The General Medical Council Order 2026 presents a complex legal, technical maze that effectively marginalises the patient's voice on critical safety issues. A mere numerical majority cannot validate policy when patient safety is at stake. Our framework establishes transparent patient expectations for a publicly funded **NHS**. It serves as a direct, rigorous response to the jargon-laden consultation questions designed by a few with vested financial interests in the outcome.

UK Patient Safety and Regulatory Reform

This is not a technical response to the GMC Order consultation - deadline 23/6/2026. https://www.gov.uk/government/consultations/reforming-the-general-medical-council-legislative-framework The argument is not that multidisciplinary teams are wrong. It is that patients must not be misled, accountability must not be blurred, and workforce gaps must not be filled by unsafe substitution under the cover of regulatory reform.

The central point is that the NHS workforce crisis must not be addressed by blurring the distinction between doctors and non-doctor roles. Patients must be able to understand who is treating them, whether that person is a doctor, what they are qualified to do, and who is clinically responsible for their care.

The draft GMC Order is therefore not just a technical regulatory change. It is a patient safety issue. The danger is that the public may see “GMC registered” and assume equivalence with a doctor, even where the practitioner is a physician assistant or physician assistant in anaesthesia. That risk needs to be addressed directly and clearly.

- The patient-facing test much more explicit:
- Would an ordinary patient know whether they are being treated by a doctor?
- Would they know what that practitioner is qualified to do?
- Would there be a clearly identifiable doctor responsible for supervision, escalation and overall clinical accountability?
- If the answer to any of those questions is no, then the Order needs stronger safeguards.

  Patients need:

1. **A clearly separate and patient-visible medical register**. If the Government proceeds with a single statutory GMC register, then the register of doctors must still be clearly distinct in all public-facing systems, employer checks, patient information and clinical settings. A technical subdivision within a broader GMC database is not enough.
2. **Clear implementation of the title changes recommended by the Leng Review**. The term “physician associate” has caused public confusion. “Physician assistant” is a more accurate description of the role and should make clearer to patients that these practitioners are not doctors.
3. **National scope and supervision limits**. Local employers should not be free to use physician assistants as substitutes for doctors in undifferentiated, high-risk or inadequately supervised clinical work. This is particularly important in emergency, acute and primary care settings.

4. **Explicit medical accountability.** Every deployment model should identify the supervising doctor, the limits of delegated work, escalation thresholds, and the process for reviewing errors, near misses and complaints. Vague “team supervision” is not sufficient where patient safety is at stake.
5. **A clear statement that regulation of assistant roles is not a substitute for medical workforce planning**. The NHS needs more doctors in training, more training posts, better retention and safe rota design. Expanding assistant roles without fixing doctor unemployment, specialty training bottlenecks and consultant workforce gaps risks worsening the workforce crisis rather than solving it.

If the GMC propose they no longer report annually to Parliament, it makes it even more important that safeguards are built in from the outset - if the draft Order is to give the GMC more flexible and autonomous rule-making powers, reducing external control over many future rule changes.