APPLICATION FOR THE REGULATION OF PHYSICIANS' ASSISTANTS (ANAESTHESIA) BY THE HEALTH PROFESSIONS COUNCIL.

The Association of Physicians' Assistants (Anaesthesia)

Background

The role of Physician or Physicians' Assistant is relatively new to the United Kingdom. It has however been practiced in the United States since the 1960s. It may be useful to look at the following definition of the US role;

"A physician assistant (PA) is a healthcare professional licensed to practice medicine with supervision of a licensed physician.[1] A physician assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of health care services that are traditionally performed by a physician. Physician assistants conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions.[2]

Physician assistants exercise autonomy in medical decision making as determined by their supervising physician. Physician assistants are educated in the medical model designed to complement physician training. Physician assistants are not to be confused with medical assistants, who perform administrative and simple clinical tasks with limited college-level education in hospitals and clinics under the direct supervision of physicians, registered nurses, nurse practitioners, or physician assistants.

1. *About Physician Assistants.* American Academy of Physician Assistants (AAPA). Accessed 26 June 2009.

2. *The PA Profession*. Yale School of Medicine, 26 March 2009. Accessed 26 June 2009."

The US PA qualification is at Masters level and all practitioners must be registered.

The National Health Services of both England and Scotland have employed United States-trained PAs for a number of years and several UK universities are now offering the qualification.

The role of Physicians' Assistant (Anaesthesia), formerly known as Anaesthesia Practitioner, is a UK adaptation of the US Anesthesiologist Assistant, itself a variant of the PA role specialising in anaesthesia rather than primary care, but again at post-graduate level.

In 1997 the Audit Commission recommended that the NHS investigate the boundaries between different staff groups involved in providing anaesthesia, through the development of pilot projects. The Royal College of Anaesthetists (RCoA) and the Department of Health (DH) jointly agreed that there was a serious impending shortage of trained specialist anaesthetists and that they would undertake to develop Anaesthesia Practitioners as a means to facilitate the delivery of services.

A joint evaluation was undertaken by the Changing Workforce Programme, the DH and the RcoA, including visits to the USA, Sweden and Holland, which resulted in the report *The role of non-medical staff in the delivery of anaesthesia services*. The AP, now PA(A), programme was subsequently established in 2003 with training commencing in January 2004 and the first PA(A)s qualifying in January 2007.

The need for a protected title is demonstrated by the fact that the initial DH title of the occupation, Anaesthesia Practitioner, became confused with the many Operating Department Practitioners and Registered Nurses practising as anaesthetic assistants describing themselves as "anaesthetic practitioners". When this job title started appearing in advertisments, the Royal College of Anaesthetists, in conjunction with the then Anaesthesia Practitioner occupation, the DH and the patient liaison group, decided to change title to PA(A), coming in to line with NHS Scotland who had decided on that title for the group as part of their Physician Assistant project.

Neither the titles Physician Assistant or Physicians' Assistant (Anaesthesia) are protected in the UK and some employers have advertised untrained posts under similar names, leading to further confusion.

This application for the regulation of the occupation of Physicians' Assistants (Anaesthesia) is made by the Association of Physicians' Assistants (Anaesthesia), the sole representative body of PA(A)s in the UK.

Part A

The occupation of Physicians' Assistant (Anaesthesia) meets the criteria of part A of the assessment as follows:

- **Invasive procedures**

All PA(A)s are required to perform invasive procedures as part of their role. These include;

- performing intravenous and arterial cannulation in order to give drugs, administer fluids, collect blood samples or set up invasive monitoring of blood pressure.
- inserting devices such as laryngeal mask airways and endo-tracheal tubes in order to maintain a clear airway in patients undergoing surgery or resuscitation.

The NHS Employers Organisation job statement documenting the minimum range of procedures required of the role is attached in part B.

An inability to perform invasive procedures such as these correctly would lead to serious patient harm.

- **Clinical intervention with the potential for harm**
- **Exercise of judgement by unsupervised professionals which can substantially impact on patient health or welfare**

These two criteria can be considered together. PA(A)s are required to maintain anaesthesia in patients undergoing surgical procedures without the direct supervision of a medical professional.

Although the supervising physician must be present at the beginning of anaesthesia (induction) and at the end of the procedure (emergence) there is no necessity for their presence during the procedure. Although it is incumbent on the supervising physician to be available to return to the anaesthetised patient within two minutes of being called, PA(A)s must make numerous and frequent decisions about interventions relating to the immediate care of the patient, including at what point the condition of the patient has deteriorated to a level requiring the input of a physician.

