General Medical Council

GMC response to *Reforming the General Medical Council legislative framework*

Summary statement – June 2026

We welcome this consultation on the proposed GMC Order, which is an important piece of legislation that will replace the Medical Act (1983) and the Anaesthesia Associates and Physician Associates Order (2024).

The Medical Act is over 40 years old, complex, and lacks flexibility, making it difficult for us to respond to change. Reform of this legislation has been a long-standing priority for us, and we therefore support plans to modernise our regulatory framework.

A more flexible framework will allow us to act more quickly, reduce unnecessary bureaucracy, and deliver a more responsive system for patients and professionals. At the same time, we recognise the obligations that such flexibility entails, and the importance of transparency and accountability as a means of demonstrating that our powers are being exercised appropriately.

We are largely pleased with the duties and powers that the draft legislation contains. In particular, we believe that the new framework will enable:

- an improved ability to protect the public
- less adversarial fitness to practise processes through swifter, more efficient resolution
- a more flexible and proportionate approach to approving and quality assuring education and training
- a streamlined and more accessible registration framework
- greater transparency as a regulator.

There are however some changes to the draft legislation that we would like to see, set out below and expanded upon in our answers to the consultation questions.

- First and foremost, **we do not support the inclusion of a 'coming into force' date** on the face of the order. Imposing a hard deadline in this way creates an unnecessary risk to public protection and patient safety. It is essential that a more flexible mechanism can be used to effectively switch on key provisions in the GMC Order in a staggered manner once it is safe to do so. This will also enable us to take into account the readiness of external stakeholders

to accommodate and work with our revised processes, therefore removing any unintended adverse impact on service delivery.

- While we welcome the inclusion of a general publication power in the draft legislation, we consider that **the power to publish information about former registrants is narrower** than required. We expand upon the challenges that this presents in our answers below.
- We note and are concerned that the draft order could **require us to publish warnings and registration measures**, such as fitness to practise sanctions, **about individual registrants indefinitely**. We consider this disproportionate and we also question the compatibility of this approach with the wider UK information rights framework, for example, the UK General Data Protection Regulation. We would like to retain the discretion we currently have to determine how long we should publish this information for.
- While we strongly support the proposed **non-compliance powers** with respect to fitness to practise proceedings, their application for registration proceedings is potentially disproportionate. In our view, the order provides other mechanisms for dealing with non-compliance in registration proceedings – albeit such powers should continue to apply for registration appeals.
- While we support the introduction of restrictions and enhancements to registration, **we note that a complete restriction on practice applies only to doctors**. We think that it is important for this to be extended to all of the three professions we regulate to ensure a clear, consistent approach and to avoid inequity in how different registrant groups who share protected characteristics are treated.
- We welcome the prospect of greater discretion to determine what could amount to impairment in the context of fitness to practise, and the ability to close cases more quickly where there is no risk to public protection. However, our view is that **findings of impairment must not be imposed on registrants without their acceptance.** Where this is not accepted, the registrant must have a clear right to a panel hearing.
- While we welcome the power to ask organisations for information and documents to support the delivery of our wider education and training functions, **we believe this should be enforceable by court order** for the very rare occasions that our requests are not fulfilled.

We also note the proposed retention of the GMC existing right of appeal against final measure decisions made by a fitness to practise panel, and the proposed introduction of a new right of appeal against interim registration measures (where also made by a fitness to practise panel). We note that these are government proposals that have arisen from recommendations made in Lord Mann's review of antisemitism and racism in the NHS.

Finally, we look forward to seeing the outcome of the consultation, the revised draft of the GMC order, and its subsequent laying in the legislatures this autumn. We also welcome further engagement with DHSC, and other stakeholders, on any of the points we have raised in our response, as well as how the new legislation will work in future to the benefit of patients and the public, doctors, PAs, AAs, and those who work with them.

Our role

The General Medical Council (GMC) is the independent regulator of doctors, PAs and AAs in the UK. We work with them and other stakeholders to:

- set the principles, values, and standards of professional behaviour expected of all doctors, PAs and AAs registered with us
- make sure medical students, PA and AA students get the education they need to meet the standards for registration with us
- check who is eligible to work as a doctor, PA or AA in the UK and work with them and their employers to confirm they are keeping up to date and meeting the professional standards we set
- give guidance and advice to help doctors, PAs and AAs understand what is expected of them
- investigate where there are concerns that patient safety, or the public's confidence in doctors, PAs or AAs may be at risk, and take action if needed.

GMC response to consultation questions

Commencement

Do you agree or disagree that a specific 'coming into force' date should be included in article 2(2)(b) of the final General Medical Council Order 2026? (Optional)

Disagree

We do not support the inclusion of a 'coming into force' date on the face of the order. Imposing a hard deadline in this way creates an unnecessary risk to public protection and patient safety.

To implement the new legislative framework, we need to first consult on our rules and develop a robust approach to operationalising these. This will include setting out how we transfer information and transition registrants, including live cases and applications, from the old systems

under the Medical Act (1983) and the Anaesthesia Associates and Physician Associates Order (AAPAO) to a new system under the GMC Order.

It is critical that this is all in place before we switch over to the new system, and therefore to enable this, it is essential that a more flexible mechanism can be used to effectively switch on key provisions in the GMC Order in a staggered manner once it is safe to do so.

