General Medical Council

Concerns about fitness to practise

Annual statistical report
Data for 2025

General Medical Council

Fitness to Practise Annual Statistics Report 2025

Presented to Parliament pursuant to section 52A of the Medical Act 1983 as amended by The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008 (SI No.1774).

General Medical Council

This publication is available at: www.gov.uk/official-documents.

Any enquiries regarding this publication should be sent to us at gmc@gmc-uk.org.

ISBN: 978-1-7391680-9-4

General Medical Council

Contents

List of abbreviations

AA – Anaesthesia associate*

FtP – Fitness to practise

GMC – General Medical Council

MPT – Medical practitioners tribunals

MPTS – Medical Practitioners Tribunal Service

PA – Physician associate†

*/ † The titles ‘physician associate’ (PA) and ‘anaesthesia associate’ (AA) are used in this report to reflect the terminology set out in the Anaesthesia Associates and Physician Associates Order 2024 and the registers we maintain. Changes to these titles have been proposed in the Leng review and are being considered by the UK government; in the meantime, we use the statutory titles currently set out in law.

Foreword

Addressing concerns about fitness to practise is a central part of our role in protecting patients and maintaining public confidence. This is a statutory duty given to us by Parliament and governed by processes set out in law. When concerns are raised about a doctor, a physician associate or an anaesthesia associate, our responsibility is to consider those concerns carefully, and to take further action where necessary.

Patients place a high degree of trust in those involved in their care, and while the vast majority of professionals we regulate practise safely and with dedication, clear processes for assessing concerns are an important part of maintaining that trust.

This report sets out relevant data about how fitness to practise concerns moved through our processes in 2025.

In recent years, the number of concerns raised by members of the public has increased, with a particularly pronounced rise in 2025. The reasons for this increase are not yet fully understood, although similar patterns have been observed by many other regulators. The increase reinforces the importance of ensuring that the wider system for raising and considering fitness to practise concerns remains accessible and inclusive.

Concerns that come to us vary widely in their nature and seriousness. Some raise clear, immediate and serious questions about patient safety, while others have resulted from communication issues, service pressures or matters that are more appropriately addressed within local healthcare systems. A proportionate regulatory system requires that formal investigations are opened only where concerns raise serious questions about fitness to practise, and that only the most serious and disputed cases should be referred to the MPTS for a tribunal hearing. Addressing concerns effectively at a local level is often the most appropriate way to protect patients and support professionals.

Over recent years we've invested in our outreach function, and our Employer Liaison Advisers work closely with responsible officers to help them understand our threshold for opening an investigation, to support them in taking appropriate action locally in relation to concerns about doctors, and to help them establish and sustain effective clinical governance systems.

The system for dealing with concerns about fitness to practise is complex, and data alone cannot fully tell the story. This year the report provides fuller context around the figures – both to support careful analysis of trends and to help readers understand how our processes operate in practice. In doing so, it also helps make sure that public discussion of referral patterns is grounded in accurate interpretation of the data. We are committed to engaging with professionals, patients and the public to find out what information it is most helpful for us to present, and the way we present data and analysis in this report in the future will be determined by what we hear.

The data in this report reflect decisions that affect patients, those who raise concerns and those close to them, those who provide evidence during the process, and the individuals whose practice is being considered. We understand that both raising and responding to concerns can be difficult, and we want the process to be conducted with compassion and clarity and in a way that encourages open engagement.

To support patient safety and proportionate outcomes, regulation needs to evolve alongside the healthcare and societal context in which concerns arise. The current legislative framework that underpins our work was not designed for the realities of modern healthcare, and this can make it more difficult to resolve concerns as quickly and proportionately as we would wish.

We have long advocated for legislative reform to modernise how concerns about fitness to practise are managed and enable concerns to be resolved more efficiently while maintaining strong protection for patients. The UK Government's decision to make changes to our underpinning legislation, in consultation with governments across Wales, Scotland and Northern Ireland, marks an important shift in enabling this change. Regulatory reform will help make sure that modern regulation can continue to meet the expectations that patients and professionals rightly place on it.

Charlie Massey
Chief Executive and Registrar

Understanding ‘fitness to practise’

The term ‘fitness to practise’ is used to describe a professional’s ability to practise safely and maintain public confidence in their profession. Assessing fitness to practise is a central part of our role as a regulator, helping to protect patient safety while upholding the standards expected of the professions we regulate.

We are required by law to consider all cases raised with us – from matters that can be concluded at an early stage to those requiring formal investigation or adjudication by an independent tribunal. Most concerns are resolved during the initial stages. Our published decision making guidance helps us determine which concerns require further regulatory action. Only a small number result in a formal investigation (997 in 2025, see table 1d), and fewer still progress to a Medical Practitioners Tribunal hearing (160 in 2025, see table 3a). Those that do are more likely to involve issues of the kind listed below which can indicate a serious risk to patient safety or a serious threat to public confidence.

In 2025, over 90% of cases that were brought to tribunal involved either misconduct, criminal convictions or both.

Further information about the types of concerns involved in cases brought to tribunal can be found in the Medical Practitioners Tribunal Service annual report, which it publishes on its website.[1]

Examples of serious concerns that may proceed beyond the initial stages of our process

- Sexual misconduct, including sexual assault or indecency, or a sexual or improper emotional relationship with a patient or someone close to them
- Violence
- Dishonesty
- Unlawful discrimination
- Gross negligence or recklessness, such as serious failures in patient care that create a risk of serious harm to patients
- Knowingly practising without a licence

When cases do proceed to later stages, the impact can be profound for people who raise concerns, for witnesses who provide evidence, and for professionals whose practice is under review. It is therefore essential that the process is fair and proportionate, and that appropriate support is available throughout.

We are now responsible for regulating physician associates (PAs) and anaesthesia associates (AAs), in addition to doctors, following the introduction of the Anaesthesia Associates and Physician Associates Order 2024. We have responsibility for assessing concerns about fitness to practise for each of these three professions.

Our statutory responsibilities

Our role in regulating healthcare professionals is set out in legislation – in the Medical Act 1983 and the Anaesthesia Associates and Physician Associates Order 2024.

The Medical Act 1983[2] provides the statutory framework for the regulation of doctors in the United Kingdom. Under the Act, we are required to investigate concerns that a doctor's fitness to practise may be impaired and, where appropriate, refer cases to an independent tribunal run by the Medical Practitioners Tribunal Service (MPTS). We also have a statutory responsibility to provide annual statistics on concerns about doctors' fitness to practise to the Privy Council, and to publish a statistical analysis.

The Anaesthesia Associates and Physician Associates Order 2024[3] requires us to assess fitness to practise concerns about physician associates (PAs) and anaesthesia associates (AAs), and where appropriate, to refer cases to case examiners or to an independent tribunal to determine whether or not regulatory action is required.

Reading this report

This section explains how the data in this report have been compiled and how they should be interpreted.

Professionals included in the data

The statistics presented in this report relate to concerns about doctors. At present, too few concerns have been raised about physician associates (PAs) and anaesthesia associates (AAs) to allow reporting while maintaining the anonymity of those involved.

Data collection

We use a secure electronic platform to record, track, and manage case information. It stores documents, correspondence, and notes relating to a case and provides an auditable record of actions and decisions taken.

The 2025 data used in this report were extracted from this platform on 5th January 2026. The dynamic nature of fitness to practise casework means that there may have been some minor changes to these numbers since the data were extracted.

Interpreting the data

The figures relate to decisions made in the 2025 reporting year, rather than tracking individual doctors from the beginning to the end of a single fitness to practise case. As a result, a doctor may appear more than once in the statistics — for example, where multiple concerns are raised about them or where their case progresses through several stages during the same year.

When reading the tables and charts, it is therefore helpful to consider proportions as well as raw counts, and to read the accompanying descriptions, which provide context for the data.

Change in reporting style this year

This year's report introduces new narrative sections that provide context, explain how fitness to practise concerns are considered, and highlight how we are working to improve our processes. These are intended to help both professional and public audiences understand and interpret the data.

How concerns are raised

This section explains how concerns about fitness to practise are raised.

We open enquiries in response to information or complaints we receive. An enquiry is an early indication that a concern may exist. It does not in itself mean that a professional's fitness to practise is impaired or that regulatory action will necessarily follow.