These might include altering ventilator and gas-flow settings in order to maintain the oxygenation of the patient, adjusting levels of anaesthesia to prevent awareness, or giving intravenous drugs and fluids using Patient Specific Directions (PSDs).

There is no statutory framework to control PA(A)s' access to the drugs that they must administer to perform their role, which include muscle relaxants to facilitate surgery,

volatile anaesthetic agents to maintain anaesthesia, opiates and other analgesics to control pain, induction agents to induce anaesthesia, resuscitation drugs given in the event of cardio-vascular collapse and many others. These are currently given under PSDs agreed at local level.

Mistakes in these interventions or failure to exercise judgement correctly would lead to catastrophic harm or death for the patient.

The following two short case studies illustrate the level of autonomous practice undertaken by PA(A)s.

Case 1 Mr Smith is attending hospital for a total hip replacement. He will be anaesthetised by a PA(A), Jane Stevens, working in a 2:1 team with a PA(A) in an adjacent operating room and a consultant anaesthetist, Dr Paul Jones, who will oversee both rooms.

On the morning of surgery Jane meets Mr Smith in the ward and, after introducing herself, takes a medical history and performs an anaesthetic assessment so that she can plan his care. Mr Smith suffers from atrial fibrillation and high blood pressure, for which he takes medication and because of anatomical considerations presents a risk of difficult endo-tracheal intubation should his airway become compromised during the procedure.

Jane confirms that Mr Smith has stopped taking the anti-coagulant drug he normally needs for his atrial fibrillation and that temporary cover with a shorter-acting drug has been prescribed, as otherwise spinal anaesthesia, known to be of benefit in major orthopaedic surgery, would be precluded.

She discusses the relative risks and benefits of both general and regional anaesthesia with him, including the risks of serious harm, and explains to Mr Smith what will happen when he arrives in the anaesthetic room. She obtains consent for general and spinal anaesthesia and for the insertion of a urinary catheter.

Before leaving the ward Jane looks up Mr Smith’s blood results and finds that his haemoglobin is low. She phones the blood bank and asks for two units of blood to be grouped and saved.

In the anaesthetic room Jane meets up with Dr Jones, gives him Mr Smith’s history and tells him what anaesthetic plan she discussed. Dr Jones agrees with the plan, including which drugs from her formulary of Patient Specific Directions she can administer, and they both discuss it with the Operating Department Practitioner(ODP). Jane asks the ODP to get equipment ready for a difficult intubation in case it is required. Dr Jones

leaves to discuss a case with the PA(A) in the adjacent room. Jane confirms that the anaesthetic equipment is checked and functioning correctly.

When Mr Smith arrives Jane welcomes him and then sites an intravenous cannula to give drugs and fluids during the procedure. She takes a set of baseline observations of Mr Smith's heart rate, oxygen saturations and blood pressure and records them. Dr Jones returns and after he has met the patient he gives intravenous drugs to send the patient to sleep. Jane sites the laryngeal mask airway that the patient will breathe through during the operation without complication. Dr Jones performs a spinal anaesthetic injection and inserts a urinary catheter before returning to the other anaesthetic room.

Jane ensures that the patient's observations are stable before letting the rest of the team know they are ready to transfer to the operating room. Jane leads the team transferring the patient onto the operating table and then sets the anaesthetic machine to deliver the correct mixture of gases and volatile anaesthetic agent to keep the patient oxygenated and asleep. Jane checks that the positioning of the patient by the surgical team has not compromised patient safety by, for example, putting pressure on nerves or the eyes. Having satisfied herself that the patient is safe and stable, Jane performs the pre-operative surgical checklist with the surgeon and the rest of the team. She confirms that anti-coagulants are prescribed and gives intravenous antibiotics as per the local protocol, having checked for allergies.

As surgery progresses Jane continually assesses the patient by looking at his physical signs and the information from the monitoring systems. She has readouts of inspired and expired gases, anaesthetic agent, blood pressure, oxygen saturation and electrocardiography which enable her to make decisions on how she should manage the anaesthetic.

After fifteen minutes the patient's blood pressure and heart rate fall to a level that Jane feels requires treatment to ensure continued safety. She decides that the fall is caused by a combination of factors; spinal anaesthesia and the volatile anaesthetic agent have caused the patient to vaso-dilate and his blood pressure medication means that he has not raised his heart rate sufficiently to compensate. She gives the patient 6mg of ephedrine as she knows this will vaso-constrict the patient and increase the rate and contractility of the heart. She reduces the concentration of anaesthetic agent slightly whilst ensuring that the patient will still be adequately anaesthetised. The blood pressure returns to a satisfactory level.

