27 August 2025

General Medical Council

Assisted Dying Review Panel: GMC feedback on the draft law

1 Thank you for the opportunity to provide feedback to the Jersey Assisted Dying Review Panel on the draft Assisted Dying (Jersey) law.

2 The General Medical Council (GMC) is the independent statutory regulator for doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK. This written submission sets out our role, scope and relevant operational processes and is intended to enhance the panel's understanding of the current regulatory framework under which we operate.

3 It also sets out:

a. the relationship between the GMC and doctors practising in Jersey

b. our position with respect to assisted dying

c. our engagement with officials from Health and Care Jersey, about the draft bill

d. any areas of ambiguity or concern within the draft legislation.

Our role

4 We work with doctors, physician associates (PAs), anaesthesia associates (AAs), patients, and other stakeholders to support good, safe patient care across the UK.

5 Our mandate is set out in the Medical Act 1983 (the Act) and the Anaesthesia Associates and Physician Associates Order 2024 (the Order). These pieces of legislation set out our responsibilities in relation to the education, registration and revalidation of doctors, PAs and AAs; for operating fitness to practise processes that enable us to take action where there are fitness to practise concerns; and for giving guidance to doctors, PAs and AAs on matters of professional conduct, performance and ethics.

6 As part of our role, we:

- set the standards of patient care and professional behaviours doctors, PAs and AAs need to meet
- make sure doctors, PAs and AAs get the education and training they need to deliver good, safe patient care
- check who is eligible to work as a doctor, PA or AA in the UK and check they continue to

meet the professional standards we set throughout their careers

- investigate where there are concerns that patient safety, or the public's confidence in doctors, PAs or AAs, may be at risk, and take action if needed

The relationship between the GMC and doctors practising in Jersey

7 The GMC's legal jurisdiction (as covered by the *Medical Act 1983* and the *Anaesthesia Associates and Physicians Associates Order 2024*) is limited to the UK and our regulatory approach is UK-specific. We have no legal jurisdiction in the Crown Dependencies.

8 Within its legal and healthcare system, Jersey has chosen to make holding a GMC registration/licence a condition for doctors to practise in their health services. International Medical Graduates (IMGs) coming to Jersey will also need to meet our requirements for registration and licensing, including demonstrating their qualifications and language skills.

9 As a result, doctors practising in Jersey are required to revalidate in the same way as all other licensed doctors and arrangements have been put in place with relevant authorities so that this can happen. Registered and licensed doctors remain subject to our regulatory jurisdiction and our professional standards no matter where in the world they are practising, in so far as they are consistent with the law in their country of practice. If they are involved in serious misconduct, they remain accountable to the GMC because they are still bound by our professional standards and a serious departure may lead to an investigation of their fitness to practise. We understand doctors working in Jersey must also be registered with the Jersey Care Commission.

The GMC's position with respect to assisted dying

10 The GMC does not have a view on what the law should be on assisted dying and considers this to be a matter for legislatures. This has been our long-standing position.

11 We do, however, have the following two pieces of specific guidance related to assisted dying:

- For doctors, PAs or AAs: *When a patient seeks advice or information about assistance to die*
- For Fitness to practise (FtP) decision makers: *Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide*[1]

12 These pieces of guidance do not provide a GMC position on assisted dying but are limited to providing clarification for doctors and fitness to practise decision makers in the context of professional practice and UK law on encouraging or assisting suicide.

13 As mentioned at paragraph 7, our regulatory approach is UK-specific, and our standards have been developed for doctors working within the UK context.

14 We appreciate that a change in the law may lead to fitness to practise concerns being raised about doctors participating in assisted dying in Jersey. We are under a legal duty to consider concerns raised which fall within section 35C(2) of the Act. Where concerns meet the threshold for further investigation, these are assessed on a case-by-case basis, in line with our relevant decision-making guidance. However, where a doctor has acted in accordance with the law in the country they are practising, it is unlikely we will need to take action on their registration.

GMC engagement during the development of policy proposals

15 Following the 'in principle' decision by Jersey Parliament in November 2021, members of the GMC were invited to attend a number of meetings and stakeholder events, at the request of officials tasked with developing policy proposals for an assisted dying service. Our contributions have been limited to providing clarification about our professional standards and our regulatory processes. We also submitted a limited response to the consultation, which can be found here. Our most recent meetings took place in June and July 2025, where we responded to questions about specific clauses in the draft bill including providing information on our approach to specifying competencies as a minimum requirement to ensure safe practise (See paragraphs 21-27 for more detail on our role in education and training, and paragraphs 28-48 for fitness to practise).

