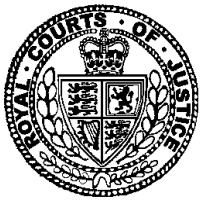

Neutral Citation Number: [2025] EWHC 960 (Admin)

Case No: AC-2024-LON-002308

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17 April 2025

Before :

Mrs Justice Lambert DBE

- -

Between :

The King (On the application of the British Medical Association)	**Claimant**
- and –	
General Medical Council	**Defendant**
-and-	
(1) The Faculty of Physician Associates **(2) The Royal College of Physicians** **(3) The Association of Anaesthesia Associates** **(4) The Royal College of Anaesthetists** **(5) Anaesthetists United (AU)** **(6) NHS England**	**Interested Parties**

- -
- -

Jenni Richards KC and Adam Boukraa (instructed by **TLT LLP**) for the **Claimant**
Ivan Hare KC and Peter Mant (instructed by **GMC** for the **Defendant**

Hearing dates: 12th and 13th February 2025; further submissions 4th March 2025

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 17 April 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Mrs Justice Lambert DBE:

Introduction

1. The claimant, the British Medical Association ("BMA") is a registered trade union and professional body for doctors and medical students in the UK; its role is to represent and support UK doctors and medical students on issues impacting upon the medical profession. The General Medical Council ("the GMC") is the independent regulator of doctors; it maintains the register of medical practitioners in the UK pursuant to its functions created by the Medical Act 1983 ("the 1983 Act"). From 13 December 2024, by reason of the Anaesthesia Associates and Physician Associates Order 2024 ("the AAPA Order") made on 13 March 2024, the GMC's regulatory ambit was extended beyond medical doctors to include a new role as regulator of Physician Associates ("PAs") and Anaesthesia Associates ("AAs").

2. The claimant challenges two decisions of the GMC in its new role as regulator of the associate professions: the use of the term "medical professionals" as a collective descriptor to refer to doctors and associates (PAs and AAs); and the decision to produce a single set of guidance on professional standards, Good Medical Practice ("GMP") which applies to both doctors and members of the associate professions.

3. PAs and AAs were introduced into the UK healthcare workforce in 2003 (PAs) and 2004 (AAs). PAs and AAs are not medically qualified and their training pathway is different to that undertaken by a doctor. Associates are able to practise clinically following completion of an undergraduate degree, typically but not necessarily in the biosciences, and following two years of clinically based experiential training. Associates work only under supervision and as part of a multi-disciplinary team.

4. There is no nationally agreed scope of practice for either PAs or AAs. The picture which emerges from various statements issued by the Department of Health and Social Care ("DHSC") is, however, of a growing workforce of associates in hospitals, including in critical care, and primary care undertaking a wide range of medical tasks under differing levels of supervision depending upon the task being performed.

5. In October 2017, the DHSC described the medical associate role as: "*part of the wider healthcare workforce… trained to the medical model to augment service delivery alongside doctors. They are competent to practise in a range of specialities and can offer continuity of care, particularly in acute settings and GP practices. As such they are dependent practitioners working within their sphere of competence releasing doctors to focus on more complex patient pathways and care whilst bolstering the healthcare team*."

6. In 2021, the DHSC issued a consultation document, "Regulating Healthcare Professionals, Protecting the Public", in which it said that a PA will "*work in both hospitals and general practice and carry out a number of tasks including taking medical histories, examinations and managing and diagnosing illnesses under the supervision of a medical practitioner*" and that an AA will "*work in hospitals as deliverers of anaesthesia and critical care in the anaesthetic team, performing pre and post operative assessment and intervention and providing anaesthesia under the supervision of a consultant anaesthetist".*

7. In a November 2023 factsheet about the role of associates, the DHSC Media Team set out under the heading "*What sort of tasks do they carry out*?" that the role and clinical duties were "very different" to those of a doctor. The factsheet said that PAs and AAs deliver "*specific aspects of patient care*" increasing the capacity of clinical teams and reducing the workload of other clinicians including doctors. It continued: "*PAs are trained to do clinical duties such as taking medical histories, carrying out physical examinations, and developing and delivering treatment and management plans. AAs work within the anaesthetic team under the supervision of a consultant anaesthetist with responsibilities such as reviewing patients before surgery, initiating and managing medications, administering fluid and blood therapy during surgery and ensuring that there is a plan for patients following their operation.*" The factsheet explained that PAs and AAs were unable to prescribe medication because they are not subject to statutory regulation but that the DHSC was working with other organisations and professional bodies to develop a case for extending prescribing responsibilities to these roles.

8. There were (and, so far as I am aware, remain) important differences between associates and doctors, in particular in matters of prescribing and autonomous working, but nonetheless there exists a substantial overlap between the work undertaken by associates and doctors, consistent with the stated function of associates - which is to free up medically qualified personnel to undertake more complex duties.

9. Underlying this claim for judicial review is the claimant's concern that the role of the associate professions in the health service is vague, leaving patients confused about their function and status. The claimant suggests that there is a growing body of evidence that the distinction between medical practitioners and associate healthcare professionals is blurred and that patients do not know that they are receiving treatment from a non-medically qualified person, on occasion with serious consequences. It is the claimant's case that patient safety requires that the distinction between medically qualified doctors and non-medically qualified associates is made clear by the GMC. It submits that the use of the term "medical professionals" to cover both professions and the use of a single set of standards guidance to apply to both doctors and associates conflates the professional roles rather than demonstrates the distinction. The defendant's decisions pose a significant risk to public safety and are likely to impair, rather than foster, public understanding of, and confidence in, the medical profession and associate professions. The concerns raised are particularly acute when considered in combination with the lack of any nationally agreed scope of practice for either PAs or AAs.

10. This claim was issued on 5 July 2024. There are three grounds of challenge:

    i) Ground one focuses upon the use of the term "medical professionals" in GMP to describe doctors, PAs and AAs. It is argued that the legislative framework creates a clear and firm distinction between "the medical profession" whose members are medically qualified doctors and anaesthesia associates or physician associates. These terms are statutory terms which bear distinct meanings drawn from their context. The use of the term "medical professionals" as an umbrella term is inconsistent with, and in conflict with, the statutory framework to which the GMC is subject and pursuant to which it exercises its functions.

ii) Ground two concerns the promulgation of a common set of professional standards and the use of the umbrella term "medical professionals" in GMP is contrary to the statutory objectives of regulation, which is public protection.
iii) Ground three is that the GMC acted irrationally in deciding to issue a common set of professional standards and in using the umbrella term "medical professionals".

11. The claimant seeks declarations to the effect that (i) the application of GMP to associates is unlawful and (ii) the use of the term "medical professionals" by the GMC, insofar as it is applied to associates as well as doctors, is unlawful. The claimant recognises that it may need an order permitting an extension of time for issuing this claim and, if so, it seeks that order. On 21 November 2024 Lang J directed that the application for permission to apply for judicial review be adjourned to be listed in court as part of a "rolled up hearing." Before me, the claimant was represented by Jenni Richards KC and Adam Boukraa and the defendant by Ivan Hare KC and Peter Mant. I am very grateful to them for their helpful submissions.

The Legal Framework

12. The Medical Act 1983 ("the 1983 Act") is concerned with the registration, training and fitness to practise of medical practitioners. It acknowledges the status of the GMC, setting out its objectives in section 1:

> *"(1) There shall continue to be a body corporate known as the General Medical Council (in this Act referred to as "the General Council") having the functions assigned to them by this Act.*
>
> *1(A) The over-arching objective of the General Council in exercising their functions is the protection of the public.*
>
> *1(B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—*
>
> *(a) to protect, promote and maintain the health, safety and well-being of the public,*
>
> *(b) to promote and maintain public confidence in the medical profession, and*
>
> *(c) to promote and maintain proper professional standards of conduct for members of that profession*."

13. In addition, paragraph 9(A) of Schedule 1 to the 1983 Act specifies that the GMC must have regard to "*the interests of persons using or needing the services of provisionally or fully registered medical practitioners in the United Kingdom*".

14. Section 2 of the 1983 Act requires the GMC to keep a register of medical practitioners:

> *"(1) There shall continue to be kept by the registrar of the General Council (in this Act referred to as "the Registrar") a register of medical practitioners registered under this Act containing*

> *the names of those registered and the qualifications they are entitled to have registered under this Act.*
>
> *(2)…*
>
> *(3) Medical practitioners shall be registered as fully registered medical practitioners or provisionally as provided in Parts II and III of this Act and in the appropriate list of the register of medical practitioners as provided in Part IV of this Act."*

15. "Medical practitioner" is defined in paragraph 10 of schedule 3 to the Health Act 1999 as "*a registered medical practitioner as defined by Schedule 1 to the Interpretation Act 1978*". Schedule 1 to the Interpretation Act 1978 in turn uses the definition of a "*fully registered person within the meaning of the Medical Act 1983 who holds a licence to practise under that Act*". Section 5 of the Interpretation Act provides that in any Act the words and expressions listed in Schedule 1 "*are to be construed according to that Schedule*" unless the contrary intention appears.

