Private (non-NHS) prescribing: call for evidence

About you

In what capacity are you responding to this survey?

On behalf of an organisation

Question for organisations

What is the name of your organisation?

General Medical Council

Questions for both organisations and healthcare professionals

Which of these prescribing or dispensing services do you provide?

Oter. Form is glitching when I select none of the above so trying 'other' to get to the next page.

Do you provide NHS or private services?

Not applicable

Where do you work?

England, Northern Ireland, Scotland, Wales

Section 1: oversight and regulation

To what extent do you agree or disagree that existing mechanisms enable the effective oversight and regulation (including enforcement) of UK registered private prescribers?

Agree

To what extent do you agree or disagree that existing mechanisms enable the effective oversight and regulation (including enforcement) of EEA registered prescribers (with medicines dispensed in the UK)?

Disagree

To what extent do you agree or disagree that existing mechanisms enable the effective oversight and regulation (including enforcement) of medicines supplied under private PGDs?

Don't know

What are the strengths of the current regulatory regime for medicines accessed through private providers?

We set professional standards for all registered doctors, physician associates (PAs), and anaesthesia associates (AAs) working in NHS and private practice.

Good medical practice (GMP) is our core guidance, supported by more detailed guidance which expands on GMP. All registrants are expected to understand and follow these standards as relevant to their roles- working only within their competence. While PAs and AAs cannot prescribe prescription-only medicines, they may propose treatments for review if this falls within their competence and locally agreed scope of practice.

Registrants must adequately assess a patient's condition and only propose, provide, or prescribe drugs when they have sufficient knowledge of the patient's health (GMP, paras 7a and 7d). Our guidance on prescribing emphasises that principles of good practice apply across all consultation modes, including face-to-face and online. If standards cannot be met in the consultation setting, then registrants should offer alternatives or signpost to other services.

Where doctors, PAs and AAs encounter systems or policies that may place patients at risk, registrants must follow our guidance on raising concerns. For controlled drugs and medicines liable to abuse, doctors must follow relevant clinical guidance, including MHRA safety updates on opioids. If they don't have essential information from a patient's medical records, they must not prescribe such medicines unless specific exceptions apply and even then, only on a very limited basis (see paras 59-60, prescribing guidance).

If a doctor is not the patient's regular prescriber, they should seek consent to contact the patient's GP or other treating clinicians for further information, and to share details once care is complete (see para 28). If the patient objects or lacks a regular prescriber, doctors must explain the risks of not sharing information and justify and document any decision to do so. Where not sharing information could pose a risk to patient safety, they should explain to the patient that they cannot prescribe, outline their options and signpost them to appropriate alternative services (see paras 29-30).

Additional safeguards apply to remote prescribing. These include robust identity checks and appropriate information sharing (para 61). Where safeguards are lacking, doctors should raise concerns.

Beyond setting standards, we support implementation of them in several ways:

• Doctors must revalidate every five years to show they are fit to practise by reflecting on evidence that their skills are current and meet GMP standards. We are developing the same model for PAs and AAs.

• We work with external stakeholders to promote understanding of professional standards.

• We have outreach teams across the four countries of the UK who run workshops with our registrants to help them apply our professional standards to their practice.

• We publish learning materials and decision tools, such as our advice on remote consultations.

• We share intelligence across the regulatory system - formally through memorandums of understanding and the Emerging Concerns Protocols, as well as informally through our teams who meet regularly with key stakeholders in healthcare.

In 2019, we also led a collaborative effort with 13 healthcare regulators and organisations to establish high-level principles high-level principles for remote prescribing, published as part of a shared commitment to good practice and patient safety. The principles build on existing professional standards, and underline the importance of making patient safety the first priority: for example, by understanding how to spot vulnerable patients, and the responsibilities of professionals to raise concerns.

What are the limitations of the current regulatory regime for medicines accessed through private providers?

We're aware of some limitations within the current regulatory regime that may pose a risk to patient safety. This includes:

Private prescribers who offer online services from outside the UK

EEA prescribers aren't legally required to be registered with the GMC, so we don't always have assurance that they uphold the same professional standards as UK registered prescribers. Furthermore, we're also aware that some EEA prescribers that have previously been registered with the GMC and subject to fitness to practise (FTP) action may attempt to circumvent this by prescribing from the EU to UK patients.

If concerns are raised with us about a GMC-registered doctor working for an online provider based outside the UK collecting evidence about this can also be challenging as the online provider is under no obligation to provide information and we have no real mechanism to compel disclosure.

