General Medical Council

Decision making principles in fitness to practise (Physician Associates and Anaesthesia Associates)

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Date of publication: December 2024

Last updated: December 2024

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

Introduction

1. This publication explains the key principles that apply to all decisions made about a Physician Associate (PA) or Anaesthesia Associate's (AA) fitness to practise.
2. Fitness to practise is an assessment of a PA or AA's ability to practise safely and effectively. It includes considering a PA or AA's overall ability to perform their individual role, their professional and personal behaviour, and the impact of any health condition on their ability to provide safe care. Further information about why and how we assess a PA or AA's fitness to practise can be found in *What we mean by fitness to practise (Physician Associates and Anaesthesia Associates)*.
3. A good decision about a PA or AA's fitness to practise should:
   - protect the public
   - be proportionate
   - be transparent, and
   - be fair.

   An explanation of each principle follows.

Protecting the public

1. We have a legal duty to protect the public[*]. The Act splits public protection into three distinct parts. It says that we must act in a way that:
   - protects, promotes and maintains the health, safety and well-being of the public ('patient safety')
   - promotes and maintains public confidence in the profession ('public confidence'), and
   - promotes and maintains proper professional standards and conduct for members of those professions ('uphold professional standards').
2. To protect the public, we must consider the relevance of, and impact on, each of the three parts of public protection when we make decisions about a PA or AA's fitness to practise.
3. When a concern is raised with us about a PA or AA, GMC decision makers and MPTS[†]

[*] Section 1(1) of the Medical Act 1983 ('the Act')
[†] The Medical Practitioner Tribunals Service (MPTS) is the tribunals service for doctors, PAs and AAs in the UK. The MPTS run hearings which make independent decisions about whether doctors, PAs and AAs are fit to practise medicine.

tribunals will need to assess whether that PA or AA poses any current and ongoing risk to one or more of the three parts of public protection, and what, if any, regulatory action may be required in response.

Protecting, promoting and maintaining the health, safety and well-being of the public ('patient safety')

4. To protect, promote and maintain the health, safety and wellbeing of the public, it's necessary to manage any current and ongoing risk posed by a PA or AA to patients or members of the public.

5. A PA or AA's behaviour, poor performance or unmanaged health condition can result in harm being caused to a patient or member of the public or can create a risk of harm. Types of harm include physical, emotional, psychological, and financial. Psychological harm is often considered a part of emotional harm and is where someone's ways of thinking and interpreting situations has been altered.

6. Harm to patient safety can arise from a PA or AA's failure to act as well as from actions they may take. While harm caused in the past is an important factor, the risk of future harm to patients associated with the risk of repetition of the PA or AA's actions or omissions is the key consideration.

7. GMC decision makers and MPTS tribunals need to assess if there is any current and ongoing risk to patient safety posed by the PA or AA. Their decision will be based on considering the circumstances in which the concern arose and what has happened since. The assessment is therefore not about the risk posed by the PA or AA to patient safety at the time the events occurred. It's about the risk posed at the time of deciding whether any action is needed. This is to mitigate against harm occurring now and in the future.

8. A PA or AA's response to a concern about their behaviour, poor performance, or the impact a health condition has had, or may have, on patient safety, is important to the assessment of current and ongoing risk. Where a PA or AA can show they've successfully taken relevant steps to address any risk of harm, it's unlikely GMC decision makers and MPTS tribunals will need to investigate or take regulatory action solely to protect patients or members of the public. This applies even where harm occurred.

Promote and maintain public confidence in the profession ('public confidence')

9. Patients and members of the public must be able to trust PAs and AAs with their lives and health. Trust in the profession is essential so that when individuals need medical care they have confidence in those who provide it. This ensures they will not be put off from seeking care. It also prevents barriers to accessing the care they need and eliminates fear of receiving less favourable treatment than others. PAs and AAs' colleagues must be able to trust them to support effective team working and to deliver safe patient care.

10. PAs and AAs must ensure their actions and behaviour justify the trust placed in them and their profession. GMC decision makers and MPTS tribunals will need to consider any risk associated with behaviour or poor performance that undermines, or is capable of undermining, the trust that a fully informed and reasonable member of the public, or a colleague, places in the profession.

