

Comment upon the General Medical Council undermining patient safety

See our draft answers to the main themes of the [DHSC GMC Order 2026 consultation](#). You can adapt/paste responses directly into the relevant free-text boxes of the consultation portal before the 23 June 2026 deadline.

Summary

Co-operators have always organised against the abusive use of power. In this case we reject the draft GMC Order 2026. This framework uses regulatory reform to hide systemic public service deskilling and will accelerate an unsafe, profit-driven two-tier healthcare system.

The catastrophic duty of care breach at the Royal Gwent Hospital, Newport, proves that expanding assistant roles to mask workforce gaps creates severe patient harm.

The NHS urgently requires more doctors in training, expanded training posts, better retention, and safe rota designs. It does not need underqualified substitution.

We strongly oppose the GMC's push to drop annual parliamentary reporting while gaining autonomous rule-making powers. Weakening any independent scrutiny threatens public safety.

While professional regulation is non-devolved, the Welsh Government controls training, funding, and deployment. We urge Welsh Ministers to enforce strict, binding safety directives across all Health Boards, or equivalent measures. They must make BMA scope of practice guidelines legally mandatory to protect patient safety.

Part 1: The Register & Public Information (The "Single Register" Proposal)

Consultation Focus: The GMC's new duty to hold a single, combined register for doctors, PAs, and AAs.

Response: Do Not Support / ~~Support only with strict safeguards.~~

Our opposition to a single statutory register is rooted in our foundational support for the NHS as a system of social ownership, owned in common for the benefit of all, and explicitly not one driven by profit or commercial market forces. Merging doctors and non-doctor roles into a single GMC database is seen by many as an ideological step toward a dangerous two-tier health service.

Our concern is that any fractured model will mean that those who can afford it will pay for private medical care to see a fully qualified doctor, while ordinary citizens relying on the public system are funnelled toward less-qualified staff.

The catastrophic failure at the Royal Gwent Hospital—where a PA undertook an advanced, invasive lumbar puncture without medical supervision—proves that when professional lines are erased, the public system erodes.

A numeric majority supporting this single register does not validate its safety. If a single data architecture is used, the public interface must be split into a completely separate, visually

distinct medical register for doctors to preserve public trust and equal access to qualified care.

Part 2: Professional Titles & Public Clarity (Leng Review Implementation)

Consultation Focus: Changing professional titles to improve clarity for patients (Recommendations 1 and 9 of the Leng Review).

Response: Support stronger, explicit protections.

Changing titles without binding legislative restrictions on clinical practice fails to protect the public interest. The Royal Gwent case highlights the systemic danger: a vulnerable patient was subjected to a traumatic, unauthorized procedure by a non-doctor practitioner, and the health board initially failed to inform the family. This represents a total failure of accountability.

Shifting terminology from 'Associate' to 'Assistant' is a bureaucratic distraction if these professionals are still deployed to fill doctor rota gaps. We are deeply concerned that both officials and politicians have fundamentally failed to get to grips with the systemic deskilling actively taking place.

This draft Order serves as a mechanism to institutionalise that deskilling. The law must mandate clear, standardised identifiers—including uniform ID badges and explicit appointment letters—stating: 'I am a Physician Assistant; I am not a medical doctor.'

Part 3: Regulation, Standards, and Education

Consultation Focus: Giving the GMC enhanced flexibility to set standards for education, training, and registration pathways.

We strongly object to granting the GMC autonomous flexibility to set standards without rigid, independent oversight. When national clinical guidelines are treated as optional—as seen in the Royal Gwent incident—patients suffer long-term trauma. Giving the GMC the power to flexibly amend regulations allows workforce gaps to be filled by unsafe substitution under the cover of regulatory reform. This is a direct official and political failure to address the core workforce crisis, choosing instead to deskill frontline public services.

The legislative framework must legally bind the GMC to enforce a strict, non-blurrable separation between medical training and associate training. It must explicitly mandate that a fully qualified, clearly identifiable doctor retains ultimate clinical responsibility and direct, real-time supervision for all care delivered by non-doctor roles, protecting the NHS from degradation into a two-tier system.

Part 4: Fitness to Practise & Governance

Consultation Focus: Overhauling the fitness to practise process and removing routine Privy Council oversight for GMC rule changes to make the regulator more "agile".