16. Part V of the 1983 Act is concerned with fitness to practise and medical ethics and sets out the framework for the investigation and determination of allegations that the fitness to practise of a fully registered or provisionally registered person is impaired.

17. Section 35 of the 1983 Act which falls within Part V sets out the GMC's power to issue guidance on professional standards:

> "*The powers of the General Medical Council shall include a power to provide, in such a manner as the Council think fit, advice for members of the medical profession on –*
>
> *a) standards of professional conduct;*
>
> *b) standards of professional performance; or*
>
> c) *medical ethics*."

18. Part VI of the 1983 Act concerns the "*privileges of registered practitioners*" and section 47 provides for the holding of appointments "*as physician surgeon or other medical officer*" only by a person who is fully registered and holds a licence to practise.

19. Section 49(1) of the 1983 Act makes it a criminal offence if any person wilfully and falsely pretends to be registered under the 1983 Act, including using a protected title or otherwise seeks to describe themselves in a way which implies that they are registered under the 1983 Act.

> "*any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary, shall be liable on summary conviction to a fine not exceeding level 5 on the standard scale*".

20. Section 49(A) penalises those who pretend to hold a licence to practise:

> "*If a person who does not hold a licence to practise (a) holds himself out as having such a licence; or (b) engages in conduct calculated to suggest that he has such a licence, he shall be liable on summary conviction to a fine not exceeding level 5 on the standard scale*."

21. Section 60 of the Health Act 1999 Act provides for a power to make orders in council for the purpose of regulating "*health professions*" and social workers. Section 60(1)(a) gives a power in respect of professions already regulated by the primary and secondary legislation under section 60(2) – which includes the medical profession as regulated by the 1983 Act – whereas section 60(1)(b) gives a power in respect of other professions which are not already regulated, concerned wholly or partly with physical or mental health, and which are deemed to require regulation.

22. A non-exhaustive list of the matters that may be provided for in an order made under section 60 are set out in para.1 of Schedule 3 to the 1999 Act. Paragraph 11 of Schedule 3 clarifies that the powers conferred by section 60 of the 1999 Act enable professions that are not already regulated to be regulated, including "*the regulation of activities carried on by persons who are not members of the profession but which are carried on in connection with the practice of the profession."*

23. On 13 March 2024, the Anaesthesia Associates and Physician Associates Order 2024 was made pursuant to section 60(1)(b) of the 1999 Act. It introduced regulation of professions not already regulated under the 1983 Act or any other legislation. The relevant provisions came into force on 13 December 2024. Prior to the AAPA Order coming into force, there was no statutory regulation of Associates.

24. Article 3 of the AAPA Order places a mandatory obligation on the GMC to determine standards "applicable to associates."

> *"(1) The Regulator must determine standards applicable to associates.*
>
> *(2) The standards must relate to –*
>
> *a) education and training*
>
> *b) knowledge and skills*
>
> *c) experience and performance*
>
> *d) conduct and ethics*
>
> *e) proficiency in the English language and*
>
> *f) such other matters as the Regulator may prescribe in rules made under paragraph 2(2)(a) of Schedule 4*

(3) Before determining a standard, the Regulator must consult such persons as the Regulator considers appropriate.

(4) The Regulator

a) must keep the standards under review; and

b) *may vary or revoke a standard*."

25. A Registrar appointed by the GMC must maintain a single register of associates who meet the requisite standards set by the GMC and comply with other requirements concerning the provision of information or other requirements made under the AAPA Order or set by the Registrar. The Associate Register must be divided into two parts, one for AAs and the other for PAs.

26. The GMC as regulator of Associates must have regard, in addition to the objectives and duties contained within the 1983 Act, to specific objectives and matters pertaining to Associates as set out in paragraph 3 of Schedule 1 to the AAPA Order:

(1) The Regulator, in addition to its objectives and duties set out in section 1(1A) and (1B)(a) of, and paragraph 9A(1)(b) of Schedule 1 to, the Medical Act 1983—

a) has the objective of promoting and maintaining—

i. public confidence in, and

ii. proper professional standards and conduct for members of, the anaesthesia associate and physician associate professions…

b) must have regard in exercising its functions under this Order, to

i. the interests of persons using or needing the services of associates in the United Kingdom

ii. any differing interests of different categories of anaesthesia associates and physician associates, and

iii ….

c) must discharge its functions under this Order in a way which is transparent, accountable, proportionate and consistent, and

d) …"

27. The Explanatory Memorandum to the AAPA Order sets out at para. 7.55 that:

> "*The objectives of the GMC and its duty to co-operate will be split across the Order and the Medical Act 1983. For completeness and to assist the reader, these are summarised below*:
>
> *Objectives*
>
> *7.56 The over-arching objective of the General Council in exercising their functions is the protection of the public.*
>
> *7.57 The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives:*
>
> - *To protect, promote and maintain the health, safety and well-being of the public*
> - *To promote and maintain public confidence in the medical profession and the anaesthesia associate and physician associate profession, and*
> - *To promote and maintain proper professional standards and conduct for members of the medical profession and the anaesthesia associate and physician associate professions*."

Background

28. I have read a number of witness statements from Mr Daniel McAlonan, Head of Professional Policy and Activities at the BMA and Mr Mark Swindells, Assistant Director of the Standards and Ethics team at the GMC. The statements are detailed and exhibit a large number of documents including minutes of various meetings, email traffic and other correspondence as well as the more relevant consultation documents. I received a supplementary bundle of material from Ms Richards in her reply and have received further material and a written submission from her since the hearing concluded. What follows therefore is a summary of the background and relevant facts leading up to the publication of the (amended) GMP on 16 December 2024 drawn from the material available.

The Decision to Regulate

29. In October 2017 the DHSC issued a consultation document on the regulation of "medical associate professions" in the UK. The term "medical associate professions" referred to four roles: physician associate; anaesthesia associate; surgical care practitioner and advanced critical care practitioner (which were grouped together because of similarities in career framework, education and training). The consultation document recognised the increased use of these new professional roles within multi-disciplinary teams and the need to explore the options for statutory professional regulation and the appropriate healthcare regulator.

30. In February 2019, the DHSC published its consultation response concluding that there was a compelling case for regulation of PAs who were "*often alone with vulnerable patients making autonomous decisions without the direct supervision of a doctor. These circumstances, particularly when coupled with a direct entry route to training and a*

planned increase in numbers in the primary care workforce in England, create a compelling case for regulation for this group." For AAs, the high-risk interventions which they perform and direct entry route into the profession made statutory regulation proportionate. The DHSC concluded that further work was needed to inform its decision on whether the GMC or the HCPC should regulate the professions determining which would be the "best fit" for the two professions.

31. On 18 July 2019 the Minister of State for Health announced that the government had asked the GMC to regulate associates across the UK on the grounds that the GMC was "*best placed*" to regulate and "*regulation will enable these groups to work to their full potential and provide the very best care to patients as part of a multi-disciplinary team*." Although the announcement was framed as a request of the GMC to regulate, from the material available to me it seems clear that there was never any serious doubt that the GMC was to be the regulator, notwithstanding the claimant's repeated submissions to the DHSC that the Health and Care Professions Council would be the more appropriate regulator.

The GMC's Approach to Regulation of PAs and AAs

32. Mr Swindells' statement covers the following main stages of research and consultation leading to the publication of GMP (as it applies to PAs and AAs) in December 2024:
    i) the research and consultation process which led to the production of interim standards guidance for associates on 21 October 2021. The interim standards were never implemented (as, by the date of the AAPA Order in March 2024, the general review of GMP had already been concluded) but the research undertaken for that purpose fed into the final decision to publish a single standards document;
    ii) the research, pre-consultation process and public consultation which led to the approval for publication by the GMC Council of the final draft version of GMP on 27 April 2023, its subsequent publication on 22 August and its coming into effect on 30 January 2024; and
    iii) following the AAPA Order on 13 March 2024, the further consultation process in March 2024, the amendments which were approved by the GMC Council in November 2024 and the publication of the final version of GMP applying to both doctors and associates on 16 December 2024.

The Development of Interim Standards

33. Following the announcement that the GMC was to be regulator, the GMC commenced a programme of research and review. It set up focus groups. It established a so-called "community of interest" which was an online function offering regular updates to people wishing to receive information about its preparations for the regulation of associates. It commissioned research into the approach of other multi-profession regulators to professional standards; into patient and public views on professional standards and into understanding how external users perceived and accessed GMC professional standards.

