General Medical Council

# Adult Protection Bill call for evidence: evidence submitted by the GMC, October 2025.

## Our role

1. The GMC is the independent regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK. We work with them and other stakeholders to:
   - 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 they need to deliver good, safe patient care
   - check who is eligible to work as a doctor, PA or AA in the UK and work with them and their employers to confirm they're keeping up to date and meeting the professional standards we set
   - give guidance and advice to help doctors, PAs and AAs understand what's expected of them
   - 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.
2. The GMC is not responsible for planning or delivering health or adult social care services, but we have an important role in setting professional standards for doctors, PAs and AAs. The core guidance on professional standards is *Good medical practice* (GMP) and this is supported by a range of more detailed guidance, including on confidentiality and decision making and consent. We also publish webpages on adult safeguarding to support those on our register to act in line with the professional standards.

3. In responding to this call for evidence our aims are to understand:

   - whether any obligations or responsibilities imposed on doctors, PAs and AAs will be consistent with the standards we set for their professional practice;
   - how the proposals will impact patients' trust in the professionals on our register and engagement with health and social care services; and
   - how we can support the development and implementation of an Adult Protection Bill and any future statutory guidance related to this.

## Overall comments

**4.** We welcome and support the intent of the Bill, which is to prevent harm to vulnerable patients. We agree with the Department that adult safeguarding is about "making sure adults at risk of harm from abuse, exploitation or neglect are protected", and that "it is also about empowering people to be as independent as possible and make choices about how they want to live" (Bill team's letter to GMC dated 8 July 2025).

**5.** We support the principles-based approach embedded within the draft legislation, set out at Clause 1 and listed in the explanatory memorandum as: prevention, autonomy, empowerment, dignity, proportionality, partnership and accountability. Additional statutory guidance that expands in more detail on the practicalities of how to implement the legislation in line with these principles will be important to guide professionals to make person centred decisions about the right way to intervene, support and empower adults at risk.

**6.** We also encourage the Department to consider how any changes introduced by the legislation will be incorporated into the education and training of health and social care professionals who encounter vulnerable adults. For instance, students and individuals in training will need an explicit understanding of their responsibilities when they suspect a patient is an adult at risk.

**7.** Communicating the changes to education providers will be essential so that they can update preventive safeguarding training for staff to recognise and report abuse, under the duties and definitions of the new legislation. Given our responsibilities for medical education and training, we are willing to work with the Department and local education providers to explore this aspect of implementing any new requirements.

**8.** When fully commenced, the Mental Capacity Act (Northern Ireland) 2016 will give new protections for individuals who lack capacity to make decisions for themselves about their care, treatment or personal welfare. There is therefore a clear and significant connection with the areas the Department is currently considering. It is important that health and social care professionals understand how the provisions in the adult protection legislation will interact with the requirements of the Mental Capacity Act.

## Areas of concern

**9.** We have two main areas of concern with the draft Bill as it stands. These are:

- How the duty to report at Clause 4 interacts with doctors', PAs' and AAs' existing professional, ethical and legal duties, and;

- The proposal to name individual professionals within the Bill – not set out in the published text of the Bill, but as suggested in the letter from the Department dated 8th July 2025.

*Mandatory reporting, confidentiality and patient autonomy*

**10.** We understand that a key driver for the proposed legislation has been the widely publicised failings at Muckamore Abbey Hospital and Dunmurry Manor Care Home, which involved individuals living with conditions likely to call into question their capacity to make decisions about their welfare. However, the legislation as currently drafted at Clause 4 appears to introduce a statutory mandatory duty to make reports about any adult, including those with capacity, deemed to be at risk.

**11.** Given that the legislation would apply to interactions with adults across all health and social care settings, we have concerns about the current drafting. The wording at Clause 4 does not refer back to the principles set out in Clause 1 (prevention, autonomy, empowerment, dignity, proportionality, partnership and accountability), nor does it acknowledge that health and social care professionals captured by the Bill may be subject to a duty of confidentiality, or other relevant professional, ethical and legal duties such respecting the rights of competent adults to make decisions about their own lives and welfare.