This will also provide three additional benefits. It will ensure that we have sufficient time to review and modify our draft rules and underpinning processes in response to the feedback we obtain during our own consultation. It will also ensure that we can take into account the readiness of external stakeholders to accommodate and work with our revised processes, therefore avoiding any unintended adverse impact on service delivery. And finally, it will allow us to realise benefits for certain areas earlier, before the remaining provisions are implemented at a later date.

That's why it is essential that commencement dates mustn't be prescribed in advance, but settled through commencement orders, to ensure secure and smooth implementation for the public and registrants.

Governance

Separate to annual report requirements relating to equality and diversity, the draft order contains the following for GMC relating to equality, diversity and inclusion:

- a duty to ensure that, in the exercise of its functions, it applies good practice in relation to equality and diversity
- where it considers that an improvement may be required, a duty to take such steps as it considers appropriate to make that improvement
- a duty to have regard to any current or future principles set by PSA regarding equality, diversity and inclusion

Do you agree or disagree with the inclusion of these requirements in the order? (Optional)

Agree

We agree with the inclusion of these requirements.

We support the inclusion of a duty to apply good practice in relation to equality and diversity. We already place significant importance on equality, diversity, and inclusion (ED&I) in the delivery of our functions and support an evidence-informed approach. This includes working with other regulators to strengthen data collection and share learning. We also note the expectation to

publish ED&I arrangements and progress. We feel this expectation is reasonable and consistent with good practice.

We welcome the expectation that regulators take steps to make improvements where these are identified. We will continue to set ambitions for improvement supported by targets, measures, and programmes of work, and publish our progress towards meeting these. Therefore, we believe that we're already operating in the spirit of the proposed duty.

It is our interpretation that this duty allows for regulatory judgement and prioritisation. Inequalities often span multiple, intersectional characteristics, and it will not always be feasible to address all issues simultaneously. In line with the planned legislation and our current approach, we will continue to determine the exact ED&I issues to address, taking account of capacity, resources and wider statutory priorities.

We support the proposal to have regard to Professional Standards Authority (PSA) expectations on ED&I issues. We have worked closely with the PSA in developing and piloting ED&I standards and have met these standards since their introduction. Our work has also featured in PSA good practice reporting.

We note that the PSA currently operates through standards and evidence frameworks rather than principles. We would welcome clarity on how any future principles would relate to existing standards, and continued engagement with the PSA and other regulators in their development.

Similarly, we welcome the expectation that regulators work with the PSA and others to agree and publish ED&I data in a consistent and comparable way. Comparable data implies a shared minimum standard for data collection across regulators, which would be beneficial in reducing inconsistency and duplication. We would expect the PSA to lead consultation on setting such a standard. This approach would enable regulators to focus on implementation and data quality, rather than repeatedly revisiting what data should be collected.

Do you agree or disagree that the provisions set out in parts 2 to 4 of the draft order enable GMC to carry out its governance and operating framework functions appropriately? (Optional)

Agree

We partially agree with this. However, there are several areas where we still hold concerns and recommend that changes be made to the drafting to address these.

We support the regulator objective as set out in article 6. It clearly reflects our core purpose and aligns with the overarching aim of public protection.

And we support the proposed approach to annual reporting and provisions relating to the setting and charging of fees.

We also welcome the proposed changes to provisions relating to cooperation (article 14), which clarify who we must cooperate with for the purpose of exercising our duties. We believe this will put beyond doubt the importance of collaboration in developing and delivering our statutory functions.

However, while we welcome an express power to publish decisions and outcomes, we are concerned that this represents a narrowing of existing powers. Under the Medical Act (1983), we have a power to publish any information relating to fitness to practise (subject to the public interest test), which provides greater flexibility than the current focus in the draft order on decisions and outcomes. There could be circumstances in which we might want to make a public statement about an ongoing investigation, for example, which would not relate to a specific decision.

We also request an explicit power to continue to publish and disclose decisions taken in relation to our registrants under the Medical Act (1983) and AAPAO frameworks. Currently, article 9 only enables us to publish and disclose decisions that have been taken under the draft order. Furthermore, although we would still be required to publish information about registrants from their register entries, we don't consider that the legislation currently gives us sufficiently clear powers to publish information about former registrants, as we do now for doctors, PAs and AAs.

There is an important distinction to draw between requirements for recording information on the register, and requirements for publishing such information online. Not all information recorded on the register will be published and we have concerns that the drafting of articles 32 and 33 does not properly make this distinction clear. We are very concerned that one impact of this is that we could be required to publish warnings and registration measures (ie fitness to practise sanctions) in relation to individual registrants on an indefinite basis.

While we agree that warnings and registration measures should be permanently recorded against a registrant's entry on the register (unless quashed), we consider it is disproportionate for them to be published indefinitely. It is also different from both the Medical Act (1983) and AAPAO, which allow us to determine how long we should publish this information for. We also question the compatibility of indefinite publication with the wider UK information rights framework, for example, the UK General Data Protection Regulation.

Currently, we publish warnings and measures in line with time limits set out in policy which vary according to the action taken and the individual's registration status. We therefore suggest amending the wording to make clear that we can set time limits for publication.

Do you agree or disagree that the powers and duties in schedule 1 on constitution of the regulator are sufficient to enable GMC and MTS to carry out their functions appropriately and proportionately? (Optional)

Agree

We agree that the powers and duties as drafted are sufficient. While we are neutral on the proposal to replace our Council with a unitary board, we accept this was a conclusion from the Department of Health and Social Care (DHSC) consultation *Promoting professionalism, reforming regulation* in 2018.