34. The GMC set up an External Advisory Group ("EAG") with the function of "*advising the GMC on the design of the regulatory framework for the Physician and Anaesthesia Associates and advising on prioritisation, opportunities, risks and potential sensitivities within the overall development plan*." The Group recognised "*the need to manage sensitivities with doctors which might otherwise exacerbate existing concerns about roles or cause confusion for patients*". It comprised of external stakeholders including

the DHSC and the BMA. Mr McAlonan was present at all but one of the 18 occasions upon which the Group met between November 2019 and October 2024.

35. In April 2020 the GMC issued a survey on professional standards to the "community of interest" and a report on the results was sent to the EAG. The report documented that the majority of those who had responded supported the proposal that the associate professions should uphold the same broad high level professional standards as doctors (90.6%). The report set out an analysis of the comments provided by those who were unsure or who had disagreed with the proposal (of shared professional standards) and took forward those minority views to the next round of engagement with focus groups.

36. The research into the approach to standards undertaken by other regulators was published on 29 January 2021. Four of the ten regulators were multi-profession regulators and each published core professional standards applicable to all of the professions that they regulated and had done so for a number of years. The report on the research stated that "*the inclusion of an overarching publication for all the regulated professions enables a framework where commonalities between professions and their conduct can be shared, particularly with respect to values and principles, and can outline a way in which these professions can work together*."

37. The research, survey responses and focus group work fed into the production of a set of interim standards for the associate professions published on 21 October 2021. In conjunction with the interim standards, the GMC published a range of supporting materials, including case studies and advice for supervisors. A report to the EAG set out that the interim guidance would be badged as relevant only to associates "*with the intention of merging with guidance for doctors following the wider review of GMP due to complete in 2023*". Mr Swindells states that no one on the EAG expressed an alternative or contrary opinion and that, even at the stage of the production of interim standards, the evidence available weighed strongly in favour of shared professional standards.

Consultation and engagement leading to the publication of GMP in August 2023

38. The review of GMP commenced in early 2021. In addition to the ongoing role of the EAG, the GMC set up an Advisory Forum. The function of this group was to act as "critical friend and sounding board" for key decisions in the development of new core standards. It comprised of 12 experts independent of the GMC and was chaired by a professor of healthcare law. The BMA were not formally represented on this body but members included the co-chair of the BMA Welsh Junior Doctors Committee (albeit acting in a personal capacity). The Advisory Forum held seven meetings between September 2021 and January 2023. In its initial meeting it was minuted that stakeholders had expressed strong support for high-level overarching principles to apply to all professional groups regulated together with a "*flexible approach to recognise multidisciplinary team working and differences between roles*". No objections to shared standards by members of the Forum were recorded in the minutes.

39. In July 2021, the GMC sent a pre-consultation survey to key stakeholders and the GMC reported on the results of that survey in August 2021. One of the specific questions posed concerned the proposition that the same core professional standards should apply to all groups. The claimant did not respond to the question but a large majority of those who did either agreed or strongly agreed with the proposition.

40. On 24 February 2022 the GMC Council was presented with a paper which highlighted that the pre-consultation activity had demonstrated a high level of support for shared standards. The draft guidance was approved for public consultation and the GMC went on to run a full public consultation on the new core standards from 27 April 2022 to 20 July 2022. The draft version of the guidance as well as the commentary on the revised version adopted the phrase "medical professionals" as an umbrella term referring to doctors, AAs and PAs.

41. In the main stakeholder consultation survey, under the heading of "style and application" the GMC explained:

> "*In our scoping and engagement activity, there is strong support for keeping the current style and level of detail in GMP. There was also support for the proposal that the core professional guidance should apply to each of the professional groups we regulate. We propose to continue to:*
>
> - *Directly address people registered with us*
> - *Have one set of core professional guidance for all medical professionals registered with us: in future this will include physician associates and anaesthesia associates*
> - *Keep the guidance concise and express the guidance as high-level; principles and duties. More information on key topics will be given in the explanatory guidance and other supportive material.*
>
> *We've adopted the term medical professionals to describe all the professional groups we regulate. This is the term which will be used in the legislation to bring PAs and AAs into regulation*".

42. Analysis of the consultation responses took place in August and September 2022. Of the 53 respondents who commented on whether GMP should apply to all registrants, 35 responded positively. 73 respondents commented on the use of the term "medical professionals" of which 35 were opposed to its use. The BMA did not address either of the two matters in its response to the consultation which included answers to the survey, a separate letter and a table of detailed and specific commentary on the text of the draft guidance.

43. In August/September 2022 the GMC produced an internal report on the outcome of the GMP consultation and between November 2022 and April 2023, GMP was redrafted. In March 2023, the GMC carried out "audience testing" on the near final draft of GMP with focus groups of PAs, AAs doctors and patients. The participants were asked to identify any language or terminology that they found confusing. None reported that the term "medical professionals" was confusing.

44. A final draft of the guidance was approved for publication on 27 April 2023. On 15 August 2023, the GMC Chief Executive wrote to a number of members of the BMA enclosing an embargoed copy of the Guidance. It informed them that the guidance would also apply to physician associates and anaesthesia associates when they were to

be regulated in the future. GMP was published on 22 August 2023, coming into effect on 30 January 2024.

GMC Consultation 26 March 2024:

45. Following the publication of the AAPA Order on 13 March 2024, the GMC launched a further consultation on proposed rules, standards and guidance for the regulation of associates in March 2024. The consultation stated that it was not covering whether associates should be brought into statutory regulation; whether they should be regulated by the GMC; the content of the AAPA Order or the scope of an AA and PA's practice. On the last point, the GMC noted that "*it was not the role of the regulator to determine what tasks individual professionals can safely carry out once they are registered with us… We won't determine scope of practice for AAs and PAs beyond initial qualification competencies, just as we don't determine it for doctors. We know that NHS England, employer bodies and royal colleges have begun looking at how AA and PA scope of practice may develop over time… when AAs and Pas come into regulation, they'll be expected to meet our standards of patient care and professional behaviour which already apply to doctors: Good Medical Practice.*"

46. The consultation document summarised the benefits of regulation of the associate professions. It acknowledged that "*as the number of AAs and PAs working in the healthcare system grow, there are wider questions being asked about their role and their place in the healthcare team. Many of these questions are not fundamentally about regulation and they are for others to address, though we continue to work with the relevant organisations to inform discussions where they intersect with our regulatory role.*"

47. In the covering letter to the claimant's response to the consultation, dated 20 May 2024, the claimant expressed general opposition to the use of the term medical professionals and the issuing of guidance common to both doctors and associates. It highlighted the public confusion surrounding the titles of PAs and AAs and went on to say "*given the inappropriate blurring of roles noted above, the standards and requirements should not only describe the knowledge, skills and capabilities expected of a PA or AA graduate but set out that these capabilities cannot be seen as equating to the unique skills and capabilities of doctors. …It therefore follows that Good Medical Practice should pertain only to doctors, with standalone guidance produced to define good associate practice. The continued use of 'medical professionals' to refer to all three distinct professions only adds to existing confusion and risks blurring the lines between clinicians with very different qualifications and training…."*

48. The claimant sent a pre-action protocol letter on 21 June 2024 and lodged this claim for judicial review on 3 July 2024.

49. At its meeting on 7 November 2024, the GMC Council approved additional changes to GMP 2024 to make it clear to PAs and AAs that, from 13 December 2024, GMP 2024 applied to them alongside doctors. The amendments included using the titles, "doctor", "PA", and "AA" in certain places where, previously, the term medical professionals had been used. Where it was retained, Mr Swindells says that this was to "optimise readability and flow". Further amendments or additions were made to address concerns raised in response to the recent consultation: for example at paragraph 82 (Domain 4: "Trust and Professionalism") the requirement that the person should introduce themselves to patients and explain their role in their care was included. At paragraph 2

(Domain 1: "Knowledge Skills and Development") the requirement that the person must only practise under the level of supervision appropriate to their role, knowledge, skills and training and the task they were carrying out was added.

50. In his witness statement, Mr Swindells summarises the reasons for the GMC's decision to issue guidance common to both doctors and associates. The central reason was the view, endorsed by extensive stakeholder engagement and the consultation processes undertaken by the GMC between 2021 and 2024, that given the nature of their role, associates should be held to the same high professional standards as medically qualified personnel. He refers to the absence of concerns to the proposal raised by members of the EAG and members of the Advisory Forum. The EAG included Mr McAlonan and although the claimant was not formally represented on the Advisory Forum, the group included a member of the BMA. He notes that the BMA did not respond to the salient points in either the pre-consultation in 2021 or the public consultation in 2022. The claimant only objected to the proposal for shared standards in May 2024 notwithstanding extensive engagement with the defendant and it having been told explicitly in August 2023 that the defendant intended to publish unitary guidance.

51. The defendant also refers to the inconsistent and patchy response by the BMA to its use of the term medical professionals. The defendant had used the term to include reference to AAs and PAs in its Corporate Strategy 2021-2025 published in November 2020. The term appeared several times in the document and the intention to use the term in due course to include PAs and AAs was explicitly stated. The draft document had been sent to the claimant and to other organisations in advance of its publication on 3 November 2020. Mr Swindells states that the responders were either supportive of the use of the term or did not raise strong objections. Mr McAlonan himself was reported to have said at that time that "the majority of members would not mind" its use.