Information reaches us through a range of routes, including online reporting forms, email, telephone contact, and referrals from organisations or other public sources.

We group enquiries in our data according to who raised the concern.

Members of the public
This includes anybody raising a concern in a personal capacity, rather than as the result of a professional experience. For example, patients, relatives, carers, and others who have chosen to share concerns as private individuals. The majority of enquiries we open result from concerns raised by members of the public.

Persons acting in a public capacity
This includes anyone whose professional role carries a duty to protect the public. It includes those within an individual's workplace, such as responsible officers, managers or clinical leaders.

It also includes those in other organisations with public-facing responsibilities, such as safeguarding leads or senior staff in social care settings, the police or prisons, as well as those whose official role gives them oversight of professionals' conduct or performance, for example employees in other regulators.

To be classified as acting in a public capacity, the individual must be acting in their professional role rather than as a private person, and their role must involve responsibilities linked to public protection.

Other sources
Other sources include organisations and individuals who may raise concerns outside formal employer or regulatory channels, for example patient groups or advocacy organisations, and individual health or social care professionals.

Concerns may also arise as a result of our own regulatory activity. For example, we may identify information through registration processes, ongoing monitoring, or other casework that may lead us to open an enquiry.

Information that may raise a fitness to practise concern can come to our attention from a range of sources, including media reports. Where this happens, we are required by law to consider it.

Additionally, professionals may refer concerns about their own practice. Self-referrals are recorded separately in our data and may arise where an individual wishes to inform us about issues that could affect their fitness to practise.

How concerns are assessed and progressed

While many concerns are raised with us each year, not all progress through the fitness to practise process. Each concern follows the route that is proportionate to the issues raised and the level of risk identified.

This section explains how concerns are assessed and the stages through which they may move where further regulatory action is required.

Assessment and investigation

Each concern is assessed through an initial triage process. This involves considering whether the information provided suggests a potential concern about a doctor's fitness to practise, and whether it meets the threshold for further regulatory action.

Concerns that meet the threshold move into a formal investigation. At this stage, we gather evidence and assess any potential risk to patients or public confidence. Following investigation, the case may be closed, resolved through specific action (for example, a warning or undertakings), or referred to the Medical Practitioners Tribunal Service (MPTS) for a tribunal hearing. Decisions at this stage are made jointly by medically qualified and lay Case Examiners who review the evidence and decide what action, if any, is required.

In certain circumstances set out in legislation – for example where a doctor has received a criminal conviction with a custodial sentence – decisions may instead be taken by an Assistant Registrar (a senior GMC decision maker exercising delegated powers) acting on behalf of the Registrar (the GMC's statutory officer with overall responsibility for regulatory decisions).

Tribunal hearings at the Medical Practitioners Tribunal Service (MPTS)

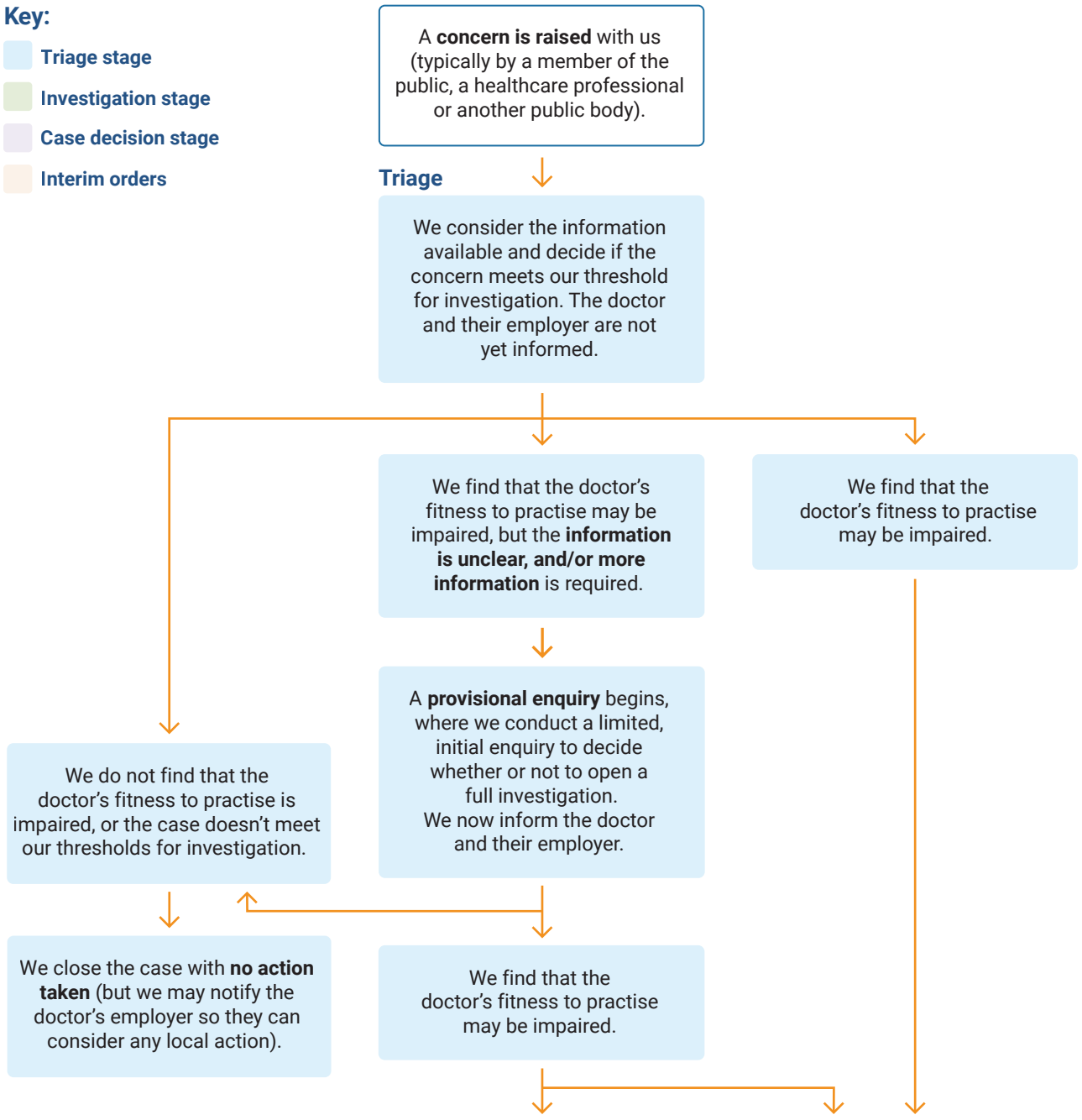
The MPTS operates separately from fitness to practise processes at the GMC. It runs medical practitioners tribunals, which determine whether fitness to practise is impaired and, if so, what action is required. It also convenes interim orders tribunals, which can impose temporary restrictions while our investigation is ongoing.

Information about upcoming and concluded tribunal hearings is published on the MPTS website.

