor Leng's recommendation is especially ironic as the recommendation was made to avoid ongoing patient confusion. Further, there is actually nothing to prevent the GMC from adopting and requiring use of the titles recommended by Leng pending and amending order being approved by Parliament to formalise that change.

16. In its own short response to the Leng Review, also published in July 2025, the PSA said that it welcomed the report and that it was "clear that there is much learning for sector leaders on how to develop existing roles and introduce new roles, while keeping people safe and maintaining professional and public confidence." A "cohesive system-wide response to the recommendations within the Leng Review" was important and the PSA was "keen to contribute to these discussions, drawing on our expertise". It was already "reviewing the full report in detail to consider the potential implications for the General Medical Council…"

17. It is unclear how far this PSA work stream has been progressed and what if any conclusions have been reached, which is what prompts the third of AU's requests. However, it cannot be right for the PSA to finalise its review of its standards and produce new ones without grappling properly with Professor Leng's recommendations. The GMC is likely to have some role in relation to most of them. In relation to some, that role will be decisive. The work to craft the new PSA standards will need to take that into account even though not all the professions regulated by the PSA are affected by the increasing use and regulation of associates.

The PSA's standards review

18. This brings us to the standards review itself. As you know, the associated consultation was initiated in February 2025. Regulatory initiatives around PAs and AAs are noted but not discussed in detail in the consultation paper because the PSA was then awaiting indications from the Government as to its likely approach (the Leng Review had been announced months earlier, in November 2024). However, the consultation was expressly concerned with establishing whether current standards were fit for the purpose of reviewing and assessing regulator performance driving improvements to regulation, establishing whether there were gaps in the PSA's regulatory oversight and whether its standards of good regulation and standards for accredited registers ought to be aligned.

19. The PSA reported on what it had learned from the consultation in October 2025. It found that significant changes in its approach were needed at a scale far greater than expected. All three areas in which change was identified as needed – leadership, governance and culture along with requirements to be aware of and declare professional suitability and criteria for applicants for accreditation - have an obvious bearing on the GMC's regulation of PAs and AAs including implementation of key Leng Review recommendations. However, surprisingly, there is no discussion whatsoever of the PSA's role in this initiative in the consultation response document.

20. Work on the draft, revised standards is ongoing as noted above, but their text has not been published. It is not clear whether there will be further public consultation before they are finalised (and there are indications on the PSAs website that there will not be). Nor is it clear how the PSA's Leng Review recommendation implementation work and the work on the draft, revised standards are being co-ordinated. Stakeholders are in

discussions with the PSA about the content of the draft, revised standards, as mentioned above. AU has not been identified as a stakeholder or consulted.

The latest PSA report on the GMC's performance

21. Meanwhile, the PSA has been reviewing the GMC's performance against the current standards. The December 2025 report on this covers the period from 1 October 2024 to 30 September 2025. Within this review period the GMC began regulating PA and AAs (specifically on 13 December 2024).

22. In short, the PSA found that the GMC met all 18 Standards and strikingly, the report only touches on how the GMC satisfactorily met the standards in the way it regulates PAs and AAs despite this being a huge new responsibility that arose early on during the course of the monitoring period.

23. At page 4 of the report, the PSA found that the GMC has met all five General Standards this year. This section of the report largely focuses on Standard 3, which is aimed at Equality, Diversity and Inclusion. Whilst very important, it does not have a direct bearing on the GMC's new regulatory responsibilities though it reaches one of a handful of largely factual (rather than evaluative) conclusions on regulation of PAs and AAs follows (our emphasis):

> "The GMC updated various rules and guidance for doctors at the same time as it introduced them for AAs and PAs. This has meant that its processes remain fair to the different professions it regulates and will prepare the GMC to progress with regulatory reform for doctors. In this review period the GMC consulted on the rules, standards and guidance for AAs and PAs, and feedback received resulted in the GMC making changes to its proposals in several areas."

24. The report then states (our emphasis):

> "The Leng review included several recommendations for the GMC. The GMC has acknowledged these, and we will consider its work in response to the recommendations in future reviews."

25. At page 8 of the report, the PSA finds that the GMC met both Standard 8 and Standard 9 (Standards for Guidance and Standards), concluding that:

> "The GMC introduced the updated version of Good Medical Practice in January 2024. In this review period the GMC has published and updated the following guidance:
>
> Good practice advice for doctors supervising AAs and PAs
>
> […] The GMC updated its standards and guidance documents in preparation for regulating AAs and PAs from December 2024."

26. On the same page, the PSA concludes:

> "As part of its patient and public involvement work, the GMC meets with patient organisations and invites patient groups to roundtable meetings twice a year. Topics discussed in this review period include the proposed changes to sanctions banding and bringing AAs and PAs into professional regulation

> (including raising awareness of the roles and benefits of them being regulated)."