52. Later communications from the BMA raised concerns over the use of the term. In December 2020 at a meeting with the GMC, Mr McAlonan said that the term had "*received negative feedback internally*" and on 21 December he sent an email to the GMC on behalf of the BMA's Professional Regulation Committee asking the GMC to reconsider its use of the term. Paul Reynolds, Director of Strategic Communications and Engagement, responded on 19 January 2021 stating that there had been wide consultation on the strategy generally and that careful consideration had been given to the responses in deciding on the final language. He continued: "*In the end, we felt the term "medical professionals" was the best option; suitably simple to help with clarity, while being broad enough to cover the three professions we'll be regulating in the near future*". He agreed that PAs and AAs have "*very different roles and responsibilities*" that should not be confused but he continued "*we don't believe the umbrella term will do that. We'll only use it when appropriate to the circumstances. The majority of our communications will be tailored to refer to each profession individually*." He stated that the GMC would be highlighting the importance of good communication as a shared professional responsibility.

53. Dr Clare Gerada, Chair of the BMA's Professional Regulation Committee wrote to the Chief Executive of the GMC on 18 February 2021 raising concerns about the use of the term. The Chief Executive responded in similar vein to Mr Reynolds. On 12 March 2021, the BMA Strategic relationships Officer wrote that there would be no follow up to the Chief Executive's response. Mr Swindells states that, thereafter, there were no further objections to the use of the term until 2024.

54. In March 2024 the organisation, Anaesthetists United, wrote to Mr Massey the Chief Executive of the defendant expressing concerns over the use of the term medical professionals. In the course of his reply of 4 April 2024, Mr Massey explained that he agreed that patients must be clear about who is treating them and that every healthcare professional had a duty to clearly explain their role. PAs and AAs, he said, "*do not have the same knowledge, skills and expertise as doctors. They are not doctors, and they can't replace them….I think professional regulation will be helpful in this context….*"

55. Mr Massey addressed the decision to use the term 'medical professionals', explaining that its use was in preference to having to separately list out each individual role. The only alternative that was considered was "registrants" but that was considered to be "cold and impersonal." He said that the term 'medical professionals' would be used "sparingly" and "when appropriate to the circumstances." He said that the terms "in practice", "practise" and "practising" are used in relation to all healthcare professionals as well as many other professional groupings outside of healthcare. The terms were not therefore exclusive to doctors and their regulation.

56. Mr Massey addressed the decision to issue a single set of core standards, explaining the process of consultation and review which had been undertaken and the absence of "significant objection…until recently." He rejected the suggestion that shared standards of conduct implied conflation of the professions. He said that "*shared standards do, however, imply equivalence in terms of standards of care and professional behaviour and we think that this equivalence is in the interests of both patients and professionals*". He said that shared standards instil confidence in colleagues and patients that all registrants are working to the same expectations and that, when concerns are raised about the conduct of doctors, PAs and AAs, those concerns will be considered against the same set of expectations.

57. In his further statements, Mr McAlonan responded to the suggestion that the claimant's engagement with the defendant on relevant issues had been patchy and late. He makes the point that the BMA is a doctors' organisation and it focuses on what is relevant to doctors rather than associates. This explains its limited response and engagement at certain times. He also refers to the wider context of government proposals for a wholesale review of medical regulation generally which was the subject of the DHSC consultation document in 2021 "Regulating Healthcare Professionals, Protecting the Public." The consultation recognised that the current model of regulation for healthcare professionals was too complex and rigid and proposed a new approach via an amendment to the 1983 Act and an order under the Health Act 1999. Many of the proposed reforms for changes in professional regulation were to apply to PAs and AAs. The claimant makes the point that it was only in February 2023 that the government announced that wider reforms were not to be introduced and that the proposal for the regulation of associates was to be uncoupled from wider regulatory changes.

Patient Safety Concerns

58. Ms Richards submits that the claimant's challenge must be seen against a background of patient uncertainty concerning the role of the associate and significant associated patient safety concerns. On 16 November 2023 the claimant issued a press release calling for an immediate halt on the recruitment of all members of the medical associate professions in the UK. The pause was to last "*until the government and NHS had put guarantees in place to make sure that MAPs were properly regulated and supervised*". The press release continued: "*The move follows a number of recent cases in which*

patients have not always known they were being treated by a physician associate and tragically have come to harm… MAP roles and responsibilities are not clearly defined. We are seeing increased instances of MAPs encroaching on the role of doctors."

59. Ms Richards has drawn my attention to various occasions upon which patients have been confused about the role of associates. I was referred to three Regulation 28, Prevention of Future Death reports.

60. Following the death of Susan Pollitt the report recorded the Coroner's findings that the actions of a PA had contributed to the death of the patient from infection; that there was no national framework of training and supervision of PAs and that there seemed to be a limited understanding and awareness of the role of a PA amongst medical colleagues, patients and families. The report referred to the use of the word "physician" as having given rise to confusion. The GMC responded in September 2024 advising on the imminent regulation of PAs by the GMC. As to the "limited understanding and awareness of the PA role" it responded that "*it is vital that patients must always be clear about who is treating them and their role within the team… regulation will be helpful in this context. Our professional standards say that PAs will have a responsibility to clearly communicate who they are and their role in the team just as doctors must do now"*. Emily Chesterton died from a pulmonary embolism after a misdiagnosis by a PA. According to her daughter she had not known that she was not seeing a GP until the inquest. On 4 March 2024, I received a further note from Ms Richards and another Regulation 28 Report, this one concerning the death of Pamela Marking. HM Assistant Coroner for Surrey noted the treatment of Mrs Marking by a PA contributed to her death. Ms Richards makes the point that this death occurred on 20 February 2024 and so postdated the publication of GMP in August 2023 and the coming into effect of GMP in January 2024.

61. Mr McAlonan's statement refers to a wider body of evidence of patient confusion. He refers to a study in 2019 by Taylor and others identifying that the role of PAs was still not widely known or understood and he states that those findings are equally applicable today. There is evidence that it is not only patients who are confused. There have been instances in which NHS and GMC employees appear to have been muddled. Nor is the BMA the only body expressing these concerns. Other national institutions have expressed significant concerns about "how the landscape in relation to PAs and AAs is taking shape." Mr McAlonan's statement sets out those concerns which cover: the absence of a nationally agreed scope of practice; education and training of associates; supervision of associates and confusion about the differences between associates and doctors. In November 2024 the DHSC announced the setting up an independent review of the physician associate and anaesthesia associate professions by Professor Leng. Its terms of reference state its purpose to be an "end to end" review covering selection and recruitment, training, scope of practice, oversight, supervision and professional regulation. The claimant submits that the fact that an independent review has been set up demonstrates the level of interest in, and concern raised by, the current role of associates as members of the healthcare workforce.

Good Medical Practice

62. GMP was amended shortly after the AAPA order came into force. The amendments were approved by the GMC Council on 7 November 2024 and the document was published on 16 December 2024. It forms part of a suite of documents available on the GMC website which previously included the document: "*More Information on PAs and AAs*" published on 24 October 2023. The document set out that: "*PAs and AAs are*

distinct professions. They are not doctors; and professional guidance expects them to always make that clear to patients and colleagues". It made the following further points:

i) PAs and AAs should never be referred to as "medical practitioners" because that term is used specifically in legislation to mean doctors.
ii) On qualifying from initial training, PAs and AAs have a defined set of knowledge and skills and are expected to work under doctor supervision.
iii) As with all members of the medical team, the level and proximity of supervision that PAs and AAs require will vary depending on their context and experience.
iv) As regulated professionals, PAs and AAs will have a responsibility to clearly communicate who they are, and their role in the team, just as doctors must do now. In Good Medical Practice 2024, we say "You must always be honest about your experience, qualifications and current role".
v) The GMC has no remit over job titles. The terms "physician associate" and "anaesthesia associate" came into use in the UK some years ago and the DHSC intend to legislate on that basis to make these protected titles. When writing about or addressing PAs AAs and doctors the GMC uses the three distinct names of each profession, except on rare occasions when it makes sense to use a single umbrella term. For example for ease of reading we use the term "medical professionals" in the updated GMP because the professional standards will apply to all three groups once regulation begins.

63. GMP includes an introduction "About Good Medical Practice" which over five main headings sets out what the document contains, how to use it and introduces the topic of professional standards and how they may relate to the fitness to practise process. The document then sets out the standards relevant to four "domains"

i) Knowledge, skills and development
ii) Patients, partnership and communication
iii) Colleagues, culture and safety
iv) Trust and professionalism.