Appeal to the courts

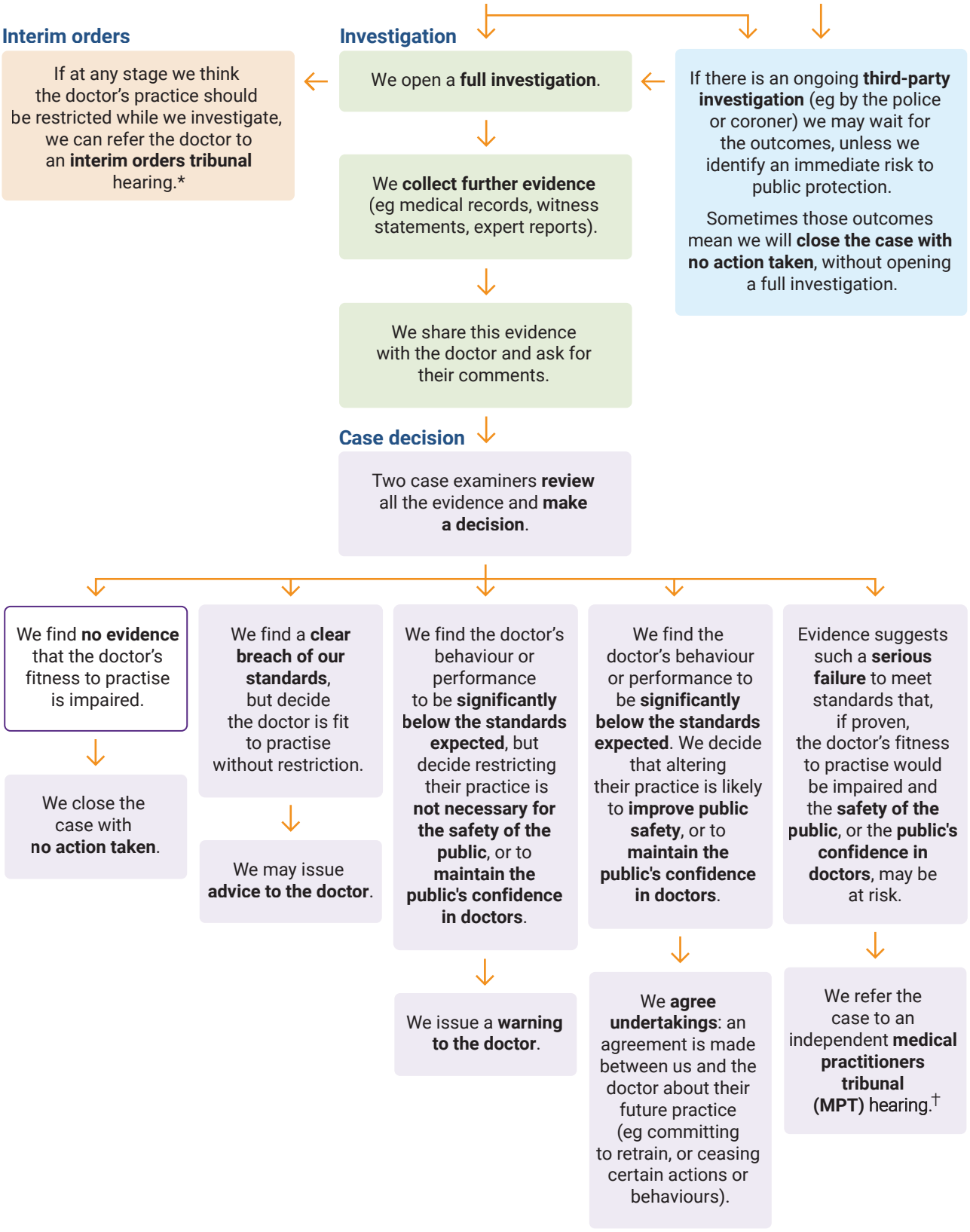
Once a medical practitioners tribunal has made a decision, there is a right of appeal to the courts. We may appeal if we believe the outcome does not sufficiently protect patient safety, uphold professional standards, or maintain public confidence. Professionals also have a right of appeal. Appeals provide a final layer of scrutiny before a case concludes.

Investigating and acting on concerns



Continues on following page

Continues from previous page



* The equivalent to an interim orders tribunal for physician associates (PAs) and anaesthesia associates (AAs) is an interim measures tribunal.

† The equivalent to a medical practitioners tribunal for physician associates (PAs) and anaesthesia associates (AAs) is an associates tribunal.

Fitness to practise data for doctors

GMC triage process

Concerns raised with us are assessed through a staged triage process, to determine whether they meet the threshold for regulatory action. Following initial review and, where necessary, further information gathering, we make a triage decision about whether action is required. These decisions mark the point at which concerns are either closed or taken forward for investigation.

Tracking triage decisions

A triage decision is the point at which we determine whether a concern requires formal investigation. Tracking the number of triage decisions we make provides a helpful way to understand changes in the volume of concerns reaching us.

Table 1a: Triage decisions in 2020-2025

	2020	2021	2022	2023	2024	2025
Doctors on register	337,717	350,976	357,198	378,054	393,357	410,566
Total triage decisions	8,468	9,074	8,893	10,031	10,769	13,465
From persons acting in a public capacity*	580	583	490	476	556	552
From members of the public	6,318	6,785	6,643	7,891	8,279	10,717
From other sources	1,570	1,706	1,760	1,664	1,934	2,196

**Of the 552 concerns from persons acting in a public capacity, 190 were received from employers.*
Note: A doctor may be the subject of more than one concern, so the number of concerns does not necessarily equate to the number of individual doctors involved. This table presents UK-wide data. Separate country-level breakdowns for England, Scotland, Wales and Northern Ireland are provided in relevant national reports.

Table 1a shows that the number of triage decisions made about doctors rose from 10,769 in 2024 to 13,465 in 2025 – an increase of 25%.

This continues a three-year upward trend and is the largest year-on-year increase in 20 years. Since 2020, triage decisions have increased by 60%. Over the same period, the number of doctors on the register increased by 22% – meaning that enquiries increased proportionately faster than the size of the medical register.

Members of the public have consistently been the main source of concerns about doctors' fitness to practise, accounting for 80% of all concerns received in 2025.

While the number of triage decisions has increased, it remains small relative to the size of the medical register. In 2025 there were 33 triage decisions for every 1,000 registered doctors.

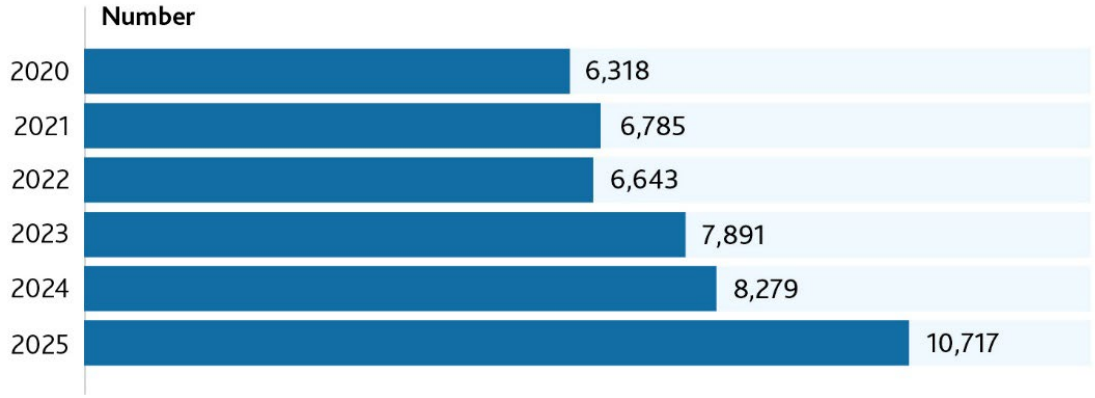
Understanding the increase in concerns raised by members of the public

We closely monitor our enquiries data to understand how the volume and nature of concerns about fitness to practise are changing over time.

Over recent years, we have seen a steady increase in the number of concerns received from members of the public.

Other regulators have reported similar increases in referral volumes,[4,5] indicating that this is not unique to us and suggesting that other factors may be influencing this trend.

Increase in concerns raised by members of the public, 2020-2025



Increased awareness of regulatory routes and the way to raise concerns is likely to be an important factor, alongside wider changes in healthcare delivery and patient experience.

There is unlikely to be a single explanation for the increase. Healthcare services continue to operate in a complex and pressured environment, and changes in how care is delivered – including greater use of digital access and more complex care pathways – may influence when and how people choose to raise concerns.

> *"There is unlikely to be a single explanation for the increase."*

Access to information about regulators and how to raise a concern has also increased, particularly with the growth of online sources. Greater visibility of regulatory routes, alongside wider cultural changes in how people share experiences and seek resolution, may influence decisions about whether and where to raise concerns.

Research we commissioned suggests that people may be uncertain about where to raise concerns about healthcare.[6] This can lead to concerns being directed to a regulator where local processes or other organisations may be better placed to consider them. At the same time, measures we have introduced to improve accessibility — including options to report by telephone and additional support for people who may find written or digital communication difficult — may also contribute to more people raising concerns with us.

Our perceptions tracking research shows that confidence among patients and the public in how doctors are regulated has remained broadly stable in recent years.[7] An increase in the number of concerns does not in itself indicate a change in professional standards. As shown elsewhere in this report, most concerns raised by members of the public are concluded at an early stage, with only a small proportion progressing to formal investigation, meaning that relatively few concerns require formal regulatory action by the GMC.