We also welcome the provisions for registration and publication of members' private interests and note that they are equivalent to those currently in the Medical Act (1983) and will therefore enable continued transparency in relation to the management of conflicts of interest.

We also welcome the requirement to specify the GMC board's procedures in standing orders, noting that this will ensure transparency, while providing flexibility for us to make changes to these as and when required. And we note that provisions for establishing committees and sub-committees will enable the GMC to continue with a proportionate and flexible governance framework.

We also support the Government's policy intention to provide a statutory power to remunerate trustees (ie the non-executive members of the Unitary Board). This is consistent with the Medical Act (1983), which enables us to pay members of the GMC Council. However, we recommend that the drafting be made more explicit on the specific point about remuneration for their duties as trustees. This will provide greater clarity and put beyond doubt our compliance with both the order and our obligations under charity law.

Do you agree or disagree that the powers and duties in the draft order in relation to the Privy Council are sufficient to support GMC to carry out its functions appropriately? (Optional)

Agree

We support maintaining an arrangement that is broadly similar to the one that we currently have in place. While we recognise that the Privy Council's reserve powers are important, we welcome the ability to make rules without recourse to the Privy Council.

As we've set out below in our response to the question on the sufficiency of our rulemaking powers, the power to prescribe and approve rules is designed to give greater flexibility to alter regulatory processes in response to changes in the UK healthcare system.

But we recognise the importance of transparency and accountability as a means of demonstrating that such flexibility is being exercised appropriately. Under the draft order, we'll be required to carry out our functions with increased transparency and accountability to make sure we continually demonstrate how we are performing as a regulator – this includes consulting on new rules, and all substantial changes to those rules, thereafter.

PSA evidence gathering

Do you agree or disagree that the draft order provides PSA with sufficient and proportionate evidence-gathering powers? (Optional)

Neither agree nor disagree

We welcome the clarity provided by the drafting with respect to the legal vires for sharing data voluntarily with the PSA.

Secondly, we note that the new evidence-gathering powers proposed for the PSA, including a power to compel information, have arisen from the Mann review. We note the rationale provided in the report of the Review.

While we understand that it will be important for the PSA to be able to compel the disclosure of specific and relevant information for the purpose of determining whether to request a revision of a GMC decision or to exercise their appeal right, broadening the use of this power to support the delivery of all of the PSA's statutory functions may go beyond what is needed by the PSA to effectively discharge their duties. We therefore believe it would be more proportionate to limit this power to requests for information relevant to revision requests and appeals only.

A broader power may also inadvertently impact on our own ability to discharge our own regulatory functions, through servicing the additional disclosure requests that may be directed at us under this power. Therefore, this power must be used in a proportionate and targeted manner, focusing solely on information that is necessary for the exercise of PSA's functions, in line with the principles of right touch regulation.

We also understand that the PSA is considering the development of a policy outlining how and when this power would be utilised, and we would expect the PSA to provide an opportunity for regulators and other key stakeholders to comment on, and inform, the development of this.

Education and training

Do you agree or disagree that GMC should be able to approve overseas undergraduate, foundation and postgraduate education and training programmes? This does not mean that people who take part in such overseas programmes would be given priority for places on the UK foundation programme or for speciality training in the UK, subject to a few limited exceptions in the Medical Training (Prioritisation) Act 2026. (Optional)

Agree

There are a range of different types of UK medical education and training provided overseas, covering different stages of training and each servicing different needs. This includes UK medical schools with overseas campuses, opportunities for doctors to undertake parts of their specialty

training overseas, and the essential training in overseas locations for doctors who work in the British Armed Forces.

While not every proposal for delivering education and training overseas will be merited, there is a practical aspect to ensuring that we can regulate the delivery of this appropriately when the need arises. Therefore, we view it as a necessary part of our regulatory functions to retain an ability to approve or refuse approval for education and training provided overseas, to check that it meets our standards, and to be able to remove approval when necessary.

Other proposed changes in the draft order will strengthen our ability to regulate overseas education and training. For example, the change to approve individual undergraduate courses, rather than whole institutions, will mean that we can target our quality assurance activity more effectively. And while we have up to now been able to recover some of our costs for regulating the provision of education and training overseas through locally arranged agreements with providers, the draft order now provides a formal statutory basis for full cost recovery.

Do you agree or disagree that the powers and duties set out in the draft order enable GMC to carry out its education and training functions sufficiently and proportionately? (Optional)

Agree

We are broadly happy with the provisions as set out in the draft order.

For doctors, we anticipate that the new framework will enable us to continue with our existing model of medical education and training, albeit with a new ability to approve individual undergraduate courses rather than whole institutions, mirroring our current approach to the approval of PA and AA courses. This will enable us to adapt and target our regulatory activities where they have the most effect so that we can continue to promote high standards in education and training, across both traditional pathways and through newer methods of learning.

The draft order continues to provide an explicit power to promote high standards, which will give us the mandate to drive improvements through our standards, policies and processes.

We will also continue to have a power to coordinate stages of education and training which will allow us to bring together relevant education and training bodies, including medical schools, royal colleges, PA and AA course providers, and other interested parties. This will help us collectively drive forward improvements in the quality of education and training for doctors, PAs and AAs, which will ultimately enhance patient safety.

Under the Medical Act (1983), to support the delivery of our functions, we currently collect, analyse and report on data from many sources, including some that is not held by education and training providers. So, we are very happy to have a provision that enables us to ask organisations

for information and documents in support of exercising our functions. In line with our wider data collection powers under Article 61, we believe this should be enforceable by court order for the very rare occasions that our requests are not fulfilled.