64. Under the heading "What is Good Medical Practice?" the introduction says:

> "*Good medical practice sets out the principles, values and standards of professional behaviour expected of all doctors, physician associates and anaesthesia associates registered with us. We use the term "medical professionals" to describe all our registrants who we address directly (as "you") throughout this guidance….*
>
> *Good Medical Practice and the more detailed guidance apply to all medical professionals to the extent that they're relevant to an individual's practice.*
>
> *Good Medical Practice is an ethical framework which supports medical professionals to deliver safe care to a good standard, in the interests of patients. It doesn't set standards of knowledge, skills or professional capabilities these can be found in our educational standards*".

65. Under the heading: "How to use Good Medical Practice" the document sets out that:

> "*It's your responsibility to be familiar with Good medical practice and the professional standards it contains wherever you practice, whatever your field of medicine or practice setting…*
>
> *You must use your professional judgement to apply the standards in Good Medical Practice to your day to day practice. This means working out which of the professional standards are relevant to the specific circumstances you are facing and using your knowledge, skills and experience to follow them in that context*."

66. Domain 1: Knowledge, skills and development. The introduction to the section refers to medical practice being "a lifelong journey". Under the sub-heading "Being competent" the guidance requires that "*you must recognise and work within the limits of your competence. You must only practise under the level of supervision appropriate to your role, knowledge, skills and training and the task you're carrying out*." Under the sub-heading "Providing good clinical care", the guidance requires that "*you must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must work in partnership with them to assess their needs and priorities*." The section continues: "*The investigation or treatment you propose, provide or arrange must be based on this assessment and on your clinical judgement about the likely effectiveness of the treatment options*." Later under the same sub-heading, the section sets out what a professional must do in providing good clinical care (for example, "*adequately assess a patient's condition*" and "*carry out a physical examination where necessary*."

67. Domain 4: Trust and Professionalism. This section sets out that "good medical professionals uphold high personal and professional standards of conduct" and under the sub-heading "Acting with honesty and integrity" the guidance requires that "*you must make sure that your conduct justifies patients' trust in you and the public's trust in your profession*." Under the same sub-heading the guidance sets out "*You must always be honest about your experience, qualifications, and current role. You should introduce yourself to patients and explain your role in their care*."

Grounds of Review

68. Ground one focuses on the terminology issue. The claimant's case is that the legislative framework of the 1983 Act and the AAPA Order creates a clear distinction between the medical profession and associates. The use of the term medical professional to cover both disciplines is therefore inconsistent with and in conflict with the statutory framework.

69. On the defendant's case, a document such as the GMP could be unlawful only on one of the bases identified in *R(A) v Secretary of State for the Home Department* [2021] UKSC 37, where at para. 45 the court set out that a policy may be found to be unlawful by reason of what it says or omits to say about the law when giving guidance for others:
    i) where the policy includes a positive statement of law which is wrong and which will induce a person who follows the policy to breach their legal duty in some way;
    ii) where the authority which promulgates the policy does so pursuant to a duty to provide accurate advice about the law but fails to do so, either because of a misstatement of law or because of an omission to explain the legal position; or

iii) where the authority, even though not under a duty to issue a policy decides to promulgate one and in doing so purports in the policy to provide a full account of the legal position but fails to achieve that, either because of a specific misstatement of the law or because of an omission which has the effect that read as a whole, the policy presents a misleading picture of the true legal position.

70. Ms Richards did not accept that GMP was a policy document of the kind under consideration in *A*, so that the three ways identified in para. 45 of the judgment in that case were not the only ones in which the policy could be stigmatised as unlawful. If that was wrong, however, she submitted that the use of the impugned phrase meant that the policy fell within categories (i) and (iii) identified in para. 45 of *A*.

71. In my judgment, however, the essence of ground one is the complaint that, by its use of terminology, the standards guidance will mislead members of the public as to the true legal position. The Supreme Court's decision in *A* now provides an exhaustive rubric for the assessment of such a complaint. Ms Richards was unable to identify any other legal test, distinct from grounds two and three, by which the standards guidance could be measured. I therefore approach ground one on the basis that I have to decide whether the inclusion of the term "medical professional" brings the standards guidance within category (i) or category (iii) in para. 45 of *A*.

72. Ground two focuses both on the terminology issue and the decision by the GMC to issue standards guidance common to both sets of professionals. The claimant argues that there is a specific statutory duty which binds the GMC in the exercise of its functions: the 1983 Act contains the mandatory overarching objective of all functions assigned to the GMC namely "the protection of the public". The promulgation of common guidance standards and the use of the term medical professionals are, when looked at separately or together, confusing for both associate and patient and therefore unsafe. Although the argument was initially formulated in a way which suggested to the defendant that it was a rationality challenge, Ms Richards appeared to accept in her oral submissions that this ground turned upon whether by reason of either or both of the matters complained of, the defendant had infringed the *Padfield* principle and had exercised its discretion to '*thwart or run counter to the policy and objects*' of the 1983 Act (per Lord Reid in *Padfield v Minister of Agriculture, Fisheries and Food* [1986] UKHL 1 at page 1030).

73. Ground 3 is a rationality challenge. Ms Richards submits that the matters above (together with a small number of further points) also establish that the GMC acted irrationally in deciding to apply GMP to associates and in deciding to refer to doctors and associates alike as medical professionals.

Ground One

74. Ms Richards makes three main points in support of this challenge. First, the legislation makes plain that the terms "medical professional" and "physician associate" or "anaesthetic associate" are statutory terms that bear distinct meanings derived from their statutory context. The "medical profession" referred to in para 1(1B)(b) of the 1983 Act is a reference to the profession regulated under that Act, namely, medical practitioners and the "members of that profession" referred to in para. 1(1B)(c) of the 1983 Act should be interpreted accordingly. By contrast, the AAPA Order 2024 refers to an "associate" defined as either an anaesthesia associate or physician associate. Medical practitioners and associates are distinct professions. The use of the term

medical professionals therefore "confuses and conflates" these distinct professions in a way which is in conflict with the statutory framework. The claimant submits that the use of the term "medical professionals" in GMP informs both patients and associates themselves that they are members of the medical profession, when they are not.

75. Second, Ms Richards submits that the fact that the term "medical professional" is not a protected title does not assist the defendant. Section 49 of the 1983 Act makes it an offence for any person to wilfully and falsely pretend to be, or take or use the name or title of (amongst others), physician or doctor of medicine. It makes it an offence to use "any name, title, addition or description" implying that the person is recognised by law as a physician or surgeon or practitioner in medicine. Ms Richards submits that the GMC's use of the term "medical professional" to describe an associate therefore encourages an associate to use terminology which is unlawful: it tells associates that they are entitled to regard and describe themselves as members of the medical profession and induces them to commit a criminal offence under section 49 of the 1983 Act.

76. Third, if the challenge is to be considered through the lens of *R(A) v SSHD*, the term "medical professional" is unlawful and the standards guidance falls within the first category of case or policy set out in para. 45. The use of the term amounts to a positive statement of law which is wrong. If the term were used by an associate to describe his role it would be likely to lead to that person committing an offence under section 49 of the 1983 Act. Alternatively (or additionally), the term falls into the third category of case on the basis that the policy purports to provide a full account of the legal position but fails to achieve this through a misstatement of the law.

77. Mr Hare submits that the use of the term "medical professional" is not unlawful. It is not a protected title under the 1983 Act and is not defined by the 1983 Act. The only mandatory provisions concerning the use of language are set out in section 49 of the 1983 Act and Article 19(b) of the AAPA Order and these provisions do not prohibit the use of "medical professionals" as a collective term. Section 49 prohibits individual persons from using specified titles implying that they are registered under the 1983 Act but use of the term in GMP cannot be construed as encouragement or endorsement of the use by an individual of a name or title that would imply that they are a registered doctor, just the opposite. The guidance does not fall within either category (i) or category (iii) in *A*. The term is neither a positive statement of law which is wrong, nor will it induce a person who follows the guidance to commit an offence. It cannot sensibly be suggested that GMP purports to provide a full account of the law on the use of titles or on any other matter.

Ground One: Discussion

78. The claimant's case under this ground is that GMP is a policy which is unlawful by virtue of its use in places of the umbrella term "medical professional" which is apt to mislead members of the public. As I have noted above, the legal standard by which such a complaint is assessed is that set out in *A's* case, where the Supreme Court adopted and restated the principles in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. The court in *A* noted at para. 38 that the *Gillick* test was best encapsulated in the formulation: "does the policy in question authorise or approve unlawful conduct by those to whom it is directed?" and that the court would intervene only when the public authority has, by issuing the policy, "positively authorised or approved unlawful conduct by others". In this "limited but important sense" public authorities have a general duty not "to induce violations of the law by others". The

court observed that the *Gillick* test was straightforward to apply, calling for a comparison of what the relevant law requires and what a policy statement says regarding what a person should do (para. 41). If the policy directs them to act in a way which contradicts the law, then it is unlawful.