We will continue to monitor these trends so that emerging issues can be identified early and reflected in our approach. We are also in contact with other regulators to discuss the rise in concerns, sharing our data and insight to help build a clearer understanding of the underlying factors.

Initial triage assessment

The initial triage assessment is the first stage of our process. Its purpose is to quickly assess new concerns and decide what level of follow-up is needed to protect patient safety and public confidence. At this stage, we are not making findings about the doctor's fitness to practise; we are deciding what should happen next. We consider:

- whether the concern relates to a doctor's fitness to practise
- the seriousness and potential risk suggested by the information
- whether we are the appropriate body to address the issue, or whether it is better handled locally, with appropriate action and follow-up by the relevant organisation
- whether further information is needed before a decision can be made

Table 1b: Outcomes of initial triage decisions in 2020-2025

	2020	2021	2022	2023	2024	2025
Provisional enquiry	415	490	476	490	547	554
Investigation	1,043	925	788	761	843	941
Refer to employer/responsible officer and closed	310	258	300	290	292	291
Closed	6,700	7,401	7,329	8,490	9,087	11,679
Total	8,468	9,074	8,893	10,031	10,769	13,465

Table 1b shows the outcomes of initial triage decisions between 2020 and 2025. The majority of enquiries each year are closed at this early stage, because most concerns do not meet the threshold for further regulatory action by the GMC.

Despite a significant increase in the number of enquiries in 2025, the overall distribution of outcomes has remained broadly consistent.

A small proportion of cases progress to provisional enquiry or are referred to an employer or responsible officer for consideration through local governance or appraisal processes, where concerns can be reviewed and addressed in the workplace, often more quickly and in the context of day-to-day practice.

The number of cases progressing to formal investigation can vary from year to year and increased by 12% in 2025. This should be interpreted in the context of higher enquiry volumes, rather than as a change in the proportion of cases progressing to investigation.

Provisional enquiries

Provisional enquiries are used when the information initially provided is not sufficient to determine whether a full investigation is required. They allow us to seek targeted information at an early stage so that we can make a proportionate and well-informed decision about next steps.

This stage helps ensure that concerns are clarified at an early point and that cases are only taken forward to full investigation where there is sufficient information to suggest that regulatory action may be required. By resolving uncertainty early, provisional enquiries support proportionate decision-making and help reduce the likelihood of unnecessary investigations, thereby limiting avoidable delay and uncertainty for those involved.

Table 1c: Outcomes of provisional enquiries in 2020-2025

	2020	2021	2022	2023	2024	2025
Investigation	76	82	63	53	63	56
Refer to employer / responsible officer	1	0	0	0	0	0
Closed	335	400	396	419	470	467
In progress	0	0	0	0	0	31
Total	415	490	476	490	547*	554

**Total includes 14 provisional enquiries that were in progress during compilation of the 2024 report, but which are now closed.*

Table 1c shows the outcomes of provisional enquiries between 2020 and 2025.

Most concerns are closed after provisional enquiries have been completed, with only a small proportion progressing to formal investigation.

This pattern is consistent with the intended role of provisional enquiries in supporting proportionate decision making, by enabling concerns to be clarified before a decision is made about investigation.

How provisional enquiries support proportionate decision making

Concluding triage decisions

We review all available information before reaching a final triage decision. This may include considering additional information gathered through provisional enquiries. Decisions at this stage are guided by the need to take proportionate action that protects patients and maintains public confidence.

Table 1d: Combined final outcomes of triage decisions in 2020-2025

	2020	2021	2022	2023	2024	2025
Investigation	1,119	1,007	851	814	906	997
Refer to employer / responsible officer	311	258	300	290	292	291
Closed	7,035	7,801	7,725	8,909	9,557	12,146
Awaiting outcome of provisional enquiry	0	0	0	0	0	31
Total	8,468	9,074	8,893	10,031	10,769*	13,465

**The 2024 total includes 14 provisional enquiries that were in progress during compilation of the 2024 report, which are now closed. Totals for previous years are reported as published in previous years and have not been retrospectively updated.*

Table 1d shows the final outcomes of concerns at the end of the triage process, combining outcomes reached at initial triage with those reached following provisional enquiry.

Across the period shown, the distribution of outcomes at this stage has remained broadly consistent, with most concerns reaching a final outcome without progressing to formal investigation.

While the number of cases progressing to formal investigation can vary from year to year, the longer-term trend since 2020 has been a reduction in the proportion of concerns progressing to this stage. These patterns should be interpreted in the context of changes in enquiry volumes and improvements in early assessment and decision-making.

At the time of reporting, a small number of provisional enquiries from 2025 were still in progress.

Most concerns do not progress to investigation

In 2025, around **9** in **10** triage decisions resulted in the concern being closed

GMC investigations

When a concern meets the threshold for further action – either at triage or following a provisional enquiry — we are required by law to open a formal investigation.

This allows us to establish the facts of a case and to make decisions that are evidence-based and proportionate to the level of risk identified.

Improvements in early assessment mean that concerns which do not meet the threshold for formal investigation can often be concluded at an earlier stage. This means we can focus our investigative resources where there may be a risk to patients or public confidence, and avoid escalating cases where there is no such risk.

Investigations themselves can be complex and may take time to complete, particularly where we need to wait for third parties to complete their processes, where detailed evidence must be gathered, or where multiple perspectives need to be considered.

Case Examiner decisions following investigations

Once the investigation has concluded and all necessary evidence has been gathered, GMC Case Examiners decide what regulatory action, if any, is required. They assess whether the doctor's fitness to practise may be impaired and determine the outcome that best reflects the seriousness of the concerns and the level of risk posed to patients and the public. Possible outcomes include referral to a tribunal, agreement of undertakings (restrictions on a doctor's practice), a warning or advice, or closing the case with no further action.

Table 2a: Outcome of Case Examiner decisions in 2020-2025

	2020	2021	2022	2023	2024	2025
Refer to tribunal	276	257	289	210	169	184*
Undertakings	52	67	73	74	81	60
Warning	59	87	90	90	106	110†
Advice	38	51	53	39	23	16
Conclude with no action	641	569	460	429	292	309‡
Total	1,066	1,031	965	842	671	679

**This figure includes 13 decisions where the doctor refused to accept undertakings. It does not include an additional 32 criminal conviction decisions by the registrar to refer to tribunal or one non-compliance decision where the case examiner referred to tribunal.*

† *This figure includes 20 decisions where the doctor refused to accept the warning, but where the warning was confirmed by Investigation Committee or subsequently accepted by the doctor.*

‡ *This figure does not include an additional 25 decisions to grant voluntary erasure by case examiners and six further decisions by the Investigation Committee to take no further action.*

Table 2a shows the outcomes of Case Examiner decisions between 2020 and 2025.

Across the period shown, the majority of cases concluded with no further action. Where further action was taken, referral to a Medical Practitioners Tribunal was the most common outcome, with undertakings, warnings and advice used in a smaller number of cases. In 2025, 184 cases were referred to a tribunal hearing.

Investigation Committee hearings

Investigation Committee hearings take place in specific circumstances, most commonly, where Case Examiners decide to issue a warning, and the doctor does not agree to that outcome. In these situations, the matter is considered at an oral hearing before the Committee.

To support transparency, these hearings are usually held in public. The Committee considers the evidence presented before deciding whether to conclude the case, uphold a warning, or refer to a tribunal.

Table 2b: Outcomes of Investigation Committee hearings in 2020-2025

	2020	2021	2022	2023	2024	2025
Uphold warning	3	7	3	3	3	7
No further action	1	0	3	2	1	6
Refer to tribunal	0	0	0	1	0	0
Total	4	7	6	6	4	13

Table 2b shows the outcomes of Investigation Committee hearings between 2020 and 2025. The number of cases heard by the Investigation Committee is very small, with only a limited number across the period.

The Medical Practitioners Tribunal Service

The Medical Practitioners Tribunal Service (MPTS) is responsible for independent tribunals that make decisions on cases we refer.

There are two main types of hearings for doctors (with equivalent processes in place for PAs and AAs):

- Medical practitioners tribunals, which determine whether a doctor's fitness to practise is impaired and what action, if any, is required once a GMC investigation has concluded.
- Interim orders tribunals, which can be convened at any stage in the process, to determine whether temporary restrictions on practice are needed while the investigation is ongoing or a final decision is pending.