However, we continue to hold the view that Article 26(3) should be revised to make explicit reference to 'institution' - confirming that this power only extends to education and training delivered by an institution outside the UK. The order will also need to set out a suitable definition for 'institution' and we would be happy to discuss further with DHSC what form this might take. This clarification preserves the wording from the Anaesthesia Associates and Physician Associates Order, and the explicit focus on 'institution' protects us from having to expend resources on assessing fake qualifications, and reduces the risk of challenge from holders of unacceptable qualifications – thereby supporting a more proportionate use of our resources.

Finally, we remain firmly of the view that the substantive power to approve the foundation programme should sit within our education and training approval powers under article 26 in part 5 of the draft order, rather than in article 37 in part 6. This is because the latter deals with restrictions and enhancements on registration, rather than education matters. We have reiterated this feedback in the question relating to the sufficiency of the proposed powers and duties for undertaking our registration function.

Postgraduate Medical Education and Training Order of Council 2010

Do you agree or disagree that the PMET Order should be revoked and the categories of speciality in practice should be set out in a new order of council? (Optional)

Agree

We agree that the PMET Order should be revoked and support the proposal to maintain a list of recognised specialties within a new order of council, but further consideration is needed as to how this should be appropriately captured in the GMC Order. We would also question the terminology used within the consultation document, and in particular the reference to 'categories of speciality in practice'.

At present, the PMET Order sets out a list of recognised and approved medical 'specialties'. Registered doctors with certificates of completion of training (CCTs) in such specialties, or those doctors with comparable levels of knowledge, skills and experience to that required for these specialties, are eligible to apply for entry to the GMC's general practice and specialist registers.

Under the draft order, given the requirement to hold a single register, our understanding is that such individuals will be eligible to apply for an 'enhancement' on their register entry to confirm that they have the necessary knowledge, skills and experience to practise in that particular specialty within the UK.

However, the consultation document suggests a policy intention to use enhancements more narrowly, by prescribing individual areas or 'categories' in which individuals are permitted to practise. We would question if this is the policy intention, and if not, would request that the new order of council focuses on recognised 'specialties', rather than 'categories of specialty in practice'.

Registration

Do you agree or disagree that doctors should be able to be registered with a complete restriction on registration? (Optional)

Agree

We partially agree with this.

We support the proposal to introduce a complete restriction in relation to all areas of medical practice for doctors (which we intend to refer to as non-practising registration) as it allows us to retain an option that is similar to our current approach for doctors under the Medical Act (1983) whereby they can hold registration only (without a licence to practise).

Registration with a complete restriction on practice could mean that doctors are not required to undergo periodic assessment (which we currently refer to as revalidation), and we recognise the benefits of this approach for doctors who are taking parental leave, considering a career break or retirement, or taking on roles for which registration may be viewed as beneficial, but for which the ability to practise is not a requirement. These doctors will be able to request the complete restriction is lifted, facilitating their return to practice.

However, the draft order specifies that this restriction only applies to doctors. We think it's important for this to be extended to physician assistants (PAs) and physician assistants in anaesthesia (PAAs) to avoid inequity in how different registrant groups are treated.

Furthermore, we do not agree with the suggestion that a complete restriction could be applied where a doctor fails to complete the periodic assessment. This contradicts the policy rationale in the restrictions and enhancements section of the consultation document, and the draft order already gives us clear powers to remove registrants from the register who fail the periodic assessment.

Do you agree or disagree that the draft order enables GMC to carry out its functions relating to registration sufficiently? (Optional)

Agree

We partially agree with this.

There are many elements of the draft order that we welcome, including for example, a single standard for registration, which replaces the multiple registration types with differing requirements in the Medical Act (1983), and provides a common framework for the elements required for registration.

We also support the new requirement for applicants to demonstrate they meet the same standards and information requirements for registration, irrespective of whether they are applying for initial registration, or applying for re-entry to the register. Requiring applicants who are applying for re-entry to meet the same standards and information requirements as those applying for initial registration will provide greater assurance that such individuals possess the relevant knowledge, skills and experience needed for practice.

Furthermore, we support the proposal that will allow us to remove individuals from the register when the standards and requirements for registration are no longer met – including those relating to English language competence and evidence of insurance and/or indemnity.

We welcome too the introduction of identity requirements for all applicants, which will address the current public protection gap created by the lack of an explicit requirement for doctors to undergo identity verification under the Medical Act (1983).

And we support the requirement for all registrants (apart from those with a complete restriction on practice in place) to demonstrate that they meet the standards on an ongoing basis via periodic assessment, with this requirement attached to registration. This means that we'll be able to remove individuals from the register where they either don't engage in periodic assessment, or where they cannot demonstrate that they meet the required standards.

Proposals where further changes are required

However, there are several areas where we still hold concerns and recommend that changes be made to the drafting to address these.

Non-compliance powers

First, while we strongly support the proposed non-compliance powers with respect to fitness to practise proceedings, their application is potentially disproportionate for registration proceedings.

The ability to impose 'registration measures' including conditions, suspension or removal is important for non-compliance in a fitness to practise context. But for registration proceedings, we consider that the same non-compliance powers would be time consuming and a disproportionate use of resources, requiring ongoing monitoring of the registration measure imposed.