Continuity of care for patients

Continuity of care can be compromised if information sharing between private and NHS providers isn't effectively managed. Patient records and systems aren't integrated, and private providers may not be able to make contact with NHS doctors in a timely fashion, or patients may also refuse to consent to their information being shared, which can have consequences for continuity of care and patient safety in certain cases.

In paragraph 31 of our prescribing guidance, we are clear that if failing to share information could pose a risk to patient safety (for example, to gain access to medications that are not clinically suitable), registrants should explain that the treatment cannot be provided, and this decision should be clearly documented.

Shared care prescribing

We've heard from our clinical fellows as well as through general enquiries (these can be received from members of the public, registrants or other organisations- small numbers, however) that shared care prescribing between private and NHS organisations can be problematic if registrants can't assure themselves of the credentials of private specialists, or can't communicate effectively with them about a patient's care.

For example, we've received several enquiries about this from GPs where prescriptions have been requested by online gender specialists who are unwilling/unable to enter into a shared care arrangement.

How could the current regulatory regime for medicines accessed through private providers be strengthened?

Our role in the healthcare regulatory regime is to set and maintain standards for doctors, PAs and AAs and to regulate their practise. While the current regime provides strong safeguards, there are areas that can be strengthened.

Overseas online prescribers

The GMC cannot investigate or take regulatory action where concerns are raised about an EEA doctor's prescribing practices to UK patients where they are not registered with us. However, we strongly encourage doctors based overseas who want to remotely treat patients based in the UK to register with the GMC, obtain a licence to practise and follow our guidance on professional standards to support safe care and ensure regulatory oversight.

Measures could be taken to ensure that online private providers aren't able to circumvent UK regulation, or they should be able to demonstrate that the service offered upholds robust patient safety standards aligning with UK regulation. Careful consideration needs to be given to the arrangements for cross border healthcare in Ireland, where healthcare is increasingly delivered on an all island of Ireland basis resulting in patients transferred for treatment across the border, sometimes at short notice. It's important that any proposals for EEA prescriptions consider implications for healthcare professionals, patients, regulators and other stakeholders in Northern Ireland and the Republic of Ireland.

Types of medicines

We held a call for evidence in 2020 as part of the work to update the latest version of our prescribing guidance. Some respondents said they were against, or mostly against the remote prescribing of medicines that could lead to harm or misuse. Although other respondents objected to a blanket ban, as some patients may have a real need to access these remotely.

Some respondents suggested safeguards by way of limiting the quantity of certain medicines being prescribed to an individual, or not allowing repeat prescriptions. We updated our guidance to address the above concerns, but EEA prescribers who are not registered with the GMC are not subject to our standards and guidance, and we are unsure what their regulators say on these matters.

Respondents also gave evidence of concerns about inappropriate prescribing of antibiotics, where remote prescribers are not aware of local resistance patterns, for example.

Information sharing

Patients requesting medication from multiple providers was an issue that was identified in the coroner reports into the tragic deaths of Kim Robinson, Jamie O'Connor and Deborah Headspeath. Facilitating more effective information sharing about what medicine is being prescribed, both as part of continuity of care and so that unsafe access to medicines can be spotted would lead to safer and more effective care.

Where regulated providers have concerns relating to a healthcare professional working for them, they have a responsibility to share information about this with other providers for which the individual is also working. Timely sharing of information is an essential part of robust clinical governance, which we highlight clearly in the information sharing principles we developed with the support of partner organisations.

Alignment between regulators

In our 2020 call for evidence on prescribing, respondents highlighted the need for regulators to be consistent in their guidance on prescribing. Variations in regulatory standards and approaches can create complexity, particularly for private providers and on and online platforms that may interact with professionals regulated by different bodies. We would very much support a joined-up and collaborative approach to developing or updating any guidance that may follow from this call for evidence.

If you are aware of any data captured on medicines accessed through private providers, please provide details on the source of the data and how it is currently used.

We don't have any data sources that would be suitable for this.

To what extent do you agree or disagree that this data is sufficient to appropriately monitor this activity?

NA

To what extent do you agree or disagree that medicines advertising in the UK is effectively regulated?

Don't know

Please share any additional evidence you would like to contribute regarding the effectiveness of existing mechanisms to oversee and regulate private prescribing.

We asked our data teams to look at how many ftp referrals we received between 2020 and 2024, where the allegation mentioned private prescribing.

