

Council, 7 July 2016

Regulation of physician associates and physician assistants (anaesthesia)

Executive summary and recommendations

Introduction

On 3 May 2016 the General Medical Council (GMC) and the HCPC held a joint workshop with stakeholders to explore the regulation of physician associates and physician assistants (anaesthesia).

This paper looks at the suggested regulation of these groups and summarises the content of the recent workshop.

Decision

This paper is to note; no decision is required.

Background information

None

Resource implications

None

Financial implications

None

Appendices

None

Date of paper

24 June 2016

Regulation of physician associates and physician assistants (anaesthesia)

1. Introduction

- 1.1 This paper looks at the suggested regulation of physician associates and physician assistants (anaesthesia) and summarises the content of a recent workshop held jointly with the General Medical Council (GMC).
- 1.2 The Executive will continue to monitor this policy area, meet with stakeholders as appropriate and update the Council. As policy decisions about the extension of regulation are for the four country governments of the UK and not the HCPC, no further specific action is required.

2. About physician associates

- 2.1 Physician associates 'support doctors in the diagnosis and management of patients'. They typically work in a variety of acute hospital and primary care settings. Scope of practice typically includes taking medical histories; performing examinations; diagnosis; analysis of test results; and developing management plans. Physician associates are not regulated and are therefore unable to prescribe; use medicines exemptions; or administer via a patient group direction. This role is well established as 'physician assistant' in the US healthcare system but was renamed in the UK to reflect that physician associates work autonomously, albeit under 'defined levels of supervision'.¹
- 2.2 Physician associate education and training is at postgraduate level and normally two years in duration. The NHS careers website lists 18 education providers that run or are planning to run, physician associate programmes (one programme in Scotland; the remainder in England). Entry requirements for programmes are normally a previous undergraduate degree in a life science subject and/or equivalent professional experience for applicants from other healthcare professions.
- 2.3 Completion of a recognised programme leads to eligibility to sit a national examination, successful completion of which leads to registration with the Physician Associate Managed Voluntary Register (PAMVR), managed by the Faculty of Physician Associates, a faculty of the Royal College of Physicians. Employers are encouraged to only employ someone registered with the PAMVR.
- 2.4 It is reported that there are approximately 300 physician associates, with 400 current students. The voluntary register includes approximately 75% of PAs in practice. It is estimated that there will be 33 qualifying programmes by the end of 2017; and 3,500 PAs by 2020.²

¹ <https://www.healthcareers.nhs.uk/explore-roles/physician-associateassistant/physician-associate>
<http://www.fparcp.co.uk/>

² Source: GMC/HCPC workshop.

3. About physician assistants (anaesthesia)

- 3.1 Physician assistants (anaesthesia) are qualified to administer anaesthesia under the supervision of an anaesthetist. Their scope of practice includes carrying out pre-operative assessment for anaesthesia; monitoring anaesthetic throughout an operation; and helping with patient care immediately after an operation. Physician assistants (anaesthesia) are not regulated and are therefore unable to prescribe; use medicines exemptions; or administer via a patient group direction.³
- 3.2 Education and training is at postgraduate level and normally 27 months in duration. There is only one programme at the University of Birmingham. Entry requirements are normally a previous undergraduate degree in a life science subject and/or equivalent professional experience for applicants from other healthcare professions.
- 3.3 Completion of a recognised programme leads to eligibility to register with the managed voluntary register maintained by the Association of Physician Assistants (Anaesthesia) (APAA). Employers are encouraged to only employ someone who is registered.
- 3.4 It is reported that there are approximately 130 PA(A)s, with 62 on the voluntary register; and 30 in training. Entry into qualifying programmes is typically a third each of the following groups: graduates; nurses; and operating department practitioners.⁴
- 3.5 The APAA previously applied to the Council for regulation of physician assistants (anaesthesia) under the aspirant groups / new professions process that was in place until 2011. The application was part way through being considered when the Council took the decision, in light of the publication of Enabling excellence, to close the process. No decision was therefore reached about whether the Council should recommend the regulation of this group.⁵

³ <https://www.healthcareers.nhs.uk/explore-roles/physician-associateassistant/physicians-assistant-anaesthesia>

⁴ Source: GMC/HCPC workshop

⁵ Council, 9 December 2010. Application for the regulation of physician assistants (anaesthesia). http://www.hcpc-uk.org/assets/documents/1000320E20101209Council_06_physicians_assistants_and_anaesthesia_application.pdf