27. The fourth of the conclusions on regulation of PAs and AAs is found in the section of the report discussing Standards 8 and 9 which relate to education and training. At page 9 of the Report, the PSA states that (emphasis added):

> "When the GMC started regulating AAs and PAs it introduced two sets of education standards; Standards for the delivery of physician associate and anaesthesia associate pre-qualification education and Standards for physician associate and anaesthesia associate curricula. The GMC says that these Standards are largely based on existing standards for doctors and that they are interim and will be reviewed in the next few years. We have not seen evidence that these standards present risks to patient safety but will monitor this."

28. Fifth, the report noted at page 13:

> "As part of its patient and public involvement work, the GMC meets with patient organisations and invites patient groups to roundtable meetings twice a year. Topics discussed in this review period include the proposed changes to sanctions banding and bringing AAs and PAs into professional regulation (including raising awareness of the roles and benefits of them being regulated)."

29. There is no further discussion in the report of how the GMC is handling its new role in a standard-compliant manner.

What scrutiny should the PSA have given the GMC's regulation of PAs and AAs?

30. The very limited extent of the PSA's scrutiny of the GMC's regulation of PAs and AAs is very difficult to understand for three sets of reasons.

Statutory responsibility

31. Given its statutory role as summarised above at paragraphs 5 and 6, it was not open to the PSA to decide to consider the GMC's work in response to the Leng recommendations in future reviews. The PSA ought to have taken active steps to ensure the GMC was complying with the public safety recommendations directly affecting its work that the Government had committed to implementing in full and which, by then, were five months old. The PSA's decision not to consider that work as part of the 2025/25 review was all the more surprising in circumstances where the GMC's action in response to the recommendations is, thus far, wholly opaque.

Policies and position statements

32. In any event, the PSA clearly anticipated it would be looking closely at this issue when corresponding with Professor Leng and in its comments on her report. The Background Paper in particular gives an indication of what the PSA considered were relevant considerations for the GMC as PAs' and AAs' new regulator.

33. There, the PSA stated:

> "5.2 In order to determine a) whether definition of scopes of practice are needed, and b) whether regulation has a part to play within that, it is important to define and understand the problem.
>
> 5.3 The PSA's Right-touch regulation (RTR) approach provides a framework for considering policy problems in healthcare, to identify whether and how regulation may be needed – see also the RTR decision tree at Annex A. It is predicated on the idea that formal regulatory mechanisms should be used only to address risk of harm, and where other mechanisms are insufficient to manage these risks.
>
> 5.4 It encourages us to ask the following questions:
>
> 1. What is the problem we're trying to solve?
>
> 2. Is it about risk of harm?
>
> 3. How great are the risks and what kinds of risks are they?
>
> 4. Are there existing mechanisms to manage them and could these be improved?
>
> 5. Could the problems be managed locally? If not, what regulatory solutions are available?
>
> 6. If there are possible regulatory solutions, do they come with unintended consequences that might outweigh the benefits of regulating?"

adding:

> "Possible regulatory solutions
>
> 5.12 If non-regulatory approaches are considered inadequate for the purpose of managing the risks identified, there would still be a range of options for regulating scopes of practice, including:
>
> - Protection of core task(s) in legislation, flexibility of scopes outside of the core tasks
> - Definition of core tasks in guidance
> - Defining scopes of practice only for a set period post-qualification (e.g. 2 years)
>
> 5.13 In line with the principles of Right-touch regulation, we recommend that the chosen solution uses the minimum regulatory force to achieve the desired result."

34. Further, the PSA's July 2025 response to the Leng Review report gives the clearest of indications the recommendations impacted on the GMC in its view and it was developing its thinking on what it would expect to see from the GMC by way of a response. This is plainly underpinned by Standard 4. As discussed in more detail below, the GMC is expected to address concerns identified about it and consider the implications for it of relevant reports about healthcare regulatory issues.

35. It follows that, at a minimum, by December 2025 when the latest performance review was completed, the PSA ought to have:

(1) considered for itself the evidence of risk of harm presented by PAs and AAs and reached conclusions on how great the risks are and what kinds of risks they are;

(2) crystalised its thinking on the Leng Review recommendations and what the GMC needed to demonstrate in terms of action in response to the that impacted it as a regulator of PAs and AAs;

(3) identified what other regulatory responses were necessary to identify, assess and mitigate the risks to public safety presented by PAs and AAs;

(4) advised the GMC of its expectations;

(5) scrutinised the GMC's action with those expectations in mind;

(6) assessed the extent to which the GMC was managing risk to public safety in line with the Right Touch Regulation approach and was grappling with Leng's conclusions and recommendations; and

(7) reported on all of this in the December 2025 review report.