In our view, the GMC Order provides other mechanisms for dealing with non-compliance in a registration context. If an individual doesn't comply with an evidence request as part of a registration application, they will not be registered. Equally, if an individual doesn't comply with a request for information or requirement relating to a registration issue, for example, by refusing to pay the annual fee or through failing to keep their contact details up to date, they could be removed under Article 39. We would give registrants numerous opportunities to resolve the non-compliance issue – which could be rectified through either paying the fee or providing updated contact details in this example – before removing them from the register.

Once removed, the draft order allows for our decision to be appealed and, perhaps more pertinently, allows us to revise removal decisions if former registrants decide to comply (within a defined time period) with the registration requirements.

However, non-compliance powers will need to be retained for dealing with appeals against registration decisions – and one way in which this can be achieved is through amending the drafting around non-compliance powers to clarify that these apply solely to parts of the legislation that deal with revisions and appeals relating to registration decisions (rather than the far broader 'registration proceedings').

We have restated this feedback in our response to the question on evidence gathering below.

Publication

Secondly, as we note above in our response to the question on governance provisions in parts 2-4 of the draft order, we are concerned about our ability to publish information about former registrants, and believe the proposed powers represent a narrowing of existing powers under the AAPAO and Medical Act (1983). While the draft order allows for the publication of decisions about former registrants and the reasons for them, the proposed powers do not explicitly allow us to publish the same information we published while those registrants were registered with us, for example, which profession the individual belonged to, and any other information published in accordance with articles 33(1)(a) and (b), (2) and (3). There are strong public interest arguments in favour of publishing information about former registrants. It helps us to meet our overarching objective and legal obligations, supports our position as an open and transparent regulator, and serves a wider public protection purpose through enabling patients to access information about registrants who they had been treated by.

As we note above, there is an important distinction to draw between requirements for recording information on the register, and requirements for publishing such information online. Not all information recorded on the register will be published and we have concerns that the drafting of articles 32 and 33 does not properly make this distinction clear. We are very concerned that one

impact of this is that we could be required to publish warnings and registration measures (ie fitness to practise sanctions) in relation to individual registrants on an indefinite basis.

While we agree that warnings and registration measures should be permanently recorded against a registrant's entry on the register (unless quashed), we consider it is disproportionate for them to be published indefinitely. It is also different from both the Medical Act (1983) and AAPAO, which allow us to determine how long we should publish this information for. We also question the compatibility of indefinite publication with the wider UK information rights framework, for example, the UK General Data Protection Regulation.

Currently, we publish warnings and registration measures in line with time limits set out in policy which vary according to the action taken and the individual's registration status. We therefore suggest amending the wording to make clear that we can set time limits for publication.

Powers to approve the foundation programme

Finally, we remain firmly of the view that the substantive power to approve the foundation programme should sit within our education and training approval powers under article 26 in part 5 of the draft order, rather than in article 37 in part 6. This is because the latter deals with restrictions and enhancements on registration, rather than education matters.

Protection of title

Do you agree or disagree that the titles of 'apothecary', 'licentiate in medicine and surgery' and 'bachelor of medicine' should no longer be protected in legislation? (Optional)

Agree

While it is not our role to determine which titles should be set out in legislation, we understand why DHSC have proposed this change. We agree that the terms 'Apothecary' and 'licentiate in medicine and surgery' do not effectively reflect current practice, and 'bachelor of medicine' is linked to a qualification, rather than a professional title.

Do you agree or disagree that 'registered medical practitioner' should become a protected title? (Optional)

Agree

While it is not our role to determine which titles should be set out in legislation, we understand why DHSC have proposed this change.

Currently, we consider that anyone falsely referring to themselves as a 'registered medical practitioner' would, through implication, fall under the current offences at Section 49 of the

Medical Act (1983). Noting that 'registered medical practitioner' is referenced within the Interpretation Act (1978), we welcome the proposal to protect this title in the draft order, alongside the other titles listed in Schedule 2, to make explicit the ability to take action in such cases.

Do you agree or disagree that the title of 'physician associate' should be changed to 'physician assistant' and protected in law? (Optional)

Agree

We note that the GMC Order is intended to give effect to the change of title recommendations of the Leng Review – which we accept.

As a professional healthcare regulator, we have no role or remit in setting local role titles or determining titles set out in legislation.

Our use of titles is informed by our existing legislative framework, and the statutory obligations this places upon us. Therefore, once the titles are amended in the GMC order, we will move to adopt these within our rules, policies and guidance.

However, we do recognise that there are varying views on the proposed title, that this remains a point of contention among stakeholders and that any change to title will require significant work to update systems, documentation and other means of identification.

As with the titles that are currently protected under the Medical Act (1983), we welcome the proposal to introduce legal protection for the new title, which will provide an ability to take action in those cases where an individual falsely claims to be a physician assistant.

Do you agree or disagree that the title of 'anaesthesia associate' should be changed to 'physician assistant in anaesthesia' and protected in law? (Optional)

Agree

We note that the GMC Order is intended to give effect to the change of title recommendations of the Leng Review – which we accept.

As a professional healthcare regulator, we have no role or remit in setting local role titles or determining titles set out in legislation.

Our use of titles is informed by our existing legislative framework, and the statutory obligations this places upon us. Therefore once the titles are amended in the GMC order, we will move to adopt these within our rules, policies and guidance.

However, we do recognise that there are varying views on the proposed title, that this remains a point of contention among stakeholders and that any change to title will require significant work to update systems, documentation and other means of identification.