Cases referred to the MPTS represent a small proportion of the concerns considered through our fitness to practise processes. They are likely to relate to concerns such as sexual misconduct, violence, dishonesty, unlawful discrimination, or serious failures in professional practice that place patients at risk of harm. In 2025, there were 160 new MPT hearings involving doctors and around nine in ten involved allegations of misconduct, criminal convictions or both.

We are seeking feedback on the information it is helpful for us to present on the types of concerns that are referred to tribunal, and will present additional analysis in future reports.

Further information about the work of the Medical Practitioners Tribunal Service in 2025 is available in its annual report, which it publishes on its website.[7]

Interim orders tribunals

An interim orders tribunal provides a formal safeguard during an investigation, allowing temporary restrictions to be considered before the facts of the case have been fully determined.

When we begin investigating a concern, we consider whether there is any immediate risk that cannot safely wait for the completion of the evidence gathering process. If such a risk is identified at any stage, we will make a referral to the MPTS for an interim orders tribunal.

The tribunal then assesses whether allowing the doctor to continue practising without restriction could put patients at risk, place the doctor at risk, or seriously undermine public confidence while the investigation continues.

The tribunal does not decide whether the allegations are proven. Its role is to assess and manage risk while the investigation is ongoing. Hearings are usually held in private because they take place before any findings have been made.

After reviewing the information available at that early stage, the tribunal can take one of three approaches:

- No interim order – the doctor continues to practise without restrictions as the tribunal does not consider them necessary at that stage.
- Interim conditions – the doctor continues to practise subject to specific restrictions designed to manage identified risks while the investigation continues.

- Interim suspension – the doctor is temporarily suspended from practice as the tribunal considers this necessary to protect patient safety, protect the doctor, or maintain public confidence.

Any interim order is time-limited and must be reviewed regularly while our investigation continues, typically at six-month intervals, to ensure that it remains necessary and proportionate. If the concerns are later found to meet the threshold for formal regulatory action, the case may be referred to a medical practitioners tribunal for a full hearing on the facts and on impairment.

Table 3a: Outcomes of interim orders tribunals in 2020-2025

	2020	2021	2022	2023	2024	2025
Suspension	40	35	34	29	52	55
Conditions	234	217	184	173	213	229
No order made	78	56	54	37	59	66
Total	352	308	272	239	324	350

Table 3a shows the outcomes of interim orders tribunals between 2020 and 2025.

In 2025, the number of cases referred to new interim orders tribunals increased compared with the previous year. Conditions remained the most common outcome, with suspensions and no orders less frequent. The proportion of cases resulting in suspension remained broadly stable.

Medical practitioners tribunals

Medical practitioners tribunals make independent decisions about whether a doctor's fitness to practise is impaired. A tribunal hears evidence from the GMC, the doctor, and any witnesses, and then makes a decision on impairment. Where impairment is found, the tribunal decides what action, if any, is required. It may take into account undertakings agreed between the doctor and the GMC when reaching that decision.

If impairment is found the following outcomes are possible:

- No further action – The tribunal finds impairment but decides that no sanction is necessary, often because the issues have already been fully addressed and there is no ongoing risk. This outcome is uncommon but there may be exceptional circumstances where no further action is appropriate.
- Conditions – The doctor remains on the register but must comply with specific, closely monitored requirements (for example, supervision, retraining, or limits on the scope of work).
- Suspension – The doctor is removed from the register for a defined period. This is used when concerns are serious but there is a realistic prospect of a safe return to practice.
- Erasure – The doctor is removed from the medical register. This is used for the most serious cases where a doctor's behaviour, performance or health means they cannot safely remain on the register.

- No impairment – The tribunal finds that a doctor's fitness to practise is not impaired and the case concludes. In some cases, a tribunal may decide that even in the absence of impairment a warning should be issued. These outcomes are reflected in the statistical reporting of tribunal decisions.

A doctor may apply to be voluntarily removed from the register. Where this application is approved, the case will close, but the doctor cannot return to practice without a full restoration process. Any application for restoration is subject to detailed consideration against the relevant criteria, and the outcome is recorded on the medical register.

Table 3b: Outcomes of medical practitioners tribunals in 2020-2025

	2020	2021	2022	2023	2024	2025
Voluntary erasure	2	4	2	2	1	2
No impairment – case concluded	16	71	58	49	24	23
No impairment – warning	17	28	21	15	6	11
Impairment – no further action	0	2	4	2	2	1
Impairment – undertakings	0	1	1	0	0	0
Impairment – conditions	14	14	18	13	9	7
Impairment – suspension	52	91	101	109	76	68
Impairment – erasure	43	58	68	60	67	48
Total	144	269	273	250	185	160

Table 3b shows the outcomes of medical practitioners tribunals between 2020 and 2025.

In 2025, the number of new cases concluded at a medical practitioners tribunal was slightly lower than in 2024.

Combined, suspension and erasure accounted for 116 of the 160 tribunal outcomes concluded in 2025. A smaller number of cases resulted in conditions, while some concluded with findings of no impairment, including a small number where a warning was issued.

Sanctions at medical practitioners tribunals

Appeals against MPTS decisions

An appeal represents the final stage of the regulatory pathway. The Medical Practitioners Tribunal Service makes independent decisions, and disagreement with a tribunal outcome is not, on its own, a reason for us to appeal. We only use our powers to appeal after careful consideration of whether a decision sufficiently protects the public. A GMC appeal acts as a safeguard where we consider that a decision made by a tribunal does not adequately protect patient safety, uphold professional standards, or maintain public confidence.

In these circumstances, we may decide to challenge the outcome in court. The court does not rehear the case in full; it considers whether the tribunal's decision was wrong, for example because it involved an error of principle or fell outside the range of decisions reasonably open to it.

Since the introduction of our section 40 appeal powers in 2016, cases involving sexual misconduct have accounted for over 40% of those we have appealed. More appeals have involved sexual misconduct than any other single category of concern. This reflects the seriousness with which concerns of this nature are viewed. Around seven in ten concluded appeals since 2016 have resulted in a successful outcome for the GMC, and a significant proportion have resulted in stronger sanctions.

GMC appeals

GMC appeals can conclude in several different ways:

- Appeals allowed at a court hearing – the court agrees that the tribunal's decision was wrong and either replaces it with a different outcome, or remits the case to a new tribunal for reconsideration.
- Appeals dismissed at a court hearing – the court upholds the original tribunal decision, confirming that the tribunal acted lawfully and reached a decision that fell within the reasonable range of possible decisions.
- Appeals resolved by consent – a revised outcome is agreed between us and the professional, which the court approves without the need for a contested hearing.
- Appeals withdrawn – we discontinue the appeal, for example where new information affects our assessment of risk or because the original concerns have been resolved.

  Appeals outstanding – appeals that have been filed but not yet determined, either awaiting a hearing date or progressing through the court's procedural stages.

Table 4a: Outcomes of GMC appeals in 2020-2025

	2020	2021	2022	2023	2024	2025
Allowed at court hearing	3	1	0	1	1	3
Dismissed at court hearing	1	0	1	0	0	1
Resolved by consent	0	0	9	0	0	0
Withdrawn	0	0	0	0	0	0
Outstanding	5	9	0	1	3	6
Total appeals	9	10	10	2	4	10

Table 4a shows the outcomes of appeals brought by the GMC between 2020 and 2025. Outcomes are reported in the year they are determined by the courts, rather than the year in which the appeal was lodged. Four appeals were concluded by the courts in 2025.

The table also shows the number of appeals ongoing in each year, including those filed in earlier years but still ongoing in that year. In 2025, ten appeals were ongoing, but at the time of reporting, a number remained outstanding.

Supporting people involved in fitness to practise cases

For many people, involvement in cases where fitness to practise is being considered can be stressful and demanding, particularly where it involves unfamiliar procedures and uncertainty about what happens next. Providing clear information and appropriate support is therefore an integral part of how we carry out our regulatory responsibilities.