16 Once legislation comes into force, doctors (along with other relevant healthcare professionals) will need support to help ensure they practise in accordance with the law and the professional standards of their regulators. As such, a programme of implementation work, including the development of operational guidance, will need to be carried out and we expect and are keen to be consulted and involved with relevant strands of such work so that we can offer and contribute our insights. We anticipate that consideration will also need to be given to cross-border issues. For example, a number of Jersey residents are referred to hospitals in the UK for treatment when specialist care isn't available in Jersey, the potential implications of this in this context will require exploration and clarification.

GMC professional standards

17 Our Professional standards , cover the principles, values, and standards of professional behaviour expected of all doctors, physician associates (PAs) and anaesthesia associates (AAs) registered with us. They are set out in our core guidance *Good medical practice*, which is supported by a range of more detailed guidance which expand on some of those standards. They don't set standards of knowledge, skills or professional capabilities: these can be found in our education standards.

- It is also important to be clear that our professional standards aren't a set of rules and that registered doctors, PAs and AAs must use their professional judgement when applying the standards into practice.
- Our professional standards are consistent with UK law; however, they do not amount to legal advice. Were the law to change anywhere in the UK, we would review and update our professional standards accordingly.

18 As mentioned at paragraphs 7 and 13 above, we do not, develop, review or update our guidance to align with the law in Jersey (nor the law in any other non-UK jurisdiction where doctors are GMC registered, including the Isle of Man).

Education and training

19 From undergraduate to postgraduate education, the GMC sets the high-level standards and learning outcomes for medical education and training in the UK. The standards are of a sufficiently high level that they would not necessarily refer to assisted dying specifically and as we do not deliver medical education and training, any specific training requirements on assisted dying would be developed and delivered at a local level.

20 Our statutory role for setting standards for medical education and training in the UK extends to undergraduate medical education, foundation programme training and postgraduate training. This is underpinned by **standards** that must be met by those directly responsible for the management and delivery of medical education.

21 Sitting under these standards are **outcomes** that medical students, resident doctors, physician associates and anaesthetist associates must meet, underpinned by the essential generic capabilities needed for safe, effective and high-quality medical care in the UK. These outcomes inform the content of curricula and the attendant programme of assessment across all levels of medical education and training.

22 The design and delivery of curricula is undertaken by medical schools at undergraduate level and the UK Foundation Programme Office (UKFPO) at foundation training level. At specialty

training level, curricula are developed by the Royal Colleges and faculties and responsibility for delivery sits with the four UK statutory education boards.

23 We do not approve undergraduate curricula, but we introduced the Medical Licensing Assessment (MLA) in 2024 that all medical students graduating from UK universities need to pass as part of their degree before they can join the medical register. The MLA content map is blueprinted to Outcomes for Graduates which sets out the outcomes that newly qualified doctors must know and demonstrate to practise safely.

24 We approve Foundation programme and Royal College specialty curricula and the attendant programmes of assessment. There are currently 65 specialties and 31 sub-specialties.

25 We set standards for providers of education and training, and we regularly check those are being met. Our quality assurance framework describes how we do this through our approval, proactive, and reactive quality assurance processes.

Fitness to practise

Fitness to practise explained

26 Fitness to practise is an assessment of a doctor's ability to practise safely and effectively. It includes considering the doctor's overall ability to perform their individual role, their professional and personal behaviour, and the impact of any health condition on their ability to provide safe care.

27 We can only assess a doctor's fitness to practise when they are registered with us and there is a legal basis for doing so. The legal bases are referred to as the grounds of impairment which are set out in the *Medical Act 1983*.

28 For doctors, there are six grounds of impairment under the Act as described in our guidance *Decision on whether regulatory action is required (Doctors)*.

29 Once we are satisfied that there is a legal basis for considering a doctor's fitness to practise, we can assess whether they pose any current and ongoing risk to one or more of the three parts of public protection. To do this we consider:

- the seriousness of the concern
- any relevant context known about the doctor and their working environment, and
- how the doctor has responded to the concern, including looking at evidence of insight and remediation and if they have kept their knowledge and skills up to date

30 Our publication *What we mean by fitness to practise explained (Doctors)* explains these concepts in more detail.

31 During the investigation process, we can refer a case to an interim orders tribunal (IOT) if we receive information that suggests the doctor's practice should be restricted or suspended on an interim basis. We have produced guidance *Decisions on interim orders (Doctors)* to support fair and consistent decision making by the Regulator and case examiners in relation to interim orders.

32 An IOT hearing by the Medical Practitioners Tribunal Service (MPTS) can:

- take no action
- impose conditions on a doctor's registration to limit their practice
- suspend the doctor while we investigate.

