Neutral Citation Number: [2026] EWCA Civ 143

Case No: CA-2025-001097

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
KINGS BENCH DIVISION (ADMINISTRATIVE COURT)
Mrs Justice Lambert
[2025] EWHC 960 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/02/2026

Before:

LORD JUSTICE COULSON
LORD JUSTICE JEREMY BAKER
and
LORD JUSTICE COBB

- -

Between:

R (British Medical Association)	**Appellant**
- and -	
General Medical Council	**Respondent**
- and –	
(1) Association of Anaesthesia Associates **(2) Royal College of Physicians** **(3) Royal College of Anaesthetists** **(4) Anaesthetist United** **(5) NHS England** **(6) Secretary of State for Health & Social Care**	**Interested Parties**

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Jenni Richards KC and Adam Boukraa (instructed by **TLT LLP**) for the **Appellant**
Ivan Hare KC and Peter Mant KC (instructed by **GMC**) for the **Respondent**
The **Interested Parties** did not appear and were not represented

Hearing date: 3 February 2026

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Approved Judgment

This judgment was handed down remotely at 10.30am on 20 February 2026 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

LORD JUSTICE COULSON:

1. Introduction

1. By an order dated 17 April 2025, following a rolled-up hearing, Lambert J DBE ("the judge") granted the appellant ("BMA") permission to apply for judicial review, but went on to dismiss the substantive claim and, in addition, refused the BMA the necessary extension of time to file the judicial review claim form. The BMA appeals against that order pursuant to leave granted by Zacaroli LJ on 29 July 2025.

2. The claim for judicial review arose out of the detailed guidance produced by the respondent ("GMC") entitled "Good Medical Practice" ("GMP"). The GMC is the independent regulator of doctors and maintains the register of medical practitioners in the UK, pursuant to its functions created and identified in the Medical Act 1983 ("the 1983 Act"). From 13 December 2024, following the Anaesthesia Associates and Physician Associates Order 2024 ("the AAPA Order") made on 13 March 2024, the GMC also became the regulator of physician associates ("PAs") and anaesthesia associates ("AAs").

3. The BMA's original challenge to GMP was essentially twofold. First, they challenged the GMC's use of the term "medical professionals" as a collective descriptor in GMP of those registered with them, namely both doctors and associates. The second challenge was to the decision to produce, within GMP, a single set of guidance on professional standards which applied to both doctors and associates. That second challenge was known as the 'unitary guidance' issue. On appeal, the challenge to the production of unitary guidance has fallen away. So this appeal is focused solely on the first ground of challenge, namely the GMC's use of the term "medical professionals" in GMP.

4. Ground 1 of the appeal asserts that the judge was wrong to find that there was no actionable misdirection in law in GMP, arising from what the BMA say was the inconsistency between the statutory framework and the term "medical professionals". Ground 2 of the appeal is an attack, on *Padfield* or *Wednesbury* grounds, on the GMC's reasoning that led them to use the term "medical professionals" at all.

5. There is also a third issue between the parties. Via ground 3 of the appeal, the BMA seeks to challenge the judge's conclusion that the judicial review claim was not brought promptly or in any event within three months of the relevant decision being taken, in consequence of which she refused to extend time for the filing of the claim form. The BMA accept that the claim was not brought within 3 months of either the decision itself, or when they were told of the decision, but submit that there were good reasons for the delay which the judge failed to address.

6. I should note at the outset that, for the purposes of the appeal, there was an entire lever arch file of fresh evidence, some of which was disclosed after the judge's judgment, and some of which only came into existence after that date. Both parties referred to this material, and no point was taken on either side as to its admissibility. The BMA rely on the material primarily in support of ground 2 of the appeal, and what they say the documents show about the GMC's reasoning and (inadequate) explanation for their use of the term "medical professionals". GMC rely on the fresh evidence to suggest – as per their Respondent's Notice - that the appeal is academic.

7. I propose to structure this judgment as follows. Section 2 sets out the statutory framework. Section 3 sets out a summary of the factual background, endeavouring not to repeat large parts of the judge's judgment, but setting out some relevant material from the fresh evidence file. Section 4 is a brief summary of the judge's judgment (the particular paragraphs of importance to the appeal are set out under the specific grounds of appeal addressed in Sections 7 and 8). Section 5 summarises the issues on appeal. Section 6 comprises a short overview of the essential issue between the parties, standing back and considering the BMA's appeal in the round. Then, as I have said, Sections 7 and 8 deal respectively with grounds 1 and 2 of the appeal. I address the extension of time (ground 3) in Section 9, and the supposedly academic nature of the appeal in Section 10. There is a short summary of my conclusions in Section 11. I am grateful to leading counsel, and the teams with and behind them, for their assistance and, in particular, for the commendable clarity and efficiency of their written and oral submissions.

2. The Statutory Framework

8. The statutory framework is set out at [12]-[27] of the judge's judgment dated 17 April 2025 ([2025] EWHC 960 (Admin)). I shall not repeat it all here. The essential provisions are noted below.

9. The 1983 Act sets out the objectives of the GMC at s.1:

> *"(1) There shall continue to be a body corporate known as the General Medical Council (in this Act referred to as "the General Council") having the functions assigned to them by this Act.*
> *1(A) The over-arching objective of the General Council in exercising their functions is the protection of the public.*
> *1(B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—*
> *(a) to protect, promote and maintain the health, safety and well-being of the public,*
> *(b) to promote and maintain public confidence in the medical profession, and*
> *(c) to promote and maintain proper professional standards of conduct for members of that profession."*

10. Paragraph 9(A) of schedule 1 to the 1983 Act provides that the GMC must have regard to "*the interests of persons using or needing the services of provisionally or fully registered medical practitioners in the United Kingdom."*

11. Section 2 of the 1983 Act requires the GMC to keep a register of "*medical practitioners*". They are defined in paragraph 10 of Schedule 3 of the Health Act 1999 by reference to Schedule 1 to the Interpretation Act 1978. Schedule 1 sets out the definition as a "*fully registered person within the meaning of the Medical Act 1983 who holds a licence to practice under that Act*".

12. Section 35 of the 1983 Act sets out the GMC's power to issue guidance on professional standards:

> "*The powers of the General Medical Council shall include a power to provide, in such a manner as the Council think fit, advice for members of the medical profession on –*
> a) *standards of professional conduct;*
> b) *standards of professional performance; or*
> c) *medical ethics*."

There is no dispute that GMP was issued pursuant to this power.

13. Section 49 (1) of the 1983 Act makes it a criminal offence for any person wilfully and falsely to pretend to be registered under the 1983 Act or otherwise seek to describe themselves in a way which implies that they are registered under the 1983 Act.

> "*...any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, surgeon, general practitioner or apothecary, or any name, title, addition or description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary, shall be liable on summary conviction to a fine not exceeding level 5 on the standard scale.*"

14. Section 60 of the Health Act 1999 provides a power to make orders in council for the purposes of regulating "*health professions*" and "*social workers*". Section 60(1)(b) provides that power in respect of other professions which were not already regulated and who were concerned wholly or partly with physical or mental health, and which were deemed to require regulation. Paragraph 11 of Schedule 3 to the 1999 Act makes plain that it enabled professions that were not already regulated to be regulated, including "*the regulation of activities carried on by persons who are not members of the profession but which are carried on in connection with the practice of the profession".*

15. On 13 March 2024 the AAPA order was made pursuant to s.60(1)(b) of the 1999 Act. It introduces regulation of PAs and AAs. Article 3 of the AAPA order obliges the GMC to determine standards "*applicable to associates*". A Registrar appointed by the GMC must maintain a single register of associates who meet the requisite standard set by the GMC. That register is divided into two parts, one for AAs and one for PAs.

16. Paragraph 3 of Schedule 1 to the AAPA order provides as follows:

> "*(1) The Regulator, in addition to its objectives and duties set out in section 1(1A) and (1B)(a) of, and paragraph 9A(1)(b) of Schedule 1 to, the Medical Act 1983—*
> *a) has the objective of promoting and maintaining—*
> *i. public confidence in, and*
> *ii. proper professional standards and conduct for members of, the anaesthesia associate and physician associate professions…*
> *b) must have regard in exercising its functions under this Order, to*
> *i. the interests of persons using or needing the services of associates in the United Kingdom*

> *ii. any differing interests of different categories of anaesthesia associates and physician associates, and*
> *iii ….*
> *c) must discharge its functions under this Order in a way which is transparent, accountable, proportionate and consistent, and*
> *d) …*"

17. There was an Explanatory Memorandum that accompanied the AAPA order. Paragraph 7.5 says:

> "*The objectives of the GMC and its duty to co-operate will be split across the Order and the Medical Act 1983. For completeness and to assist the reader, these are summarised below:*
> *Objectives*
> *7.56 The over-arching objective of the General Council in exercising their functions is the protection of the public.*
> *7.57 The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives:*
>
> 1. *To protect, promote and maintain the health, safety and well-being of the public*
> 2. *To promote and maintain public confidence in the medical profession and the anaesthesia associate and physician associate profession, and*
> 3. *To promote and maintain proper professional standards and conduct for members of the medical profession and the anaesthesia associate and physician associate professions.*"

3. The Factual Background

3.1 PAs and AAs: General

18. PAs and AAs have been working within the NHS for over 20 years. Although they are not medically qualified, they are able to practice clinically following completion of an undergraduate degree (usually in the biosciences) followed by two years of clinically based training. They work only under supervision and as part of a larger multi-disciplinary team. The evidence suggests a growing workforce of associates, particularly in hospitals.

19. The Department of Health and Social Care ("DHSC") described associates in October 2017 as being "*trained to the medical model to augment service delivery alongside doctors…They are dependent practitioners working within their sphere of competence. Releasing doctors to focus on more complex patient pathways and care whilst bolstering the health care team*".