**12.** Confidentiality is an important ethical principle in medical practice. It is central to trust between doctors, PAs, AAs (and other health and social care professionals) and patients – patients may avoid seeking help, or may under-report symptoms, if they are concerned that their information will be disclosed without their consent or the opportunity to have some control over the timing or amount of information disclosed. It is also an important part of respect for patients' rights to autonomy. The people on our register must respect a patient's rights to self-determination as long as they have capacity to make decisions for themselves, and their decisions do not expose others to a risk of death or serious harm.

**13.** Confidentiality is also a legal duty, and our guidance on *Confidentiality* reflects our understanding of the common law. Doctors, PAs and AAs may breach their usual duty of confidentiality only where:

- the patient consents, or
- disclosure is required by law, or
- the disclosure is justified in the public interest (that is, where a failure to do so may put others at risk of death or serious harm).

(In the next section we have set out in more detail the professional standards that doctors, PAs and AAs adhere to. See paragraphs 24 to 32.)

**14.** We urge the Department to carefully consider how any further statutory duties they intend to lay upon organisations and/or individual professionals will relate to, and interact with, doctors', PAs, AAs and others' existing professional, ethical and legal duties.

**15.** Doctors, PAs and AAs, along with other health and social care professionals, play a vital role in adult safeguarding across a wide range of contexts, and confidential medical care is recognised in law as being in the public interest. If trust in health and social care professionals is eroded, then a crucial first line of support may be undermined which could lead to an increase in safeguarding issues going undetected at earlier stages if patients are dissuaded from seeking advice from healthcare professionals for fear of being reported.

**16.** We understand from our conversation with the Bill team on 9th September 2025 that the policy intention is, in fact, for professionals to be guided by the principles in Clause 1 and to use their professional judgement to arrive at decisions that centre the interests and rights of adults at risk. We would therefore like to see this clarified within the text of the Bill itself to avoid any confusion or unintended consequences arising from the legislation.

**17.** We would welcome the opportunity to comment on the forthcoming statutory guidance that will support implementation of the Bill. This will be an important opportunity to provide clarity about organisational, individual and professional duties, and to refer to relevant existing materials such as the GMC's guidance.

*Naming of individual professionals within the Bill*

**18.** A second set of concerns that we have are around naming individual professionals within Clause 4 of the Bill. Further to the currently published text of the draft Bill (which we initially understood to engage general medical services contract holders rather than all individuals/healthcare professionals delivering primary care) we understand that the intention is also to add a number of professional titles to the legislation – including Medical Practitioner (as set out in the letter dated 8 July 2025).

**19.** The explanatory notes to the Bill state that the aim is to bring Northern Ireland in line with other parts of the UK where safeguarding legislation already exists. However, creating a new legal duty on individual professionals would be out of step with legislation in the other UK nations in relation to adult safeguarding (as we currently understand them) which are aimed at organisation level. It may be useful to consider any learning from the application of safeguarding legislation and reporting duties in Scotland and Wales, and comparisons with England which has decided not to follow this approach.

**20.** Were the scope of the Bill to be extended to individual professionals, we also have concerns that, even if the drafting is amended to clarify the professional discretion aspect, the prospect of such a law may well cause individuals not to exercise their professional judgement for fear of falling foul of it.

**21.** We also wondered who would be responsible for investigating any potential breaches of the duty, where individual professionals are concerned. Whilst a breach of a mandatory duty to report could raise professional regulation concerns which we would want to be able to consider, we don't believe that professional regulation should be used as an enforcement mechanism for statutory failures by individuals. Our fitness to practise

process involves an assessment of whether there is a current and ongoing risk to public protection and would not necessarily lead to regulatory action being taken by the GMC, as it involves considering factors such as seriousness and context. It would not therefore be appropriate for the fitness to practise process to be used as the enforcement mechanism ie. deciding what the law means and whether a breach occurred, but rather as a parallel regulatory process.

**22.** We encourage the Department to continue exploring with stakeholders the potential (unintended) consequences, risks and benefits of a mandatory reporting duty in this context, whether laid on organisations or individual health and care professionals. If a mandatory duty is introduced, it would be preferable to set the statutory duty at organisation level – in line with other UK legislation. The statutory guidance could then focus on how the organisational duty will interact with health and social care professionals existing duty of confidentiality and their scope to exercise professional judgement about whether and when to make a disclosure.