36. The December 2025 review report suggests none of this work has been done: work on the recommendations was a matter for "future reviews" and the extent to which the GMC's approach to its own standards presented risks was simply a matter to be monitored.

37. Compounding this problem, the review report uncritically noted that, in contrast to the none other bodies for which the PSA is responsible, the GMC was positively adverse to risk-based regulation (our emphasis):

> "Managing risk
>
> Last year we found through our audit that the GMC does not require risk assessments to be separately documented in the same way that other regulators we oversee do. We therefore could not be sure when and how risk had been considered. We identified that there was an opportunity for the GMC to improve the controls it has in place, by being clearer about how and when staff are identifying, considering and responding to evidence of risk in cases. The GMC told us that it has spoken to other regulators and has identified improvements that could be explored in order to be proportionate in recording risk, such as reviewing how staff guidance and how record keeping of risk can be shown on the systems.
>
> We will continue to monitor how the GMC improves the way it records risk."

38. With respect, this was not an adequate regulatory response from the PSA to the GMC assuming responsibility for PAs and AAs, especially given the risks that had been identified and the PSA's statutory role in protecting the public from them.

The significance of AU's judicial review of the GMC

39. The degree of scrutiny to which the PSA has subjected the GMC's regulation of PAs and AAs thus far is particularly surprising given the outcome of the claim for judicial review AU, Marion and Brendan Chesterton brought against the GMC.

40. Lambert J considered the PSA's submissions on the Leng Review at paragraphs 106-112, pages 35-37 pages of her judgment. She observed at paragraph 112 that:

> "the question of whether to impose detailed profession-wide limits on the practice of PAs and AAs is a complex multi factorial policy question which is not appropriate for a court to determine in a claim for judicial review. It does not matter whether or not the defendant considered each (or any) of the factors informing the debate when determining not to impose limits on associates' practice. The fact is there is a debate and it is one which engages policy and politics. This means that the outcome rationality ground must inevitably fail. The court cannot rule on whether the premise of the claimants' criticisms is correct."

41. Further, at paragraph 133, page 44 she noted:

> "the submission of the PSA to the Leng Review reveals perhaps a fuller range of policy issues. It also places those issues in their relevant economic and social context. The associate profession is expected to make an important contribution to the healthcare workforce over coming years... The impetus from the government is to increase the scope of associates' practice to include tasks currently prohibited (for example, prescribing), the object being that they are able, under supervision, to perform tasks which will free up doctors for the more complex work. Whilst I agree that this may on the one hand suggest the need, perhaps the strong need, for appropriately defined limits on practice, the authors of the PSA submission point out a range of other countervailing considerations"

42. In short, having considered the PSA's then un-concluded position on the need for the GMC to set limits on the practice of PAs and AAs as explained in the Background Paper, the judge concluded that this was a regulatory matter, rather than one for the courts.

Evidence of the risks presented by PAs and AAs and the need to regulate them differently to doctors

43. To prepare for the judicial review, AU gathered together a huge volume of evidence of these risks and the reasons why the GMC was wrong to adopt an identical regulatory approach. The evidence of risk was not materially disputed, save to the extent that the GMC criticised some of the doctors' survey evidence on the basis that it came from a self- selecting group. However, that survey evidence was consistent with the surveys the GMC itself had commissioned. The GMC disagreed with much of AU's evidence about the importance of regulating PAs and AAs differently from doctors, leading by imposing limits on practice. As noted above, Lambert J held that this was primarily a regulatory matter rather than a legal issue for determination in judicial review proceedings.

44. In the circumstances, it is vital that the PSA grapples with the evidence for itself. It is enclosed with this letter along with two annexes which summarise what it shows.

45. Please confirm this material will be considered by the PSA with the Right-Touch Regulation principles in mind when deciding whether the GMC is complying with the current standards and the new, revised ones when they are issued.

AU's submissions on the GMC's failure to address these risks in compliance with the standards

46. Had the PSA subjected the GMC the regulatory scrutiny its new role called for, multiple issues of standards compliance would have come to light. We shall now identify the main ones.

47. It is helpful to take the relevant standards out of turn, starting with Standards 5 then 4 as these are relevant to the way the GMC decided on the approach it has taken to regulating PAs and AAs. As the PSA will know, that approach is a homogenised one – i.e. the GMC has decided it ought to regulate PAs and AAs as far as practicable in exactly the same way as doctors – and it has chosen not to set limits on their practice that do not apply to doctors. Further, the GMC chose not to impose a professional obligation for PAs and AAs to identify themselves as such and to state clearly that they are not qualified doctors. It appears that the GMC's position on all of this has not changed despite the recommendations made by the Leng Review.

GMC non-compliance with Standard 5

48. This standard is concerned with the way PSA-regulated regulators inform themselves of stakeholder views before deciding on what the risks are that they need to manage and how to do so using their regulatory standards. It also calls for a cooperative approach and evidence-based decision-making.