20. Four years later, in 2021, the DHSC said that a PA would "*carry out a number of tasks including taking medical history, examinations and managing and diagnosing illnesses under the supervision of a medical practitioner".* An AA was described as someone working in hospitals "*as deliverers of anaesthesia and critical care in the anaesthetic team, performing pre and post operative assessment and intervention and providing anaesthesia under the supervision of a consultant anaesthetist".*

21. In November 2023 the DHSC fact sheet relating to associates repeated much of the previous material, noting that AAs' responsibilities included "*reviewing patients for surgery, initiating and managing medications, administering fluid and blood therapy during surgery and ensuring that there is a plan for patients following their operation"*. The fact sheet also noted that PAs and AAs were unable to prescribe medication because they were not subject to statutory regulation.

22. In summarising the differences and overlaps between associates and doctors, the judge said at [8] of her judgment:

> "There were (and, so far as I am aware, remain) important differences between associates and doctors, in particular in matters of prescribing and autonomous working, but nonetheless there exists a substantial overlap between the work undertaken by associates and doctors, consistent with the stated function of associates - which is to free up medically qualified personnel to undertake more complex duties."

I adopt that summary, which has not been challenged on appeal.

3.2 The Decision to Regulate PAs and AAs

23. In October 2017, the DHSC issued a consultation document regarding the regulation of "Medical Associate Professions" in the UK, including PAs and AAs. Following the consultation, in February 2019, the DHSC published its consultation paper which concluded that there was a compelling case for regulation of PAs, and that for AAs the high-risk interventions which they performed and the direct entry route into that profession made statutory regulation proportionate. On 18 July 2019, the Minister of State for Health announced that the Government had asked the GMC to regulate associates across the UK. As the judge noted at [31] of her judgment, there was never any serious doubt that, when the necessary legislation was passed, the GMC would be the relevant regulator.

3.4 The First Use of the Term "Medical Professionals"

24. The GMC first used that expression "Medical Professionals" in its Corporate Strategy 2021-2025, published in November 2020. The intention to use the term to refer to PAs and AAs, as well as doctors, was explicitly stated. Mr McAlonan of the BMA, who was on the engagement group referred to at paragraph 29 below and subsequently provided witness statements on their behalf, initially indicated that "the majority of members [of the BMA] would not mind" its use (as recorded by the judge at [51]). However, in December 2020, Mr McAlonan reported to the GMC that the term had "received negative feedback internally". On 21 December 2020, he asked the GMC to reconsider the use of the term. A detailed response from the GMC dated 19 January 2021 explained why the use of the term "medical professionals" was the best option, primarily because it was suitably simple and therefore clear. The letter denied that there was any potential for confusion. There was a further exchange between the BMA and the GMC in the following weeks where the same points were repeated.

25. The GMC's position was summed up in their letter of 2 March 2021 to the BMA. They said, amongst other things:

> "*We agree that PAs and AAs have very different roles and responsibilities to doctors; but I hope we can also agree that they are all professional occupations, and that PAs and AAs make a valuable contribution to patient care across the UK. As you'll appreciate the term "medical associate professions", which includes PAs and AAs, is used by organisations across the UK including employers, statutory education bodies and the Department of Health and Social Care.*
>
> *However, like you, we believe it is important to help patients and the wider healthcare team understand more about PAs and AAs, the limits of their competencies, and how their training, scope of practice and capabilities differ from doctors. Our communication and engagement activity will absolutely make that clear. PAs and AAs all have distinct and important parts to play in the UK's health system. But they do not have a primary medical qualification, and they are not doctors.*
>
> *I should also reiterate, we only plan to use the term "medical professionals" when appropriate to the circumstances, for example when referring to the collective professionals that we regulate, rather than listing out each individual role. The majority of our communications, including direct correspondence to patients and others about regulatory matters, will absolutely be tailored to refer to each profession individually.*"

26. As between the BMA and the GMC, that letter remained the last word on the matter throughout the detailed consultations set out below. At no time after the receipt of that letter, and before the BMA had received what was, to all intents and purposes, the final draft of GMP in August 2023, did the BMA ever, at any time, raise an objection to the term "medical professionals".

3.5 The First Stage of the Drafting of the GMP

27. The GMC began the work of research and consultation in connection with the possible regulation of PAs and AAs. Although that would eventually lead to the publication of GMP in its present form, it was originally intended to produce interim standards guidance for associates only. Those interim standards were produced on 21 October 2021 but were never implemented, because they were overtaken by the wide consultation which led to the publication of GMP. However, research undertaken for the production of the interim standards fed into the final decision to publish a single standard document.

28. The judge summarised the events in relation to the development of the interim standards at [33]-[37]. It is clear from that history that, from early 2021 onward, and as the GMC expressly noted the following year, there was significant general support

for the production of "*an overarching publication for all the regulated professions"* ([36]).

29. The wider review of GMP commenced in early 2021. The external advisory group ("EAG") which had originally been set up to look at interim standards was closely involved. In addition, the GMC set up an Advisory Forum. Members of the BMA were involved in both.

30. In July 2021, the GMC sent a pre-consultation survey to key stakeholders. The results of that survey were produced in August. One of the questions that had been asked concerned the proposition that the same core standards should apply to all groups. The BMA did not respond to that particular question, but most of those who did either agreed, or strongly agreed, with the proposition. Thereafter, in February 2022 draft guidance was approved for public consultation. That took place between 27 April and 20 July 2022.

31. The draft guidance adopted the phrase "medical professionals" as the umbrella terms referring to doctors, AAs and PAs. In the main consultation survey on that draft, the GMC said:

> "*In our scoping and engagement activity, there is strong support for keeping the current style and level of detail in GMP. There was also support for the proposal that the core professional guidance should apply to each of the professional groups we regulate. We propose to continue to:*
>
> 1. *Directly address people registered with us*
> 2. *Have one set of core professional guidance for all medical professionals registered with us: in future this will include physician associates and anaesthesia associates*
> 3. *Keep the guidance concise and express the guidance as high-level; principles and duties. More information on key topics will be given in the explanatory guidance and other supportive material.*
>
> *We've adopted the term medical professionals to describe all the professional groups we regulate. This is also the term which will be used in the legislation to bring PAs and AAs into regulation*."

32. A number of respondents to the consultation addressed the use of the term "medical professionals". In their response, the BMA did not address that term at all, although they did raise several other specific issues on the text of the draft guidance.

33. In addition, I note that the EAG did not object to the term either. The highest that it was put, at a meeting on 3 October 2022, was when one member asked whether 'muti-disciplinary' would be a better descriptor. Reasons were given at that meeting by the GMC as to why, when a collective noun was needed, "medical professionals" would be the term used "*to describe our three registrant groups*". Reference was also made to the corporate strategy (paragraph 24 above) and the intended legislative scheme (paragraph 33-36 below).

3.6 The Intended Legislative Scheme at The Time

34. As noted in paragraph 31 above, the GMC's consultation document had explained their use of the term "medical professionals" and had gone on to say that it was "also" the term to be used in the relevant legislation. This was because, during this first stage of the drafting of the GMP, and the public consultation in mid-2022, the intended legislative scheme involved a draft Statutory Instrument entitled '*The Medical Professions Order 2022'*. This set out detailed proposals for the regulation by the GMC of "medical professionals", those were defined in the draft order as:

> *"(a)Medical Practitioner*
>
> *(b) Anaesthesia Associate, or*
>
> *(c) Physician Associate,*
>
> *and "medical professions" must be construed accordingly*".

35. The DHSC published a commentary on the proposed order which said:

> "*'Medical Professional' covers the professions that will be regulated by the GMC within the MPO. An equivalent definition will need to be included in each regulators' legislation for the profession/professions that they will regulate. We note that further work may be required around the definition of medical professional. We intend to undertake a legal review of the full order to consider the consistency and accuracy of when the terms 'medical professional', 'medical practitioners' and 'person' have been used.*"

36. In the response to the consultation, the GMC noted (amongst other things) that "*the majority of comments focused on the one issue that is not in our gift to change: the use of the term* ***medical professionals*** *to describe doctors, PAs and AAs*". They went on to say:

> "*We'll continue to use the term 'medical professional' because it is DHSC's preferred collective name for the GMC's three registrant groups and so is likely to feature in future legislation relating to the GMC*."

3.7 The Second Stage of the Drafting of the GMP

37. By September 2022, it had become apparent that there was not the Parliamentary time to repeal the 1983 Act or to replace the existing regulatory system with the Medical Professions Order. Instead it was decided to leave the 1983 Act as it was, and deal with PAs and AAs by reference to their own statutory instrument. Thereafter, GMP was redrafted with that in mind. In March 2023 the GMC carried out "audience testing" on the near final draft of GMP with various focus groups. The term "medical professionals" was again used as a collective noun to refer to doctors, PAs and AAs, as it had been in all the previous drafts. Nobody reported that the term was or might be confusing.

3.8 The GMP of August 2023

38. A near-final draft of the GMP was approved for publication on 27 April 2023. An embargoed copy was sent to a number of members of the BMA on 15 August 2023.

They were informed that the guidance would also apply to PAs and AAs when they were to be regulated in the future. This version of GMP was then published on 22 August 2023, coming into effect on 30 January 2024. It was this August 2023 version that was the subject of the judicial review challenge, although the challenge was not brought until July 2024.