Jane also monitors the intravenous fluid input she is giving and balances it with the blood loss from surgery and the urine output. Towards the end of surgery Jane decides to give the patient a unit of a starch-based plasma volume expander instead of further

cristalloid solution to compensate for a 500ml loss of blood which she feels is insufficient to warrant a blood transfusion.

She keeps a record of all treatments given and of the information from the monitoring which will remain in the patient's medical notes.

The surgery proceeds uneventfully and as the surgeon is closing the skin Jane telephones Dr Jones to let him know they will soon be finished. He arrives and Jane informs him of what treatment she has given. He completes the paperwork by signing for the drugs Jane has given and the patient is transferred back into bed. Dr Jones returns to the other anaesthetic room where a new patient has arrived and Jane takes Mr Smith to the Post-anaesthetic Care Unit.

Jane helps the nurse in the PACU to connect the monitoring to the patient and then gives her a full handover including the relevant parts of the medical history, what surgery has been performed, what anaesethetic technique was used and what post-operative care has been prescribed. Mr Smith recovers sufficiently from the anaesthetic that Jane and the PACU nurse remove his laryngeal mask airway. Jane tells the nurse that she is returning to the operating room and that she or Dr jones will be available if required.

Later in the day Jane will return to the PACU and then the ward to check on the patient's progress.

Case 2 Jane is scheduled to perform local anaesthesia for six cataract removal operations, having undertaken a further training course provided by her employer.

As with all PA(A)s providing regional anaesthesia Jane is a certified Advanced Life Support provider. On arriving in the ophthalmic theatres she checks that the equipment and drugs she would need to resuscitate a patient in the event of an adverse reaction to the local anaesthetic are available.

She checks that Dr Jones, the supervising consultant, is in the adjacent theatre and the first patient is sent for.

Jane introduces herself to Mrs Briggs and expains her role and the local anaesthetic technique that will be performed. She confirms with the patient which eye is being operated on and checks that this agrees with the notes. Whilst the ODP positions the patient, attaches monitoring and prepares the eye with antiseptic solution she checks the patient's medical history. Mrs Briggs does not have any medical condition that

prevents her from having her surgery, but she does take a low-dose aspirin. Jane warns her of the slightly increased risk of haemorrhage and confirms that Mrs Briggs is happy to proceed. She also checks the biometry measurements of Mrs Brigg's eye to make sure it falls within the limits of her protocol. As all the patient's parameters are within normal limits Jane does not need to discuss the case with her supervisor.

Jane washes her hands, dons sterile gloves and prepares her equipment. She explains to Mrs Briggs what is going to happen as she proceeds. She inserts a speculum to hold the patient's eye open whilst she performs the procedure. She uses forceps and scissors to make an incision in the conjunctiva and Tenon's capsule of the eye. She inserts a curved cannula and advances it to the back of the eye before injecting a mixture of local anaesthetic and an enzyme. She removes her intruments and applies gentle pressure to help the spread of the anaesthetic. After a few minutes the eye has become sufficiently anaesthetised and Jane and the ODP transfer the patient to the operating room and reattach the monitoring. Jane makes notes of the procedure she has performed.

This procedure is repeated for the remaining five patients. As they all fall within the parameters of Jane's protocol she has no need to contact Dr Jones during the list. At the end of the list Jane goes to the ward to check that there have been no problems before she leaves the department.

The National Practitioner Programme factsheet and the DH "toolkit" document which detail the level of independent decision making required of PA(A)s are attached in appendices 1.1 and 1.2

Appendix 1

Part B

The occupation of Physicians' Assistant (Anaesthesia) fulfils the criteria of part B of the assessment as follows;

SECTION 1 Contact details

Main contact David Wilkinson

Address Department of Anaesthesia, Royal Devon and Exeter Hospital, Barrack Road, Exeter, EX2 5DW.

Telephone 07952 873378

Email info@anaesthesiateam.com

Website www.anaesthesiateam.com

Name of applicant occupation Physicians' Assistant (Anaesthesia)

SECTION 2 Previous applications

No previous applications have been made by Physicians' Assistants (Anaesthesia) for regulation by the HPC or its predecesssor.

SECTION 3 Consideration of alternative routes to regulation

Has the occupation explored regulation as a distinct subsection within a profession already being regulated and if so have you rejected this route?

The Association of Physicians' Assistants (Anaesthesia) understands that occupations that already have a regulator are ineligible for registration by the HPC and has therefore explored the option of distributed regulation.