49. Under Standard 5, the PSA's expectation is therefore that:

> "The [GMC] consults and works with all relevant stakeholders across all its functions to identify and manage risks to the public in respect of its registrants"

50. AU's first point about this standard is that it is impossible to reconcile the PSA's December 2025 conclusion on the one hand that this standard is met with its "[m]anaging risk" finding that "the GMC does not require risk assessments to be separately documented in the same way that other regulators we oversee do. We therefore could not be sure when and how risk had been considered…"

51. Turning to consultation, the GMC's approach thus far has been wholly at odds with Standard 5 and Right-Touch Regulation because the GMC chose not to consult on matters which lay at the very heart of the regulatory assessment of risk and the related decisions it needed to take: risks to the public and how they ought to be mitigated, including whether limits on PAs and AA's practice were needed.

52. The GMC's only relevant consultations were conducted in 2022 on revisions to Good Medical Practice (some time before it had been made responsible for PAs and AAs) and then, in 2024, on Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards and guidance.

53. The 2022 consultation mentions PAs and AAs in a footnote.

54. As the GMC's Professor Melville emphasised in his second statement for the judicial review at paragraphs 61 and 75-77, the GMC then adopted and maintained a deliberate, high-level position <u>of not</u> consulting on matters including associates' scope of practice or whether there should be <u>any</u> other "limits on the types of work that associates could undertake". This was because the GMC had already reached a settled view on the regulatory approach it would take before consulting. The explanation, such as it is, is

given in his first statement at paragraph 99: “It is not possible to pinpoint a single date on which the GMC decided not to set scope. However, the starting point for the GMC was that its approach to regulating doctors was well-established and known to safeguard patients”.

55. The GMC then proceeded to deliberately confine its 2024 consultation to training, registration mechanics, fitness-to-practise procedure and fees, while maintaining a “high-level” position that it would not consult on whether there should be any limits on associates’ scope of practice or other associate-specific safeguards. That exclusion was not accidental: the GMC had already adopted the foundational “starting point” premise that associates should be regulated in the same way as doctors, and that scope-specific controls were therefore inappropriate. This premise itself was never consulted upon, notwithstanding its determinative effect on the entire regulatory scheme for PAs and AAs.

56. The criticism is sharpened by the context in which the 2024 consultation occurred. By then, the GMC was on notice of repeated and serious patient-safety concerns arising from associates practising beyond their competence, including coroners’ Prevention of Future Death (‘**PFD**’) reports and extensive representations from clinicians, representative bodies like the BMA, the Royal Colleges and others. Yet the GMC did not consult on whether regulation should respond to those risks by imposing ceilings on practice, strengthening supervision requirements, or mandating clear rules to secure informed patient consent.

57. The GMC remained stubbornly unwilling to reconsider its position despite mounting stakeholder evidence that it was misconceived. For instance, it continued to maintain there should be no limits on practice with a regulatory underpinning (regardless of who framed them), despite:

    (1) the Royal College of Anaesthetists (‘**RCoA**’) defining and publishing its recommended Scope of Practice for AAs;

    (2) a February 2024 Council meeting of the Royal College of Surgeons of England concluding that there was an urgent need to define a national scope of practice and training curricula because of concerns about the variability, and in some cases inappropriateness, of clinical activities within individual NHS Trusts;

    (3) an Extraordinary General Meeting of the Royal College of Physicians held on 23 March 2024 recommended that "Advanced 'scope', including 'ceiling' of practice [for PAs], must be nationally defined on a specialty-by-specialty basis following multi-stakeholder participation”;

    (4) the Royal College of General Practitioners published a document in October 2024 setting out that “PAs must work within their scope of practice, which must not extend beyond the scope of practice in this guidance"; and

    (5) the Royal College of Physicians of Edinburgh published a statement in October 2024 expressing concern that there were multiple published Scope of practice documents and urging that “These documents must be unified into a single core scope document, ideally covering all four nations of the UK, ideally covering all surgical and medical specialties, and ideally indicating a clear "ceiling of practice" for PAs.

58. The GMC then maintained its hubristic unwillingness to consult when it went on to introduce material regulatory guidance, such as the new “Supervision Practice Advice” for doctors supervising associates. That document was not consulted upon either,

despite addressing precisely the supervision issues which the GMC had previously declined to consult on during two associate-related consultations.

59. Meaningful consultation and co-operation consistent with Standard 5 was especially important in circumstances where PAs and AAs were being regulated for the first time. The evidence demonstrates that the GMC did not, and has still not properly identified, still less managed, the distinctive and well-documented risks to patient safety arising from the deployment of physician associates and anaesthesia associates.