Supporting people who come to us with concerns

People often come to us following difficult or distressing experiences. We provide clear guidance on how to raise a concern and what information is most helpful to share at the outset. Throughout the process, we aim to explain what will happen next, what decisions have been made, and the reasons for those decisions.

Where a concern progresses to an investigation or provisional enquiry, our Liaison Service offers a meeting to explain what will happen next and answer questions. The service also offers a meeting to discuss the outcome once a decision has been made. We seek to ensure that those who come to us with concerns feel listened to and treated with respect, even where the outcome may not be what they had hoped for.

> *"We seek to ensure that those who come to us with concerns feel listened to and treated with respect, even where the outcome may not be what they had hoped for."*

This approach sits within our wider commitment to openness, clear communication and respectful engagement with patients, relatives, carers and others who raise concerns, as set out in our Charter for patients, relatives and carers.[8]

Supporting witnesses

Witnesses play a vital role in helping us establish the facts of a case and we recognise that their circumstances and needs vary. We tailor our engagement to each individual and agree early on how we will keep in touch, what support they may need, and the best way to share information. We are also implementing a more structured way of capturing an engagement plan with each witness, so that expectations and arrangements are clear and support is consistent throughout their involvement.

We provide a range of supportive guidance for example on giving witness statements, understanding how hearings work, and what to expect on the day if they are asked to attend. Our teams outline the practical arrangements, including the support witnesses will have access to. This now includes access to a dedicated paralegal who can assist them during proceedings, a role we have recently introduced to support witnesses at hearings. This helps to reduce uncertainty and enables witnesses to take part more comfortably in proceedings.

Supporting professionals whose fitness to practise is under review

We have recently made changes to how we communicate with professionals whose fitness to practise is under review. In the past, they were first informed that an investigation had been opened when they received a formal letter. Now, wherever possible, we offer an initial telephone call as the first point of communication, a change we put in place following feedback that this approach would feel less daunting and more supportive.

This is part of our wider commitment to compassionate regulation, as we adapt how we communicate with professionals to make early engagement feel less formal and more supportive.

“This is part of our wider commitment to compassionate regulation, as we adapt how we communicate with professionals to make early engagement feel less formal and more supportive.”

During this call we explain what to expect, outline next steps, and provide an opportunity to ask questions. Wherever possible, they can speak to the same member of staff throughout the process, no matter how long it takes. They will also be kept updated on progress and expected timelines as the investigation proceeds. Staff are trained to communicate clearly and respectfully, respond appropriately to questions and concerns, and listen to and act on feedback.

We also emphasise the importance of seeking appropriate advice and support at an early stage. Doctors are able to access our confidential Doctor Support Service, which is run by the BMA in a service we commission. And PAs and AAs are able to access confidential support in a service run by Victim Support. These services are available throughout an investigation and tribunal proceedings.

Additionally, we provide support if a professional is unwell during an investigation. Once appropriate safeguards are in place, the process can be paused so they can take time to seek treatment. Our Health Investigation Team has recently refined its approach to make sure individuals with health concerns are treated with compassion and supported appropriately. Cases that relate solely to a professional’s health will never result in erasure and are usually managed without the need for a tribunal.

Additional support where it is needed

In some cases, people involved in fitness to practise cases – whether they have raised concerns, are providing evidence, or are subject to investigation – may need additional support. We work with specialist organisations to ensure that those who may be vulnerable, distressed, or have particular needs are able to access specialist support.

This includes a dedicated support service delivered by Victim Support. We can refer patients who have raised concerns, family members, or other witnesses to access confidential practical and emotional support from trained advisers. In cases involving sexual misconduct, we are also developing further specialist support, including access to independent sexual violence advisers (ISVAs).

We are developing a more trauma-informed approach to our work, recognising that individuals involved in regulatory processes may be asked to revisit difficult or distressing experiences. Training has already been provided to staff involved in this work, and a wider programme in development will make sure this becomes part of everyday practice across the organisation.

We have also recently introduced trained intermediaries and can arrange this support where people have language barriers, disabilities, or other communication needs that may make it more difficult to engage with proceedings. A trained intermediary will work with them to understand their communication needs and help them participate effectively in the process.

We can also offer independent advocacy support through POhWER to help people who need additional support when making an initial complaint to us.

If you would like to read more about how we can support members of the public raising concerns, witnesses, and professionals, please visit our website.

Listening to and learning from witnesses

A witness is anyone who can provide information relevant to an investigation. This includes the person who raised the concern, the doctor, PA or AA involved, patients, colleagues, or others with knowledge of the matters under consideration.

Witnesses play an important role in fitness to practise cases by helping tribunals establish the facts of a case, but their experiences of doing so can sometimes be difficult or distressing. This was highlighted in *Witness to Harm*,[9] a 2022 study led by Professor Louise Wallace examining the experiences of witnesses involved in regulatory investigations and tribunals.

It is important that we provide appropriate support to those we are asking to give evidence. We are putting the voice of the witness at the centre of our work in this area, creating opportunities for witnesses to contribute directly to how support is developed, so that the improvements we make respond to experience of real need rather than assumption.

We have conducted quantitative and qualitative research into the experiences of witnesses, helping us understand what matters most at different points in the process and where support can be improved.

We have traditionally asked witnesses to feed back to us on their experience once their involvement in a case has ended. Following publication of the *Witness to Harm* research, we have re-launched our witness surveys and now invite everyone who provides a witness statement to share feedback shortly after doing so. This allows us to capture their reflections while their experience is still recent.

We review survey results regularly and use them to inform improvements to how we communicate with witnesses, the information and guidance we provide, and the practical support available throughout their involvement. We are also planning to introduce focus groups, inviting witnesses who have consented to further contact to share more in-depth and reflective insight. This will help us better understand witness experience and shape how support is developed.

Listening to witnesses helps us understand how the process is experienced by those who take part. By sharing their perspectives, they help shape how support is designed and guide ongoing improvements to the fitness to practise system.

Helping people understand our role and processes

For professional regulation to function effectively, it is important that patients, professionals and others understand how concerns about fitness to practise are assessed.

In recent years we have strengthened our dedicated outreach function, with liaison advisers now working in every region across all four countries of the UK. Employer Liaison Advisers work closely with Responsible Officers, to discuss local processes and expectations, and provide advice about our fitness to practise thresholds and other regulatory functions. Regional Liaison Advisers in England and Liaison Advisers in Northern Ireland, Scotland and Wales support good practice by delivering workshops on professional standards, fitness to practise and other topics for doctors and medical students. We also hold sessions with students to help address misconceptions from the earliest stages of their careers.

Improving public awareness of how and when to contact us is important. We work with patient groups and advocacy organisations, holding regular one-to-one meetings and roundtables to discuss elements of how fitness to practise concerns are considered, provide updates on regulatory reform, and seek feedback on patient perspectives.

> *"Improving public awareness of how and when to contact us is important."*

In December 2025, we held a focus group with patient group roundtable members from across the four nations to explore how we communicate with patients at the point a complaint is closed. This conversation helped us reflect on how we communicate decisions to patients and the wider public. In particular, it helped us consider the tone and clarity of the messages we send when explaining why a complaint has been closed.

We develop tailored information for specific settings, for example, we have recently developed a resource for women and their families who have concerns about their maternity or neonatal care, explaining our role and how to contact us. We worked with maternity charities and patient representative groups to make sure we are presenting the information in a helpful format that is sensitive to the needs of women and families. We've made sure it is easily accessible on our website and have shared it with maternity charities, Trust, Board, and Health Board PALS teams and Maternity and Neonatal Voice Partnerships in locations where we know concerns have been raised. We've asked them to share this resource with people they work with to help raise awareness of our role and how to raise concerns with us.

When working with specific communities we have provided information translated into a number of different languages. We are collecting feedback on these materials and gathering insight from public consultations and research to help us communicate more effectively. This includes insight from our perceptions research, which helps us understand how different groups experience and view our processes.[7] We also work with the media to help ensure that public reporting about fitness to practise reflects accurate information about the role of regulation.

Alongside these targeted activities, our Outreach team and national offices share information about how we respond to concerns through ongoing engagement meetings with partners, as well as at conferences and stakeholder events. These interactions provide opportunities to speak directly with key audiences, understand their roles and perspectives, and identify how best we can support them to help improve working environments and practice.