Whilst approximately 60% of PA(A)s were formerly healthcare professionals such as Registered Nurses or Registered Operating Department Practitioners, there is no requirement by employers for them to retain this registration in order to practice as a PA(A).

The remaining 40% of PA(A)s are direct-entry science graduates with no previous healthcare registration. In order to prevent the attrition of scarce specialist healthcare professionals and in view of the fact that direct entry students are paid a bursary which is substantially cheaper than the salary paid to existing staff, it is likely that employers will seek to increase the proportion of student PA(A)s drawn from this sector in future. Reliance on existing regulators would, therefore, leave a significant and increasing proportion of the occupation unregulated.

After consultation with the membership of the association, the APA(A) does not wish to pursue a model of regulation that would divide the occupation into two groups, one regulated and one not. This would lead to confusion both for patients and employers, with probable negative impact on the employment prospects of the unregulated group.

The NHS Employers organisation does not consider the PA(A) role an extension of existing healthcare professions, but as an independent occupation (by its former title of Anaesthesia Practitioner) under Agenda for Change. (Job profile attached in appendix 3.1)

Has the occupation considered joining other unregulated occupations in a similar field who are currently seeking HPC regulation or may do so?

The occupation has considered making a joint application with Physician Assistants practicing in general medicine.

Both the APA(A), representing PA(A)s, and the United Kingdom Association of Physician Assistants (UKAPA), representing Physician Assistants in general practice,

were invited in 2009 to join a group at the University of Hertfordshire (UoH) tasked with setting up an MVR for PAs of both disciplines.

The project was instigated at the behest of the DH, who wished to have a register of PA(A)s onto which overseas Nurse Anaesthetists could be placed as part of a scheme to employ them in treatment centres. The DH have now abandoned this scheme.

The UoH expended considerable time and effort on making the MVR work using their existing infrastructure, including modifying their student disciplinary procedure, and both APA(A) and UKAPA were in agreement that they would encourage their membership to join what would in effect be a two part register.

Due to the small number of potential registrants it was clear that the MVR would not be self-funding and it was initially thought that UoH would be able to use its existing staff to manage the register, but it has since transpired that this will not be possible due to legal constraints on how their budget is spent and the project is currently on hold.

Throughout the committee process of creating the MVR it was made clear by UKAPA and representatives of bodies training and employing PAs (General) that while they were in principle happy to be part of a voluntary register with PA(A)s, their preferred route to formal regulation would be through the General Medical Council in the first instance.

It is the view of UKAPA that they do not wish to pursue a joint application to the HPC at this time. The minutes of the last meeting of the UoH steering group indicating this and a letter stating their position are attached. (Appendix 3.2, 3.3)

Although the two occupations now share a common title stem, “Physicians’ (or Physician) Assistant” and are studied at postgraduate level there are significant differences between them.

As mentioned in Section A, PA(A)s were initially designated “Anaesthesia Practitioners”, but the proliferation of ODPs using this title was thought to be leading to confusion. The RcoA, AAGBI and the occupation itself therefore decided to use the title already in use in Scotland of Physicians’ Assistant (Anaesthesia) and this change was made in 2007 after consultation with the DH.

PA(A)s practice specifically in the secondary healthcare care setting as deliverers of anaesthesia and critical care and the curriculum is therefore biased heavily towards that. The Physician Assistants represented by UKAPA practice in primary care, usually in GP surgeries, and therefore their training is more closely modelled on under-graduate medical education. There would appear to be very little overlap between the two

occupations; holders of one qualification cannot not be employed to practice the other role.

The APA(A) is not aware of any core modules shared between the courses, even when provided by the same HEI.

The PA(A) qualification is a postgraduate diploma and a Masters can be gained by dissertation in an additional time period wheras the PA qualification is always a Masters.

For these reasons the APA(A) is understanding of the view of UKAPA that they do not wish to pursue a joint application.

Appendix 3

SECTION 4 The occupation must cover a discrete area of activity displaying some homogeneity.

All Physicians' Assistants (Anaesthesia) provide anaesthesia and critical care services, following the established model of medical practice.

All PA(A)s must hold a Postgraduate Diploma awarded by one of the four UK universities forming the Higher Education Institute (HEI) group, in conjunction with the Royal College of Anaesthetists. These are the Universities of Birmingham, Edinburgh, Hull and Hertfordshire. All PA(A)s follow the same curriculum and sit the same exit examination, regardless of education provider.