As with the titles that are currently protected under the Medical Act (1983), we welcome the proposal to introduce legal protection for the new title, which will provide an ability to take action in those cases where an individual falsely claims to be a physician assistant in anaesthesia.

Do you agree or disagree that there should be a transition period in relation to moving from the associate titles to the assistant titles? (Optional)

Neither agree nor disagree

While we are neutral on the introduction of a transition period, we would suggest that the following factors be taken into account when determining how long any period should be:

- Given that the protection of title offences will only take effect once the transition period has elapsed, to minimise the gap in public protection during which physician assistants and physician assistants in anaesthesia will be able to practise without registration, this period must be as short as possible. We note that the cumulative effect of the new provisions effectively push back the existing transition period that's currently in place for physician associates and anaesthesia associates from the 13 December 2026 to the 13 June 2027.
- Minimising the length of the transition period will also provide greater clarity and certainty to patients and the public, recognising that some professionals may adopt the new titles in advance of the transition period expiring, while others may continue to use the existing titles during this period.
- However, both of these considerations must be balanced with the need to afford sufficient time for employers and system partners to make the necessary practical changes to introduce the new titles. To further minimise existing levels of uncertainty, sufficient time must be provided to ensure that all parts of the system in each country, can move as far as practicable, to introduce the new titles at the same time.

Should there be any protection of the 'physician associate' and 'anaesthesia associate' titles alongside the proposed new titles? (Optional)

Neither agree nor disagree

We can understand the arguments for protecting the existing titles of 'physician associate' and 'anaesthesia associate' alongside the new titles of 'physician assistant' and 'physician assistant in anaesthesia'.

Protecting the existing titles would remove the public protection gap that may be presented by individuals continuing to practise as 'associates', after the new titles have been introduced, without registering with the GMC. We have long supported statutory regulation for physician associates and anaesthesia associates because they perform complex roles, and operate, while supervised, with some degree of autonomy, which presents a significant potential risk to patients. Therefore, care should be taken to ensure that the new legislation does not inadvertently create any loopholes that will allow such practice to continue without any form of regulatory oversight.

However, if the titles are to be protected, a different form of protection will be needed to that which is proposed for the new titles (where it will be an offence to use the title of physician assistant or physician assistant in anaesthesia, after the transition period has expired, without being registered with the GMC). We cannot have a scenario where it is feasible for an individual, provided they are registered with the GMC, to refer to themselves as either a physician associate or a physician assistant, an anaesthesia associate or a physician assistant in anaesthesia – this would further undermine the purpose of the proposed title change to reduce public confusion.

Therefore, if protection is to be introduced, it must serve to remove the existing titles completely so that it is an offence to continue using these, irrespective of whether they are registered with the GMC.

Fitness to practise - mandatory removal from the register

Do you agree or disagree with the listed offences set out in schedule 4 of the draft order? (Optional)

Agree

We support the inclusion of the listed offences set out in schedule 4. We believe that such offences are incompatible with continued registration as a healthcare professional. We therefore support mandatory removal for any individual convicted for an offence under part 1 of schedule 4 or an offence listed under part 2 of schedule 4 - for which a custodial sentence has been imposed.

Do you agree or disagree that former registrants who have been mandatorily removed from the register following conviction for a listed offence should not be able to apply for re-entry to the register, save for in the limited exceptional circumstances prescribed in the draft order? (Optional)

Agree

We welcome the introduction of a mandatory removal process for registrants who are convicted of certain very serious criminal offences. Given that a conviction for one of these offences would be fundamentally incompatible with continued registration as a healthcare profession, we agree that anyone removed following conviction for a listed offence should not be able to apply to re-enter the register, and consider that this should apply to any offence that is included in either the first or second part of Schedule 4.

The exception to this would be in the limited circumstances set out in the draft order. Namely, where the conviction has been quashed, or if the custodial sentence for a lower-level listed offence (as set out in schedule 4 part 2) has been quashed and a non-custodial sentence imposed. This aligns with the position that Social Work England have in place and will therefore promote a consistent approach to the regulation of health and social care professions.

Fitness to practise - grounds for action

Do you agree or disagree with the grounds for action set out in the draft order? (Optional)

Agree

We warmly welcome the inclusion of a ground for action relating to health. We have consistently advocated for this. It will ensure that we can act to protect the public, before harm occurs, where a registrant's health condition may present a risk to patients - while also enabling us to continue to manage cases involving a registrant's health as compassionately as possible.

We have worked hard over several years to ensure a compassionate approach to how we manage concerns about the impact of a registrant's health condition. We consider that having to take action against registrants with health concerns that impact their fitness to practise solely on the basis of an inability to provide care to a sufficient standard or misconduct (the other two grounds for action) is inappropriate and would seriously undermine a compassionate approach. It could also impact on a registrant's willingness to engage with the fitness to practise process. Concerns involving a registrant's health raise particular issues and should be identified as a distinct ground for action.

We also remain of the view that our current six grounds for action under the Medical Act (1983), which are tried and tested in case law, should be retained. We are concerned that the change

risks creating uncertainty about our ability to protect the public from a range of concerns relating to clinical performance, English language and criminal conduct.

Fitness to practise - proceedings

Do you agree or disagree that the fitness to practise powers and duties set out in the draft order for GMC and MTS are sufficient and proportionate for the safe and effective regulation of the professions GMC regulates? (Optional)

Agree

We partially agree with this. However, there are several areas where we still hold concerns and recommend that changes be made to the drafting to address these.