60. Those risks were neither speculative nor marginal. By the time the GMC assumed regulatory responsibility, there existed a substantial evidential base including coroners' PFD reports, academic analysis, Royal College concerns, practitioner evidence and patient experiences, all pointing to systemic dangers arising from associates acting as de facto doctors, confusion as to their role and competence, inadequate supervision, and the absence of informed patient consent. These risks were known, recurring and escalating, yet the GMC failed to treat them as risks requiring targeted regulatory intervention. There is no risk assessment of any kind identifying and calibrating them in the way Right-Touch Regulation recommends, or indeed using any other recognised risk assessment approach. That is perhaps unsurprising to the PSA, given what it found in the 2024 and 2025 reviews about the GMC's aversion to risk assessment, but it should not be condoned by the PSA.

61. Rather than risk assess and then determine the appropriate and proportionate regulatory response, the GMC began the task of regulation from a fundamentally flawed starting point. Rather than identifying the risks inherent in a new, dependent profession with limited and non-standardised post-qualification training, the GMC simply assumed that PAs and AAs could be regulated through the same broad framework used for doctors. That assumption was treated as axiomatic and was not revisited even when confronted with evidence demonstrating that associates present materially different risks, particularly in relation to diagnosis, escalation, delegation and supervision. As a result, the GMC mischaracterised the nature of the risk it was required to manage, treating it as one of individual misconduct remediable through *ex post* fitness-to-practise processes, rather than as a systemic safety risk requiring *ex ante* controls.

62. Having failed to identify the risks accurately still less calibrate them, the GMC adopted regulatory measures incapable of mitigating them. The principal safeguard relied upon is a general requirement that associates act within their competence, supplemented by the possibility of fitness-to-practise proceedings after serious or persistent breach. The evidence, however, is said to demonstrate that this approach had already failed prior to regulation and continued to fail thereafter. As Leng repeatedly noted, PAs and AAs, by reason of their truncated training and lack of structured career pathways, have difficulty identifying the limits of their competence, while doctors and employers likewise struggled to judge what could safely be delegated. In those circumstances, a competence-based obligation without authoritative scope boundaries, mandatory supervision structures or clear lines of responsibility could not be a meaningful risk-management strategy at all.

63. One way the GMC has sought to justify its 'hands-off' approach is to rely on local decision-making by employers and supervising clinicians to manage risk. However, there is extensive evidence summarised in Annex 1 that local arrangements are themselves a source of danger, driven by workforce pressures and financial incentives to stretch associate roles beyond safe limits. The GMC nevertheless treated variability in local practice as acceptable and declined to impose national controls, notwithstanding that such controls were the very mechanism by which systemic risk might be constrained. In doing so, it abdicated responsibility for managing risks which Parliament intended a national regulator to address, leaving patient safety dependent on the very arrangements that had already failed.

64. The GMC has also failed to respond meaningfully to risks relating to informed consent. The repeated finding that patients were unaware they were being treated by associates, and therefore unable to make informed choices or seek second opinions, was a consistent theme of the coronial evidence. Yet the GMC has not treated this as a distinct safety risk requiring clear regulatory rules. Instead, it relied on generic ethical guidance and minimal amendments introduced late in the process, which stopped short of imposing a proactive duty to disclose associate status in circumstances where patients would reasonably expect to be treated by a doctor.

65. These are not abstract matters. They go to the core of public safety-driven regulation. Even where deaths have occurred and PFD reports have been issued by coroners, including reports directed at the GMC, there is little evidence of fitness-to-practise investigations, still less of regulatory learning or systemic reform. That failure underscores the inadequacy of a model which relies on retrospective enforcement while declining to impose clear, preventative standards.

GMC non-compliance with Standard 1

66. Under this standard, the PSA's expectation is that:

> "The [GMC] provides accurate, fully accessible information about its registrants, regulatory requirements, guidance, processes and decisions"

67. In respect of PAs and AAs, the GMC has failed to discharge this basic but critical function of effective regulation by providing clear, accurate and accessible information about who its registrants are, what regulatory requirements apply to them, how relevant guidance operates in practice, and how regulatory decisions are taken. In a regulatory environment where patient safety depends upon patients, clinicians, employers and associates themselves understanding the limits of associate practice and the safeguards that apply, the absence of authoritative, intelligible and consolidated information compounds the risks which regulation was intended to address.

68. The first problem here that needed to be identified and addressed by the GMC is the opacity surrounding the status of PAs and AAs as registrants. There is extensive evidence, accepted by Leng, that patients frequently assume PAs and AAs are doctors, an assumption reinforced by the clinical settings in which they practise and by the absence of clear, standardised disclosure requirements. The GMC has not imposed obligations on PAs and AAs to provide clear information which would reliably enable patients to understand the distinction between doctors and associates, the limits of their roles, or the significance of being treated by a dependent practitioner. This information deficit directly undermines informed consent and public confidence. By contrast, the GMC does require medical students to identify themselves as such and the underlying rationale for this is that patients need to appreciate they are consenting to treatment by student rather than a fully qualified doctor. By the same logic, PAs and AAs ought to be required to properly identify themselves as a matter of professional obligation.