The curriculum defines the necessary training, skills and knowledge that PA(A)s require to plan and implement the pre-, peri- and post-operative anaesthesia care of the patient, in conjunction with a supervising physician where appropriate. The curriculum is agreed and accredited jointly by the HEI group and the PA(A) committee of the RCoA, on which the APA(A) is represented. The input of the students of the first cohorts of PA(A)s on subsequent curriculum development has been acknowledged.

The Post-Graduate Diploma is of a minimum of twenty-seven months' duration, seven university terms. Students may opt to continue for a further year to complete a Master's qualification by dissertation. Successful completion of the two exit examinations at twenty-four months is followed by three months of supervised practice before the final award of the PGDip.

Following succesful completion of the course the following learning outcomes must have been achieved:

- Be able to elicit the relevant history from the patient to identify potential problems before, during and after anaesthesia and to communicate this information to all members of the team.
- Demonstrate a thorough working knowledge of relevant anaesthetic pharmacology and be able to articulate in theory and practice the physiological action of these drugs and their interactions with the patient's existing medication.
- Demonstrate a clear knowledge of the normal physiological changes which occur in the body during and after anaesthesia and be able to use the information to assess the wellbeing of the patient before, during and after anaesthesia.
- Be able to use knowledge of physiology and pathology to identify and report the needs of patients who may be an anaesthetic risk due to pre-existing medical conditions.

- Demonstrate a clear working knowledge of the applied anatomy and physiology of the respiratory, cardio-vascular and nervous systems in order to induce anaesthesia and undertake emergency resuscitative procedures.
- Demonstrate a clear working knowledge of the physics relevant to anaesthesia and use that knowledge to monitor and measure patients' wellbeing during and after anaesthesia.
- Have the skills to reflect on their practice and to use the outcomes of that reflection for personal development and for innovation and change in practice.
- Have developed the ability to support the learning of colleagues entering practice.

Typically, on a day-to-day basis PA(A)s examine and take histories from patients pre-operatively in the ward or clinic environment, providing explanation and gaining consent for the appropriate anaesthetic technique. They liase with the operating theatre team to ensure equipment and drugs are available and checked. They induce anaesthesia in the presence of the supervising physician and maintain the patient's condition throughout surgery and then plan and implement post-operative care in conjunction with staff from the post anaesthetic care unit.

The KSF outline (Appendix 3.1) and job description and the draft standards of proficiency are attached. (Appendix 4.1, 4.2)

Are there professions regulated by the HPC with whom the scope of practice overlaps?

There is some overlap of scope of practice with the existing regulated profession of Operating Department Practitioner, specifically in the areas of preparation of anaesthetic equipment, drugs and infusions. Physicians' Assistants (Anaesthesia) are however distinct in that they plan and *administer* anaesthesia, within guidelines, rather than providing assistance to the medically trained anaesthetist in the manner of the Operating Department Practitioner.

There is some overlap with the existing regulated profession of Paramedic in the performance of invasive procedures such as intra-venous cannulation and the use of adjuncts to maintain the patient's airway, but PA(A)s are distinct in that they practice within elective anaesthesia, not emergency care.

There is clear overlap of scope with several professions regulated by the HPC in the areas of physical examination, history taking and the planning of patient care episodes. PA(A)s are distinct in that these patient care episodes relate to the planning and provision of anaesthesia.

Appendix 4

SECTION 5 The occupation must apply a defined body of knowledge.

Anaesthesia has a defined and scientific body of knowledge found in many thousands of textbooks and peer-reviewed journals internationally. The Royal College of Anaesthetists, which administers one of the two the exit examinations for the occupation and sets its educational standards, publishes one of the most prestigious, the British Journal of Anaesthesia. This body of knowledge has formed the basis of the Postgraduate Diploma which all PA(A)s must hold. PA(A)s will have undertaken a minimum of five years' study at undergraduate and postgraduate level to gain the requisite body of knowledge required to practice.

Traditionally in the United Kingdom anaesthesia has been administered solely by medically-trained anaesthetists. The introduction of PA(A)s has led to a second, as yet unregulated, occupation applying the same body of knowledge.

The HEI group and the PA(A) committee of the RCoA ensure that the taught body of knowledge is consistent across the institutional and occupational providers of education, through internal university quality assurance schemes and training site visits.

The curriculum document for the postgraduate diploma is attached in the appendix to section 10.

PA(A)s are the sole non-medically qualified group recognised as applying this body of knowledge in the UK.

Are there professions currently regulated by the HPC with whom the applicant occupation's body of knowledge overlaps?

There is some overlap with the bodies of knowledge required of many HPC regulated professions in that knowledge is required of subjects such as anatomy and physiology, basic sciences and pharmacology. However, Physicians' Assistants (Anaesthesia) are distinct in that they are they require knowledge of these subjects as they relate to anaesthesia at postgraduate diploma and master's level, demonstrated by both continuous assessment and final examination.