33 You can read more about interim sanctions on the MPTS website.

34 At the end of an investigation once we've gathered all the information we need, two of our senior decision makers (one medical and one non-medical) will review the evidence. They'll decide whether to:

- conclude the doctor's case with no further action
- issue a warning
- agree undertakings with the doctor to address a problem with their practice
- refer their case to the MPTS for a hearing before a tribunal.

35 Our webpage *Our sanction for doctors* provides further detail on these actions.

36 We are happy to further explain our fitness to practise processes to those working on the Jersey legislation if they would find it useful.

Articles 39, 70 and 85

37 We note the draft legislation makes provision for the sharing of fitness to practise information with the GMC and other professional regulators. However, as currently drafted, we think there is a risk that the relevant provisions could be interpreted narrowly and in a way which would restrict disclosure. Below we have suggested a discrete drafting amendment which we think would reduce this risk.

38 Article 39(1) prohibits disclosure of information relating to specific cases (i.e. the identity of the person seeking an assisted death) unless one of the exemptions at Article 39(2) can be relied on (i.e. the information is already available to the public). Articles 70(1) and 85(1)

prohibit the disclosure of information about the practice of an assisted dying practitioner and the register respectively but paragraph (2) of each Article permits disclosure if one of the exemptions at Article 39(2) are engaged. We think, however, there is a small risk that where Article 39(2) states 'but the person may disclose **the information',** this could be interpreted narrowly to mean that only the information falling within Article 39(1) could be disclosed using these exemptions, and not the information at Articles 70(1) and 85(1).

39 Whilst this is one potential narrow interpretation, we consider a court would likely adopt a more purposive interpretation, which is that where Articles 70(2) and 85(2) refer to disclosure of 'the information as permitted by Article 39(2)(a) to (g)' the reference to **'the information'** is to the category of information within that specific Article and does not link back to Article 39(1) which covers a different category of information. We understand the drafting intent to be that the exemptions are effectively 'borrowed' from Article 39(2) to avoid duplicative drafting.

40 To reduce the risk and to improve clarity, we think the drafting could be tweaked to say:

"But the Committee/Service (respectively) may disclose the information in the circumstances described in Article 39(2)(a) to (g)".

41 The disclosure of fitness to practise information is crucial to enable us to effectively investigate concerns and to ensure that we can (where necessary) act quickly to protect the public. We would therefore respectfully encourage the drafter to consider actioning the above amendment to prevent the provisions being interpreted in a way which is inconsistent with what we understand the policy intent to be.

Article 83

42 As discussed on 15 July 2025, from a fitness to practise perspective we had some suggestions relating to Article 83.

43 On our initial reading we were concerned with the drafting of Article 83 and felt it created a broader public protection gap. This is because although the Assisted Dying Assurance and Delivery Committee may investigate the practice of an assisted dying practitioner as per Article 69, the Committee lack the power to take any necessary restrictive action. Instead, the individual remains registered on the Assisted Dying Register until the regulator, such as the GMC can undertake and conclude the fitness to practise process. If there are no grounds for cancellation or suspension of the individual's GMC registration, then the individual would continue to hold Assisted Dying registration. This could pose risks to both public protection and patient safety.

However, having discussed our concerns with Anna Hamon, we acknowledge the mitigations in place to ensure public protection:

- as the Assisted Dying Service will be the only employer, they can determine which professionals are employed, and
- that the annual renewal registration requirement would mean in the circumstances where there were issues with the individual's practice, their registration would not be renewed.

44 To avoid any public protection gaps, we also suggest that you explicitly mention interim suspensions in Article 83. As explained above, we can refer a case to an interim orders tribunal (IOT) to consider imposing an interim order while we investigate a complaint against a doctor. We do this when we believe the doctor's practice should be restricted to protect members of the public, or if it's in the doctor's interest. The IOT may suspend or impose conditions on a doctor's registration for up to 18 months. Article 83(1) should reference suspension, on an interim or substantive basis.

45 In discussing the draft legislation, we also suggested that you may want to consider including reference to 'conditions' alongside suspension in Article 83. This is because conditions imposed by us to restrict a doctor's practice may lead the Committee to consider that it would be appropriate to suspend or remove the doctor from the Assisted Dying register. We suggested that it may be useful to use the term 'restrictive action' in the legislation rather than 'outcomes' to help with this issue.

46 The use of the term 'cancellation' in Article 83 is not consistent with the terminology used by health and social care regulators in the United Kingdom. This means that as currently drafted, there is a risk that you will not capture all types of removal from our register.

[1] At the time of writing, this Fitness to Practice (FtP) guidance had not been updated following the start of the GMC regulating PAs and AAs (in the UK) on 13 December 2024.