39. It is only necessary to refer to the first page of the GMP of August 2023, which explains what it is:

> "*What is Good Medical Practice?*
>
> *Good medical practice sets out the principles, values and standards of care and professional behaviour expected of all medical professions registered with us. It is an ethical framework, which supports medical professionals to deliver safe care to a good standard, in the interests of patients.*
>
> *We work closely with medical professionals, patients and others to develop Good medical practice, so it is a shared agreement of what the professional standards should be.*
>
> *We use the term 'medical professionals' to describe all our registrants*[1] *who we address directly (as 'you') throughout this guidance.*
>
> *Good medical practice is divided into four domains to make it easier to navigate. Each domain is equally important in describing what makes a good medical professional."*
>
> [1] *At the time of publication we regulate doctors. We are preparing to regulate Physician Associates and Anaesthesia Associates in the future, at which point this guidance will also apply to them.*

40. It is unnecessary to set out any more of this first version of GMP, for the reasons noted below.

3.9 The Amended GMP

41. The AAPA order was made in March 2024. That confirmed that the GMC was now obliged to regulate PAs and AAs. Following a further consultation, at its meeting on 7 November 2024, the GMC approved changes to GMP 2023 to make it clear to PAs and AAs that, from 13 December 2024 GMP 2024 applied to them alongside doctors. The amendments included using the titles "doctor", "PA" and "AA" in certain places where previously the term "medical professionals" had been used. Where that term was retained, such as on the opening page, the GMC said that it was to "optimise readability and flow". Other minor changes were made to the substantive parts of the text.

42. It is appropriate to set out parts of the text of the amended version of GMP, because this was the version that was the subject of argument before the judge. I am however

satisfied that there were no changes in the text, material to this appeal, from August 2023 to December 2024.

43. The section *What is Good medical practice?* now reads as follows:

> "*Good medical practice sets out the principles, values, and standards of professional behaviour expected of all doctors, physician associates ('PAs') and anaesthesia associates ('AAs') registered with us. We use the term 'medical professionals' to describe all our registrants who we address directly (as 'you') throughout this guidance.*
>
> *We work closely with medical professionals, patients and others to develop Good medical practice, so it is a shared agreement of what the professional standards should be. The standards in Good medical practice and the more detailed guidance apply to all medical professionals to the extent that they're relevant to an individual's practice.*
>
> *Good medical practice is an ethical framework, which supports medical professionals to deliver safe care to a good standard, in the interests of patients. It doesn't set standards of knowledge, skills or professional capabilities: these can be found in our education standards.*
>
> *Good medical practice is divided into four domains to make it easier to navigate. Each domain is equally important in describing what good practice looks like*."

44. Under the heading "*How to use Good medical practice*" the amended GMP states:

> "*How to use Good medical practice*
>
> *It's your responsibility to be familiar with Good medical practice and the professional standards it contains, wherever you practise, whatever your field of medicine or practice setting.*
>
> *But it isn't a set of rules. You must use your professional judgement to apply the standards in Good medical practice to your day-to-day practice. This means working out which of the professional standards are relevant to the specific circumstances you are facing, and using your knowledge, skills and experience to follow them in that context.*
>
> *If you do this, act in good faith and in the interests of patients, you'll be able to explain and justify your decisions and actions*."

45. GMP is divided into four domains. Each domain includes an introduction which refers to "medical professionals", and then goes on to set out a series of numbered points, always addressed to '*you*'. It is these numbered points which comprise the specific guidance to "the medical professionals". Domain 1 deals with knowledge, skills and development. The introduction to that section reads as follows:

> "*Medical practice is a lifelong journey. Keeping pace with rapidly changing social, legal and technological developments means learning*

> *new skills while maintaining others. Sharing knowledge – gained through research and innovation, as well as experience – is fundamental to good practice.*
> *Good medical professionals are competent, keep their knowledge and skills up to date and provide a good standard of practice and care. They strive to develop and improve their professional performance. They reflect regularly on their standards of practice and use feedback and evidence to develop personal and professional insight.*"

46. Under the sub-heading "Being competent" the guidance sets out at point 2: "*You must recognise and work within the limits of your competence. You must only practice under the level of supervision appropriate to your role, knowledge, skills and training of the task you are carrying out"*.

47. Domain 4, which is concerned with trust and professionalism, begins with the following introduction:

> "*Patients must be able to trust medical professionals with their lives and health, and medical professionals must be able to trust each other.*
>
> *Good medical professionals uphold personal and professional standards of conduct. They are honest and trustworthy, act with integrity, maintain professional boundaries and do not let their personal interests affect their professional judgments or actions*."

48. Point 81 of the guidance requires that "*you must make sure that your conduct justifies patients' trust in you and the public's trust in your profession"*. Point 82 requires that *"you must always be honest about your experience, qualifications and current role. You should introduce yourself to patients and explain your role in their care.*"

3.10 The Judicial Review Challenge

49. As noted above, during the consultations and other exchanges between early 2021 and August 2023, the BMA did not object to the term "medical professionals". The BMA's first formal objection to the term was first made on 20 May 2024, as part of the further consultation which the GMC had launched following the publication of the AAPA order in March 2024. That consultation was strictly limited: it did not cover whether associates should be brought into statutory regulation; whether they should be regulated by the GMC; the content of the AAPA order; or the scope of an AA's or a PA's practice. However, in their letter of response dated 20 May 2024, the BMA expressed general opposition to the use of the term "medical professionals" and the issuing of guidance common to both doctors and associates.

50. Subsequently the BMA sent a pre-action protocol letter on 21 June 2024 and lodged the claim for judicial review on 3 July 2024.

4. The Judgment Below

51. Having set out the legal framework, the judge dealt in detail with the factual background between [28] and [67]. At [68]-[73], she dealt with what were then the three grounds of challenge to the GMP. Ground one was what the judge called "the

terminology issue", namely the use of the term "medical professionals". The judge addressed that at [68]-[71], and then in detail at [74]-[84]. Within that part of the judgment, the judge also resolved a separate debate about whether or not the BMA had to demonstrate unlawfulness in the sense explained by the Supreme Court in *R(A) v Secretary of State for the Home Department* [2021] UKSC 37 ("*R(A)*").

52. The second ground of challenge before the judge was concerned with the *Padfield* principle and irrationality. This primarily concerned the decision to produce unitary guidance covering both the doctors and the associates. This was the subject of a detailed analysis by this judge at [85]-[105]. As I have indicated, that issue does not arise on appeal. However, some of the arguments that were advanced under the second ground of the judicial review challenge were also concerned with the use of the term "medical professionals", and the judge addressed those (*inter alia*) at [85], [91], [95], [102] and [112].

53. The third original ground of challenge was a separate irrationality issue, dealt with by the judge between [106]-[114]. Finally there was the question of delay and the judge's decision not to extend time to serve the claim form. That is dealt with in the judgment at [115]-[123].

54. I shall refer back to some of the specific paragraphs of the judgment when I come to consider the particular issues that remain on appeal.

5. The Issues on Appeal

55. Ground 1 of the appeal is concerned with what the judge described as the "terminology issue": namely, the decision to use the term "medical professionals" to cover both doctors and associates. Although that ground is divided into three sub-grounds, they are all based on one over-arching submission: that the use of the term "medical professionals" was a misdirection in law because it was inconsistent with or contrary to the statutory framework set out in Section 2 above. Ms Richards KC accepted that, if that foundational submission was wrong, the entirety of ground 1 fell away.

56. As to the sub-grounds of appeal, it is said (ground 1A) that the judge was wrong to find that the inconsistency between the statutory framework and GMP should be analysed solely by reference to *R(A).* Ground 1B is that, if *R(A)* was the right touchstone for the analysis, the judge was wrong to find that GMP did not fall within the categories of unlawfulness identified in *R(A).*

57. Ground 1C is that the judge erred because she did not find that the alleged inconsistency between GMP and the statutory framework:

    (i) breached the *Padfield* principle (namely that GMP did not promote, but instead defeated or frustrated, the purpose and object of the statutory framework); and/or

    (ii) was irrational in the *Wednesbury* sense.

58. Ground 2 of the appeal is that, independently of ground 1, in the process that led to the decision to use the term "medical professionals", GMC breached the *Padfield* principle and/or was *Wednesbury* irrational. This ground seeks to attack the GMC's

reasoning and decision-making process which resulted in the use of the term in GMP. The BMA rely on material that suggested that the GMC felt that they were bound to use the term "medical professionals", and submit that the GMC did not properly analyse why they were using that term or whether, if they did, they were furthering the objectives of the 1983 Act and the AAPA order.

59. Ground 3 of the appeal is concerned with the judge's failure to grant an extension of time. This argument in turn depends, first, on what date should be taken as the date of decision. The judge said that the relevant date was 27 April 2023 when the decision to use the term "medical professionals" was taken (see paragraph 38 above). The claim form was not served for well over another year, hence the extension of time issue. However, the BMA argue that, at that point, the GMP was still a draft, and that an extension was appropriate given that: the AAPA order was only made in March 2024; there was a consultation in mid-2024 when the point was taken by the BMA; and GMP was altered in December 2024 anyway.

60. As I have indicated above, there is a Respondent's Notice which seeks to rely on further evidence. In particular, reference is made to the Leng Review, published on 16 July 2025, which recommended separate regulation for doctors and associates. It is suggested by the GMC that, because they are now considering this Review, it renders the appeal academic.

6. Overview

61. Before plunging into the trees that invariably seem to make up this kind of public law appeal, it is as well to stand back and survey the wood. This court is concerned now with a simple terminology issue, the use of a collective noun in GMP. Was the use of the term "medical professionals" by the GMC, accompanied as it was with a clear explanation of what the term encompassed, actionable by the BMA on public law grounds? In my judgment, the instinctive answer to that question is No.

62. In the absence of any remaining issue about the provision of unitary guidance within GMP, this is no more and no less than a complaint about a label that was first used by the GMC in 2020. After an exchange of letters in 2020/21, in which the point seemed to have been resolved by the GMC (paragraph 25 above), the BMA did not comment adversely on the use of that label until 2024. That strongly suggests that the BMA saw no real issue with it. Moreover, it is hard to see how they could have done, given the explanation about its use that the GMC provided.