SECTION 6 The occupation must practice based on evidence of efficacy.

Research into the efficacy of the applicant occupation's practice.

Anaesthesia, as part of medicine, is a scientific, evidence- and research-based discipline. Tens of thousands of textbooks and learned journals world wide testify to its efficacy. As detailed in section 5, it is very difficult to separate the specific practice of PA(A)s, and therefore its efficacy, from that of medically-trained anaesthetists as PA(A)s are trained and required to practice within that traditional medical model.

As detailed in Section 4, the postgraduate curriculum requires that, as with the traditional medically-trained practitioners of anaesthesia, PA(A)s gain the necessary skills to reflect on the outcomes both of their own practice and that of the speciality as a whole. Numerous research papers are published monthly exploring the efficacy of both existing and potential new treatment options in anaesthesia. A copy of the paper *Perioperative Epidural Analgesia and Outcome After Major Abdominal Surgery in High-Risk Patients* by Peyton *et al,* which explored the efficacy of the two most commonly used methods of post-operative pain relief for laparotomy, is attached. (Appendix 6.1)

Evidence of practice outcomes.

Despite the relatively short time that PA(A)s have been in practice in the United Kingdom, reports and research data to which PA(A)s have contributed are available showing that the practice of PA(A)s is as efficacious as existing systems. For example, Modi *et al* [1] demonstrated no difference in patient satisfaction when anaesthesia for cataract surgery was administered by either a consultant anaesthetist, a nurse practitioner or a PA(A). Sanders *et al*[2] and the National Practitioner Programme[3] showed increases in efficiency when PA(A)s were included in the anaesthesia team.

Internationally there is a large volume of evidence that the practice of anaesthesia by similar non-physician grades such as Anaesthesiologist's Assistants and Certified Registered Nurse Anesthetists is efficacious. Both the American Association of Nurse Anesthetists (AANA)[4] and the International Federation of Nurse Anesthetists (IFNA)[5] promote research into practice outcomes. In a study published by the AANA Pine *et al*[6] found no significant difference in mortality rates when comparing the outcomes of 404,000 cases where anaesthesia was provided by non-physicians, physicans or teams including both specialities.

Evidence based practice.

PA(A)s are expected to have the ability to interpret such research data, perform audit and present complex case studies and to use the information gained to inform future practice, as evidenced by the course learning outcome "Have the skills to reflect on their practice and to use the outcomes of that reflection for personal development and for innovation and change in practice."

Wilkinson[7], for example, compared the results of the paper of Peyton *et al* mentioned above (Appendix 6.1) with the conflicting conclusions of the meta-analysis of Rogers *et al*[8] in order to make recommendations on the pre-operative information offered to patients.

References to section 6

1 Modi N, Shaw S, Allman K, Simcock P, *Local anaesthesia during cataract surgery: Factors influencing perception of pain and overall satisfaction.* Journal of Perioperative Practice 2008; **18**:1;28-33

2 Sanders D, Grayling M, Lillie H, *Defining efficiency requires more fidelity.* Anaesthesia 2008; **63**:2;204-5

3 DH/National Practitioner Programme/Royal College of Anaesthetists, *A toolkit to support the planning and introduction of training for Anaesthesia Practitioners.* 2007; 43-45

4 www.aana.com

5 www.ifna-int.org

6 Pine M, Holt K, You-Bei L, *Surgical mortality and type of anesthesia provider.* AANA Journal 2003; 71:109-116

7 Wilkinson D, *Epidural, friend or foe?* Anaesthesia Points West Spring 2006

8 Rodgers A, Walker N, Schug S, McKee A, Kehlet M, van Zundert A, Sage D, Futter M, Saville G, Clark T, MacMahon S, *Reduction of postoperative mortality and morbidity with epidural or spinal anaesthesia: results from overview of randomised trials* BMJ. 2000 December 16; 321(7275): 1493

Appendix 6

SECTION 7 The occupation must have at least one established professional body which accounts for a significant proportion of that occupational group.

The Association of Physicians' Assistants (Anaesthesia) is the sole body representing the interests of the occupation. It was formed on the 15th of March 2008 with the aim of seeking the regulation of PA(A)s to ensure the highest standards of patient care.

It became registered company 6592581 on the 14th of May 2008. The Memorandum and Articles of Association and minutes of committee meetings are attached in appendices 7.1, 7.2 and 7.3

2010 Election results are attached in appendix 7.4. The ballot was conducted secretly and results collected by an uninterested party.