4. Policy context

- 4.1 The Physician associate role is becoming embedded in the health system in at least some of the UK countries. Health Education England's 2016-17 workforce plan includes a 220% increase in commissions of places on physician associate and physician assistant (anaesthesia) programmes.⁶
- 4.2 UK Government policy on professional regulation is still based on 'Enabling excellence' published in 2007 which said that the Government would only consider extending regulation to further professions where there was a compelling patient safety case on the basis of risk and where assured voluntary registration would be insufficient to manage that risk.
- 4.3 There have been calls for the profession to be regulated, driven in part by a desire for the profession to be able to prescribe medicines. Stakeholders have suggested that either the General Medical Council (GMC) or the HCPC should become the regulator. The Scottish Government have stated their view that this profession should become regulated, but to date have stated their desire to ensure that the regulation of healthcare professionals is carried out on a UK basis. There has been no policy decision made by the UK Government on the regulation of this group.⁷

5. Workshop on the regulation of Physician Associates and Physician Assistants (Anaesthesia)

- 5.1 The GMC and the HCPC agreed to host a joint workshop to explore with stakeholders the regulation of these professions. Objectives included the following.
 - To improve understanding of the roles of PAs and PA(A)s and the overlaps/differences between them.
 - To gain a shared understanding of the views/ initiatives currently being taken forward by different key interest groups.
 - To see if there is a shared view about the development of the roles and the need for some form of regulation.
 - To see if there is a shared view about the need for statutory regulation.
 - To explore issues and challenges relating to statutory regulation.

⁶ Health Education England (2015). Commission and investment plan for England 2016-17. <https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/commissioning-investment-plan-england-2016-17>

⁷ GMC Council, 30 September 2015. The scope of medical regulation: physician associates. <https://www.hee.nhs.uk/our-work/planning-commissioning/workforce-planning/commissioning-investment-plan-england-2016-17>

- To set out a process for bringing new groups into statutory regulation.

5.2 The workshop took place on 3 May 2016 and included a presentation from Marc Seale on the process for bringing a new profession into regulation; presentations from both professional bodies; and small group discussion. Attendees included representatives from Health Education England, PSA, Royal College of Anaesthetists, Royal College of Physicians; and the Scottish Government.

Summary of what was discussed

5.3 There appeared to be overall consensus at the meeting that these groups should be regulated by the majority of those in attendance. The following briefly describes the key themes in the workshop discussion.

Factors influencing whether PAs and PA(A)s should be regulated

- Patient safety was considered to be the overriding consideration, with level of clinical decision making autonomy being a key factor in assessing risk.
- Although PAs are 'dependent' on medical supervision, this was often indirect, with PAs exercising high levels of autonomy.

Workforce and service delivery issues

- Statutory regulation would give other practitioners more confidence in working with and/or commissioning the services of PAs (but might restrict workforce flexibility).
- Statutory regulation would enable prescribing, the lack of which currently represents an inefficient use of resources. The ability to prescribe would reduce the risks associated with the current 'workarounds' which are in place.

How to regulate and by whom

- The GMC or the HCPC would both be suitable to regulate these groups.
- One potential approach might be to regulate PAs and PA(A)s with Advanced Critical Care Practitioners (ACCPs) and Surgical Care Practitioners (SCPs) under the umbrella of 'medical associates'.
 - ACCPs undertake an extended role in critical care / intensive care settings. They are normally nurses, ODPs or PA(A)s who have relevant experience and who undertake a further postgraduate degree.
 - SCPs undertake an extended role in surgical settings. They are nurses, ODPs or other registered professionals with relevant experience and who work in a surgical environment.

Limitations of current voluntary registration arrangements

- The risk, and impact of, legal challenge from practitioners was greater in a voluntary system.
- Voluntary registers had limited ability to hold practitioners to account because removing someone from a voluntary register would not affect their legal ability to practise.

The importance of consensus

- The importance of consensus about regulation amongst key stakeholders was a theme throughout.
- The Governments would need to be satisfied that there was support across the four countries, the profession, education providers and other key stakeholders.
- There should be consensus on both whether to regulate and what form that regulation should take.
- There was some debate at the meeting about the degree of cross-over between the PA and PA(A) roles. It was generally considered that whilst some areas such as communication skills might be common, these were very distinct groups.