The Royal College of Pathologists
Pathology: the science behind the cure

Reforming the General Medical Council legislative framework – RCPath response

June 2026

1 Introduction

The Royal College of Pathologists (RCPath) welcomed the opportunity to respond to the draft General Medical Council Order 2026, which would reform how the General Medical Council (GMC) regulates medical practitioners, physician associates and anaesthesia associates across the UK.

The proposals set out in this consultation, which is a joint consultation on behalf of the Secretary of State for Health and Social Care and the Scottish ministers, seeks insights and experiences to shape regulatory reforms that underpin high standards, uphold public confidence and, most of all, protect patients and the public for generations to come.

The response focused on the importance of the role of medical royal colleges, including RCPath, in continuing to determine the high standards of training and capability required to achieve specialist status.

The response was collated by the Workforce and Engagement team within the Professional Practice Directorate, informed by feedback from Specialty Advisory Committees and the Trainees' Advisory Committee. The response was submitted via an online form and all questions were optional. The questions asked are listed below with the RCPath responses in the text boxes below each question.

2 Commencement

We need to ensure that the commencement of the General Medical Council Order 2026 is managed in a safe and effective way that mitigates the risks of a regulatory gap during this transition.

A 'coming into force date' mechanism has been included for parts 2 to 10 of the draft order. However, we have not specified a date for when parts 2 to 10 come into force as per article 2(2)(b) of the draft order. Article 2(2)(b) relates to the coming into force of the majority of the provisions within the draft order.

Although a coming into force date for the General Medical Council Order 2026 would provide clarity, there would be advantages in allowing flexibility regarding when provisions are activated, in particular for areas involving transition of cases from the old framework to the new. This could be achieved by specifying dates in tertiary legislation – for example, to be made through a Privy Council Order.

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?
Neither agree nor disagree.

Please explain your answer.
It is recognised that there is no final coming into force date for this draft order, to give the GMC flexibility – which is appreciated given the potential complexity of the changes. We have some reservations that the new framework could have implications for fitness to practice proceedings in progress, as well as any current registration or specialty registration and portfolio pathway applicants. There is need for advice on how, without a clear timeline, the government will implement these changes without a regulatory gap and while avoiding any confusion among registrants.

3 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?
Agree.

Please explain your answer.
We agree that this is a fair and proportionate.

Parts 2 to 4 of the draft order relate to GMC's governance and operating functions. This includes provisions relating to:

- delegation of exercise of functions
- disclosure of information
- guidance
- annual reports
- fee setting and other financial requirements
- default powers of the Privy Council.

The provisions in these sections aim to improve the efficiency of GMC's administrative functions, reducing bureaucracy.

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?
Agree.

Please explain your answer.
We agree that this is fair and proportionate.

Schedule 1 of the draft order includes provisions to enable GMC and MTS to effectively operate. It outlines how the GMC board may operate under the order, how committees may function and how adjudicatory bodies such as appeal panels may operate. It also puts a duty on GMC to appoint a registrar and case examiner or case examiners to exercise certain functions on behalf of GMC. In addition, the Privy Council must, by order, make further provision as to the constitution of the regulator.

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?
Disagree.

Please explain your answer.
The draft order does not provide assurance that medical practitioners will be represented within governance structures. We note that Schedule 1, Part 1 would allow the GMC's governing body to be constituted without a single medical practitioner. Given the expansion of the GMC's remit to include physician assistants and physician assistants in anaesthesia, the current draft order could permit a governing body composed entirely of lay members and/or members of other regulated professions by the GMC. Given the GMC's expanding responsibilities across education, training, specialty recognition and registration, it is essential that medical expertise remains central to this decision-making, not just as an option but as a requirement.

The draft order proposes that the Privy Council's default powers continue to apply (they are currently contained in section 50 of the Medical Act 1983). These are powers which the Privy Council may use if it feels that GMC has failed to carry out its regulatory functions. In relation to GMC's rule-making powers in the draft order, the Privy Council will no longer be required to approve new rules or rule changes made by GMC under the draft order. However, should any future rules be deemed to require Privy Council approval, such approval will be put in place.