Private prescribing was mentioned in fewer than 2% of all prescribing-related FTP referrals (n.6169), and a smaller fraction progressed to an investigation. Over the period this represented between 7 and 18 referrals relating to private prescribing per year.

It's difficult to draw strong conclusions from this data, because we don't capture private prescribing as a specific category- so data may be missing. We're also relying on people reporting to us, and there will inevitably be cases where concerns go unreported.

Themes in FTP private prescribing enquiries included:

• Prescribing online without adequate risk/safeguarding assessments – including prescription of hormone medication for gender dysphoria.

• Prescribing privately without holding a licence to practise.

• Prescribing privately for friends/family.

• Forgery of private prescriptions to obtain controlled drugs.

• Failure to communicate with patients' GPs about private online prescribing.

• Online prescribing of large quantities of controlled drugs.

• Concerns from UK doctors asked to prescribe on the recommendation of a doctor in the EEA.

• Issues in the interface between private and NHS care – e.g. when NHS doctors do not follow prescribing recommendations made by private specialists.

While these issues are wide-ranging and not unique to private prescribing, some overlap with themes raised in our 2020 call for evidence, particularly:

• Poor information sharing between the private and public sector.

• Inadequate clinical assessments.

• Unsafe prescribing of controlled medicines.

Our investigations team have also recently flagged two cases involving private online services. The team identified a risk that doctors may over-rely on the systems and policies of private online providers as offering sufficient safeguards when they may in fact be inadequate. Ultimately, it is the doctor's responsibility to ensure that prescribing is safe and appropriate- and to raise concerns where this is not the case.

The team also highlighted the challenges in investigating concerns about GMC registered doctors considering the different online provider models. Where the online provider and the pharmacy that distributes the medication are based outside the UK, this presents challenges in evidence collection to substantiate concerns.

In relation to the regulation of advertising: we can't comment on how medicines advertising is regulated as a whole, but we do have some professional standards that are relevant to this area.

The principles for doctors, PAs and AAs who are involved in advertising their services are set out in GMP (paragraphs 88-91) and our more detailed guidance on using social media. Any information that the people on our register share must be accurate, not false or misleading; it must not exploit people's vulnerability or lack of medical knowledge and must be in line with wider duties to promote and protect the health of patients and the public. Any conflicts of interest must also be declared, and there are further duties on our registrants to actively manage conflicts of interest (identifying and managing conflicts of interest).

Registrants must also comply with relevant law, guidance and regulatory codes including those from the Committee of Advertising Practice, the Advertising Standards Authority and the Competition and Markets Authority (See also our guidance on Using social media as a medical professional, paragraphs 10-13).

We set out clear expectations of doctors, PAs and AAs with regard to conflicts of interest in our guidance on Identifying and managing conflicts of interest. We say if a registrant, someone close to them, or their employer has a financial or commercial interest in an organisation providing healthcare, such as a pharmacy or dispensary, they must not allow that interest to affect the way they prescribe for, advise, treat, refer or commission services for patients.

Doctors, PAs and AAs must be open and honest about any such interests that could be seen to affect the way they prescribe for, advise, treat, refer or commission services for them. They must not try to influence patients' choice of healthcare services to benefit them or someone close to

them. If their organisation dispenses medicines, we say that doctors must not allow their financial or commercial interests to affect the way they prescribe.

Section 2: patient safety and access to medicines

What do you understand to be the main reasons for patients to access medicines from private providers?

Patients turn to private providers to access medicines for a variety of reasons, many of which relate to accessibility, stigma, or the type of care available. The reasons we have identified are largely gathered from intelligence we received in our 2020 call for evidence as well as general enquiries that we receive.

A common driver is waiting times. Patients report difficulties in obtaining a timely diagnosis and access to treatment within the NHS, particularly for conditions such as ADHD where long waiting lists can significantly delay care. In these circumstances, patients may turn to private providers to seek quicker assessments and treatment options.

An example of this can be seen in Northern Ireland when patients have been waiting over a year for hospital treatment, they can access private treatment in the Republic of Ireland and prescription costs linked to a treatment episode are reimbursed. Prescriptions could also be dispensed in Northern Ireland.

Another potential factor is the stigma associated with accessing care in person. In our 2020 call for evidence, one independent healthcare provider suggested that for some patients, such as trans individuals, the experience of sitting in a waiting room may feel uncomfortable or exposing. Online platforms, often operated by private sector providers, can be perceived as a more discreet and a less stigmatising way of obtaining medicines and care.