The association has represented the occupation on numerous committees and working groups nationally on issues such as regulation, educational standards, workforce planning and scope of practice.The association holds an educational conference, open to all PA(A)s, annually, in addition to the AGM for members featuring the annual report and accounts. The association website, www.anaesthesiateam.com, is used to disseminate information to PA(A)s, employers and patients.

Number of practitioners of the occupation.

According to figures provided by the RCoA, by the 6th of November 2009 64 PA(A)s had successfully completed the recognised qualification and a further 57 were in training, of whom 48 (40%) are members of the association.

Other professional bodies.

On the 24th of June 2010 there were no other professional bodies or representative organisations for the occupation.

Grandparenting arrangements.

The APA(A) has no members who have not followed the defined routes of entry to the profession and currently has no resources to assess the educational standards or fitness to practice of such practitioners. When the Managed Voluntary Register at the UoH was proposed, it was supposed by the DH that they would use their educational resources to assimilate other practitioners into the profession and the APA(A) was prepared to participate in that process. Following discussions with the RcoA the UoH decided that they would not undertake such an assimilation service as it conflicted with the view of both the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland that only practitioners who have gained the postgraduate

diploma through the recognised training programme should be considered qualified to practice the occupation.

There may be practitioners employed in the role in the UK who have not followed the defined routes of entry, in which case their employers must have satisfied themselves as to the fitness to practice of the candidate.

Appendix 7

SECTION 8 The occupation must operate a voluntary register.

The Association of Physician's Assistants (Anaesthesia) launched a Managed Voluntary Register on the 25th of June 2010 after those members present at the 2010 annual general meeting voted unanimously to support the undertaking.

The launch of the register has been publicised on the APA(A) website and via email to members, who have been asked to inform any colleagues who are not members of its existence. There is no necessity to join the Association to be entered on the register which is open to all PA(A)s who have succesfully completed the recognised training programme.

The APA(A) and RCoA have written jointly to employers asking them to encourage all PA(A)s to join the register and also to partcipate in the reporting process. A copy of the letter is attached in appendix 8.1

The APA(A) expects PA(A)s to conform to the standards of conduct, performance and ethics laid down by the HPC and anyone found by their employer to have breached those standards will be removed from the register.

The application form, which also includes explanatory notes and data protection information is attached in appendix 8.2

Employers and members of the public can check whether PA(A)s are registered by contacting the APA(A) electronically or by telephone.

Currently 31 PA(A)s have joined the Voluntary Register.

Appendix 8

SECTION 9 The occupation must have defined routes of entry to the profession.

Currently there is only one recognised route of entry to the occupation. Physicians' Assistants (Anaesthesia) must have undertaken and successfully completed all modules and the final examination to gain the Post-Graduate Diploma (Physicians' Assistants (Anaesthesia)), formerly known as Post-Graduate Diploma (Anaesthesia Practitioner).

This qualification has been awarded by the universities of Hull, Hertfordshire, Birmingham and Edinburgh. Only Birmingham and Edinburgh currently have students enrolled on the programme. Information on their courses can be found at;

http://www.anaesthesiapractice.ed.ac.uk/

http://www.postgraduate.bham.ac.uk/programmes/taught/medicine/physician-assistant-anaesthesia.shtml

Evidence that demonstrates that only individuals choosing one of the entry routes are recognised as being practitioners of the profession.

The joint position statement of the RCoA and Association of Anaesthetists of Great Britain and Ireland of October 2007 stating that they only recognise PA(A)s who have succesfully completed the approved training programme as being practitioners of the profession and advising employers not to recognise any other route of entry is attached in appendix 9.1.

The HEIs will only award the diploma to those students who have succesfully completed the approved programme.

The Workforce Review Team analysis of the role which mentions no alternative route of entry is attached in appendix 9.2

A specimen person specification and job advertisment demonstrating the route of entry recognised by employers are attached in appendices 9.3 and 9.4

Information about the applicant occupation's QAA Subject Benchmark or equivalent.

The HEIs providing the academic component of the course have subjected their modules to internal quality assurance scrutiny. Doctor T. Clutton-Brock, who chairs the RCoA educational sub-committee for PA(A)s, is submitting the University of Birmingham modules for formal QAA Subject Benchmarking.

SECTION 10 The occupation must have independently assessed entry qualifications.

The qualification is administered jointly by a committee of Higher Education Institutes and the Royal College of Anaesthetists, on which the APA(A) is represented, who ensure that educational standards are met.