11. We maintain and uphold public confidence by acting where an individual PA or AA's behaviour or poor performance could undermine trust in their profession. The types of behaviour or poor performance that are capable of undermining public confidence in the profession may vary or develop over time in response to changes in wider society.

12. PAs and AAs must follow the law,[*] and so behaviour that leads to a criminal conviction or caution can undermine public confidence, including some behaviours arising outside a PA or AA's professional practice. A PA or AA's behaviour can undermine the public's trust in the profession and impact on public confidence in the following circumstances:

- where the specific nature of behaviour in a PA or AA's private life indicates a high level of seriousness
- where the behaviour is such that the public would view it as a fundamental breach of trust, and / or
- where it would make a member of the public or colleague question how the PA or AA would act in their professional capacity.

13. Occasionally we may still need to investigate further and consider taking regulatory action even where a PA or AA has successfully taken relevant steps to address a risk of harm to patient safety arising from their behaviour or poor performance. This is because the seriousness of the concern itself could affect the public's trust in the profession and pose a risk to public confidence.

14. A PA or AA's health condition will not on its own undermine public confidence. Trust in the PA or AA will only be called into question where the health condition has impacted, or is likely to have an impact, on their performance or behaviour. In these circumstances it is

[*] Paragraph 4, Good Medical Practice 2024.

the concern about the PA or AA's behaviour or performance, and the impact it has on trust, that may undermine public confidence in the profession.

Promote and maintain professional standards and conduct ('uphold professional standards')

15. *Good Medical Practice* sets out the principles, values, and standards of care and professional behaviour expected of all PAs and AAs registered with the GMC. It is an ethical framework, which supports PAs and AAs to deliver safe care to a good standard, in the interests of patients. *Good medical practice* is supported by a range of more detailed guidance which expands on some of the standards it sets out.

16. If a PA or AA seriously departs from the professional standards, it can mean that they pose a current and ongoing risk to public protection.

17. To assess how serious a concern is, GMC decision makers and MPTS tribunals will look at the extent of any departure from the professional standards along with specific factors that may impact on seriousness. This includes if the concern is an isolated incident or has been repeated, whether it was premeditated or persistent, or whether it was an abuse of power.

18. A departure from the professional standards may require regulatory action to be taken to uphold them. This is because regulatory action sends a message to the individual PA or AA, the wider profession, patients and members of the public about the principles, values, and standards of care and professional behaviour expected of PAs and AAs.

Being proportionate

19. GMC decision makers and MPTS tribunals must be proportionate in their approach to decision making throughout the fitness to practise process. This means asking themselves, in the context of the individual case and decision being made, what is required and no more than necessary to achieve public protection in a timely way. To assess what is proportionate, GMC decision makers and MPTS tribunals should be clear on the options available to them.

20. Where appropriate, GMC decision makers and MPTS tribunals can consider the impact on those affected by the decision. This will include the interests of individual patients and members of the public and the interests of the PAs and AAs we regulate, including the individual PA or AA. But, in all cases, the need to protect the public from any current and ongoing risk posed by a PA or AA, is more important than the interests of any individual.

Being transparent

21. Transparency is the basis for establishing trust that our actions are protecting the public. Being open and clear in a timely way about the steps taken in response to concerns about PAs and AAs enables patients, members of the public and the PAs and AAs we regulate to

understand our decisions and hold us to account. This may also help others in similar situations make decisions that will help keep patients and members of the public safe.

22. We're open about how decisions are made throughout the fitness to practise process by making information accessible. This includes publishing decision making guidance on the GMC and MPTS websites. To make decisions accessible, GMC decision makers and MPTS tribunals are expected to give reasons and record decisions in a way that can be understood by patients, members of the public and PAs and AAs, using plain and clear language.

23. The *Policy on publication and disclosure of fitness to practise information for Physician Associates and Anaesthesia Associates* guidance sets out our position in relation to the routine publication and disclosure of specific fitness to practise information. To be transparent about when regulatory action is required, we publish decisions on the MPTS website and on the GMC's medical register unless this is not appropriate under the policy. We also share information with interested parties - provided it's appropriate to do so and in line with our legal obligations - and provide access to information that's relevant to them.