Patients also seek access to medicines or specialist services not readily available through the NHS. This includes treatments such as medicinal cannabis, prescribed in certain cases for children with epilepsy, or medicines linked to gender reassignment. Where patients are unable to obtain these – or will experience a significant delay – through NHS pathways, they may look to private provision instead.

Broader changing attitudes to healthcare also play a role. Younger people in particular are familiar with digital platforms and are more likely to view online consultations and prescribing as a convenient and acceptable way to access services. The ease of access and familiarity with online interaction can make private sector platforms an attractive option.

Practical barriers also matter. For housebound patients or those in poorly resourced rural areas, online services offered by private providers may be one of the few accessible routes to obtaining medicines, as they reduce the need for travel and in-person attendance. There is also demand for cosmetic interventions that are not considered clinically essential and therefore not offered by the NHS, such as Botox and dermal fillers. Patients who wish to pursue such treatments must turn to the private sector.

Similarly, patients may choose private providers for wellbeing interventions that are not clinically proven, such as intravenous vitamin drips or intramuscular injections marketed as enhancing wellness. These are not offered on the NHS and are therefore accessed through private clinics.

We've heard from our clinical fellows that patients can attempt to circumvent a GP refusing to prescribe a drug that they consider is not clinically indicated or in their best interest, by obtaining the prescription privately.

What do you understand to be the main reasons for patients to access medicines from healthcare professionals under private PGDs?

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To what extent do you agree or disagree that patients can safely access medicines from UK private providers?

Agree

To what extent do you agree or disagree that patients can safely access medicines from EEA providers?

Disagree

What are the risks of patients accessing medicines through private providers?

We've identified the following risks from our 2020 call for evidence and general enquiries:

Limited access to patient records means that prescribers may fail to:

λ identify drug-seeking behaviour.

λ recognise where a patient is accessing medicines from multiple providers.

λ avoid inappropriate prescribing where allergies or contraindications are undisclosed.

λ provide appropriate repeat prescribing.

Prescribing of medicines which could cause harm. This includes:

λ inappropriate prescribing of antibiotics in remote and private settings as private providers may be operating nationally without reference to local resistance patterns.

λ independent providers prescribing inappropriate quantities of controlled drugs. There are also particular risks where patients have complex needs, but the prescriber does not have full access to their records.

λ women being overprescribed HRT (in particular, high levels of oestrogen) outside clinical guidelines and the terms of the medicine's licence.

Ineffective information sharing between private providers and NHS services. Issues include:

λ fragmented care and avoidable harm.

λ patients not providing consent to share information with their GP, patients assuming information will be shared with their GP, private providers relying on patients to relay information.

λ a patient's GP being unaware that an online provider has declined to issue further medicines as decision not communicated.

Lack of procedural systems and inconsistent IT safeguards which undermine safe prescribing by:
λ allowing multiple patient accounts.

λ not flagging duplicate prescriptions.

λ failing to enforce age verification, processing electronic prescriptions without linking to all relevant patient information, making it harder for prescribers to undertake a full review before issuing medication.

λ the absence of a national database that is accessible across providers is a barrier to ensuring joined-up care and preventing unsafe prescribing.

Reliance on online questionnaires to assess patients in place of robust clinical assessment. Risks include:

λ patients providing incomplete or misleading information, whether intentionally or unintentionally, and prescribers have limited means of validating these responses in the absence of wider medical records.

λ patients learning to 'game' questionnaires to obtain particular medicines, further increasing the risk of misuse or inappropriate prescribing.

λ poor practice in the pre-screening and monitoring of patients prescribed hair loss drug, Finasteride.

Vulnerable patients. Risks include:

λ hose holding victims of modern-day slavery and sex-trafficking may be more likely to use remote services for their victims

λ difficulties in confirming the identity and age of children and their carers may make children at increased risk of harm.

Doctors in the private sector not always following patient safety alerts for example for isotretinoin which has been raised with us as a concern by colleagues in MHRA.

Inability to investigate concerns about EEA doctors as they're not on our register. We can refer them to their regulator but there is no guarantee that they'll take the concerns forward as standards may differ.

Former GMC registered doctors circumventing FTP action of erasure from the register as either they were dual registered with another country, or they manage to enter the register of an EEA country despite our FTP action and disclosure to the regulator.

What are the benefits of patients accessing medicines through private providers?

The benefits we have identified are largely gathered from intelligence we received in our 2020 call for evidence on online prescribing as well as general enquiries.