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?

Disagree.

Please explain your answer.

We disagree that the powers and duties in the draft order in relation to the Privy Council are sufficient. While reducing bureaucracy and improving efficiency are reasonable objectives, the proposals increase the autonomy of the GMC without introducing equivalent safeguards.

The Privy Council currently provides important independent oversight of the GMC's rules, including approval of significant changes. Removing this requirement risks weakening checks on the regulator's rule-making powers. The draft order gives the GMC broad discretion to make and amend rules without routine external approval, raising concerns about oversight of decisions that can directly affect registration, fitness to practise, and education and training. It is unclear how this increased discretion will be balanced by ongoing Privy Council oversight, or when such oversight would be reintroduced.

No organisation with such wide-ranging statutory responsibilities should operate without robust external scrutiny, particularly in the interests of patient safety. The reduction in Privy Council oversight, the lack of clarity around safeguards for rule-making and limited assurance regarding the representation of medical practitioners within governance structures, raises concerns about whether appropriate checks and balances are in place to ensure the GMC is carrying out its functions effectively.

4 PSA evidence gathering

The draft order, as per a recommendation of the Mann Review, provides for a consequential amendment to be made to the National Health Service Reform and Health Care Professions Act 2002 to allow PSA to have a power to compel information from GMC.

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

Agree.

Please explain your answer.

We agree that the draft order provides the PSA with sufficient and proportionate evidence-gathering powers. Strengthening the PSA's ability to obtain information is an important safeguard that ensures effective oversight of the GMC's functions.

5 Education and training

The draft order sets out that GMC can approve overseas undergraduate, foundation and postgraduate education and training programmes.

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.

Neither agree nor disagree.

Please explain your answer.

We support the principle that the GMC should be able to approve high-quality overseas education and training programmes where they demonstrably meet standards equivalent to those required within the UK. However, approval should be supported by rigorous and transparent quality assurance processes. We are concerned that the draft order does not provide sufficient assurance regarding how standards will be assessed, monitored and maintained. In particular, the wording suggests that direct assessment of training environments may occur but does not require it.

Recognition of overseas programmes should involve specialty-specific expertise, including meaningful input from medical royal colleges, and should include robust mechanisms for monitoring, review and reassessment. Specialty colleges remain best placed to design and approve specialty training programmes, as they understand the

needs of their members as well as the communities they serve. International pathways should only be recognised where they demonstrably achieve standards equivalent to UK specialist medical training, to ensure that patient interest and safety remain the highest priority.

We recognise that the order will not include the level of detail that outlines a mechanism for ensuring that the quality of the training and/or experience is of a sufficient level to ensure safe NHS practice. However, before we can support this, we need to understand the robustness of the process underpinning the order.

Part 5 of the draft order relates to GMC's education and training functions. This includes provisions relating to:

- standards in connection with practising as a regulated professional
- approval of education and training, an examination or assessment or a qualification
- supply and production of information and evidence
- criminal offences
- certification of completion of a course
- other related powers.

Our proposed changes aim to enable GMC to undertake more flexible and swifter education and training functions.

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?
Neither agree nor disagree.

Please explain your answer.
The draft order (part 5) proposes to provide the GMC with broader and more flexible powers in relation to education and training. We understand that the intention is to enable the GMC to undertake its education and training functions in a more flexible and responsive way, including adapting more quickly to changes in workforce and service needs.

While we welcome and recognise that introducing more flexibility into the GMC's education and training functions may have benefit, there are concerns about the implementation of and implications of this order practice. These concerns sit alongside the proposed revocation of the Postgraduate Medical Education and Training (PMET) order (see section below), and we would welcome reassurance as to how these will be addressed.