63. Moreover, the label "medical professionals" is accurate as a matter of language. Doctors are obviously medical professionals. But so too are associates. The judge found at [83] that PAs and AAs were "fairly described as medical professionals". Importantly, there is no appeal against that finding. Moreover, I consider that the judge was right to so find. Associates are professionals because they are paid for providing a service. They provide that service in connection with or relating to the practice of medicine (the dictionary definition of 'medical'), because they are helping to treat physical and mental ill health. So associates are not doctors, but they are medical professionals.

64. GMP does not say that a PA or AA should introduce themselves to their patients as a "medical professional", and – so it seems to me - neither expressly nor impliedly

encourages such conduct. But if a PA or AA did introduce themselves in that way, they would not be committing any offence of any kind, *provided* that they did not say that they were doctors, and *provided* that they went on to make plain the strict limits of their medical role. Of course, if AAs or PAs described themselves as a doctor or a medical practitioner they would be committing an offence under s.49 of the 1983 Act. But GMP does not call them doctors or medical practitioners, or provide any encouragement to them to so describe themselves; on the contrary, it expressly warns associates against so describing themselves (see point 82 of the guidance, at paragraph 48 above).

65. In addition, the use of the label is explained up front and in clear terms on the first page of GMP (see paragraphs 39 and 43 above). The GMP says expressly that it applies to "all registrants": that is to say, all those registered with them. Doctors must be registered with them; following the AAPA order PAs and AAs must be registered with them too. But the GMC decided that "registrants" was not a clear or obvious term: indeed, it was rightly described by the GMC in a letter to one of the interested parties as "cold and impersonal". On the other hand, "medical professionals" is a clear and obvious term. The way in which the label is used in GMP as a label to cover all those registered with the GMC is clear: there was no evidence that the label itself was or is confusing to the public, a point I elaborate on in paragraph 69 below.

66. There is also the context in which this label is used. GMP is not a conventional policy document as such. Nor is it primarily a public-facing document at all: it is principally intended to be read by doctors and associates (the "you" used throughout GMP). It is intended to provide them with general ethical guidance as to how to do their jobs. It is not really concerned with their legal obligations: GMP describes itself as "an ethical framework". I quite accept that it is statutory guidance. But it remains some way from the sort of document that would ordinarily be thought capable of challenge by way of judicial review.

67. However, to the extent that the GMP is public facing, it must be considered in the light of the other information available to the public on this topic, the most accessible of which is on the GMC website. That contains a considerable amount of useful information about doctors and associates and the relationship between the two. I note the following statements:

"(a) More Information of PAs and AAs

About the Professions

Physician associates (PAs) have been working in the UK for 20 years; anaesthesia associates (AAs) for a little less.

PAs and AAs are distinct professions. They are not doctors; and professional guidance expects them to always make that clear to patients and colleagues.

PAs and AAs should never be referred to as 'medical practitioners" because that term is used specifically in legislation to mean doctors.

(b) How PAS and AAs describe themselves

PAs and AAs are distinct professions. They are not doctors.

As regulated professionals, PAS and AAs will have a responsibility to clearly communicate who they are, and their role in the team., just as doctors must do now. In Good medical practice 2024 we say "you must always be honest about your experience, qualifications, and current role."

…

If someone is falsely using a protected title or implying they are a licensed doctor when they are not, we have powers to act. These range from sending cease and desist letters to a referral to the police. Anyone can report a concern about unregistered medical practice using the information available on our website.

(c) The names of the Professions

We have no remit over job titles. The terms 'physician associate' and anaesthesia associate' came into use in the UK some years ago and the DHSC intends to legislate on that basis to make these protected titles.

Patient safety and patient understanding are important. Patients should always be clear on who they're being treated by. We welcome the new guidance from the FPA and the conversation that has started.

When writing about or addressing PAs, AAs, and doctors, we use the three distinct names of each profession, except the rare occasions when it makes a sense to use a single umbrella term.

For example , for ease of reading, we use the term 'medical professionals' in the updated (https://www.gmc-uk.org/professional-standards/good -medicalpractice-2024) Good medical Practice (https://www.gmc-uk.org/professional-standards/good-medicalpractice-2024) , because the professional standards will apply to all three groups once regulation begins."

68. Thus the website information only confirms the clarity achieved by the use in GMP of the label "medical professionals"; the express limits of that description; and the warning against associates describing themselves as doctors.

69. Finally, I would make this observation. In my view, there is a disjunct between the basis for the challenge in the present case, and the two words that are challenged. Ms Richards made repeated references to the evidence of patient confusion and consequential safety concerns. I have no doubt that they are very real. But it was clear from that evidence that the confusion and concern arose out of the term 'associate': it is the nature and scope of the professions of physician associates and anaesthesia associates that the public does not always understand and has led to safety concerns. As Ms Richards put it in her opening oral submissions, "there is one common thread [as to patient confusion]: the limited understanding of the role of associates and the limits of their role". That was supported by the statements of Mr McAlonan and the documents to which he referred, all as recorded by the judge at [58] – [61]. As stated in the evidence, the term 'associates' "is not well understood".

70. But that is not a term that the GMC has any control over: it is the term that Parliament has used throughout the AAPA order. It is those 'associates' that the GMC is obliged by law to regulate, alongside doctors. So the evidence shows that it is not the label for all three professions – "medical professionals" – that causes the potential confusion, but the term "associates", which is something entirely different, and not the subject of this judicial review challenge.

71. Standing back, therefore, this appeal is all about a label, which is clearly explained, for use in GMC ethical guidance, to be read primarily by doctors and associates, who know very well whether they are doctors or associates, and the differences between them. It is an accurate and fair label. Unlike the use of the term "associates", there is no evidence that it is the source of any public confusion. In all those circumstances, it is very hard to see how there can be a coherent public law challenge to the use of that label in GMP. However, in deference to the detailed arguments that were advanced before us, I turn to deal with the individual grounds.

7 Ground 1: The Lawfulness of GMP

7.1 The Relevant Law

(a) The Test for Judicial Review of a Policy at Common Law

72. The leading case is *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC112. That was concerned with the lawfulness of a policy of giving contraceptive advice and treatment to a girl under 16 without informing her parents. The case established that there had to be some form of legal basis for the challenge. Lord Fraser identified the legal basis as whether or not a doctor who followed the guidelines in the policy would thereby be encouraged to commit an offence contrary to s.28 of the Sexual Offences Act 1956 by aiding and abetting the commission of unlawful sexual intercourse. The legal basis identified by Lord Templeman in his dissenting judgment was the potentially unlawful interference with the rights of the girl's parents. Finally, Lord Scarman (whose formulation was emphasised in *R(A)*), said that "it was only if the guidance permits or encourages unlawful conduct in the provision of contraceptive services that it can be set aside as being the exercise of a statutory discretionary power in an unreasonable way".

73. Lord Scarman also said that it was not the role of policy guidance to eliminate all uncertainty regarding its application and all risk of legal errors by doctors. As confirmed at [34] of the later case of *R(A)*, the drafter of a policy statement is not required to imagine if anyone might misread the policy and then to draft the policy to eliminate that risk.

74. Furthermore, as also identified in *R(A)* at [40], it would be unjustified for the courts to be drawn into reviewing and criticising the drafting of policies to an excessive degree. In effect they would have a revising role thrust upon them, requiring them to produce elaborate statements of the law to deal with hypothetical cases which might arise within the scope of a particular policy.

75. *R(A)* was concerned with the guidance in respect of the Child Sex Offender Disclosure Scheme. The leading judgment of Lord Sales and Lord Burnett was plainly

designed to clarify the ways in which policy guidance could be rendered unlawful because of an error of law. Three types of potential challenge were identified:

> "46. In broad terms, there are three types of case where a policy may be found to be unlawful by reason of what it says or omits to say about the law when giving guidance for others: (i) where the policy includes a positive statement of law which is wrong and which will induce a person who follows the policy to breach their legal duty in some way (ie the type of case under consideration in *Gillick*); (ii) where the authority which promulgates the policy does so pursuant to a duty to provide accurate advice about the law but fails to do so, either because of a misstatement of law or because of an omission to explain the legal position; and (iii) where the authority, even though not under a duty to issue a policy, decides to promulgate one and in doing so purports in the policy to provide a full account of the legal position but fails to achieve that, either because of a specific misstatement of the law or because of an omission which has the effect that, read as a whole, the policy presents a misleading picture of the true legal position. In a case of the type described by Rose LJ, where a Secretary of State issues guidance to his or her own staff explaining the legal framework in which they perform their functions, the context is likely to be such as to bring it within category (iii). The audience for the policy would be expected to take direction about the performance of their functions on behalf of their department from the Secretary of State at the head of the department, rather than seeking independent advice of their own. So, read objectively, and depending on the content and form of the policy, it may more readily be interpreted as a comprehensive statement of the relevant legal position and its lawfulness will be assessed on that basis. In the present case, however, the police are independent of the Secretary of State and are well aware (and are reminded by the Guidance) that they have legal duties with which they must comply before making a disclosure and about which, if necessary, they should take legal advice.
>
> 47. In a category (iii) case, it will not usually be incumbent on the person promulgating the policy to go into full detail about how exactly a discretion should be exercised in every case. That would tend to make a policy unwieldy and difficult to follow, thereby undermining its utility as a reasonably clear working tool or set of signposts for caseworkers or officials. Much will depend on the particular context in which it is to be used. A policy may be sufficiently congruent with the law if it identifies broad categories of case which potentially call for more detailed consideration, without particularising precisely how that should be done. This was the approach adopted by Green J in *R (Letts) v Lord Chancellor (Equality and Human Rights Commission intervening)* [2015] EWHC 402 (Admin); [2015] 1 WLR 4497 ("*Letts*")."