Access to services

Private providers can provide access to certain specialist services, such as prescribing medical cannabis for children with epilepsy, which may be more difficult to access through NHS pathways. In this way, private provision expands patient choice and meets demand where NHS services are unavailable or limited. Where there are large waiting times in the NHS for a diagnosis of conditions such as ADHD and an associated NHS right to choose scheme, patients may seek private consultations and prescriptions. This may provide patients with more timely access to diagnosis and treatment, while alleviating some demand on NHS services (although this can come with its own challenges- see our answer to the question about the impacts that private prescribing can have)

Discretion Patients accessing care may prefer the discretion that private and online services can provide. As mentioned earlier, trans patients may feel uncomfortable or stigmatised when accessing care in person, and may therefore turn to private online platforms. These services can reduce barriers to care by allowing patients to access treatment in a more private environment.

Convenience Online platforms run by private providers may also be seen as more convenient. For some patients, particularly those who are housebound or in poorly resourced rural areas, remote access provides a practical alternative to in-person consultations. For younger patients, the familiarity and ease of digital interaction can make online prescribing feel accessible and aligned with their expectations of healthcare delivery.

How can the risks to patients from accessing medicines through private providers be mitigated?

In our 2020 call for evidence on remote consultations and prescribing we identified several areas that may be worth considering as mitigations:

Improving access to patient records and information sharing

Limited access to medical records was identified as a “core issue” for safe prescribing remotely. Without joined-up records, prescribers may be unaware of allergies, contraindications, or whether a patient is already receiving the same medicine from another source. The Paterson Inquiry also highlighted the issue of incomplete information sharing between the public and private sectors. Consideration could be given to strengthening expectations around the sharing of prescribing information, particularly with a patient’s registered GP, to reduce the risk of fragmented care.

Stronger safeguards around medicines with higher risks

Concerns were raised about the prescribing of antibiotics without regard to local resistance patterns, and the potential for inappropriate or excessive prescribing of controlled drugs. Additional safeguards may need to be considered for medicines with addictive potential, harmful

side effects or complex prescribing requirements, to ensure that patient safety is prioritised over convenience or commercial pressures.

Systems and IT infrastructure

Risks also arise where the IT systems private providers use are not designed to support safe prescribing. This includes systems that allow multiple accounts, fail to link prescribing to allergy or medication histories, or do not enforce robust identity checks. It may be valuable to consider whether a minimum standard of IT functionality should be expected to underpin safe prescribing across providers.

Procedural checks and professional safeguards

Respondents noted the difficulty of detecting drug-seeking behaviour or validating patient-reported information when consultations are remote. Reliance on online questionnaires can be problematic if patients tailor responses to obtain specific medicines. Encouraging providers to adopt procedural safeguards, such as verifying information where possible or ensuring appropriate follow-up with a patient's GP, could help mitigate these risks. Developing a system where all electronic and paper prescriptions by private providers can be tracked to collect data on prescribing practices within the private sector would be beneficial. This would provide an overall picture of prescribing habits, and potentially help to identify drug seeking or stockpiling of medication behaviours.

Patient identity and safeguarding

Concerns were also raised about whether sufficient checks are always in place to verify patient identity in online settings. Proportionate identity verification, tailored to the risks associated with the medicines being prescribed, could be one way to reduce the likelihood of inappropriate access.

To what extent do you agree or disagree that sufficient safeguards are in place to prevent harm caused by medicines accessed through private providers?

Don't know

To what extent do you agree or disagree that appropriate safeguards are in place to protect patients against counterfeit (fake) medicines?

Don't know

How easy or difficult is it for dispensers (pharmacists) and other healthcare professionals to verify the authenticity of prescriptions from UK private prescribers?

Don't know

How easy or difficult is it for dispensers (pharmacists) and other healthcare professionals to verify the authenticity of prescriptions from EEA prescribers?

Don't know

What are the risks associated with prescriptions received electronically from private providers, compared to on paper?

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In your experience, what medicines are patients seeking to access through alternative legal routes (non-NHS), and why?

Based on intelligence from our general enquiries, patients appear to seek access to a range of medicines and treatments through private providers, including:

• ADHD medication – where patients report difficulties accessing timely diagnosis and treatment within the NHS due to long waiting lists.

• Medical cannabis – this includes in relation to children with epilepsy, where families have sought access to medicines not routinely available on the NHS.

• Cosmetic and wellbeing interventions – such as Botox, dermal fillers, hair loss drugs, or intravenous vitamin drips, which are not typically available through the NHS as they are considered non-essential or not clinically proven.