Of critical importance is ensuring that medical input remains a core part of standard setting, and that there is clear public understanding of the role of doctors and the training they have undertaken. The use of broad terms such as 'regulated professional' and 'persons as the regulator considers appropriate' risk not clearly distinguishing medically qualified practitioners from other regulated healthcare professionals, nor do they provide assurance that specialty expertise will remain central to decisions regarding education and training.

We are concerned that the proposed framework substantially expands the GMC's powers in education and training while weakening the role of medical royal colleges in defining and maintaining specialist standards. Although generic professional competencies are fundamental to medical practice, consultant-level practice depends upon specialty-specific knowledge, judgement, standards and professional identity developed through advanced postgraduate medical training. These standards are not optional additions to generic training but represent the culmination of the specialist training pathway and underpin safe independent specialist practice.

The draft order permits the GMC to determine standards, qualifications, examinations, assessments and certification with broad discretion and without a statutory requirement to involve medical royal colleges. This risks transferring responsibility for defining specialist standards away from organisations with the greatest specialty-specific expertise. We are also concerned by provisions allowing variation of training standards and by the lack of clarity regarding how qualifications, assessments and training pathways may be deemed equivalent. Any future framework must ensure that flexibility does not result in dilution of the standards required for independent specialist practice.

There is further need to consider the potential impact on smaller specialties. The current medical royal college structure enables specialties of varying size to contribute meaningfully to curriculum development, assessment design, standard setting and

quality assurance. A more centralised approach risks disadvantaging smaller specialties whose training requirements may be less visible within a national regulatory framework.

6 PMET Order of Council 2010

As a consequence of modernising the GMC's register and legislative framework, many of the current provisions contained within the Postgraduate Medical Education and Training Order of Council 2010 ('the PMET Order') will become obsolete.

The draft order therefore proposes that the PMET Order is revoked, including the list of recognised specialties currently contained in the schedule to the PMET Order, and the Privy Council is given a power to specify categories of speciality in practice in the UK in an order of council.

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?
Neither agree nor disagree.

Please explain your answer.
The current framework provides a clear statutory relationship between recognised medical specialties, approved postgraduate training pathways, CCT and specialist registration and this relationship provides transparency for patients, employers and healthcare professionals and supports confidence in specialist accreditation.

We have some concerns about how specialty recognition would be delivered through GMC-determined 'enhancements' applied to a single register. Insufficient information has been provided regarding how enhancements would be awarded, maintained or removed, making it difficult to determine whether the proposed system would provide safeguards equivalent to those that currently exist. Reassurance is required that specialist accreditation will not become increasingly detached from recognised medical training pathways.

As previously mentioned, we are also concerned that the proposed framework may disproportionately affect smaller specialties. The current statutory recognition of specialties provides clarity and protection irrespective of workforce size. Moving specialty recognition into a more flexible enhancement-based model creates

uncertainty regarding how smaller specialties will be recognised, represented and protected in future.

Despite these concerns, we acknowledge that there are benefits to the proposed changes that will allow for much needed flexibility, ensuring that specialty recognition is agile and aligns with the role that doctors are performing. For example, we recognise that this will allow medical royal colleges to progress with name changes for specialties more swiftly through the Privy Council – where currently there are significant delays in the system.

The balance is to ensure that workforce flexibility does not come at the expense of maintaining clear, trusted and professionally grounded standards for specialist medical practice. The College would welcome the opportunity to be engaged in further discussions about implementation of the proposed changes should they be approved.

7 Registration

The draft order provides that medical practitioners may be able to be registered despite having a complete restriction on registration. This means they will be registered as a medical practitioner but not allowed to practise. A medical practitioner may choose to have a complete restriction on their registration, or a complete restriction could be, for example, the result of failing to complete periodic assessment.

Do you agree or disagree that doctors should be able to be registered with a complete restriction on registration?
Neither agree nor disagree.