76. In *R(BF) Eritrea v Home Secretary* [2021] UK SC38; [2021] 1WLR 3967, the same constitution of the Supreme Court heard another policy guidance challenge. The Supreme Court held that a person promulgating policy guidance was under an

obligation not to direct recipients of that policy to do something that was contrary to their legal duty. They also reiterated that there was no general duty at common law to promulgate a policy which removed the risk of possible misapplication of the law on the part of those who were subject to a legal duty.

77. Once again, Lord Sales and Lord Burnett gave the leading judgment. They said:

> "48. In our judgment in the *A* case, to which we refer, we have sought to provide general guidance regarding the principles to be applied to test the lawfulness of policy guidance. In a case where the lawfulness of policy guidance is in issue, it has to be asked what the obligation or obligations were of the person promulgating the guidance with regard to its content.
>
> *(i) The Gillick obligation*
>
> 49. The principal obligation is that explained in *Gillick*, so in our opinion the parties were right to focus on this in their submissions in this court. The *Gillick* obligation is not to give policy direction to recipients to do something which is contrary to their legal duty: see the *A* case, paras 29-47.
>
> 50. In Mr Hermer's submission, criterion C in the context of both versions of the EIG and *Assessing Age* "permits or encourages unlawful conduct" by immigration officers (to use Lord Scarman's formulation in *Gillick* at p 181F), in the requisite sense. According to Mr Hermer, criterion C "permits" or "encourages" unlawful conduct because it does not sufficiently remove the risk that immigration officers might make a mistake when they assess the age of an asylum seeker who claims to be a child.
>
> 51. In our view, this submission involves a misinterpretation of what was said in *Gillick* and cannot be sustained. As we explain in our judgment in the *A* case, the meaning of the formula used by Lord Scarman is much narrower than suggested by Mr Hermer. It involves comparing two normative statements, one being the underlying legal position and the other being the direction in the policy guidance, to see if the latter contradicts the former. Mr Hermer's submission as to the effect of *Gillick* distorts this test by comparing a normative statement with a factual prediction, ie comparing the underlying legal position with what might happen in fact if the persons to whom the policy guidance is directed are given no further information. If correct, this would involve imposing on the person promulgating the guidance a very different, and far more extensive, obligation than that discussed in *Gillick*. It would transform the obligation from one not to give a direction which conflicts with the legal duty of the addressee into an obligation to promulgate a policy which removes the risk of possible misapplication of the law on the part of those

> who are subject to a legal duty. There is no general duty of that kind at common law."

(b) Rationality and Frustrating the Purpose of Legislation

78. *Associated Provincial Picture Houses Limited v Wednesbury Corporation* [1948] 1 KB 223 is authority for the well-known proposition that, in a judicial review challenge, the court is not set up as an arbiter of the correctness of one view over another. If a person entrusted with a discretion calls his own attention to the matters to which he is bound to consider and excludes from his consideration matters which are irrelevant to what he has to consider, then his decision is likely to be unassailable. The classic formulation of irrationality is that the decision in question must be "so unreasonable that no reasonable authority could ever have come to it".

79. In *R(Law Society) v Lord Chancellor* [2018] EWHC 2094 (Admin); [2019] 1WLR 1659 at [98], Leggatt LJ explained that there might be two aspects of such a challenge. One related to the outcome of any decision: that the result was irrational. The other concerned the process by which the decision was reached. A challenge based on that second aspect necessitated the demonstration of a flaw in the reasoning that led to the decision, such as significant reliance being placed on an irrelevant consideration, or there being no evidence to support an important step in the reasoning.

80. A challenge based on *Padfield* grounds is different. In *Padfield & Ors v Ministry of Agriculture, Fisheries and Food* [1968] A.C.997, the House of Lords held that, where Parliament conferred a discretion on a Minister in order that the policy and objectives of an Act could be promoted, that discretion was not unlimited. If it appeared that the effect of the Minister's refusal to take a particular step was to frustrate the policy of the Act in question, the court was entitled to interfere.

81. That statement of law has been restated in various ways. In *Braintree DC Ex Parte Halls* (2000) 32 H.L.R., Laws LJ said that "the rule is not that the exercise of the power is only to be condemned if it is incapable of promoting the Act's policy, rather the question is: what was the decision-maker's purpose in the instance case, and was it calculated to promote the policy of the Act?" That formulation may have the effect of turning a negative test (does it frustrate or thwart the policy of the Act?) into a broader positive test (does it promote the policy of the Act?), and may not always be applicable. However, as we shall see, such a distinction is immaterial in the present case.

7.2 The Judgment Below

82. At [69]–[71] the judge held that a guidance document such as GMP could be unlawful only on one of the bases identified at [46] and [47] of *R(A).* The two bases potentially relevant here were (i) (where the policy includes a positive statement of law which is wrong and which will induce a person who follows the policy to breach their legal duty in some way), and (iii) (where the authority, even though not under a duty to issue a policy, decides to promulgate one and in doing so purports in the policy to provide a full account of the legal position but fails to achieve that).

83. Although the judge noted that the BMA did not accept that *R(A)* applied, she said at [71] that the BMA had been unable to identify any other legal test by which the standards guidance in GMP could be measured. The judge therefore approached this issue on the basis that she had to decide whether the inclusion of the term "medical professionals" brought GMP within one or other of the two categories noted above.

84. Subsequently, the judge further explained why the test in *R(A)* applied at [78]-[79]. She also noted that the court in *R(A)* had explained why a narrow formulation was appropriate: it was because guidance policy documents are issued to promote practical objectives. If a policy was issued, there was no obligation for it to take the form of a detailed and comprehensive statement of law in a particular area and, since there was no such obligation, there was no basis on which a court should strike a policy down if it failed to reach that standard.

85. The judge then went on to address whether or not GMP fell into the categories identified in *R(A)*. She concluded that they did not. She said:

> "82. I consider first whether GMP falls into category (i) in para. 45 of *A*. In my judgement, the policy does not include a positive statement of law, let alone a positive statement of law which is wrong.
>
> i) The term "medical professional" is not a term defined in the 1983 Act or any other legislation. That being so, the use of that term is not a statement of law at all. Moreover, because the term is not a title protected by the 1983 Act or other legislation, a physician associate or anaesthesia associate person who used the term "medical professional" would not commit any offence or otherwise act unlawfully. Accordingly, even if the use of the term in GMP induced a physician associate or anaesthesia associate to refer to themselves as a "medical professional" it would not induce them to breach any legal obligation of theirs.
> ii) However GMP does not suggest that doctors, PAs or AAs should introduce themselves as "medical professionals." As GMP explains, where the term is used in the guidance, it is as a collective way of describing the three sets of professionals regulated by the GMC: doctors, PAs and AAs: *"We use the term "medical professionals" to describe all our registrants who we address directly (as "you") throughout this guidance…"*
> iii) Use of the term "medical professionals" in GMP does not imply that associates are regulated doctors. Far from suggesting that PAs and AAs can, or should, misdescribe themselves as regulated physicians, GMP makes clear that all medical professionals have a clear ethical duty to be honest about their experience and role. Under Domain 4, which contains guidance on "Trust and Professionalism", the reader is informed: "*you must always be honest about your experience, qualifications and current role. You should introduce yourself to patients and explain your role in their care*". The guidance therefore imposes a duty on the person to explain their current role in the care of the patient when introducing themselves. In the case of an associate, this may include explaining that they are non-medically qualified members of a multidisciplinary team working under supervision.

> 83. Nor does the policy purport to provide a full account of the legal position regarding the duties of regulated persons as to self-description. However, even if it did, on a fair overall reading of the policy it does not give a misleading account of the law. It uses an umbrella term in places for members of the three different professions, who are all fairly described as medical professionals, while stressing that a member of the PA and AA professions should not misdescribe themselves as a medically qualified person when they are not."

7.3 Summary of Submissions on Appeal

86. *Grounds 1 and 1A*: On behalf of the BMA, Ms Richards submitted that the judge was wrong to find that the inconsistency between GMP and the statutory framework should be analysed solely by reference to *R(A)* (Ground 1A). She said that the essence of this ground of challenge was that it was unlawful to promulgate guidance under s.35 of the 1983 Act and under the AAPA order that was inconsistent with the framework of that primary and secondary legislation. She submitted that the decision in *R(A)* did not provide an "exhaustive rubric" (the judge's term) for an assessment of BMA's case, because the categories in *R(A)* were directed at a very specific goal, namely policies which were intended to give guidance about the law and/or provide a specific framework for lawful decision-making.

87. Mr Hare KC, on behalf of the GMC, had an overarching point in response to ground 1, namely that the BMA's argument was based on a false premise: there was nothing about the statutory framework that made it unlawful for the GMC to use the term "medical professionals" in its standards guidance to describe doctors, PAs and AAs. Indeed, he suggested that for a variety of general reasons, the use of that term in the GMP could not give rise to a judicial review challenge at all.

88. As to ground 1A specifically, he reiterated the judge's point that no alternative public law basis for analysing the alleged inconsistency had ever been identified by the BMA. He said the case fell squarely within *R(A)* because it was the essence of the BMA's case that the use of the label meant that the GMP would mislead doctors and associates, and members of the public, as to the true legal position.

89. *Ground 1B*: In the alternative, if the categories in *R(A)* were applicable to the BMA's case, Ms Richards maintains that the judge was wrong to find that GMP did not fall within those categories of unlawfulness. She said that the judge's reasoning, set out above, was too narrow a way of answering the question identified in *R(A)*. The contradiction between what the law required and what GMP approved was wider than s.49: it encompassed a failure to follow a clear statutory distinction between the medical profession and the associate professions. She went on to say that in any event GMP did authorise or approve a breach of s.49, because that section made it a criminal offence for an individual to describe themselves in any way that expressly or implicitly suggested that they were a doctor. She made a number of other points as to why the judge had erred in failing to find that it fell within category (i) of *R(A)*. In the alternative she said that it fell within category (iii) of *R(A)*.