• Hormone treatment – trans healthcare and menopause. It is difficult to determine the extent to which patients are turning to private providers specifically to access controlled drugs as compared with the NHS, though concerns have been raised in the context of remote prescribing.

In your experience, what is the impact on patient safety of medicines supplied under private PGDs?

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To what extent do you agree or disagree that private prescribing improves medicines access for people with protected characteristics within the meaning of the Equality Act 2010?

Don't know

Please describe any benefits or barriers related to inequalities you've observed that have been caused by private prescribing.

Based on feedback from 2020 our call for evidence on remote consultations and prescribing, insights from our general enquiries, and conversations with our clinical fellows, the following groups may experience benefits or barriers in relation to private prescribing: Groups who may benefit

• Age: Young people may benefit where private providers offer faster access to diagnosis and treatment, for example in relation to ADHD. However, where they cannot or do not want to continue with a private prescription of medication, they may face barriers (see below). They may also find online platforms more convenient and aligned with their expectations of healthcare delivery. Children with epilepsy may benefit from access to specialist medicines, such as medical cannabis, that are not always readily available through NHS routes. At the other end of the

spectrum, older adults who are housebound may benefit from access to online consultations and prescribing, provided they are IT literate or have support in using digital services.

• Gender reassignment: One Private Healthcare Provider in our 2020 call for evidence on online prescribing reported that trans patients may find private providers helpful in reducing barriers as they offer discretion and privacy, avoiding the stigma they may feel when accessing services in traditional waiting room settings. Trans patients may also find private providers help to reduce time barriers to care given the long waiting times they can experience before their first appointment with a specialist service provider in the NHS.

• Disability: People with conditions such as ADHD may experience quicker access to diagnosis and treatment through private providers compared to NHS waiting times. Housebound patients, including those with disabilities, may find online platforms particularly valuable for accessing prescriptions without the need to travel. Groups who may face barriers

• Age/IT literacy: Older patients who are not confident using digital technology may find online platforms less accessible, limiting their ability to benefit from private online prescribing.

• Young people: Long waiting times for NHS diagnostic services often lead parents to seek private assessments for neurodevelopmental conditions such as ADHD in their child – this is also supported by England by the “Right to Choose scheme”. While this can provide quicker access to a diagnosis, it creates significant challenges when they return to their GP for ongoing care. A recognised diagnosis is essential for accessing educational support and receiving medication free of charge. However, in Scotland, GPs cannot prescribe medication for ADHD, they have to refer the patient to a psychiatrist. In England, many GPs feel prescribing these medications falls outside their competency. Additionally, GPs may be unable to verify the processes and standards of private providers, or may not have the capacity to carry out ongoing monitoring, making them reluctant to enter shared care agreements. This lack of consistency in diagnostic models and prescribing responsibilities can result in distress for young patients and their families, as well as for GPs who feel professionally compromised.

• Socio-economic status (not a protected characteristic): While not covered by the Equality Act 2010, cost is also a barrier. Patients from lower socio-economic backgrounds may be priced out of private provision and therefore unable to benefit from the choice or convenience it offers.

To what extent do you agree or disagree that sufficient training and education on private prescribing is available to healthcare professionals?

Don't know

Please share any additional evidence you would like to contribute regarding the impact of private prescribing on patient safety and access to medicines.

In response to the question on whether there is sufficient training and education on private prescribing for healthcare professionals, we wanted to highlight the outcomes expected for graduates in relation to prescribing:

Outcomes 2 - Professional skills - GMC. We expect newly qualified doctors to be able to prescribe medication safely (para 18) and this includes being able to:

λ access reliable information about medications and be able to use the different technologies used to support prescribing (para 18e)

λ communicate appropriate information to patients about what their medication is for, when and for how long to take it, what benefits to expect, any important adverse effects that may occur and what follow-up will be required (para 18i)

λ recognise the risks of over-prescribing and excessive use of medications and apply these principles to prescribing practice. (para 18o)

The Practical skills and procedures list, which supplements Outcomes for graduates, also includes prescribing procedures (and an expected level of competence) medical students must have demonstrated before graduating" All medical schools have to demonstrate that their curricula will deliver the outcomes that we set and then we quality assure this as part of the way we oversee medical education.

Prescribing is also assessed as part of the medical licensing assessment: 'Prescribes, reviews, communicates and monitors the effects of medicines safely and effectively'

Beyond the GMC requirements there's also the Prescribing Safely Assessment which all Foundation year 1 doctors are required to pass.