Please explain your answer.
We recognise that there is value in allowing doctors to remain registered while not actively undertaking clinical practice, for example during periods of research, academic work, career breaks, retirement or while working overseas. We therefore do not object in principle to a mechanism that enables doctors to remain on the register without practising, similar to the current position of being registered without a licence to practise.

However, we have concerns about the proposed terminology of 'restriction' and how this may be interpreted by the public and the profession. The use of the term 'restriction' could be viewed with negative connotations, where it is used to describe both doctors is in good standing who are not practising, and those whose practice is limited due to fitness to practise concerns or regulatory sanctions. It is essential that there is a clear differentiation on the public register between:

- doctors in good standing who have voluntarily chosen not to practise
- doctors in training who may have defined or supervised scopes of practice as part of their progression, rather than as a result of regulatory concern
- doctors whose practice is restricted because of regulatory or conduct proceedings.

The terminology and presentation of this information must be designed to avoid any misunderstandings and to maintain public confidence.

We also note the different approach being proposed for physician assistants and physician assistants in anaesthesia, who will not have restrictions applied and will instead be either registered or not registered. While this may offer clarity for this regulated group, applying different rules within a single register risk confusing the public and undermining transparency, as it may not be clear that different standards and categories apply to different professional groups.

Part 6 of the draft order relates to registration and includes provisions regarding the process of entering the register. It also includes provisions which enable GMC to provide assurance that individuals on its register have the necessary education, training, knowledge, skills and experience required to practise safely in the UK.

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

Please explain your answer.
While we recognise the intention to simplify the registration system and agree in principle that the Specialist and GP Registers *could* be replaced with a single, doctor-

only register with specialist status recorded through annotations or enhancements, this must not come at the expense of transparency or statutory safeguards.

The proposal to maintain a single register that includes both doctors and other regulated professionals (such as physician assistants and physician assistant in anaesthesia) risks further blurring of the distinction between doctor and non-doctor roles. The Leng Review emphasised the need for clearer boundaries between doctors and non-doctor roles. In this context, merging professions within a single register appears contrary to those aims and risks further muddying the distinction between doctors and non-doctors, rather than improving clarity for patients and the public.

Additionally, the proposed revocation of the PMET Order, and the lack of clarity regarding the relationship between legislative specialty accreditation and how the GMC will determine and apply annotations or enhancements for specialty and scope of practice, is concerning. Patients and employers currently benefit from a transparent, legislatively underpinned framework that identifies those who have completed recognised specialist medical training and achieved nationally recognised standards for specialist practice.

However, it is not clear how the GMC will determine the criteria and governance of the ‘enhancements’, nor how they will consistently link to recognised specialty training pathways. This creates uncertainty about the robustness and credibility of specialist recognition.

In a single-register model that includes multiple professions, it is also unclear whether similar or overlapping ‘enhancements’ could be developed for different professional groups, potentially leading to confusion where an area of practice (e.g. a specialty) appears to be shared across professions with very different training and qualifications requirements.

We are also concerned about the impact on smaller specialties. The current statutory framework provides visibility and protection for specialties regardless of workforce size. The proposed model introduces uncertainty as to how smaller specialties will be recognised within a single-register system.

8 Protection of title

Protected title status means it is a criminal offence for someone to practise and use a protected title without being registered with the relevant regulator and on the relevant register, or part of the register, relating to that regulated profession.

The draft order proposes that the titles of ‘apothecary’ and ‘licentiate in medicine and surgery’ should no longer be protected in legislation as they are not reflective of current practice. It also proposes that the title of ‘bachelor of medicine’ should no longer be protected as this is linked to a qualification rather than a professional 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)

Neither agree nor disagree.

Under the draft order, ‘registered medical practitioner’ is due to become a protected title.

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

Agree.

Please explain your answer.

We agree that ‘registered medical practitioner’ should be a protected title.