90. In response to ground 1B, Mr Hare noted that the judge expressly addressed the question of whether the GMP authorised or approved a breach of s.49 and was right to conclude that it did not, for the reasons that she gave. He noted that the BMA had

failed to identify any other substantive legal requirements that could even arguably be said to be breached by following or applying GMP. When read as a whole and in context there was no encouragement to PAs or AAs to introduce themselves as medical professionals. He referred in particular to the substantive requirements in GMP for associates to be open and honest and to explain their role. In addition, Mr Hare said that, even if GMP could be read as authorising PAs and AAs to describe themselves as medical professionals, the guidance could not be read as authorising or approving a breach of s.49 because that required a wilful and false use of a protected title or descriptor implying that the individual was a doctor, and GMP got nowhere near to doing that.

91. *Ground 1C*: Ms Richards submitted that the judge erred in failing to conclude that the inconsistency between GMP and the statutory framework breached the *Padfield* principle and/or was *Wednesbury* irrational. It was not entirely clear whether ground 1C added anything to grounds 1A and 1B. That was because, as noted in paragraph 27 of Ms Richards' skeleton argument, the submission was that "if, for all the reasons set out above, the use of "medical professionals" in GMP is inconsistent with the statutory framework, it follows that its use breaches the *Padfield* principle and/or is *Wednesbury* irrational*"*. In other words, this argument only gets going if Ms Richards' basic submission, that the use of the term is inconsistent with the statutory framework, is successful. If the use of the term "medical professional" was not inconsistent with the statutory framework, or it did not authorise or approve unlawful conduct, there was no basis for any challenge.

7.4 Ground 1: Is There an Inconsistency or Misdirection in Law?

92. It is as well to analyse the core point at the heart at ground 1, before going on to look at grounds 1A-1C. That is whether or not the BMA is right to say that the use of the label "medical professionals" in GMP is unlawful because it is inconsistent with the statutory framework and amounts to a misdirection in law. In my judgment, that assertion is unsustainable. Some of the reasons for that conclusion will have been apparent from my observations in Section 6 above. In addition, I make the following three general points.

93. First, the term "medical professionals" is not a protected title. It is not a term defined in the 1983 Act or any other legislation. So the judge was right to conclude that the use of that expression in GMP was not a statement of law. In addition, as I have already indicated, the label was factually accurate and its use was "fair" (the word used by the judge). It was clearly explained on the first page of GMP. The label might also be said to be consistent with s.60(i)(b) of the Health Act 1999, which talked about the power to regulate "*other professions concerned wholly or partly with…physical or mental health*" (paragraph 14 above).

94. Secondly, GMP identified the various "registrants" to which it applied. It is clear from the text that "medical professionals" is simply another label for "registrants" and similarly intended to cover both doctors and associates. Its use does not suggest or encourage one profession to describe itself as another. On the contrary, GMP is clear that all registrants must be "open and honest" and to explain their role to their patients. Accordingly, I reject the BMA's core submission that GMP authorises or approves PAs and AAs describing themselves as doctors or medical practitioners.

95. Thirdly, I have already noted that the arguments about patient confusion were aimed at the wrong target. The judge found at [122] that "there is no evidence that serious patient safety concerns ***are the result of the decisions under challenge***" (ie the use of the term "medical professionals"). I agree with that assessment of the evidence. So although Ms Richards submitted that the label "medical professionals" was contrary to the statutory framework because it undermined public confidence and led to confusion, for the reasons that I have explained at paragraphs 69 and 70 above, any confusion arose from a different source, namely the statutory title 'associate', which has nothing to do with the GMC and is not the subject of this challenge.

96. In my view, the high-water mark of the BMA's case on ground 1 was as follows:

(a) The "medical profession" referred to in the 1983 Act was a reference to doctors only;

(b) An associate cannot say that they are a member of the "medical profession" because that would be inconsistent with the statutory framework and/or a breach of s.49;

(c) The use of the label "medical professionals" in the GMP would encourage an associate to do just that, and so it is unlawful.

97. In my view there are a number of flaws in this chain of reasoning:

(a) The reference in the 1983 Act to the "medical profession" is not a reference to a protected title. In the 1983 Act, the "medical profession" was made up of doctors, but that was because, in 1983, it was only doctors who were capable of registering with the GMC.

(b) An associate should not say that they are a member of the "medical profession", because that *might* be contrary to the 1983 Act, although I note that it is not one of the titles or names identified in s.49 as leading to a criminal charge if it is falsely used.

(c) In any event, there is nothing in GMP that would encourage an associate to say that they were a member of the "medical profession". It is not a term to be found in GMP. As we shall see (paragraphs 121 and 128 below) later documents emanating from the GMC make clear that an associate is not and should not be referred to as a member of the "medical profession".

(d) The GMP does not say that a PA or AA can introduce themselves as a "medical professional". However, since the label is fair and accurate (see [83] of the judge's judgment and my paragraph 63 above), it seems to me that they could do so, provided they add the qualifications identified in paragraph 64 above.

(e) "Medical professional" is not a protected title. Accordingly, its use in GMP cannot be (and is not) inconsistent with any part of the 1983 Act or the AAPA order.

98. In addition, to be unlawful, the use of the label "medical professionals" in GMP would have to permit/induce/encourage associates to act in breach of s.49. But for the reasons noted below, it does not.

99. By reference to the express words of s.49, the use of the term "medical professionals" in the GMP would not permit/induce/encourage an associate "*wilfully and falsely*" to pretend to be or to take or use the name of "*physician, doctor of medicine, or licentiate in medicine and surgery, bachelor of medicine and surgery, general practitioner or apothecary*, *or any name, title, addition description implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon or licentiate in medicine and surgery or a practitioner in medicine or an apothecary*." There is no provision in the 1983 Act relating to "medical professionals", and there is no element of s.49 that could be triggered by a PA's or AA's use of that label.

100. I note that, despite Ms Richards' suggestion that the case was based on more than s.49, no other potential unlawful conduct was identified, either in the skeleton, or orally. So, for the reasons I have set out, there is an unbridgeable gap between the fair/accurate/fully explained use of the label in GMP, and that which would be required to argue that there had been a challengeable misdirection in law.

101. For these reasons, therefore, I consider that ground 1 of the appeal must fail. It is therefore unnecessary to spend too long on dealing with individual grounds 1A, 1B and 1C. It is also unnecessary to express any concluded views on all Mr Hare's five propositions, developed orally, which suggested that the nature of the GMP was such that no judicial review challenge could lie against it in any event.

7.5 Ground 1A: The Applicability of R(A)

102. The judge concluded that, in the absence of any proposed alternative way of testing or analysing the challenge to the lawfulness of the label "medical professionals", the most appropriate methodology was by reference to *R(A)*. Although the BMA sought to challenge that approach, just as they endeavoured to do before the judge, they have been unable to identify any other public law basis for analysing the alleged unlawfulness. Describing it as actionable merely because it is a 'misdirection of law' is unhelpful, because that makes no attempt to delineate the nature, scope and extent of any public law challenge, and the tests that must be applied, to see if a 'misdirection in law' is capable of founding a judicial review challenge in any particular case.

103. Of course, as with all public law challenges, this court must be wary of putting challenges into "entirely separate boxes" (see *R v Secretary of State for the Home Department ex parte Oladhinde* [1990] 1AC 254 at 280). The law of judicial review is not hermetically sealed. But neither should it be allowed to become the Wild West, with every case being decided afresh on newly-minted principles. The law of precedent generally, and the law and practice of judicial review in particular, requires there to be some form of solid foundation for any judicial review challenge. What is the test to be applied? What is the legal basis for the challenge?

104. The legal basis of the BMA's challenge in this case is that the GMC are said to be misdirecting either PAs or AAs (or the public in general), by giving erroneous advice as to the law, to the effect that associates can say they are members of the medical profession, (and therefore doctors), in breach of s.49 of the 1983 Act. But that sort of situation is broadly (if not precisely) encompassed by *R(A),* because it is the BMA's case that, by the use of the label, GMP will mislead associates and/or members of the

public as to the true legal position. That is the legal hook on which this challenge hangs. *R(A)* is not limited to the situation where the policy in question is intended to give guidance about the law: on the contrary, at [49] of their judgment in *BF*, Lord Sales and Lord Burnett made plain that, in their judgment in *R(A),* they had "sought to provide general guidance regarding the principles to be applied to test the lawfulness of policy guidance".

105. For those reasons therefore, it seems to me that the judge was right to conclude that the test that she should apply was, at least in general terms, the test in *R(A).* I accept that this case is not factually on all fours with *R(A)*, but it seems clear to me that, because GMP is said by the BMA to contain erroneous statements of law, the same broad principles apply. That distinguishes it from *R (CPH) v SSHD* [2025] EWHC 848 (Admin) (on which Ms Richards purported to rely) which was not in fact concerned with statements of law at all.

106. Furthermore, the test in *R(A)*, or something very like it, must apply as a matter of common sense. The drafters of polices and guidance, such as the GMP, are not sitting law exams. If there is some inconsistency or misstatement in their document, that is not of itself enough to warrant a challenge. It must be shown to have some probable effect: in other words, it must be shown that the misstatement of law would permit/induce/encourage unlawful conduct.

107. Accordingly, I consider that the judge was, in the absence of any other suggested test or criteria, entitled to apply the principles in *R(A)*.