For Physician Associates and Anaesthesia Associates, the relevant requirements for managing prescribed medicines safely are detailed at paragraph 29 of the document Physician associate and anaesthesia associate generic and shared learning outcomes.

Newly qualified PAs and AAs must be able to suggest or recommend commonly used medications to a prescriber safely, appropriately, effectively and economically, and be aware of the common causes and consequences of prescribing errors. They must recognise when to seek advice from other healthcare professionals and escalate the decision to the supervising doctor or healthcare professional, particularly when suggesting or recommending new medications. They must be able to manage and monitor the efficacy and effects of medication in a simulated environment We are not aware that there is additional training for private prescribing as the standards and education outcomes that we set are consistent regardless of what setting the prescribing is happening in.

Recent restrictions on the sale and supply of puberty-suppressing hormones

Do you wish to answer questions regarding placing restrictions on the sale and supply of puberty-suppressing hormones?

Yes

Restrictions on the sale and supply of puberty-suppressing hormones to under 18s for gender incongruence and/or gender dysphoria have been effective in limiting prescribing by UK private prescribers.

Don't know

Restrictions on the sale and supply of puberty-suppressing hormones to under 18s for gender incongruence and/or gender dysphoria have been effective in limiting prescribing by EEA registered prescribers.

Don't know

The prescribing of cross-sex hormones to under 18s for gender incongruence and/or gender dysphoria is undertaken in accordance with NHS guidelines (offered with extreme caution and with a clear clinical rationale) by UK private prescribers.

Don't know

The prescribing of cross-sex hormones to under 18s for gender incongruence and/or gender dysphoria is undertaken in accordance with NHS guidelines (offered with extreme caution and with a clear clinical rationale) by EEA registered prescribers.

Don't know

Government and NHS guidance on the sale and supply of medicines for gender incongruence and/or gender dysphoria to under 18s (puberty-suppressing hormones and cross-sex hormones) is sufficiently clear for frontline practitioners.

Don't know

Is there anything else you would like to tell us about the recent restrictions on the sale and supply of puberty-suppressing hormones?

We do not have a view on the recent restrictions on the sale and supply of puberty-suppressing hormones, as we do not give clinical advice or comment on the safety or appropriateness of treatments. However, we can confirm that we have an article on our website making doctors aware of the government regulations to restrict the use of puberty suppressing hormones. It directs to NHS England guidance for prescribers, pharmacists and dispensing doctors, as well as information for primary care.

Since the introduction of the ban, we have not seen a significant number of general enquiries or FTP referrals relating to it or its implementation. However, one thing to consider is that if patients are seeking to circumvent the ban by going to private providers based abroad then it is unlikely that they would want to make us, or any other regulator, aware of this.

Section 3: quality of care

In your experience, what impact does patient access to UK private prescribers typically have on the quality of care received?

Don’t know

In your experience, what impact does patient access to healthcare professionals operating under private PGDs typically have on the quality of care received?

Don’t know

In your experience, what impact does patient access to EEA registered prescribers have on the quality of care received?

Don’t know

How can the quality of patient care received from private providers be strengthened?

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To what extent do you agree or disagree that patients receive appropriate consultation and clinical advice when prescribed or supplied medicines by private providers?

Don't know

To what extent do you agree or disagree that patients are routinely monitored by an authorised healthcare professional when prescribed or supplied medicines by private providers?

Don't know

If there is anything else you would like to tell us about patient consultation and monitoring when accessing medicines through private providers, please include it here.

Our guidance, Good practice in proposing, prescribing, providing and managing medicines and devices, sets out the standards doctors must follow to support safe care in any setting.

Key expectations include:

λ Adequate assessment and consent: Doctors must be satisfied that they can make an adequate assessment of the patient, establish a dialogue, and obtain informed consent through the mode of consultation being used (paras 33–43).

λ Information sharing: Where doctors are not the patient’s regular medical professional, they must seek consent to share relevant information with the patient’s usual prescriber to ensure continuity and safety, particularly for treatments that require follow-up or monitoring (paras 26–32, 52–57).

λ Suitability of consultation mode: Doctors should agree with patients which consultation mode is most suitable and consider circumstances where a face-to-face consultation is more appropriate. This includes situations where capacity is uncertain, a physical examination is required, or there are safeguarding concerns (paras 20–21).

λ Communication and reasonable adjustments: Doctors must respond to patients’ communication needs and make reasonable adjustments so that care meets the patient’s needs (para 24).