79. The claimant must establish that the policy falls into one of the three categories in para. 46 of *A*. Those categories are designed to give effect to the principle that a policy will only be struck down as unlawful for what it says or omits to say about the law if it positively authorises or approves conduct which would be unlawful. The test is a narrow one. The court in *A* set its face against broader tests which would hold a policy to be unlawful just because it may "permit" unlawful conduct (see para. 48). The correct test to be applied was the narrow test "without the gloss."

80. The court in *A* explained the reasons why it considered a narrow formulation to be appropriate at para. 39 and para. 40. Guidance and policy documents are issued to promote practical objectives. They come in many forms and may be more or less detailed and directive depending on what a public authority is seeking to achieve by their issue. Often there will be no obligation to issue guidance. If a policy is issued there will be no obligation for it to take the form of a detailed and comprehensive statement of law in a particular area equivalent to a textbook or the judgment of the court. Since there is no such obligation then there is no basis on which a court should strike a policy down if it fails to reach that standard. Nor was it the role of the policy drafter to eliminate all uncertainty regarding its application and all risk of legal errors. The policy has to be read objectively having regard to its intended audience and the drafter is not required to "imagine whether anyone might misread the policy and then to draft it to eliminate that risk."

81. Section 49 of the 1983 Act creates protected titles and prevents a person falsely pretending to be a person with such a title. That is the normative legal requirement (see *A* para. 41). The question for me therefore is whether the policy (GMP) would authorise or approve breach of that legal requirement.

82. I consider first whether GMP falls into category (i) in para. 45 of *A*. In my judgement, the policy does not include a positive statement of law, let alone a positive statement of law which is wrong.

    i) The term "medical professional" is not a term defined in the 1983 Act or any other legislation. That being so, the use of that term is not a statement of law at all. Moreover, because the term is not a title protected by the 1983 Act or other legislation, a physician associate or anaesthesia associate person who used the term "medical professional" would not commit any offence or otherwise act unlawfully. Accordingly, even if the use of the term in GMP induced a physician associate or anaesthesia associate to refer to themselves as a "medical professional" it would not induce them to breach any legal obligation of theirs.

    ii) However GMP does not suggest that doctors, PAs or AAs should introduce themselves as "medical professionals." As GMP explains, where the term is used in the guidance, it is as a collective way of describing the three sets of professionals regulated by the GMC: doctors, PAs and AAs: *"We use the term "medical professionals" to describe all our registrants who we address directly (as "you") throughout this guidance…"*

    iii) Use of the term "medical professionals" in GMP does not imply that associates are regulated doctors. Far from suggesting that PAs and AAs can, or should, misdescribe themselves as regulated physicians, GMP makes clear that all

> medical professionals have a clear ethical duty to be honest about their experience and role. Under Domain 4, which contains guidance on "Trust and Professionalism", the reader is informed: "*you must always be honest about your experience, qualifications and current role. You should introduce yourself to patients and explain your role in their care*". The guidance therefore imposes a duty on the person to explain their current role in the care of the patient when introducing themselves. In the case of an associate, this may include explaining that they are non-medically qualified members of a multidisciplinary team working under supervision.

83. Nor does the policy purport to provide a full account of the legal position regarding the duties of regulated persons as to self-description. However, even if it did, on a fair overall reading of the policy it does not give a misleading account of the law. It uses an umbrella term in places for members of the three different professions, who are all fairly described as medical professionals, while stressing that a member of the PA and AA professions should not misdescribe themselves as a medically qualified person when they are not.

84. For these reasons, I dismiss ground 1.

Ground 2

85. Ground 2 covers both the decision to produce unitary guidance and the use of the term "medical professional" in GMP.

86. Ms Richards submits that the underlying purpose of the 1983 Act is stated at the beginning of the Act where the specific statutory objectives which bind the GMC in the exercise of its functions are set out. Section 1 of the 1983 Act contains the mandatory overarching objective of all the functions assigned to the GMC: "the protection of the public." The pursuit of that objective involves the three specific objectives in section 1 (1B): the protection, promotion and maintenance of the health, safety and well-being of the public; the promotion and maintenance of public confidence in the medical profession; and the promotion and maintenance of proper professional standards and conduct for members of the profession. The GMC is required to have proper regard for the interests of persons using or needing the services of medical practitioners (paragraph 9A, Schedule 1 to the 1983 Act). A similar obligation arises under paragraph 2 of Schedule 1 of the AAPO Order, which stipulates that the GMC has the objective of promoting and maintaining public confidence in, and proper professional standards and conduct for, members of the associate professions.

87. Ms Richards submits that the location of the self-contained purpose at the beginning of the 1983 Act cannot be understated: there is no need to look further into the Act or the statutory scheme. Ms Richards points to various documents in which the GMC has stated that it understands its duty is to protect the public, for example, the GMC Thresholds Guidance for referral to the fitness to practise regime published in April 2024, which sets out at para. 2: "*Our legal duty is to protect the public. Public protection is split into three distinct parts and requires the GMC to act in accordance with the statutory objective.*"

88. Ms Richards submits that GMP has an important status because it is the document which represents the exercise of the section 35 regulatory function under the 1983 Act and the similar function under the AAPA Order. The public should be entitled to look to that particular piece of guidance, which has a particular statutory status, and to ask

"what does it tell me about what associates can do?" bearing in mind all the patient safety matters which form the backdrop to the claim. Ms Richards submits that given the absence of a nationally agreed scope of practice, no reader of GMP would understand the differences between the two roles or the supervision requirement for associates.

89. In support of her submission that GMP is contrary to the statutory objectives, Ms Richards make the following observations:

i) The introduction to the first domain states that "*Medical practice is a lifelong journey.*" It refers to "Good medical professionals" as competent, who keep their knowledge and skills up to date and provide a good standard of practice and care. The claimant submits that any reader of this section would not appreciate that the knowledge and skills of a doctor on the one hand and a PA or AA on the other are fundamentally different.

ii) Paragraph 6 of the first domain states: "You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities." This paragraph sets out what a professional must do in providing clinical care in a way which does not distinguish in any respect between what a doctor may do and what an associate may do.

iii) Paragraph 18, which falls within the second domain, "Patients partnership and communication", explains that "you must recognise a patient's right to choose whether to accept your advice and respect their right to seek a second opinion" and continues at para. 28: "you must give patients the information they want or need in a way they can understand" including information about their condition, likely progression and any uncertainties about diagnosis and prognosis, treatment or management options and potential benefits, risks of harm, uncertainties about and likelihood of success for each option. The claimant submits that framing the duty in this way gives the impression that the provision of full advice in this way is just as much the responsibility of associates as doctors, which is wrong.

iv) Paragraph 41 concerns safeguarding children and adults who are at risk of harm. It directs the reader to follow more detailed guidance on "protecting children and young people and 0-18 years: guidance for all doctors." This section, submits Ms Richards, suggests that all registrants are doctors or medical practitioners or at least blurs the distinction between doctors and associates.

90. The *Padfield* principle requires that statutory discretions be used to further the objectives of the legislation. Ms Richards does not accept that the principle is infringed only by actions which "frustrate or thwart" the underlying policy objective. That, she argues, casts the principle too narrowly. The issuing of single guidance of application to doctors and associates, without distinguishing between them or between their separate and different training and skills, carries the potential for public confusion as to who is and who is not a doctor and associate and on this basis the GMC has, she submits, failed to act in accordance with the statutory objectives in relation to patient safety and confidence. The GMC's approach cannot be reconciled with its overarching objectives or with the obligation to have proper regard to the interests of persons using or needing the services of medical practitioners. It fails to reflect that there are fundamental differences between associates and doctors. It does not even tell the reader that associates should act under supervision.

91. Ms Richards submits that the use of the term "medical professional" is not consistent with public safety and was used by the defendant either for ease of reading or because the GMC initially believed that this was the term which would be used in the reform legislation, which was then abandoned.

92. Mr Hare submits that there are two key aspects to Lord Reid's dictum in *Padfield.* First, the policy and aim of an Act must be determined by reference to the Act as a whole and, second, in undertaking that exercise of construction the court must ask itself whether the decision-maker has used their discretion to thwart or run counter to the policy and objects of the Act. So, having identified the policy or purpose of the Act he submits that the question for me is whether there is "a rational connection" between the challenged requirement and the purpose of the legislation. See *R (Rights of Women) v Lord Chancellor* [2016] EWCA Civ 91 at para. 42 "*Any inquiry as to frustration of purpose must consider whether there is a rational connection between the challenge(d) requirement and the legislation's purpose*."