We know that confidence in regulation depends on how well it is understood. By continuing to communicate clearly about how concerns are handled in practice, we can help ensure that people feel able to speak up and engage with our processes, so that the system can operate effectively in the interests of patient care and public confidence.

Fitness to practise concerns and protected characteristics

The following analysis focuses on doctors and does not include PAs and AAs. Regulation of these professions was introduced recently, and the number of concerns received during the reporting period is too low to support meaningful analysis. Presenting breakdowns by protected characteristic would risk identifying individuals and would not support reliable statistical interpretation. As volumes increase, we will include this analysis in future reporting.

Table 5a summarises the characteristics of doctors involved in triage, investigation and tribunal decisions completed in 2025, alongside the characteristics of doctors on the register. It presents aggregated data on decisions made at each stage during the year; it does not follow a cohort of doctors through the process. Individual doctors may therefore be counted more than once if their case progresses through multiple stages, or if more than one concern is raised about them within the reporting period.

Some groups of doctors are overrepresented in our fitness to practise casework. The data in Table 5a might at first glance appear to show differences in outcomes between groups of doctors across protected characteristics. However, these data must be interpreted with caution. Summary tables do not capture the complex relationships between protected characteristics and other factors that may influence outcomes, such as the nature of concerns raised and the source of the referral. Advanced statistical analysis can provide a more accurate understanding of the factors associated with fitness to practise outcomes. As part of our ongoing equality, diversity, and inclusion (ED&I) work, we continue to examine these patterns, with more detailed analysis published separately.

Table 5a: Decisions at each stage of the process in 2025, split by protected characteristics

Demographics	Demographics details	% on the register (# on the register)	% Triages (# Triages)	% CE Outcomes (# CE Outcomes)	% CE Outcomes of action taken or referral to tribunal (# CE outcomes of action taken† or referral to tribunal)	% MPTS Outcomes (# MPTS Outcomes)	% MPTS Outcomes of erasure or suspension (# MPTS Outcomes of erasure or suspension)
Gender	Man	50.5% (207,290)	43.8% (5,897)	77.0% (523)	76.8% (272)	76.9% (123)	75.9% (88)
	Woman	49.5% (203,276)	23.8% (3,204)	23.0% (156)	23.2% (82)	23.1% (37)	24.1% (28)
	Not known*	0% (0)	32.4% (4,364)	0% (0)	0% (0)	0% (0)	0% (0)
Ethnicity	Asian or Asian British	33.7% (138,218)	21.4% (2,884)	33.9% (230)	33.1% (117)	31.9% (51)	31.0% (36)
	Black or Black British	7.3% (29,851)	4.1% (549)	11.5% (78)	12.2% (43)	13.8% (22)	13.8% (16)
	Mixed	2.7% (11,089)	1.6% (219)	3.0% (20)	2.3% (8)	3.8% (6)	3.4% (4)
	White	44.6% (183,034)	31.3% (4,217)	37.1% (252)	38.1% (135)	35.6% (57)	37.1% (43)
	Other ethnic groups	6.5% (26,842)	4.6% (625)	7.4% (50)	7.9% (28)	6.3% (10)	6.0% (7)
	Prefer not to say	3.1% (12,588)	2.0% (266)	3.8% (26)	3.4% (12)	3.8% (6)	3.4% (4)
	Not known	2.2% (8,944)	34.9% (4,705)	3.4% (23)	3.1% (11)	5.0% (8)	5.2% (6)
Sexual orientation	Bisexual	1.1% (4,684)	2.1% (279)	1.3% (9)	0.6% (2)	1.3% (2)	0.9% (1)
	Heterosexual/Straight	77.5% (318,297)	45.7% (6,158)	75.7% (514)	76.0% (269)	70.6% (113)	70.7% (82)
	Lesbian/Gay	1.6% (6,626)	1.2% (159)	3.2% (22)	4.8% (17)	1.3% (2)	0.9% (1)
	Other	0.4% (1,624)	0.2% (32)	0.3% (2)	0.3% (1)	0.0% (0)	0.0% (0)

	Prefer not to say	10.1% (41,593)	7.3% (979)	10.8% (73)	12.4% (44)	15.6% (25)	16.4% (19)
	Not known	9.2% (37,742)	43.5% (5,858)	8.7% (59)	5.9% (21)	11.3% (18)	11.2% (13)
Religion	Buddhist	2.3% (9,346)	0.8% (101)	0.9% (6)	0.9% (3)	1.3% (2)	0.9% (1)
	Christian	27.2% (111,811)	16.6% (2,235)	26.2% (178)	26.8% (95)	28.8% (46)	31.9% (37)
	Hindu	9.4% (38,695)	6.5% (874)	9.6% (65)	8.2% (29)	12.5% (20)	12.1% (14)
	Jewish	0.6% (2,624)	1.2% (155)	1.3% (9)	1.7% (6)	0.0% (0)	0.0% (0)
	Muslim	19.2% (78,927)	11.2% (1,502)	22.7% (154)	24.6% (87)	14.4% (23)	14.7% (17)
	Sikh	0.9% (3,572)	0.7% (90)	1.3% (9)	1.7% (6)	2.5% (4)	2.6% (3)
	No religion	22.1% (90,546)	12.9% (1,730)	19.3% (131)	20.6% (73)	16.3% (26)	14.7% (17)
	Prefer not to say	8.2% (33,484)	6.1% (822)	8.3% (56)	7.9% (28)	11.9% (19)	12.1% (14)
	Not known	9.2% (37,741)	43.5% (5,858)	8.7% (59)	5.9% (21)	11.3 (18)	11.2% (13)
	Other	0.9% (3,820)	0.7% (98)	1.8% (12)	1.7% (6)	1.3% (2)	0.0% (0)
Disability	No	94.7% (388,836)	95.1% (12,804)	93.2% (633)	93.5% (331)	88.1% (141)	87.1% (101)
	Yes	5.3% (21,730)	4.9% (661)	6.8% (46)	6.5% (23)	11.9% (19)	12.9% (15)

**Sometimes there is not enough information at the triage stage to identify the doctor's gender; 'not known' relates to these cases.*

†'Action taken' relates to warnings or undertakings.

How we use the data

Data on concerns about fitness to practise help us understand how and why concerns arise, the types of issues being reported, and how cases move through the system. Examining patterns over time allows us to identify emerging themes in professional practice and wider pressures affecting healthcare. This insight informs a range of activity aimed at improving regulation and helping to promote safer care.

Improving our processes

The data we gather help us improve how we operate. By examining how cases enter and progress through the system, we can identify opportunities to make the process more efficient, supportive, accessible, and inclusive.

Insights from past data have helped us make significant improvements to early case assessment, and to the way we engage with those involved in fitness to practise cases. We continue to look for ways to strengthen our approach, to make sure that concerns are handled fairly and proportionately and that we communicate compassionately with everybody involved.

Supporting wider learning

Insights from data are also shared more widely to support improvement across healthcare. Trends in the concerns we receive can highlight pressures within healthcare systems which we can share with policy makers and workforce planners.

We also use data and insights to inform our outreach work. Understanding the types of concerns raised and the contexts in which they arise helps us target support, share learning and promote good practice with professionals and organisations.

By using this information to shape engagement activity, we aim to help prevent concerns from arising and support safer, more effective care.

Informing research and data development

Data help us shape our wider research objectives. Themes emerging in our enquiries data can highlight areas where further analysis or evidence-gathering may be needed to better understand risks to patient safety or pressures affecting the workforce.

Annex

Further reading

Statistics on concerns about fitness to practise

- Previous editions of our annual statistical report
  Provides historical data and analysis on concerns raised about doctors.

How our processes work

- Information about how to raise a concern with us
  Provides information for members of the public and healthcare professionals about raising a concern.

- Information about types of hearings run by the Medical Practitioners Tribunal Service (MPTS)
  Explains the different types of tribunal hearings held by the MPTS and how cases are considered.

- Information about support available if you are involved in a fitness to practise case
  Explains the practical and emotional support available to patients, witnesses and professionals involved in cases.

Additional context and analysis

- Our reports on medical education and practice in the UK
  Reports analysing the medical workforce and workplace experiences in the UK.

- Our progress reports on our equality, diversity and inclusion targets
  Reports analysing our work and that of others towards equality, diversity and inclusion targets in medical education and practice, and regulation.