Being fair

24. Our role is to ensure that anyone can raise a concern about a PA or AA with us and to gather relevant evidence that enables GMC decision makers and MPTS tribunals to reach a fair decision that protects the public.

25. When gathering evidence, GMC staff should demonstrate professional curiosity to recognise, explore and better understand a concern. They should evaluate information from all sources, ask questions, challenge assumptions, and remain open to new evidence or changing circumstances or perspectives to avoid accepting evidence at face value.

26. To be fair in their approach, GMC decision makers and MPTS tribunals should act reasonably, be consistent, be impartial and be aware of the risk of bias and how to mitigate it. GMC decision makers and MPTS tribunals should:

- act independently, in good faith and for a proper purpose
- comply with relevant legislation
- follow any relevant policies and guidance unless there is a reason to make an exception
- consider and apply relevant case law
- consider all available information relevant to the decision they are making
- make the decision on reasonable grounds and based on evidence, and
- give reasons for the decision which includes an analysis of the evidence and explains the weight applied to different factors relevant to the decision.

27. GMC decision makers and MPTS tribunals are supported to be fair in their approach through policies and guidance, regular training and feedback. Many decisions made

throughout the fitness to practise process are regularly monitored through internal and external audits to assess quality and consistency.

28. GMC decision makers and MPTS tribunals must consider all the information provided to them that is relevant to the decision they are making and decide what weight to attach to it. The evidence considered may include information from a variety of sources, including PAs and AAs, experts, complainants, and other witnesses. Having quality evidence from these individuals will support good decision making.

29. We know that the fitness to practise process can be stressful for those involved. This can impact on how individuals engage in the process and on the quality of the information they provide. To get the best evidence we can to support fair decision making, it's important that individuals involved in all stages of the fitness to practise process are treated with compassion and respect. We provide support* and guidance† on the fitness to practise process and what we expect from individuals to help them participate effectively and provide quality evidence.

Complying with equality rights legislation

30. GMC decision makers and MPTS tribunals must be aware of, and adhere to, equality and human rights legislation. More information can be found in the *GMC's Equality, diversity and inclusion policy*.

Differences in culture, faith and communication

31. The same professional standards are expected of all PAs and AAs regardless of their cultural background, faith, or specific circumstances. However, a PA or AA – or another individual involved in the fitness to practise process - may think, feel, or behave differently because of their cultural background or faith. It's therefore important that GMC decision makers and MPTS tribunals are aware of how cultural, faith or other differences, such as a disability, may affect the way an individual engages with the fitness to practise process and / or communicates with us.

32. Decisions should be informed by information that's known to us about an individual's cultural background or faith and the impact it has had on that individual's behaviour, performance, or engagement with us.

33. GMC decision makers and tribunals should also be aware of how their own culture, faith or other personal differences might shape assumptions about others. They must critically review the personal and professional biases that may affect their own decisions and set aside any personal feelings or beliefs to maintain an open mind. To support them with this, we deliver training on matters such as cultural competence and bias.

* Support for PAs or AAs
† What to expect when you raise a concern with us

Communication during in-person interactions*

34. When a person is speaking in their second language, they may use the conventions of their first language to frame and structure sentences, often translating as they speak. This may be reflected in their pronunciation and / or intonation and as a result they may not adhere to the convention or display the subtleties or nuances of their second language. There may also be differences in the way that individuals use non-verbal cues to convey a message including eye contact, gestures, facial expressions and touch.

35. Disabilities, such as neurodiversity, can also have an impact and create barriers to cognition, social communication, and the perception of an individual's behaviour. Some disabilities may lead to individuals having a literal understanding of language, appearing blunt or aggressive, and / or having difficulties reading facial expressions or tone of voice.

Written communication

36. When a person is writing in their second language, they may use the conventions of their first language to select information, frame, and structure sentences. This may be reflected in their linguistic accuracy and in how they present and organise information. As a result, they may not adhere to the cultural and contextual appropriacy of particular vocabulary, or the presentation of information, in their second language.

37. Disabilities, such as neurodiversity, can also have an impact and create barriers to cognition and written communication. Some disabilities may lead to individuals having a literal understanding of language and expressing themselves in a way that appears blunt or aggressive.

* Includes direct telephone communication, face to face meetings, virtual meetings, tribunal hearings