Association of Anaesthetists

Position statement on Anaesthesia Associates

January 2024

Over the past year, there have been many developments in how both Government and the profession view the role of Anaesthesia Associates.

The Association has been centrally involved in discussions about Anaesthesia Associates (AAs) for a number of years. We've met regularly with the General Medical Council, NHS England (formerly Health Education England), NHS Education for Scotland and the Royal College of Anaesthetists (RcoA) and have worked on various publications and guidelines. We have responded to government consultations and have met with politicians across the United Kingdom to talk about the role and how it contributes to the anaesthesia team.

The response of the profession and of our membership has revealed significant concerns about the roll-out of the AA project, which we are committed to voicing. While the GMC have addressed some of these issues in their recent letter to NHS England[1], concerns remain.

We are conscious that AAs themselves are impacted by all of this and that we have AAs as associate members; we have been mindful of that whilst writing this.

In particular, the NHS Long Term Workforce Plan[2] suddenly projected a huge expansion of AAs with no concomitant expansion in numbers of doctors in anaesthesia. To many, this looked like replacement of doctors with AAs, rather than employing AAs to complement the anaesthesia team, as had been previously portrayed.

Social media and news reports have shown us examples of medical associate professionals (MAPs) in the wider sense working in ways that have caused concern, specifically regarding their scope of practice, levels of autonomy and misleading representations of equivalence of MAP roles to doctor roles. Concerns about this have been raised by the BMA junior doctors' committee[3] and the Doctors' Association UK[4] among others. The Association of Anaesthetists has strong trainee and SAS representation who have both carefully examined this evolving topic. They have each passionately advocated for their constituency's voice, and in particular raised concerns regarding impact on quality of training, inequity of opportunity, and financial disparity. This voice has been heard by us loud and clear.

The RCoA's extra-ordinary general meeting[5] was a formal expression of these concerns (and others) and we have to take into account its results.

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[1] https://www.gmc-uk.org/-/media/documents/20-10-203-nevans-spowis-final-nosig_pdf-103738151.pdf
[2] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/
[3] https://www.bma.org.uk/news-and-opinion/bma-junior-doctors-committee-and-gp-registrar-committee-statement-on-maps
[4] https://www.dauk.org/news/2023/10/31/dauk-urges-gmc-reevaluation-over-2800-doctors-warn-against-pa-regulation-risks/
[5] https://www.rcoa.ac.uk/news/outcome-rcoa-extraordinary-general-meeting-17-october-2023

Association of Anaesthetists

A legislative order governing regulation of AAs and Physician Associates (PAs) was published by both the Westminster and at the Scottish Parliaments on 13 December 2023 and regulation will follow one year later. We set out below the Association's views on some of the key areas of concern relating to Anaesthesia Associates. Some reflect previous statements we have made and some are in response to recent developments.

General

Anaesthesia provision in the UK should continue to be led by and delivered by doctors. AAs are valuable members of the anaesthesia team in addition to doctors, but they are not a solution to the current workforce crisis, nor to the growing waiting lists. We continue to call for expansion in consultant numbers, an expansion in training scheme places for doctors in anaesthesia, and for the development of the large number of Specialty Doctors and locally-employed doctors already in post. Creation of SAS Specialists and consultants via the GMC's new portfolio pathway would create many more independent doctors in anaesthesia.

Regulation

Regulation of AAs is a non-negotiable requirement. All healthcare professionals should be subject to mandatory regulation. This will provide consistent standards for both their training and subsequent practice, maintain standards and contribute to patient safety. As per the draft Order laid before the UK and Scottish Parliaments, registration will be undertaken by the GMC. However, we share the increasing concerns expressed by others that this potentially further blurs the distinction between doctors and AAs.

Distinction of registration

We note that the GMC have now said that AAs and PAs will be given a registration number format that distinguishes them from doctors and we welcome this. However, we want the GMC to go further than this and to present doctors and AAs/PAs on separate registers, whether that be online or in print form. There should be clear distinction between the register of doctors and other registers. This is in order to provide absolute clarity for patients and others accessing the registers. It is to protect everyone from accidental or deliberate misrepresentation. There is no legitimate reason that this could not be done with modern information technology systems.

Scope of Practice

There should be a national scope of practice for AAs both on their qualification and for any post-qualification extension of practice. Any future changes to scope should be developed in conjunction with the regulator and should be agreed at a national level. We understand that the GMC will not regulate extended scopes of practice. This is regrettable. If the GMC cannot do this, extended scopes of practice should be devised according to national frameworks. It is unacceptable for employing organisations to devise their own extended scopes of practice without reference to some national framework that has the confidence of the regulator and standard setters. Doctors in anaesthesia should be directly involved in all devising any changes to scope of AA practice, whether at qualification or extended.

We do not support extension of roles beyond the scope of practice at qualification until national guidance is issued, and where organisations are planning such extension, it should be paused. Where AAs are already working in an extended role, this should be recorded on the organisation's risk register and the organisation should ensure it has full confidence in standards of supervision, access to support, indemnity (of the AA and the supervising doctor) and patient information and consent.

Expansion of numbers

AAs have a role to play as part of the wider anaesthesia team but it is important to make sure this is a complementary role. The Association's position is that AAs are an addition to the workforce and not a replacement for doctors. Expansion in AA numbers should not be at the expense of expansion in numbers of doctors in anaesthesia. Introduction of AAs should not impact on the capacity to train doctors in anaesthesia. Before a department introduces AAs, or employs additional AAs, it should assess its ability to provide both training and supervision.

Trainees should have a voice in this conversation. These potential impacts should be subject to continuous review as the situation is likely to be dynamic. Surveys relating to training should specifically ask about this issue. As well as possible impact on opportunities for doctors training in anaesthesia, Specialty Doctors and LEDs, an increase in the number of AAs needing to be trained and supervised also has the potential to impact on service delivery. It may be necessary for departments to produce training plans to outline how this will be managed. It is important that departments maintain a balance in numbers of doctors and AAs and that numbers of AAs are not increased to fill gaps in departments that are unable to recruit doctors.

Assessment

It is important that assessment for AAs is standardised at a national level. The Association believes that a national body undertaking the assessment processes for AAs is the best way to ensure confidence in the competencies of the AA. It may be possible for this to be delivered locally with very stringent controls in place to make sure consistency is maintained.

Supervision

We believe that AAs should be supervised on a 1:1 basis. Those doctors involved in the supervision and training of AAs will need guidance in how to carry out both roles and checks will need to be in place to make sure the curriculum is delivered consistently. Guidance should take account of those who are not content to supervise AAs.

Indemnity

More information is required around indemnity cover both for AAs and any doctors supervising them. The Association remains concerned about the lack of clarity on this issue. Good Medical Practice expects all doctors to make sure they are adequately indemnified and we believe the same should apply to AAs. Many doctors in anaesthesia are worried about medicolegal liability when working with AAs and clear guidance is urgently needed. While reference is made to accountability, more information is required on how this will work in practice if complaints or problems arise.

Prescribing rights

Some AAs, for instance those with a nursing background, may already have prescribing rights from their parent profession. We understand that the Commission on Human Medicines is responsible for deciding which professions are able to prescribe and will wait for their decision before commenting further.

It is imperative that our members' interests are reflected in whatever shape the future NHS workforce takes. We will advocate on our members' behalf to ensure the issues in this statement are heard by governments, and policy- and decision-makers. We recognise that working in partnership with other organisations is key to achieving this goal. We will continue to engage constructively with the RCoA, AAs, GMC and others to advocate for these changes to achieve a satisfactory outcome.