However, we would also urge caution in the use of broader, non-statutory terms such as ‘medical professional’. This term is not clearly defined in legislation and may be used to describe multiple professional groups regulated by the GMC. These risks creating ambiguity for patients and the public. Clear, legally defined titles are essential to ensure that individuals can distinguish between doctors and other roles, and to avoid any confusion about qualifications, training, and scope of practice.

In line with the recommendation of the Leng Review, the draft order proposes that ‘physician assistant’ replaces the title of ‘physician associate’, and ‘physician assistant’ becomes a protected title.

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

Agree.

Please explain your answer.

We agree with the findings of the Leng review, that greater clarification is required doctor and non-doctor roles. The use of 'associate' is misleading and should be changed and protected in law.

To allow time for the healthcare service to implement the new titles effectively, we are proposing that the protection of the 'physician assistant' and 'physician assistant in anaesthesia' titles will commence following a transition period of 6 months after the order comes into force, if approved by Parliament.

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

Disagree.

Please explain your answer.

We do not agree that a transition period is necessary. The Leng Review was published in July 2025 and recommended changes to professional titles to improve clarity and clear boundaries between doctor and non-doctor roles. There appears to be no fair or reasonable justification for delaying the implementation of these recommendations.

Given the importance of this regarding patient safety, the transition to the titles 'physician assistant' and 'physician assistant in anaesthesia' should be implemented as soon as possible. Prolonging the use of existing titles risks perpetuating confusion for patients and the public.

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

No.

Please explain your answer.

There should not be any protection of these titles alongside the proposed titles. Keeping these titles protected undermines the rationale for changing them.

9 Fitness to practise – mandatory removal from the register

The draft order requires the GMC to mandatorily remove a registrant from its register, if the registrant has been convicted of a serious criminal offence, as set out in schedule 4 (known as a listed offence), without GMC having to investigate or MTS having to hold a fitness to practise panel hearing to determine whether the registrant's fitness to practise is impaired.

Do you agree or disagree with the listed offences set out in schedule 4 of the draft order?
Agree.

Please explain your answer.
We agree that this is a fair and proportionate.

Under the draft order, former registrants of GMC who have been mandatorily removed from the register following conviction for a listed offence in schedule 4 of the draft order will not be able to apply for re-entry to the register.

Exceptions would apply where the conviction has been quashed or was for a lower-level listed offence (blackmail or extortion), and the custodial sentence has been quashed and replaced with a non-custodial sentence.

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?
Agree.

Please explain your answer.

We agree that this is a fair and proportionate.

10 Fitness to practise – grounds for action

Grounds for action set out the basis on which regulators can investigate and take action where there is a concern about a regulated healthcare professional's fitness to practise. A regulated professional's fitness to practise can only be found to be impaired if 1 or more of the grounds for action are met.

The draft order proposes that the fitness to practise of a regulated professional may be impaired if the regulated professional:

- is unable to provide care to a sufficient standard
- has behaved in a way which amounts to misconduct
- is adversely affected by a physical or mental health condition.

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

Please explain your answer. Do not include any personal information in your response. (Optional)
We agree that the grounds for action set out in the draft order are in general, fair and proportionate. We welcome the inclusion of adverse physical or mental health as a separate ground for action within Article 49(1)(c). This recognises the importance of health as a distinct factor for fitness to practise and supports compassionate regulatory approaches.

11 Fitness to practise – proceedings

Fitness to practise proceedings are one of the primary ways by which GMC ensures public protection. The fitness to practise model outlined in the draft order aims to make fitness to practise proceedings swifter, fairer and less adversarial for GMC's registrants and people who raise concerns.

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?
Neither agree nor disagree.

Please explain your answer.
We broadly agree that the fitness to practice framework seems a fair and proportionate approach across the 3-stage model.

However, we are concerned that the draft order does not require tribunals considering doctors' fitness to practise to include a medical practitioner. As drafted, tribunals could be composed without direct medical expertise. The order should be amended to ensure medical practitioners are involved in decisions relating to doctors' fitness to practise.