93. Mr Hare invites me to focus upon the character of the duties. He submits that the duty is a target duty or similar to a target duty. In *R(AA and others) v National Health Service Commissioning Board* [2023] EWHC 43 (Admin), the regulation under scrutiny was regulation 45 of the NHS Commissioning Board Regulations 2012 which imposed a duty on the relevant body to "make arrangements to ensure" a particular outcome. Chamberlain J considered a number of authorities and at paragraphs 87-90 drew together some of the features of target duties: the open textured framing of a duty; the requirement for a person who owes the duty to act "with a view" to achieving a particular result; or the duty is owed to the population as a whole. Whether any of these features are present is a matter for the court construing the statute. Mr Hare however submits that the 1983 Act imposes duties which are open-textured. They are framed as objectives and, whereas a duty concretises as an object which must be achieved, an objective is something which must be pursued. As such it is, or is similar to, a target duty: aimed at the public at large, expressed in the broadest possible terms and conferring a very wide discretion on the defendant as to how best to pursue the animating purpose of the statute.

94. Mr Hare submitted that I should also take into account the broad structure and contents of the AAPA Order and the 1983 Act. There is a correspondence between the regulatory functions of the GMC under each. This is no accident. There must have been a deliberate decision by the legislature to make the same regulatory provision for doctors and associates for the same matters in the same terms. Just as the GMC was determined by the DHSC to be the most appropriate body to undertake the regulation of the associate professions, so one can infer from the structure of the 1983 Act and AAPA Order that the legislature took the view that the best way to protect the public was to subject associates to the same regulator and regulatory structure as doctors. The legislature left to the discretion of the regulator how to pursue the overarching objectives in this context and how it should discharge its duty to determine standards on performance conduct and ethics. The nature of that duty was open-textured and similar to a target duty giving the defendant an extremely wide discretion about how it should pursue its objective of patient safety in the regulatory context.

95. Mr Hare posed the question whether there is a rational connection between the decision to have single guidance and public protection. He submits that the answer to that question is, self-evidently, in the affirmative. If public protection is to be meaningful then associates need to be held to the same high standards as doctors. As to the use of

the term "medical professionals", it is not a hangover from abandoned legislation but was first used in the November 2020 five-year strategy. After consultation it was considered that it was "suitably simple to help with clarity while being broad enough to cover the three professions we'll be regulating in the near future". There is no evidence that the use of the term has prejudiced patient safety.

Discussion: Ground 2:

96. Ms Richards accepts that this ground turns upon whether the promulgation of standards guidance of application to both doctors and associates and/or the use of the term "medical professional" infringes the *Padfield* principle.

97. In *Padfield*, Lord Reid explained that, when Parliament confers a discretion by a statutory provision, it "*must have conferred the discretion with the intention that it should be used to promote the policy and objects of the Act [which] must be determined by construing the Act as a whole…If the Minister.,.. so uses his discretion as to thwart or run counter to the policy and objects of the Act, then our law would be very defective if persons aggrieved were not entitled to the protection of the court*." In *R v Secretary of State for the Environment, Transport and the Regions, Ex. p Spath Holme* [2001] 2 AC 349 the House of Lords said at p. 381 that the principle was that: "…*no statute confers an unfettered discretion on any minister. Such a discretion must be exercised so as to promote and not to defeat or frustrate the object of the legislation in question*…"

98. The uncontroversial starting point for me is therefore to identify the purpose or object of the 1983 Act. In this case it is stated in the legislation itself. There is no need to infer the purpose from other material. The 1983 Act conferred a discretionary power on the GMC to provide advice on standards of professional conduct for medical doctors, PAs and AAs and that power was to be exercised in accordance with the objectives in s.1(1A) and (1B), that is, the protection of the public through the pursuit of the three identified subsidiary objectives. The underlying public safety purpose of the 1983 Act and the function of the GMC in its regulatory role is neither obscure nor poorly understood.

99. Once the purpose has been identified, the court must ask whether the statutory discretion has been exercised to promote, rather than to frustrate, that purpose: see e.g. *R (on the application of Kent County Council) v SSHD* [2023] EWHC 3030 and *Anzhelika Khan v Secretary of State for the Foreign Commonwealth and Development Affairs* 2025 EWCA Civ 41. The *Padfield* principle requires the court to consider whether the objective at which the decision-maker was aiming was aligned with the statutory purpose. This is an important constraint. It means that decision-makers cannot act for purposes collateral to those for which the discretion was given. But the *Padfield* principle does not empower the court to quash the exercise of a statutory discretion on the basis that, in the court's view, it will not in fact achieve (or optimally achieve) the statutory purpose: see *Kent County Council*, at [33] and the cases cited there: "*the principle has no application where the holder of a statutory discretion is "trying but failing" to achieve the statutory purpose*." That would involve the substitution of the court for the decision-maker to whom Parliament entrusted the discretion.

100. Ms Richards submits that the promulgation of common guidance on professional standards applying across the three professions did not promote public safety. She draws my attention to certain specific paragraphs in the guidance which are she submits simply not apt to the role of associate and which again do nothing to convey to the

reader the difference in the roles. She criticises the GMC for failing, in the absence of a nationally agreed scope of practice for associates, to make the difference in roles clear to the reader of the professional standards guidance.

101. In my judgement, this submission misunderstands the limited scope of the *Padfield* principle. My focus on ground two is on the purpose of the exercise of discretion by the defendant and not its effect. I am satisfied that, in promulgating common professional standards of application to both doctors and associates, the GMC acted for the purpose of promoting patient safety, the purpose for which the discretion was conferred. There was no other, collateral, purpose. Ms Richards' case under ground two amounts, in substance, to a complaint that the GMC has not *achieved* the statutory objective, but the *Padfield* principle does not and could not require that.

102. All of the evidence indicates to me that, in producing shared standards, the GMC acted to further patient safety. It undertook a lengthy process of consultation and pre-consultation before the final decision to issue merged guidance was made by the GMC Council in April 2023. The process included seeking advice from the EAG and the use of the Advisory Forum as critical friend. It included research into various topics, including how other multi-profession regulators approached the task of the setting of standards and the use of focus groups. All these steps were designed to inform the GMC as to the form of regulation which would best protect the public. The outcome of the process pointed, in the GMC's view, in one direction: that associates should be held to the same high professional standards as doctors and that a single set of guidance for use by doctors and associates was (as Mr Massey, the GMC Chief Executive explained in his letter of 4 April 2024 to Anaesthetists United (see paras. 54 – 56 above)) in the interests of both patients and professionals. It would instil confidence in colleagues and patients that all registrants are working to the same expectations and that, when concerns are raised about the conduct of doctors, PAs and AAs those concerns would be considered against the same set of expectations. The history of the development of the policy clearly demonstrates that the GMC acted at all stages with the aim of promoting the statutory purpose. The term "medical professionals," was used on occasions in GMP as a shorthand for "member of one of the three professions of doctor, PA and AA to which this guidance relates." It was used for the purpose of clarity and readability and only where the GMC considered the circumstances made it appropriate. It is impossible to say that the use of this term in a document intended to promote patient safety was an administrative act which was unlawful in *Padfield* terms.

103. There was a dispute between the parties about whether, when considering a challenge under the *Padfield* principle, the court was limited to considering whether the exercise of the discretion was "rationally connected" with the statutory purpose, or could go further. In my judgement, this way of framing the issue conflates two distinct foci of public law review: objective and result. The *Padfield* principle constrains the first. However closely aligned the decision-maker's objective is with the statutory purpose, the decision can still be impugned if the means chosen to achieve the objective lie outside the range of options rationally open to the decision-maker. This, however, is the focus of ground 3.

104. Finally, I mention Mr Hare's submission concerning the nature of the duty imposed by section 1 of the 1983 Act and whether it amounted to a target duty or not. I understand his point that the duty is broadly framed as an objective to be pursued rather than a duty which is (to use his word) concretised into an object which must be achieved. However,

for the reasons which I have given above, this issue does not assist with my analysis (and disposal) of ground 2.

105. For these reasons, I dismiss ground 2.

Ground 3: Irrationality

106. The third ground upon which the terminology issue and the lawfulness of the policy are challenged is under the general head of "irrationality" or unreasonableness. Ms Richards relies on all of the matters set out above in connection with ground 2. In addition she relies in her skeleton argument upon three further points:
    i) Article 3 of the AAPA Order places a mandatory obligation upon the GMC to determine standards applicable to associates. GMP has, Ms Richards submits, "at its heart the professional standards applicable to doctors" and has been applied without qualification or amendment to associates. This is not a rational exercise of the defendant's functions.
    ii) As a consequence of the approach taken by the GMC associates are being asked to re-interpret or re-formulate for themselves the standards "as they think ought to apply to them."
    iii) Characterising associates as medical professionals and "members of the medical profession" runs the risk of associates referring to themselves in terms that are protected by primary legislation and committing a criminal offence under section 49 of the 1983 Act. NHS bodies themselves have been guilty of holding out associates as doctors.

107. In respect of the terminology issue, Ms Richards compares the stated reasons for using the term medical professionals with the dangers posed by its use. Those reasons include the readability of GMP and the perception that other terms were regarded as being "cold and impersonal." These reasons cannot, Ms Richards submits, rationally outweigh the risk of confusion and consequently the risks to patient safety and confidence in the respective professions.