Response: Do Not Support the removal of independent oversight.

We strongly oppose removing routine independent oversight, such as Privy Council approval, for GMC rule changes. Crucially, the GMC proposes that it will no longer report annually to Parliament. If this draft Order gives the GMC highly flexible, autonomous rule-making powers while simultaneously stripping away external parliamentary accountability, robust safeguards must be built into the legislation from the outset. Reduced external

control allows a regulator to prioritise institutional convenience and political targets over patient safety.

The Royal Gwent Hospital incident—where a PA undertook an advanced, invasive lumbar puncture against clinical guidelines, followed by alleged falsification of clinical notes—proves that when oversight is weak, patients face catastrophic harm.

Public interest is further undermined by the way the GMC is appointed, which features zero transparency or democratic accountability. We are deeply concerned that the UK government proposes to continue permitting the GMC to appeal Medical Practitioners Tribunal Service (MPTS) findings. This creates a fundamentally asymmetric, hostile system.

Furthermore, the legislative architecture exposes a stark constitutional inequality: while Scotland and Northern Ireland retain significant powers in relation to professional regulation, in Wales it remains a case of 'see England', forcing Welsh patients to rely on a Westminster framework that ignores local operational realities.

We urge the UK Government to ensure the retention of mandatory external scrutiny, strict statutory accountability to Parliament, and a removal of the GMC's right to appeal independent tribunal outcomes.

Part 5: Overall Impact & Patient Safety (General Comments)

Consultation Focus: Any further comments on the impact of the draft GMC Order 2026.

A. Inaccessible Consultation Framework and Democratic Deficit

As a collective, we wish to record our profound concern regarding the format of this public consultation. The documentation is highly convoluted and technically prohibitive, effectively restricting meaningful participation to industry insiders. This structure systematically suppresses public response rates. We reject the premise that an agreeable majority among a restricted pool of respondents equates to broad public acceptance. This represents a severe regression from the public engagement standards established by the GMC in the 2000s under Sir Graeme Catto.

B. Systematic Risks to Patient Safety and Public Trust

The proposals in this Order consolidate complex regulatory shifts without adequate safeguards for patient safety. This systemic disregard for clinical standards directly undermines public and professional confidence in the NHS, political leadership, and regulatory bodies. We join calls for the Secretary of State for Health and Social Care, with devolved governments, to urgently instigate an independent, comprehensive review into professional healthcare regulation to re-establish institutional accountability and public trust.

C. Disproportionate Regulatory Culture

We are deeply alarmed by an evolving regulatory culture that appears to prioritise political conformity over clinical excellence. Under current frameworks, fully qualified medical practitioners risk losing their registration for non-clinical civil disobedience linked to personal conscience. Meanwhile, institutionalised role confusion and systemic clinical

risks are actively accommodated. The priority of regulation must remain strictly focused on patient safety, not policing personal morality.

D. Workforce Degradation and the Two-Tier Healthcare Model

The NHS is a common ownership asset, funded publicly for the benefit of all. It must not be leveraged to facilitate workforce downgrades or transition into a profit-driven, two-tier system. Expanding medical assistant roles without addressing core structural failures—including doctor unemployment, specialty training bottlenecks, and consultant workforce vacancies—compounds the crisis. The public interest is entirely unserved by utilising less-qualified roles to plug structural gaps. We demand a strategy focused on increasing training posts, securing retention, and implementing safe rota designs for qualified medical doctors.

E. NHS Wales training, funding, and deployment

While professional regulation is a non-devolved Westminster matter, the Welsh Government holds full, devolved responsibility for NHS Wales training, funding, and deployment. The Royal Gwent Hospital breach proves local employer deployment frameworks are failing. We call on the Welsh Government to use its devolved authority over workforce deployment to reject the ongoing deskilling of our public services.

Even if the UK government forces a single register through, the Welsh Government must issue a legally binding deployment directive across all Welsh Health Boards, or equivalent, making the BMA scope of practice guidelines strictly enforceable, banning non-doctors from advanced clinical procedures, and ensuring a fully qualified doctor is always physically present for real-time supervision.

All in all, this is a totally poorly conceived set of proposals. This flawed legislative process should be halted immediately in favour of a more thorough, transparent, and democratically accountable review of the GMC and wider healthcare professional regulation.