We welcome the greater discretion that the draft order provides to determine what could amount to impairment in the context of fitness to practise and therefore enable investigations to be conducted proportionately.

We also support the extension of powers to resolve cases without the need for a panel hearing where a registrant accepts that their fitness to practise is impaired and the outcome proposed. This will allow some cases to be resolved more quickly and in a less adversarial way, reducing stress for registrants, complainants and witnesses alike.

However, the proposed drafting does not consistently reflect the intended role of case examiners (CEs), and we believe that changes should be made to confirm that case examiners must determine impairment wherever possible, and should therefore only refer to a panel where they cannot properly reach a determination on the written evidence.

We also note that the proposed drafting does not currently require registrants' consent for finding of impairment in cases where CEs do not propose a registration measure. In our view, CEs must not impose a finding of impairment without the registrant's acceptance, and where this is not accepted, the registrant should have a clear right to a panel hearing.

We feel that the draft order must, in the interests of fairness to the registrant, also enable a CE to determine either to impose a registration measure where a regulated professional has not responded to an accepted outcome proposal or to refer the matter to panel. However, the drafting does not currently reflect this agreed policy position and amendments are therefore required to enable a CE, where a registrant does not respond to the CE's proposal, to either refer a case to a panel **or** to impose a measure.

The draft order requires us to publish CE decisions even in cases where the decision is one of no impairment, and there is no warning issued. We think this is disproportionate as there has been no adverse finding against the registrant and the case is not in the public domain.

We also recommend other amendments to ensure publication requirements are proportionate and aligned with procedural outcomes. We believe that the current drafting could require publication of a CE decision where a measure cannot be imposed because a registrant has refused to accept the measure. The outcome of this would be referral to panel and it would not be appropriate to publish a decision at that stage. We also do not consider it proportionate that we should be required to publish a decision to revoke an interim registration measure imposed on a regulated professional. Currently, if an interim registration measure is revoked, we remove it from publication given there are no findings against the registrant and a decision has been taken that there is no current risk requiring any restriction.

With respect to both final and interim registration measures, our view is that the current drafting needs to more clearly describe when a referral to a panel can be withdrawn. For final registration measures, the consultation document helpfully sets out that this can take place if a panel has not yet reached a determination *on whether fitness to practise is impaired*. The drafting however states 'has not yet reached a determination'. A panel could make a number of determinations including case management directions or a determination on facts and so the clarification contained in the consultation document should be added to the Order. For interim registration measures, we recommend that the draft order be amended to allow for withdrawal up to the point at which a panel has reached a determination on whether an interim registration measure should be imposed.

Finally, for interim registration measure reviews, we consider that the draft order should be amended so that we are only required to notify employers and third-parties where a decision is made to modify the measure, and not where a review results in no change.

Interim registration measures

Do you agree or disagree that a fitness to practise panel's power should be extended so that it can impose an interim registration measure during registration proceedings as well as fitness to practise proceedings? (Optional)

Agree

We agree with the proposed approach on the basis that it will allow us to mitigate any public protection risk, which might arise during registration proceedings, in a more streamlined way.

For example, when we are investigating whether someone has fraudulently obtained registration, we will be able to ask a fitness to practise panel to determine whether an interim

registration measure should be imposed to restrict practice until we have completed our investigation and made our final decision.

Evidence gathering

Do you agree or disagree that the draft order provides GMC with sufficient and proportionate evidence-gathering powers? (Optional)

Agree

We agree that the draft order provides the GMC with sufficient evidence-gathering powers. However, while we strongly support the non-compliance powers with respect to fitness to practise proceedings, their application is potentially disproportionate for registration proceedings.

As we noted in our response to the question on the sufficiency of powers and duties for undertaking our registration function, while the ability to impose 'registration measures' including conditions, suspension or removal is important for non-compliance in a fitness to practise context, it does not work for registration proceedings. We consider that the same non-compliance powers would be time consuming and a disproportionate use of resource, requiring ongoing monitoring of the registration measure imposed.

In our view, the GMC Order provides other mechanisms for dealing with non-compliance in a registration context. If an individual doesn't comply with an evidence request as part of a registration application, they will not be registered. Equally, if an individual doesn't comply with a request for information or requirement relating to a registration issue for example, by refusing to pay the annual fee or through failing to keep their contact details up to date, they could be removed under Article 39. We would give registrants numerous opportunities to resolve the non-compliance issue – which could be rectified through either paying the fee or providing updated contact details in this example – before removing them from the register.

Once removed, the draft order allows for our decision to be appealed and, perhaps more pertinently, allows us to revise removal decisions if former registrants decide to comply (within a defined time period) with the registration requirements.

However, non-compliance powers will need to be retained for dealing with appeals against registration decisions – and one way in which this can be achieved is through amending the drafting around non-compliance powers to clarify that these apply solely to parts of the legislation that deal with revisions and appeals relating to registration decisions (rather than the far broader 'registration proceedings').

We also restate our request for a power to compel organisations, by court order, to provide information and documents required to support the delivery of our education and training functions, in line with our wider data collection powers under Article 61.

Rule-making powers

Do you agree or disagree that the rule-making powers in the draft order are sufficient and proportionate for the regulation of the professions GMC regulates? (Optional)

Agree

We agree that the rule making powers are sufficient and proportionate for the regulation of the professions we regulate. We support the approach taken to the drafting which enables prescriptive detail on how our statutory powers and duties to be set out in rules.