108. Ms Richards submits that no reasonable regulator in the GMC's position could, in the face of undeniable evidence of public confusion and concern have made the decisions under challenge. Those decisions fail to have regard to: the concerns raised by well-informed representative bodies; known instances of patient harm caused by confusion over the associate professions. The approach of the GMC "supports the impression that associates can do anything and everything that a doctor can do." By denying that any harm has been caused by GMP, the GMC is adopting a "wait and see" approach to patient safety which is irreconcilable with its statutory objectives.

109. The defendant denies that the publication of common professional standards is irrational or unreasonable. It submits that this ground adds nothing to ground 2 and that neither separately nor together do the points raised come close to establishing that the publication of GMP was either unreasonable in outcome or so unreasonable that no reasonable authority could ever have come to it or unreasonable because of any shortcoming in the process of decision making.

Discussion: Ground 3

110. In the very recent case of *R (on the application of KP) v Secretary of State for Foreign Commonwealth and Development Affairs and others* [2025] EWHC 370 Admin Chamberlain J said at para. 55 that "*rationality is the standard by which the common*

law measures the conduct of a public decision-maker where there has been no infringement of a legal right, no misdirection of law and no procedural unfairness." He said that it encompasses "*both the process of reasoning by which a decision is reached (sometimes referred to as "process rationality") and the outcome ("outcome rationality")*." Process rationality includes the requirement that the decision maker must have regard to all mandatorily relevant considerations and no irrelevant ones; and that the process of reasoning should contain no logical error or critical gap. Outcome rationality is concerned with whether, even where the process of reasoning leading to the challenged decision is not flawed, the outcome is so unreasonable that no reasonable authority could ever have come to it, or (in another formulation) whether it is outside the range of reasonable decisions open to the decision maker.

111. The claimant does not identify any mandatorily relevant consideration that was left out of account or any irrelevant consideration that was taken into account. It follows that, in order for the claimant to succeed on this ground I must be satisfied that there was a logical error or critical gap in the chain of reasoning, or the outcome of the process of reasoning was so outside the range of reasonable conclusions or both. I find neither.

112. The defendant is an experienced regulator. Its decision to produce single guidance followed an exhaustive and detailed process of consultation, research and inquiry which engaged all major stakeholders, including the claimant. The process pointed towards the application of the same high standards of practice for associates as for doctors. The guidance was developed in the knowledge of various concerns having been raised about the role of associates which the defendant considered may be addressed by the holding of associates to the same high standards as doctors. The fact that the guidance was to be used by three sets of professionals was made clear in the introduction and, as recorded earlier in this judgment, additional changes were made to the guidance to reflect the application of the guidance to those professionals and to address concerns raised in response to the earlier consultation. Ms Richards suggests that associates were required to work out for themselves which standards applied to them. It is true that the guidance does invite the reader to establish for themselves which standards are relevant to their specific circumstances; but this has always been the case even in the previous iterations of GMP which applied to doctors only. No one set of standards guidance will apply to all registrants irrespective of their clinical circumstances, whether doctor or associate. Although there were some objections to the use of the term "medical professional" during the consultation phase, there was no objection by the EAG or Advisory Forum. The defendant considered and rejected at least two alternatives, including Medical Associate Professional (which included two other branches of the associate profession, surgical care practitioners and advanced critical care practitioners as well as PAs and AAs) and registrant (which was thought to be cold and impersonal). Although Ms Richards is critical of the rejection of the term "registrant" on the grounds that it was impersonal it is not irrational to take into account, when drafting guidance, the style and tone of the guidance as well as its content.

113. Nor was the outcome of the reasoning process, in my judgement, outside the range of reasonable responses open to the defendant. On the contrary, I conclude that it was open to the GMC to consider that the protection of the public would be best served by applying the same high professional standards to associates, who are trained to the medical model and who undertake medical duties in order to free up qualified doctors for more complex work. The use of shared standards was logical given the overlap in work undertaken by doctors and associates and the need for regulatory concerns affecting all three professions to be considered against the same standards. There is

nothing irrational or inherently confusing about the application of the same standards to doctors and associates. Nor is there anything irrational or inherently confusing about the use of the term "medical professionals." Associates are members of a profession, trained to the medical model, undertaking work which might otherwise be performed by doctors and working as members of a multi-disciplinary team in a healthcare context. Viewed in this way, the defendant was entitled to conclude that the term "medical professional" was apt.

114. I dismiss ground three.

Delay

115. CPR r. 54.5 determines the time limit for bringing a judicial review claim. CPR r. 54.5(1) provides that the claim form must be filed promptly; and in any event not later than 3 months after the grounds to make the claim first arose. The time limit can be extended pursuant to the court's general powers of case management under CPR 3.1(2)(a). In *Maharaj v National Energy Corporation of Trinidad and Tobago* [2019] UKPC 5 the court set out that "the statutory test is not one of good reason for delay but the broader test of good reason for extending time." This is likely to bring in many considerations beyond those relevant to an objectively good reason for the delay, including "the importance of the issues, the prospect of success, the presence of absence of prejudice or detriment to good administration and the public interest."

116. In support of an extension, the claimant relies on the following points:

i) When GMP was published on 22 August 2023, it was '*subject to new legislation being introduced by the UK Government*' (i.e. the AAPA Order), which was not certain at that point to become law and which the claimant was actively lobbying against. It would therefore have been premature to bring a challenge before the AAPA Order came into force on 13 March 2024.

ii) The process subject to challenge could be said to be ongoing as the defendant was still considering its 26 March 2024 consultation, and it was at least reasonable for the claimant to await publication of that consultation before commencing proceedings.

iii) The subject matter of the claim raises substantial issues of patient safety and that there have been deaths arising from associate practice and the confusion concerning associates is ongoing;

iv) The system of regulation under challenge does not come into force until December 2024 (that date not having passed at the time this argument was made in the Statement of Facts and Grounds).

v) The defendant would not be required to undertake substantial or unduly burdensome additional work if the claim were to succeed, and what work there would be is justified by the public interest.

117. The claimant accepted in the course of submissions that whether the date for time to run was the date of the AAPA Order coming into force or the date of the 26 March 2024 consultation, the claim was issued more than three months after that point, but says the magnitude of the delay is not great.The defendant's case is that the relevant date for time starting to run is neither of the claimant's proposed dates in 2024, but the decision

by the General Council in 27 April 2023 to approve GMP for publication and the decision then made that the guidance would apply to associates as well as for doctors.

118. An extension, the defendant says, would be contrary to good administration, because there has been extensive stakeholder engagement and consultation on GMP, including with the BMA, which it says did not raise any concern about the matters under challenge at the time. The further work required if the claim were to succeed would be burdensome and would affect the defendant and other stakeholders and consultees. It would divert resources away from other public interest functions. The defendant says that there is no good reason for the delay. There was never any real doubt that the GMC would be the regulator of associates or that the AAPA Order would be passed. Furthermore, as the challenge is not a challenge to the AAPA Order, its coming into force does not affect the date of the decision subject to challenge.

119. Regarding the issue of public interest, the defendant argues that the court should be careful to avoid conflating broader concerns about the role of associates more generally with the specific challenge to GMP and the use of the term "medical professionals."

120. The defendant also points out that, even though the claimant accepts that there was more than a three month delay after even the 26 March 2024 date, the claimant has not provided a good reason for this delay. The claimant is a well-advised and well-resourced body that was involved throughout the process leading to GMP, and should not have delayed in bringing its claim.

Delay/Discussion

121. The claim concerns the decision to promulgate common professional standards for doctors and associates. That decision was made by the GMC Council on 27 April 2023. This claim should have been issued within 3 months of that date.

122. The legal principles applicable are not in dispute between the parties. As set out in *Maharaj*, all the circumstances are relevant, including whether there has been an adequate explanation for the delay, the prospects of success, and any hardship to any party or to good administration. Here, there has been no explanation for the delay in commencing proceedings. I have already determined the prospects of success: this is not a case in which the court is being asked to determine the prospects of success at the permission stage, but having heard full argument and reviewed the evidence in detail. My refusal of the application for an extension does not therefore cause the claimant hardship. I take into account that it may still be appropriate to extend time if there is, exceptionally, sufficient public interest to do so (taking into account the other factors as well). But this is not the case. As the defendant points out, the challenge here is not to the existence, use, training or scope of practice of associates in general, all of which are a source of concern for the claimant's members and may pose risks to patients, but to two aspects of the defendant's decision making in respect of how associates are referred to and regulated by GMP. There is no evidence that serious patient safety concerns are the result of the decisions under challenge.

123. I refuse the application for an extension of time.

Conclusion

124. As for the claim for judicial review, I grant permission but dismiss the claim. I refuse the application for an extension of time.