69. There is also a marked lack of clarity and accessibility in the GMC's regulatory requirements and guidance. The applicable framework for PAs and AAs consists of a patchwork of generic documents—Good Medical Practice, Leadership and Management, Decision Making and Consent, and Delegation and Referral—none of which were designed with PAs and AAs in mind and none of which articulate associate-specific obligations with precision. Although these documents were belatedly extended to PAs and AAs, they remain abstract, non-prescriptive and silent on the very matters which give rise to risk, including scope of practice, supervision structures and escalation

thresholds. The GMC's website materials add little, offering high-level summaries rather than concrete guidance. The result is a regulatory scheme which is technically present but practically unintelligible to those expected to comply with it.

70. A further problem concerns the accessibility of the GMC's regulatory processes, particularly in relation to Fitness to Practise. The GMC has not explained, in a way accessible to the public or professionals, how fitness-to-practise standards are to be applied to PAs and AAs in the absence of clear scope boundaries or supervision rules.

71. A regulator such as the GMC that is charged with protecting the public cannot rationally rely on obligations, standards and processes which are insufficiently articulated, poorly signposted and inaccessible to those whose behaviour they are meant to shape. In circumstances where PAs' and AAs' roles are novel, poorly understood and associated with known safety risks, the failure to provide accurate and comprehensible information about the regulatory regime is said to amount to a further abdication of the GMC's statutory purpose, leaving patients and practitioners to navigate uncertainty at their own risk.

GMC non-compliance with Standard 2

72. Under this standard, the PSA's expectation is that:

> "The [GMC] is clear about its purpose and ensures that its policies are applied appropriately across all its functions and that relevant learning from one area is applied to others."

73. Applying policies appropriately across the GMC's functions necessarily involves treating registrants differently where there are material differences. Despite the evidence in Annex 2 that the regulatory challenges and risks presented by PAs and AAs were not the same as those presented by doctors and without ever consulting on this issue, as noted above, the GMC decided to regulate them in the same way.

74. It was wrong to do so. PAs and AAs are not simply doctors at an earlier stage of development, but members of fundamentally different professions, presenting materially different risks to patients. That difference is not one of degree alone but of kind. Doctors form part of a profession with a long-established history, clearly understood by the public and embedded within a comprehensive and structured system of education, training, supervision and progression. By contrast, PAs and AAs are a relatively recent workforce innovation, introduced to support doctors in delivering specific aspects of care, whose role remains poorly understood by patients and inconsistently understood within the healthcare system itself. The regulatory framework must respond to that reality.

75. A critical distinction lies in training and entry requirements. Doctors undertake a minimum of five years' medical education followed by foundation training and, in most cases, several further years of structured specialty training. That pathway is competitive, sequential and cumulative. It provides an intelligible proxy for competence at each stage and enables both doctors themselves and others to understand what tasks may safely be undertaken. PAs and AAs, by contrast, complete only two years of postgraduate training following undergraduate study which, in the case of PAs, need not be scientific at all. Although training programmes are now regulated, many practising PAs and AAs entered the workforce under earlier, unvalidated regimes. This truncated training model materially limits both actual competence and the ability reliably to identify its boundaries.

76. The differences are reinforced by the structure of registration. Doctors are subject to layered and conditional registration: provisional registration on graduation, full

registration thereafter, and access to senior or specialist roles only upon completion of recognised specialty training and inclusion on a specialist register. These mechanisms operate as de facto limits on practice and ensure that responsibility and autonomy increase only in line with demonstrable competence. PAs and AAs, however, are fully registered immediately upon qualification, with no equivalent gradation, specialist registers or nationally mandated limits on the work they may undertake. Once registered, they may in principle be deployed across a wide range of clinical settings, notwithstanding the absence of any structured progression framework.

77. A further and decisive distinction concerns the dependent nature of PA and AA practice. PAs and AAs are, by definition, dependent practitioners who may practise only under the supervision of doctors. Doctors, even when supervised during training, exercise independent clinical judgment and ultimately become autonomous professionals. AU emphasises that dependency magnifies risk: it requires not only that PAs and AAs understand their own limits, but that supervising doctors can reliably judge what may safely be delegated. In the absence of clear scope boundaries or nationally defined limits, that task becomes uncertain and inconsistent, particularly in pressured clinical environments. Regulation which treats dependent practitioners as if they were autonomous professionals is conceptually flawed.