λ Non-surgical cosmetic medicines: Physical examination is required for prescribing injectable cosmetic medicines, which must not be prescribed remotely (para 25).

These standards apply regardless of whether the doctor is working within private practice or the NHS and regardless of whether the consultation is face-to-face or online.

Please also see our comments in section two to the question 'What are the risks of patients accessing medicines through private providers?' This includes access through online platforms where we outlined some of the risks raised regarding the use of online questionnaires.

In your experience, what patient medical information is relied upon when prescribing privately?

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How effectively is patient medical information shared between NHS and private prescribers, and vice versa?

Our standards are clear about what is expected of doctors, PAs and AAs. In GMP we set out the need for doctors, PAs and AAs to contribute to the continuity of care for patients and that they must promptly share all relevant information about patients with others involved in their care, within and across teams, as required (para 65a).

In Good practice in proposing, prescribing, providing and managing medicines and devices, we state that if a doctor is not a patient's regular medical professional, they should ask for consent to contact the patient's GP or treating doctors to obtain or confirm information if this is needed before prescribing a medication (para 28). If failing to share information could pose a risk to patient safety, and the patient refuses consent, the doctor should explain that they cannot prescribe the medication (para 31).

While our guidance sets these expectations, we are aware that in practice, medical information is not always effectively shared between NHS and private prescribers. This remains a key challenge for ensuring continuity and safety of care.

For example, a recurring theme in our 2020 call for evidence on remote consultations and prescribing was the lack of effective information sharing between private providers and NHS services. Respondents highlighted that data sharing was often inconsistent or poor. In some cases, private prescribers relied on patients to pass on relevant information to their GP. In others, prescribers were constrained where patients withheld consent for information to be shared.

These gaps can create risks, such as doctors being unaware of drug allergies, concurrent medications, or patterns of drug-seeking behaviour and it also hinders continuity of care.

Some respondents pointed to service models where prescribers had access to more complete patient records, which they felt enabled safer prescribing by allowing them to confirm allergies or identify potential interactions.

If there is anything else you would like to tell us about private prescribing data, please include it here.

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What impacts does private prescribing have on the wider healthcare system?

We are aware of a number of challenges that arise when patients move between NHS and private care, particularly in relation to shared care arrangements.

Through general enquiries we have received, issues have been raised in the following areas:

• ADHD: “Right to choose” diagnoses made by private providers, with subsequent difficulties for patients in obtaining NHS prescriptions for medication.

• Medical cannabis: Prescribing in the private sector and the challenges patients face in transferring this care to the NHS.

• Trans healthcare: Hormone treatment prescribed by private providers and subsequent concerns about NHS providers being asked to dispense these medicines.

These examples highlight the impact on patient expectations and the wider system where there is uncertainty about responsibilities between providers, or disagreement about whether ongoing prescribing is appropriate.

Our guidance, Good practice in proposing, prescribing, providing and managing medicines and devices, sets out the shared care principles (paras 75–79). We are clear that if a doctor prescribes based on the recommendation of another professional, they must be satisfied the prescription is needed, appropriate for the patient, and within the limits of their competence. Shared care requires the agreement of all parties, including the patient, and effective communication between them. Importantly, if a doctor judges it unsafe to enter into a shared care agreement, they are not obliged to follow the recommendation.

In this way, while our standards provide clarity about what is expected of doctors, tensions between private and NHS care in practice continue to have an impact on patients and the wider healthcare system.

We're also aware that off label prescribing in private practice has had an impact on medicines shortages in recent years. For example, GLP-1 receptor agonists (GLP-1 RAs). In 2023 we published a joint statement with other statutory health and care regulators about this, to rasie awareness of the shortages being experienced by people with type 2 diabetes trying to access these medicines. https://www.gmc-uk.org/news/news-archive/joint-statement-on-meeting-regulatory-standards

Please share any additional evidence you would like to contribute regarding the impact of private prescribing on quality of patient care.

While this call for evidence primarily focuses on prescribing in the private sector, the services that private providers offer are broader than that and may need some consideration too.

Our fitness to practise investigation teams have highlighted the issue of private providers giving improper sick-notes or providing medical reports to support applications for firearms certificates despite not having access to a patient’s full medical record. It may be worth considering whether

these sorts of services should also be reviewed and whether some should always be performed by a patient's GP or named clinician, in particular where there are significant risks involved, such as where a patient is seeking a firearm certificate.

Submitting further evidence

Would you like to upload a contribution of data, research or other reports?

No