7.6 Ground 1B: Categories (i) and (iii) in R(A)

108. It is of course right that the categories in *R(A)* are not intended to impose "a rigid categorisation upon types of unlawful cases": see Cavanagh J in *R (Timson) v SSWP* [2022] EWHC 2392 (Admin) at [143]. But he went on to say, in my judgment rightly, that "it will nonetheless usually be helpful to make use of the categories of cases identified by the Supreme Court…as a guide when considering whether written policy or guidance is unlawful…". So looking at that analysis, the test becomes whether the GMP induces a person who follows the policy to breach their legal duty in some way (*R(A)* category (i)) or whether the use of the label presents a misleading picture of the true legal position (*R(A)* category (iii)). It is the BMA's submission that GMP falls into one or both of these categories because it "fails to follow the clear statutory distinction between the medical professions and the associate professions".

109. In my view, neither category is applicable to the facts here, primarily for the reasons explained by the judge at [82] and [83], set out at paragraph 85 above. An associate could only breach their legal duty if they describe themselves as a doctor or medical practitioner. But as I have explained, the use of the term "medical professionals" does not permit/induce/encourage an associate to describe themselves in that way: on the contrary, it is very clear that accurate information must be given. For the same reasons, the use of the label does not present a misleading picture of the true legal position. Instead, the label makes clear the three professions that it encompasses and explains why the collective term has been used as a matter of convenience, in order that the rest of GMP can be addressed to "you". Neither R(A) category (i) or category (iii), no matter how fluidly or flexibly they are applied, arise here.

110. I therefore reject ground 1B of the appeal.

7.7 Ground 1C: Padfield and Wednesbury

111. It is said that the use of the term "medical professionals" was contrary to the *Padfield* principle, because it was inconsistent with the purpose and objective of the 1983 Act and the AAPA order. It is also said to be irrational in the *Wednesbury* sense.

112. In my view, neither of these points are sustainable. Indeed, I note that the judge thought that the *Padfield* and *Wednesbury* points were primarily related to the unitary guidance aspect of the case, which is no longer pursued on appeal. That seems to me to be understandable. It stretches public law to breaking point to suggest that the simple labelling exercise represented by the two words "medical professionals" could give rise to a *Padfield* or *Wednesbury* argument.

113. In any event, since the use of the term "medical professionals" was not inconsistent with the statutory framework; since it did not permit/induce/encourage unlawful conduct; and since there was no confusion caused by the term itself, then there could be no claim based on irrationality or improper purposes contrary to the 1983 Act and the AAPA order.

114. For all these reasons, I would reject ground 1 of the appeal. If I was wrong about that, I would in any event reject sub-grounds 1A, 1B, and 1C of the appeal.

8. Ground 2: The Independent *Padfield* and *Wednesbury* Challenge

8.1 The Judge's Judgment

115. As noted above, the judge considered that the principal *Padfield* and *Wednesbury* challenge was aimed at the unitary guidance issue. But it is wrong to say, as Ms Richards did, that the judge did not engage with this challenge in so far as it related to the GMC's decision-making process that led to the use of the term "medical professionals" . The relevant paragraphs are set out below.

116. The judge identifies that this ground of challenge covered both the unitary guidance issue and the use of the term "medical professional" [85]. She noted at [91] the submission that the use of the term "medical professional" was not consistent with public safety. She noted at [95] that the "use of the term was not simply a hangover from the abandoned legislation but had first been used as early as November 2020." She also found that there was no evidence that the use of the term had prejudiced patients' safety.

117. At [102] the judge said this:

> "…The history of the development of the policy clearly demonstrates that the GMC acted at all stages with the aim of promoting the statutory purpose. The term "medical professionals," was used on occasions in GMP as a shorthand for "member of one of the three professions of doctor, PA and AA to which this guidance relates." It was used for the purpose of clarity and readability and only where the GMC considered the circumstances made it appropriate. It is impossible to say that the use of

this term in a document intended to promote patient safety was an administrative act which was unlawful in *Padfield* terms."

118. Finally, as to rationality, the judge said this:

"112. The defendant is an experienced regulator. Its decision to produce single guidance followed an exhaustive and detailed process of consultation, research and inquiry which engaged all major stakeholders, including the claimant. The process pointed towards the application of the same high standards of practice for associates as for doctors. The guidance was developed in the knowledge of various concerns having been raised about the role of associates which the defendant considered may be addressed by the holding of associates to the same high standards as doctors. The fact that the guidance was to be used by three sets of professionals was made clear in the introduction and, as recorded earlier in this judgment, additional changes were made to the guidance to reflect the application of the guidance to those professionals and to address concerns raised in response to the earlier consultation. Ms Richards suggests that associates were required to work out for themselves which standards applied to them. It is true that the guidance does invite the reader to establish for themselves which standards are relevant to their specific circumstances; but this has always been the case even in the previous iterations of GMP which applied to doctors only. No one set of standards guidance will apply to all registrants irrespective of their clinical circumstances, whether doctor or associate. Although there were some objections to the use of the term "medical professional" during the consultation phase, there was no objection by the EAG or Advisory Forum. The defendant considered and rejected at least two alternatives, including Medical Associate Professional (which included two other branches of the associate profession, surgical care practitioners and advanced critical care practitioners as well as PAs and AAs) and registrant (which was thought to be cold and impersonal). Although Ms Richards is critical of the rejection of the term "registrant" on the grounds that it was impersonal it is not irrational to take into account, when drafting guidance, the style and tone of the guidance as well as its content.

113. Nor was the outcome of the reasoning process, in my judgement, outside the range of reasonable responses open to the defendant. On the contrary, I conclude that it was open to the GMC to consider that the protection of the public would be best served by applying the same high professional standards to associates, who are trained to the medical model and who undertake medical duties in order to free up qualified doctors for more complex work. The use of shared standards was logical given the overlap in work undertaken by doctors and associates and the need for regulatory concerns affecting all three professions to be considered against the same standards. There is nothing irrational or inherently confusing about the application of the same standards to doctors and associates. Nor is there anything irrational or inherently confusing about the use of the term "medical professionals." Associates are members of a profession, trained to the medical model, undertaking work which might otherwise be

> performed by doctors and working as members of a multi-disciplinary team in a healthcare context. Viewed in this way, the defendant was entitled to conclude that the term "medical professional" was apt."

8.2 Summary of Submissions on Appeal

119. During her oral submissions at the appeal hearing, Ms Richards relied on two separate strands of documentary evidence in connection with ground 2. The first were documents which were before the judge but to which Ms Richards said the judge failed to have any or any proper regard. These were primarily the documents to which I have referred at paragraphs 34-36 above, namely those that indicated the link between "medical professionals" and the proposed legislation in 2022 which was subsequently shelved. Ms Richards' argument was that these documents showed that the phrase was linked to the intended legislation and when that was abandoned, they should have rethought the expression, asking themselves whether it promoted public trust and so on.

120. The second strand of evidence was not before the judge. Here, Ms Richards relied on internal GMC's documentation, all of which post-dated the decision to use the label in GMP 2023. A GMC meeting on 11 June 2024 indicated that "medical professionals" was a collective term that required permission before it was used. Those minutes referred to a GMC multiprofessional terminology guide, current in June 2024. That did not mention "medical professionals" at all, so was of little assistance. I note that it referred to "medical practitioner" (which of course, being a term identified under the 1983 Act, was in an entirely different category) and "multiprofessional", a term that was encouraged because the GMC "regulate three different professions".

121. The December 2024 version of that terminology guide contained a number of guidelines for those drafting GMC communications. There is a passage which says:

> "*Use with caution the word 'medical' when talking about our registrants or our role as a regulator if alternatives are available. We may occasionally refer to our whole population of registrants as 'medical professionals', but prefer to say 'doctors', PAs, and AAs'. For example, see the separate entry about the term 'medical professionals'*."

It then includes the following statement:

> "*The medical profession*
>
> *'The medical profession' is singular, and we have historically used it to mean 'doctors'. Now we regulate two additional professions - PAs and AAs – therefore when talking about our work generally, we can no longer use the singular term 'the medical profession".*
>
> *Don't use the term 'the medical profession' when referring to PAs or AAs. You can still use it, if necessary, when referring only to doctors, but it' always preferable to simply say 'doctors' if that's what you mean.*

> *'The medical profession' is not the same as 'medical professionals' – please see the separate entry in this guide (below)…*
>
> *Medical Professional(s)*
>
> *Some doctors are concerned about the use of the collective term 'medical professionals' to refer to doctors, physician associates (PAs) and anaesthesia associates (AAs).*
>
> *1. If you need to describe who we regulate, you must always list each profession in full and in this order: doctors, physician associates (PAs) and anaesthesia associates (AAs).*
>
> *2. If spelling out the three professions would cause significant repetition, you should refer to 'registrants' instead (please refer to our guidance on the use of this term).*
>
> *3. Don't use the term 'medical professionals' in information for patients, on social media, in media quotes, on presentation slides or in blogs.*
>
> *4. For staff needing to directly quote Good medical practice, where the term 'medical professionals' is used, this is ok.*
>
> *The above may seem confusing, but we want teams to take time to consider their writing and to always think what is clearest to the reader. If you need advice please contact terminology@gmc-uk.org and we will review on a case-by-case basis.*"

122. Ms Richards' submission was that this material ran counter to the argument, which the judge had accepted, that the use of the term "medical professionals" in the GMP was to promote clarity/readability/accuracy. She contrasted that with the express warning not to use the term in public-facing documents.

123. On the basis of these two strands of documentary material, Ms Richards submitted that the evidence of the GMC's decision-making did not demonstrate that it was calculated to promote the policy of the 1983 Act and/or the AAPA order. She said that the documents showed that the GMC's use of the term "medical professionals" was not for the purpose of promoting the statutory objective and was not rationally connected to the statutory objective. She said that the GMC's mistaken belief that it was not in its "gift" to change the term was a logical error or a critical gap in its reasoning. The underlying complaint was, again, based on the evidence of public and patient confusion about the roles of associates.