78. Post-qualification structures further differentiate the professions. Doctors progress through well-established training pathways, with formal assessment, appraisal and revalidation processes that scrutinise scope of practice and competence over time. Despite Leng's recommendation on this issue, PAs and AAs have no equivalent national post-qualification training pathway and, at present, no system of appraisal or revalidation capable of measuring competence against defined standards of practice. The GMC's stated intention to introduce revalidation without reference to scope of practice is said to underscore, rather than resolve, the difficulty. Without a baseline against which competence can be assessed, ongoing regulatory oversight cannot operate effectively.

79. Regulating PAs and AAs in the same way as doctors is inconsistent with effectively protecting the public. The absence of clear limits on practice assumes a level of training, autonomy and professional self-regulation which PAs and AAs do not possess. It also assumes a shared understanding—among patients, clinicians and employers—of what PAs and AAs may safely do. Such an understanding does not exist. In those circumstances, the imposition of limits on practice using scopes of practice or otherwise is not an unwarranted restriction but a necessary regulatory response to the distinct risks presented by a dependent profession with limited and variable training.

80. To proceed otherwise is to regulate unlike cases alike, and in doing so to fail to discharge the protective function Parliament intended the GMC to perform as PAs' and AAs' regulator.

GMC non-compliance with Standard 4

81. Under this standard, the PSA's expectation is that:

> "The [GMC] reports on its performance and addresses concerns identified about it and considers the implications for it of findings of public inquiries and other relevant reports about healthcare regulatory issues."

82. There are three sets of failures by the GMC to meet this standard.

83. First, the GMC did not grapple with the criticisms of its approach to PA and AA regulation from key professional stakeholders or the evidence they presented. For instance, the

Royal Colleges and professional bodies had repeatedly emphasised that, without nationally defined limits on what PAs and AAs may do, safe delegation and supervision become unreliable, particularly in high-risk or diagnostic contexts. Those concerns were supported by evidence of PAs and AAs acting beyond intended roles, sometimes with fatal consequences. Yet the GMC responded not by analysing whether those concerns were well-founded, but by maintaining a settled position that scope of practice and other lit-setting was not an appropriate matter for regulatory intervention. This was not a reasoned disagreement with stakeholder evidence, but a refusal to engage with it.

84. As regards supervision and delegation, stakeholders had repeatedly warned that the dependent nature of PA and AA practice required robust, role-specific supervision rules, including clarity as to who bears responsibility for delegation decisions and how supervision should operate in practice. The GMC acknowledged these representations only at a high level, while continuing to rely on generic guidance drafted for doctors and local decision-making by employers. The GMC never squarely addressed the substance of the concern: namely, that generic principles were insufficient to manage a known systemic risk arising from confusion, workload pressures and the lack of authoritative guidance.

85. The GMC's response to stakeholder evidence on informed consent was also deficient. Professional bodies and clinicians highlighted consistent patient misunderstanding about whether they were being treated by a doctor or a PA or AA, and the implications of that misunderstanding for patient autonomy and safety. The GMC's position—that informed consent did not generally require explicit disclosure of PA or AA status—was unjustifiable in light of that evidence. The GMC did not grapple with the professional view that, in many clinical contexts, treatment by a PA or AA is itself a material fact which reasonable patients would wish to know.

86. Secondly, the GMC did not respond to coroners' PFD reports consistently with Standard 4. Those reports did not merely recount individual clinical failings. They identified systemic dangers arising from the deployment of PAs and AAs in circumstances where patients were unaware of their status, where the limits of their competence were unclear to themselves and others, and where supervision and escalation arrangements were inadequate. PFD reports are intended precisely to draw regulators' attention to risks which have already materialised and to prompt preventative action.

87. At no stage has the GMC analysed the PFD reports as evidence of regulatory failure or as a basis for reconsidering its pre-determined regulatory model. Although several of the PFDs pre-dated the commencement of the GMC's regulation of PAs and AAs, they arose in circumstances where doctors were already within the GMC's regulatory remit and where the very risks later said to justify regulation had already crystallised. The PFDs demonstrated that reliance on generic professional standards, individual judgments of competence and post hoc enforcement was insufficient to prevent harm. Yet the GMC did not respond by introducing additional safeguards or by revisiting its assumption that no associate-specific limits or controls were required.

88. The GMC also failed to treat the recurrence of similar themes across multiple PFD reports as indicative of a systemic problem. The coroners repeatedly highlighted confusion between doctors and PAs, failures of supervision, and inappropriate delegation in high-risk diagnostic contexts. These were not isolated anomalies but manifestations of structural weaknesses in how PAs and AAs were deployed. The GMC's response, however, is said to have been fragmented and passive, treating the reports as discrete events rather than as evidence demanding a coordinated regulatory response.

89. AU's concerns about this are driven home by the absence of meaningful regulatory consequences following the PFDs. Despite deaths and explicit coroner warnings, there is little evidence of fitness-to-practise investigations, enforcement action, or published learning outcomes attributable to the GMC.