**23.** Again, we'd be very happy to work with the Department on forthcoming guidance to ensure alignment with our professional standards. We've also outlined the professional standards set out in our guidance below, for information.

## Doctors, PAs and AAs role in adult safeguarding

**24.** Doctors, PAs and AAs play a vital role in adult safeguarding. The professional standards that we set are clear that they must:

- consider the needs and welfare of people (adults, children and young people) who may be vulnerable, and offer them help if their rights are being abused or denied (GMP paragraph 41)
- act promptly on any concerns about a patient – or someone close to them – who may be at risk of abuse or neglect, or is being abused or neglected (GMP paragraph 42).
- act promptly if patient safety or dignity is, or may be, seriously compromised (GMP paragraph 75)

**25.** Doctors, PAs and AAs must also support patients in caring for themselves and empower them to improve and maintain their health (GMP paragraph 38). This may include:

- helping patients to access information and support to manage their health successfully
- supporting patients to make decisions that improve their health and wellbeing.

**26.** As noted above, our Adult Safeguarding webpages bring together information and advice from relevant sections of the professional standards, in addition to signposting to other useful resources such as the BMA's safeguarding toolkit.

## What our guidance says about disclosing information about adults who may be at risk of harm

**27.** As noted above, in our *Confidentiality* guidance we say that doctors, PAs and AAs should, as a rule, make decisions about how best to support and protect adult patients in partnership with them. They must support and encourage patients to be involved, as far as they want to and are able, in decisions about disclosing their personal information (paragraph 52).

*Where disclosures are required by law*

**28.** At paragraph 53, our *Confidentiality* guidance recognises that there are various legal requirements to disclose information about adults who are known or considered to be at risk of, or to have suffered, abuse or neglect. Our guidance is clear that doctors, PAs and AAs must disclose information if it is required by law. They should:

- be satisfied that the disclosure is required by law
- only disclose information that is relevant to the request, and only in the way required by the law
- tell patients about such disclosures whenever practicable, unless it would undermine the purpose of the disclosure to do so.

*Where a patient lacks capacity*

**29.** Where patients lack capacity, even if there is no legal requirement to do so, doctors, PAs and AAs must give information promptly to an appropriate responsible person or authority if they believe a patient who lacks capacity to consent is experiencing, or at risk of, neglect or physical, sexual or emotional abuse, or any other kind of serious harm.

**30.** The only exception to this would be if the doctor, PA or AA believes that sharing the information would not of overall benefit to the patient to do so. If this is the case, then they should discuss the issues with an experienced colleague. If, following discussion, they still decide not to disclose information, they must document in the patient's records the discussions that have taken place and the reasons for deciding not to disclose. They must be able to justify their decision (*Confidentiality*, paragraph 56).

*The rights of adults with capacity to make their own decisions*

**31.** As a principle, adults who have capacity are entitled to make decisions in their own interests. If an adult patient who has capacity to make the decision refuses to consent to information being disclosed, this should be explored with the patient. It may be appropriate to encourage them to consent to the disclosure and to warn them of the risks of refusing to consent (*Confidentiality* paragraphs 57-58). This is in line with our general position that adults with capacity have the right to make decisions that others may consider irrational or unwise - for example, in refusing medical treatment (*Decision making and consent* paragraph 48).

**32.** Doctors, PAs and AAs should usually abide by a patient's refusal to consent to disclosure, even if their decision leaves them (but no one else) at risk of death or serious harm. They should do their best to give the patient the information and support they need to make decisions in their own interests – for example, by arranging contact with agencies to support people who experience domestic violence. Adults who initially refuse offers of assistance may change their decision over time (*Confidentiality* paragraph 59).

**33.** In exceptional cases where a patient has refused consent, disclosing personal information may be justified in the public interest if failure to do so may expose others to a risk of death or serious harm. The benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential. Examples given in the guidance include if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person (*Confidentiality* paragraphs 63 – 70).