These independent bodies ensure that the fitness for purpose of the curriculum is reviewed on a regular basis as evidenced by the introduction to the curriculum document itself. (Appendix 10.1)

The universities have submitted their components of the course and examinations to rigorous internal benchmarking procedures. The Objective Structured Clinical Examination, run by the Royal College of Anaesthetists in conjunction with the HEIs, is administered by examiners who are medically qualified anaesthetists and therefore independent of the PA(A) occupation.

HEI Group

Dr Thomas Clutton-Brock, Senior Lecturer in Anaesthesia and Critical Care at the University of Birmingham supplied the following information on the work of the HEI group;

“In 2004 the University of Birmingham was awarded the contract to produce a national curriculum for the Anaesthesia Practitioner Post Graduate Diploma / MSc programme (this has subsequently been renamed the Physicians’ Assistant (Anaesthesia)). This was completed in 2005 and the first intake of students went to the Universities of Birmingham, Newcastle, Hertfordshire and Edinburgh. All of the HEIs work to the same curriculum and assessments are conducted nationally

This unified curriculum with common learning outcomes and summative assessments has been a major factor in the success of the programme across the UK but has naturally required a considerable degree of collaboration between the HEIs delivering the programme. A national HEI subgroup was formed from the programme leads and their representatives at the individual institutions. This group initially met twice a year at the Royal College of Anaesthetists but now meets annually in Birmingham after the Mock OSCE examination in May

This group is currently chaired by the programme director in Birmingham and has representation from the Royal College of Anaesthetists as well as trainee and qualified Physicians’ Assistants (Anaesthesia). It reports to the Anaesthesia Related Professionals committee at the Royal College of Anaesthetists and to the programme boards of the partner HEIs. cont....

Curriculum Development

The HEI group also has responsibility of curriculum development. The curriculum has undergone significant development since 2005 primarily as a result of student and tutor feedback. The latest version is due to be published by the end of 2010 and arrangements have been made to host this in the public domain."

Appendix 10

SECTION 11 The occupation must have standards in relation to conduct, performance and ethics.

Since its formation, the Association of Physicians' Assistants (Anaesthesia) has, with the agreement of the HPC, instructed its members to abide by the standards of performance, conduct and ethics required by the HPC[1].

References to section 11

1.http://anaesthesiateam.com/code.php

SECTION 12 The occupation must have disciplinary procedures to enforce those standards.

The APA(A) does not have the resources to undertake formal disciplinary proceedings against PA(A)s. The APA(A) asks any applicant to the Managed Voluntary Register to confirm that they have read and understood the standards of conduct, performance and ethics expected of them, which are those of the HPC, and that they agree that their name will be removed from the register should their employer find them in breach of those standards. The application form which provides this information is attached in appendix 8.2. The joint letter from APA(A) and the RCoA asking employers to participate in this process is attached in appendix 8.1.

Currently, any cases of professional misconduct would be dealt with at Trust level but reported to the APA(A) and the RCoA Anaesthesia Related Professionals committee, on which the APA(A) is represented. No case involving a qualified PA(A) has been reported to date.

Any PA(A) found by their employer to be unfit to practice through a breach of standards of conduct, performance or ethics will have their name removed from the Managed Voluntary Register, subject to any appeals process they may have with the employer being exhausted.

SECTION 13 The occupation must require commitment to Continuous Professional Development.

The Association of Physicians'Assistants (Anaesthesia) expects its members to keep a portfolio detailing all CPD activity and to maintain a logbook of all patient care episodes undertaken. The Anaesthesia Related Professionals committee of the Royal College of Anaesthetists, on which the Association is represented, is in agreement with this policy.

In common with the HPC and other professional organisations the APA(A) does not specify the number of hours of study to be undertaken, but practitioners must be able to demonstrate that sufficient activity has been performed to remain competent. The APA(A) lacks the resources to investigate the CPD of members at the present time. However, all those PA(A)s currently in practice work within the NHS and are therefore subject to an annual performance review which includes assessment of their CPD activity.

The APA(A) runs an annual conference with content tailored to the educational needs of the occupation. The programme of the 2010 conference is attached. (Appendix 13)

SECTION 14 Views of others

The Royal College of Anaesthetists is in full support of the regulation of Physicians' Assistants (Anaesthesia) by the HPC and has communicated that view to the HPC via the attached letter. (Appendix14)

The Patient Liaison Group of the RCoA, the lay body that has represented the interests of patients throughout the development of the PA(A) role, has written to the HPC giving its opinion that regulation is essential for the protection of the public.

The four UK Chief Medical Officers and the DH have been contacted, but no formal replies have been received to date.

Appendix 14