90. Thirdly, as discussed at paragraph 14 above, there is nothing yet to suggest the GMC taking any form of action in the light of the Leng Review recommendations. Even if it is doing so, that issue has not yet been considered by the PSA.

GMC non-compliance with Standards 6 and 7

91. Under these standards, the PSA's expectation is that:

> "The [GMC] maintains up-to-date standards for registrants which are kept under review and prioritise patient and service user centred care and safety.
>
> …The [GMC] provides guidance to help registrants apply the standards and ensures this guidance is up to date, addresses emerging areas of risk, and prioritises patient and service user centred care and safety."

92. The GMC has failed to maintain standards for PAs and AAs which are sufficiently current, responsive and oriented towards patient and service-user safety.

93. The GMC relies on the extension of Good Medical Practice and other generic ethical standards to PAs and AAs, they are ill-suited to the risks now known to arise from PAs and AAs in practice. They were conceived for a different profession, operating under different conditions of training, autonomy and accountability, and to have been applied to PAs and AAs without systematic review of whether they adequately address the realities of dependent practice, diagnostic uncertainty and supervision pressures. Standards which do not evolve in response to identified harm cannot properly be described as being kept under review.

94. A stark example is patients' lack of awareness they are being treated by PAs or AAs, do not understand the limits of their role, and are thereby deprived of meaningful choice or the opportunity to seek further medical input. This was a major concern flagged in the PFD reports and then the Leng Review Report. Yet the GMC's standards still stop far short of imposing basic, affirmative, enforceable obligations to ensure that patients are informed they are being treated by a PA or AA and what that means. A regulatory framework which leaves such matters to implication or local discretion fails to place patient autonomy and safety at its centre. This was recently acknowledged to be mistake by the GMC in evidence given by Mr Massey to the Health Select Committee:

> "I'm sorry, with the benefit of hindsight, that we [the GMC] weren't clearer about distinguishing between those [roles]. We did make a decision to have different reference numbers for PAs and doctors but we could, and with the benefit of hindsight, should have gone further in terms of that differentiation than we did."

95. However, this simply begs the question of why the GMC has done nothing since to be clearer about distinguishing between the roles, and to require PAs and AAs themselves to clearly state the position, just as medical students must.

96. The guidance relied upon is also generic, abstract and insufficiently tailored to the clinical realities faced by PAs and AAs and those supervising them. Documents such as Leadership and Management, Delegation and Referral, and Decision Making and

Consent are said to offer broad ethical principles but little practical assistance in determining what tasks may safely be undertaken, how supervision should be structured, or when escalation to a doctor is required. Guidance which leaves registrants to resolve such matters for themselves does not meaningfully support compliance with standards in high-risk settings.

97. Nor has the GMC kept its standards under review in light of emerging risks. By the time regulation commenced, there was already a substantial body of evidence identifying systemic dangers associated with PA and AA deployment, including failures of supervision, escalation and diagnosis. That evidence continued to develop, including through additional PFD reports and professional body warnings. The GMC's response, however, remained largely static. Rather than revisiting and strengthening standards to address those risks, it relied on the continuation of high-level obligations—such as the requirement to act within competence—which had demonstrably failed to prevent harm. The GMC has yet to engage in the iterative review of standards which effective risk-based Right-Touch Regulation requires.

Conclusion

98. The need for the PSA to give critical scrutiny to the GMC's compliance with its standards in relation to regulation of PAs and AAs and to think carefully about the effectiveness of those standards in that context could not be more timely and compelling. The PSA's primary purpose is to ensure those regulators it has responsibility for are protecting the public adequately. The PSA has recognised that there is an ongoing and dynamic debate about the appropriate form and effectiveness of regulation. It recognises that regulation must be risk-based. It is aware of the need for leadership in this space, particularly in light of the concerns recorded in the Leng Review and its recommendations. Responding to the Leng Review report, the PSA recognised it had a leadership role to play. It has been reviewing its own regulatory standards to ensure they are fit for purpose in the future. It has identified a need for significant change and is partway through the task of reshaping its standards to bring that about. Changes are to be made that plainly impact on the regulation of PAs and AAs.

99. The PSA's December 2025 report runs very much against the grain of all of this. Its consideration of the GMC's regulation of PAs and AAs is, at best, superficial. In the circumstances, the PSA might be expected to have made the GMC's new regulatory role the centrepiece of its report, not the subject of a handful of references, very limited conclusions, deferral of consideration of the GMC's response to the Leng recommendations and passive, uncritical acknowledgement that the GMC chooses not to risk assess unlike all other comparable regulators.

100. AU asks that you look again at whether the GMC has adhered to your standards, this time properly.

101. We look forward to hearing from you.

Yours faithfully

[redacted]

Bindmans LLP