The power to prescribe in rules how our regulatory functions will operate, is designed to ensure there is flexibility to alter them in response to changes in the UK healthcare system.

But we recognise the importance of transparency and accountability as a means of demonstrating that such flexibility is being exercised appropriately. Under the draft order, we'll be required to carry out our functions with increased transparency and accountability to make sure we continually demonstrate how we are performing as a regulator – this includes consulting on new rules, and all substantial changes to those rules, thereafter.

With regard to the specific power to make rules in relation to non-compliance, we welcome in particular the provisions in Article 65, which will enable us to continue to take effective but proportionate action in cases where regulated professionals do not comply with directions to carry out assessments or provide information required as part of a fitness to practise investigation.

Under the Medical Act (1983) we can refer a matter to a noncompliance hearing for a panel to consider whether conditions or a suspension should be imposed on a registrant who does not comply with directions needed to progress an investigation. However, the AAPAO only allows us to remove a registrant in these circumstances. We therefore welcome the new drafting which enables us to take more proportionate action up to and including removal, depending on the circumstances of the case.

Revision of decisions

Do you agree or disagree that the draft order provides GMC with sufficient and proportionate powers and duties in relation to revision of decisions? (Optional)

Agree

We agree that the draft order provides sufficient and proportionate powers in relation to the revision of decisions. We welcome the introduction of a clear revision power and, in particular, the ability to amend decisions swiftly where prescribed grounds are met.

We welcome the ability to set the grounds for revision in rules, as it creates the scope to tailor suitable grounds for different types of decision, recognising that there may be different circumstances in which each decision should be revised.

We also support the provision to quash a decision and remit it to a new decision maker similar to provisions under the Medical Act (1983) – which represents a change to how revisions work under the AAPAO. Separating out the decision in this way will facilitate an independent review stage for certain decisions, as part of the revision process.

Appeals

Do you agree or disagree that the powers in the draft order provide individuals with sufficient and proportionate appeal rights? (Optional)

Agree

We partially agree with this. However, there are several areas where we still hold concerns and recommend that changes be made to the drafting to address these.

The overall framework is clearer and more consistent, and the range of decisions that may be appealed internally or to the courts appears broadly appropriate. However, some gaps remain, meaning that the appeal rights are not fully comprehensive. In particular, the draft order does not include an appeal route for decisions to vary or revoke an enhancement. Nor does it provide an internal appeal route for cases where a re-entry application is refused on the grounds that the applicant, having previously been removed for fitness to practise reasons, does not meet the standards for registration. These omissions limit the completeness of the framework and may result in inconsistent routes of redress for comparable decisions.

We also think more substantive changes to the drafting in respect of re-entry appeals are required to make clearer what exactly is appealable. For simplicity, we believe that the appeal in this instance should lie against the final decision to refuse the re-entry application (based on the decision of the registrar), rather than against a specific element that led to that final decision (ie the impairment decision or assessment of whether our registration standards are met).

The amended drafting would also need to clarify that all re-entry decisions would be appealable to an internal appeal panel, unless the registrar has made that decision because an FTP panel has

determined that the applicant is impaired (in which case the appeal should be directly to the courts).

Do you agree or disagree that GMC should have a right of appeal to these courts against specific interim registration measure and fitness to practise decisions made by a fitness to practise panel? (Optional)

Neither agree nor disagree

We note the proposed retention of the GMC existing right of appeal against final measure decisions made by a fitness to practise panel, and the proposed introduction of a new right of appeal against interim registration measures (where also made by a fitness to practise panel).

The Williams review into gross negligence manslaughter in healthcare had previously recommended that the GMC right of appeal against medical practitioner tribunal decisions should be removed, a recommendation which the government accepted.

The proposal to retain the GMC right of appeal for registration measure decisions by tribunals, and the introduction of a new appeal right for interim registration measures, is therefore a government decision, which we understand to have arisen from the Mann review recommendations. We note the rationale provided for this proposal in the report of the Review.

In the meantime, we will continue to exercise any appeal powers carefully and proportionately to protect the public.

Do you agree or disagree that PSA should be able to appeal specific fitness to practise decisions and interim registration measure decisions made by a fitness to practise panel to these courts? (Optional)

Neither agree nor disagree

We agree with the proposal to enable the PSA to appeal specific fitness to practise decisions made by a fitness to practise panel to the courts. This is consistent with the PSA's statutory oversight role and with existing arrangements that permit appeals in relation to final registration measure decisions.

Secondly, as with the related question above, we understand that the proposal to create a new appeal right for interim registration measure decisions has arisen from the Mann review recommendations. We note the rationale provided for this proposal in the report of the Review.

While we do recognise the additional safeguards that this new power will provide, the effectiveness of this measure will depend on the extent to which the legislation deals with the potential overlap between the PSA and GMC right of appeals. We would suggest that the GMC Order includes wording similar to s40B of the Medical Act (1983), which deals with the existing overlap for final measure appeals.

Do you agree or disagree that the draft order provides GMC with sufficient and proportionate powers and duties to administer its appeals function? (Optional)

Agree

We agree that the draft order provides broadly sufficient and proportionate powers and duties to administer our appeals function. We welcome the overall approach, particularly the flexibility to set out grounds for internal appeals in rules, which will allow these to be tailored appropriately across different types of decisions.

We also support the ability to revise appealed decisions without the need to proceed to a full appeal, where grounds for revision are met. This will allow us to resolve contested decisions or correct errors more swiftly – where appropriate to do so.