12 Interim registration measures

Under the draft order, a fitness to practise panel's powers will be extended so that the panel can impose interim registration measures during registration proceedings, as well as during fitness to practise proceedings.

This would allow the panel to impose an interim registration measure while investigating whether a register entry is fraudulent, for example.

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?
No response.

13 Evidence gathering

Under the draft order, the GMC may, for the purpose of gathering evidence in connection with registration, fitness to practise and interim registration measure proceedings, require a person to supply such information or produce such a document as the GMC may specify. The GMC will also be able to require a witness to attend a fitness to practise panel hearing or an appeal panel hearing.

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

Agree

14 Rule-making powers

Under the draft order, the GMC is able to make rules on specific procedures in relation to:

- governance and operating framework
- education and training
- registration
- fitness to practise
- interim registration measures
- revision of decisions and internal appeals.

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?

Neither agree nor disagree.

Please explain your answer.

We recognise that the GMC should be able to make rules across key areas such as education and training, registration and fitness to practise, and that greater flexibility may support more efficient regulation. However, expanding these rule-making powers raises concerns where they are not accompanied by robust external scrutiny and meaningful involvement of specialist expertise.

The proposed removal of routine Privy Council oversight means that significant rule changes could be made without independent review, making it unclear how these decisions will be effectively checked and balanced. It is also concerning that there is no statutory requirement to involve stakeholders, including medical royal colleges, in the development or amendment of rules, despite their central role in setting and maintaining specialty-specific standards.

Given the importance of these regulatory functions, stronger assurance is needed that appropriate checks and balances are in place, and that specialist expertise will continue to inform decision-making to support patient safety and maintain public confidence.

15 Revision of decisions

Under the draft order, the GMC will be able to revise specific:

- registration decisions (except emergency registration decisions)
- fitness to practise decisions (except fitness to practise panel decisions)
- case examiner interim registration measure review 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?
No response.

16 Appeals

Under the draft order, applicants for registration, registrants and former registrants of the GMC will have rights of appeal against specific registration and fitness to practise decisions.

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

Under the draft order, as per a recommendation of the Mann Review, the GMC will have a right of appeal against specific interim registration measure decisions and fitness to practise decisions made by a fitness to practise panel to the:

- High Court of Justice in England and Wales
- Court of Session in Scotland
- High Court in Northern Ireland.

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?
No response.

Under the draft order, a consequential amendment will be made to the National Health Service Reform and Health Care Professions Act 2002 to allow PSA to appeal specific fitness to practise and interim registration measure decisions made by a fitness to practise panel to the:

- High Court of Justice in England and Wales
- Court of Session in Scotland
- High Court in Northern Ireland.

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?
Agree.

Under the draft order, GMC will be permitted to administer its own internal appeals function. Applicants for registration, registrants and former registrants will be able to appeal specific registration and fitness to practise decisions to an appeal panel of GMC.

Do you agree or disagree that the draft order provides GMC with sufficient and proportionate powers and duties to administer its appeals function? (Optional)
No response.

Contact details

Please contact the Workforce and Engagement team within the Professional Practice Directorate of RCPath if you have any questions: workforceplanning@rcpath.org.

About the Royal College of Pathologists

The Royal College of Pathologists is a professional membership organisation with more than 11,000 fellows, affiliates and trainees, of which 23% are based outside of the UK. We are committed to setting and maintaining professional standards and promoting excellence in the teaching and practice of pathology, for the benefit of patients.

Our members include medically, dentally and veterinary qualified pathologists and clinical scientists in 17 different specialties, including cellular pathology, haematology, clinical biochemistry, medical microbiology and veterinary pathology.

The College works with pathologists at every stage of their career. We set curricula, organise training and run exams, publish clinical guidelines and best practice recommendations, and provide continuing professional development. We engage a wide range of stakeholders to improve awareness and understanding of pathology and the vital role it plays in everybody's healthcare. Working with members, we run programmes to inspire the next generation to study science and join the profession.