124. In response to these arguments, Mr Hare dealt with the applicable principles, first from *Padfield* and then *Wednesbury*. He submitted that the first stage was to identify the objectives of the 1983 Act and the AAPA order. He said that, in this context, the objective of both was to subject associates to the same rigorous ethical standards that

applied to doctors. That is what GMP did. In addition, there was nothing in the 1983 Act or the AAPA order which identified what the individual topics in any such guidance should be, much less anything which limited or excluded the use of (accurate) collective nouns.

125. As to the specific points on the documents, he said that the evidence did not demonstrate that, in some way, the GMC had been dictated to by the DHSC: the expression "medical professionals" had first been used by them in 2020, before the intended legislation had been drafted. Furthermore, he submitted that it could hardly be unlawful or irrational in any event for the GMC to follow the proposed legislation. But once that legislation had been shelved, the GMC retained the label for the reasons that they explained. The label was not just a hangover from the abandoned legislation but was a term which they had consistently used. He said that nothing in either strand of the documentary evidence demonstrated that there was any gap in the GMC's reasons for using the label "medical professionals".

8.3 Discussion and Conclusions

126. In my view, the evidence did not support Ms Richards' submission that the term "medical professionals" was only used by the GMC because it was the term to be used in the proposed legislation. It also did not establish that, once that had been shelved, the label should have been reconsidered. On the contrary, the evidence shows that, both before and after that proposed legislation, the GMC had used the expression "medical professionals" and had good reasons to do so. The consultation process (paragraphs 31 and 33 above) made plain that the GMC always intended to use that term, and simply noted that it was "also" going to be used in the proposed legislation. That fact was simply a further point in its favour: because it was going to be used in proposed legislation, its use could not, in my view, possibly be said to be irrational. Its use in the draft legislation had the additional effect that, for a period, any change to it was outside the GMC's control.

127. Once the legislation had been shelved, the GMC could have revisited the term. But why would they rationally have done so, since they had used the term before the proposed legislation had been drafted, and there had been no significant challenge to it in the various consultations? Once everyone was aware that the legislation would change, no-one suggested an alternative term. The GMC had no reason to reconsider it, particularly as it was a fair and accurate label, and its use in GMP was fully explained. So why did the GMC need even to consider changing it? No answers to these questions were forthcoming. In those circumstances, the *Wednesbury* challenge must fail: there was no gap in the GMC's logic or their reasoning at any stage of the decision-making process.

128. In addition, I consider that Ms Richards sought to read far too much into the internal GMC documents which were not before the judge (paragraphs 120-121 above). First, they post-dated the decision to use the term "medical professionals", so could shed no light on the decision-making process. Second, it seems to me that the internal advice (that the expression "medical professionals" should be used with caution) was sensible, as this litigation has shown. Indeed, the related reference to some doctors being concerned about the term may well be a reference to this judicial review challenge, which was up and running by the date of the later terminology guide. Thirdly, the passages relied on ultimately demonstrate that, certainly for staff (who

were the primary audience of GMP), the use of the term was "OK". And finally, the guide said in terms that "medical professionals" were not the same as "the medical profession", thus running completely counter to the BMA's underlying argument in this appeal.

129. Applying the principle from *Padfield*, it is quite impossible to say that the GMP acted contrary to the purpose and objectives of the 1983 Act or the AAPA order, by using the label "medical professionals". Nothing about the label thwarted or frustrated the purpose of the 1983 Act or the AAPA order. To the extent that the wider formulation of the test in *Braintree* is appropriate, I agree with Mr Hare: the GMC were endeavouring to ensure that associates were subjected to the same rigorous ethical standards as doctors. That was why the GMC put them together with doctors in the collective term "medical professionals", and then in the specific paragraphs of guidance, referred to all three professions generically as "you". That positively promoted the objectives and purposes of both the 1983 Act and the AAPA order because, by making sure that associates were not held to lesser standards than doctors, it sought to protect, promote and maintain the safety of the public; promote public confidence in the three professions; and promote and maintain proper professional standards.

130. For all these reasons, therefore, I would reject ground 2. That means that, if my Lords agree, this appeal fails. Although it is strictly unnecessary therefore to go on to consider ground 3 (the extension of time), what I say about it can be relatively brief.

9. Extension of Time (Ground 3)

131. There was some debate about the potential tension between the judge's decision to grant permission and her refusal to extend time. In the end nothing turns on that, and it seems to me to have stemmed from the fact that the hearing before the judge was a rolled-up hearing, at which she refused the judicial review claim on its merits.

132. As to the test for an extension of time, there is no dispute as to the principles. A judicial review claim must be brought promptly and in any event not later than three months after the grounds first arose (CPR 54.5(1)). Time generally starts to run at the date of the decision under challenge: *R v Department of Transport Ex Parte Presvac Engineering* [1992] 4 Admin LR 121. If, however, the decision is not made known to the claimant until a later date, an extension of time will commonly (but not automatically) be granted for that intervening period.

133. The test for extending time can be found in *Maharaj v National Energy Corporation of Trinidad and Tobago* [2019] UKPC 5; [2019] 1WLR 983. Lord Lloyd Jones said:

> "38 In the same way, questions of prejudice or detriment will often be highly relevant when determining whether to grant an extension of time to apply for judicial review. Here it is important to emphasise that the statutory test is not one of good reason of delay but the broader test of good reasons for extending time. This will be likely to bring in many considerations beyond those relevant to an objectively good reason for the delay, including the importance of the issues, the prospect of success, the presence or absence of prejudice or detriment to good administration, and the public interest. (see for example, *Greenpeace 2* [200] Env LR 221,

> 262-264 and *Manning v Sharma* [2009] UKPC 37 at [21]). Here the Board finds itself in agreement with the observations of Kangaloo JA in *Mohammed* (para 25) cited above, para 17. In Trinidad and Tobago these are all matters to which the court is entitled to have regard to by virtue of section 11(3). More fundamentally, where relevant, they are matters to which the court is required to have regard.
>
> 39 If prejudice and detriment are to be excluded from the assessment of lack of promptitude or whatever a good reason exists for extending time, the law will not operate in an even-handed way. It is not controversial in these proceedings that, even where there is considered to be a good reason to extend time, leave may nevertheless be refused on grounds of prejudice or detriment. By contrast, if, without taking account of the absence of prejudice or detriment, it is concluded that there is no good reason for extending time, leave will be refused and their absence can never operate to the benefit of a claimant."

134. Ms Richards said that, since GMP 2023 was not made available to the BMA until August 2023, time should not run until that date. Thereafter, she accepted that there was a delay, but said that the judge should have granted an extension of time to cover it. She relied on a variety of matters. The first was that, even in August 2023, GMP was not quite in its final form. She noted that it was not going to come into force until January 2024 anyway. She went on to say that, because it was not finalised until December 2024, the BMA could have abandoned their first challenge, and then challenged the final version after December 2024, without any difficulty as to time limits. Secondly, she said that, as of August 2023, the GMC were not necessarily going to be the regulator of PAs sand AAs. That did not happen until the AAPA order came into force in March 2024, which meant that the claim was brought within 3 months of that date.

135. I accept that, if the BMA had commenced proceedings promptly after their receipt of the draft GMP in August 2023, then they probably would have been entitled to an extension of time up to that date (although issues may have arisen over their failure to object during the consultation processes in 2022 and 2023). But they did not. Thereafter, I am not persuaded that they have demonstrated good reasons for extending time.

136. The fact that, in August 2023, GMP was not quite finalised is immaterial, given that this challenge, which is all about the use of the two words "medical professionals", went to a part of GMP that had been unchanged since the start of the drafting exercise two years before. By August 2023 at the latest, it would have been plain to the BMA that a decision had been taken to use the term "medical professionals" in GMP. The fact that GMP was not due to come into force until January 2024 is irrelevant; if anything, it points up the need for a prompt challenge well in advance of that date, to prevent publication from otherwise being hijacked by a late judicial review challenge.

137. There is nothing in the point that the GMC were not confirmed as the regulator of PAs and AAs until March 2024. The GMC had been producing the earlier drafts of GMP on the assumption, which the judge found to have been entirely sound, that they would be the relevant regulator. The consultations in 2021-2023 and the August 2023

draft were expressly predicated on that assumption. So the subsequent formal confirmation of the GMC's role as regulators changed nothing.

138. Nor could the BMA have abandoned the first challenge to the August 2023 draft and then sought legitimately to challenge the finalised version of GMP of December 2024. That assumes that the making of a "decision" which is, in effect, simply repeating an earlier "decision" (i.e. the decision to use "medical professionals" in August 2023, which was repeated in December 2024) starts time running all over again. That would mean that, every time a policy document was revised, no matter how immaterial the revision, the time to challenge something that had been included in the previous iteration began to run all over again. That is contrary to principle and the requirements of good administration.

139. Of course, *Maharaj* also identifies the merits or otherwise of the claim as at least one factor for the court to take into account. For the reasons that I have given in Sections 6, 7 and 8 above, and in agreement with the judge, I do not consider that there is any merit in these claims for judicial review. Accordingly, that is a further factor that lead the judge rightly to refuse the necessary extension of time.

140. For these reasons, I would reject ground 3 of the appeal.

10. Is The Appeal Academic?

141. The GMC suggest in their written submissions that the appeal is academic. This is because, in July 2025, the Leng Review recommended that there should be separate guidance for doctors, on the one hand, and associates, on the other, and the GMC have said that they are now actively considering those recommendations.

142. In my view, those events have not rendered the appeal academic. The Leng recommendation effectively goes to the unitary guidance issue, which is not a matter for this appeal. It does not go to the GMC's use of the label "medical professionals", which is the only matter that we have been asked to consider. Ms Richards made that point in her oral submissions, and I am satisfied that it was right.

11. Conclusions

143. For the reasons set out above, if my Lords agree, I would dismiss this appeal.

LORD JUSTICE JEREMY BAKER

144. I agree.

LORD JUSTICE COBB

145. I also agree.