References

1. Medical Practitioners Tribunal Service. Reports to Parliament and GMC Council. Available at: https://www.mpts-uk.org/about/how-we-work/reports-and-management (accessed 2 July 2026)
2. Medical Act 1983. Available at: https://www.legislation.gov.uk/ukpga/1983/54 (accessed 2 July 2026)
3. The Anaesthesia Associates and Physician Associates Order 2024 (SI 2024/596). Available at: https://www.legislation.gov.uk/uksi/2024/374/contents (accessed 2 July 2026)
4. Nursing and Midwifery Council. *Fitness to practise annual report*. Available at: https://www.nmc.org.uk/about-us/reports-and-accounts/fitness-to-practise-annual-report/ (accessed 2 July 2026)
5. Social Work England. *Fitness to practise referrals and outcomes data*. Available at: https://www.socialworkengland.org.uk/about/publications/fitness-to-practise-referrals-and-outcomes-data/ (accessed 2 July 2026)
6. General Medical Council. Understanding public and employer complaints about doctors: research report. Available at: https://www.gmc-uk.org/-/media/gmc-site/about/understanding-the-rise-in-fitness-to-practise-complaints-from-members-of-the-public.pdf (accessed 2 July 2026)
7. General Medical Council. Corporate strategy and perceptions tracking survey 2025: interim report. Available at: https://www.gmc-uk.org/cdn/documents/gmc-interim-survey-2025-final-report_pdf-113960521.pdf (accessed 2 July 2026)
8. General Medical Council. Charter for patients, relatives and carers. Available at: https://www.gmc-uk.org/about/what-we-do-and-why/charter-for-patients-relatives-and-carers (accessed 2 July 2026)
9. Wallace L, Ryan S, Searle R, Hughes G, Sorbie A, Ryan-Blackwell G, Haider S, et al. Witness to Harm: Holding to Account. The Open University. Available at: Available at: https://wels.open.ac.uk/research/witness-harm-holding-account (accessed 2 July 2026)

Glossary

Aggregated data
Aggregated data are data that have been combined or summarised so that information about individuals cannot be identified. In statistical reports, data are often aggregated across groups or categories to present overall patterns while protecting confidentiality.

Anaesthesia Associates and Physician Associates Order 2024
The Anaesthesia Associates and Physician Associates Order 2024 is legislation that brought anaesthesia associates (AAs) and physician associates (PAs) under the regulation of the General Medical Council (GMC). It establishes the framework for the GMC to maintain registers for these professions and to set standards, approve education and training, and operate processes for considering concerns about fitness to practise.

Anaesthesia associate
Anaesthesia associates (AAs) are healthcare professionals who work as part of the anaesthesia team to support the delivery of anaesthetic care. They are trained to undertake a range of tasks relating to the administration and monitoring of anaesthesia, working under the supervision of a consultant anaesthetist. In the UK, AAs are regulated by the GMC following the introduction of the Anaesthesia Associates and Physician Associates Order 2024. The Department of Health and Social Care has indicated that it intends to consult on potential changes to professional titles following the Leng review. This report uses the current statutory title.

Assistant Registrar
An Assistant Registrar is a senior GMC staff member authorised to exercise certain statutory powers on behalf of the Registrar. Assistant Registrars may make or approve specific regulatory decisions when considering concerns about fitness to practise, such as accepting undertakings or issuing warnings, under delegated authority.

Authorised Decision Maker
An Authorised Decision Maker is a GMC staff member with the necessary skills, competency and experience to exercise powers and functions assigned under the Anaesthesia Associates and Physician Associates Order 2024 and associated rules. An Authorised Decision Maker may make or approve specific regulatory decisions when considering concerns about fitness to practise.

Case Examiner
Case Examiners are decision makers at the GMC. A key part of their role is reviewing evidence gathered during a fitness to practise investigation and deciding what action should be taken. These decisions are made in pairs, comprising one medically qualified examiner and one lay examiner. They may decide to close a case, issue a warning, agree undertakings with a professional, or refer the case to a tribunal run by the Medical Practitioners Tribunal Service (MPTS).

Conditions
Conditions are restrictions placed on a professional's registration by a tribunal run by the Medical Practitioners Tribunal Service (MPTS). These conditions allow the individual to continue practising but require them to meet specific requirements, such as working under supervision or limiting certain areas of practice.

Court
The relevant UK court that hears appeals against decisions of the Medical Practitioners Tribunal Service. Depending on the jurisdiction, this is the High Court of Justice in England and Wales, the Court of Session in Scotland, or the High Court of Justice in Northern Ireland.

Enquiry
An enquiry is opened when the GMC receives information that raises a question about a professional's fitness to practise. Each enquiry is reviewed to decide whether it should be closed, progress through further triage stages, or move to a formal investigation.

Erasure
Erasure is the removal of a professional's name from the relevant register following a decision by a tribunal run by the MPTS. It is the most serious sanction available in fitness to practise cases and prevents the individual from practising as a registered professional.

Fitness to practise
Fitness to practise refers to whether a regulated professional is able to practise safely and effectively. Concerns about fitness to practise may arise where a professional's conduct, performance or health could put patients or public confidence in the profession at risk. The GMC investigates such concerns and, where necessary, refers cases to a tribunal run by the MPTS.

General Medical Council
The General Medical Council (GMC) is an independent professional regulator. It sets standards for medical education and professional practice, approves and monitors medical education and training, maintains the medical register, and investigates concerns about doctors' fitness to practise. Following the introduction of the Anaesthesia Associates and Physician Associates Order 2024, the GMC now regulates anaesthesia associates and physician associates as well as doctors.

Interim order
Interim orders are temporary restrictions placed on a professional's registration while a fitness to practise investigation is ongoing. They are imposed where necessary to protect patient safety or the public, or in the interests of the professional, and remain in place until the investigation is concluded or the order is reviewed.

Interim orders tribunal
An interim orders tribunal is a tribunal run by the MPTS that considers whether interim restrictions are needed while a fitness to practise investigation is ongoing. The tribunal may impose an interim suspension or interim conditions on practice.

Investigation
An investigation is the formal stage in the process for considering concerns about fitness to practise. During an investigation, the GMC gathers evidence to assess whether regulatory action is required. At the end of an investigation, the case may be closed, resolved through undertakings or a warning, or referred to a tribunal run by the MPTS.

Medical Act 1983
The Medical Act 1983 is the primary legislation governing the regulation of doctors in the United Kingdom. It sets out the statutory functions and powers of the GMC, including maintaining the medical register and assessing concerns about fitness to practise.

Medical Practitioners Tribunal Service
The Medical Practitioners Tribunal Service (MPTS) runs tribunals that make independent decisions on cases about a professional's fitness to practise. It is operationally separate from the GMC, which investigates concerns and refers appropriate cases to a tribunal. The MPTS also runs interim orders tribunals, which can impose temporary restrictions while an investigation is ongoing.

Outcome
An outcome is the decision made to resolve a fitness to practise case. Outcomes may include closing a case with no further action, issuing a warning, agreeing undertakings, or decisions made by a tribunal run by the MPTS, such as conditions, suspension or erasure.

Physician associate
Physician associates are healthcare professionals who work as part of multidisciplinary teams in medical settings. They are trained to assess patients, take medical histories, perform examinations, and support diagnosis and management of illness under the supervision of a doctor. In the UK, physician associates are regulated by the GMC following the introduction of the Anaesthesia Associates and Physician Associates Order 2024. The Department of Health and Social Care has indicated that it intends to consult on potential changes to professional titles following the Leng review. This report uses the current statutory title.

Privy Council
The Privy Council is a formal body that advises the Sovereign and has statutory responsibilities in relation to a number of professional regulators in the United Kingdom. Under the Medical Act 1983, the GMC provides its annual fitness to practise statistical report to the Privy Council as part of the oversight arrangements set out in legislation.

Protected characteristic
Under the Equality Act 2010, protected characteristics are specific personal characteristics that are protected from discrimination in law. These include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. In this report, data relating to sex are presented using the term gender, reflecting how information is recorded in GMC data.

Register
The official lists maintained by the GMC of professionals who are authorised to practise. These include the medical register and the registers of physician associates (PAs) and anaesthesia associates (AAs).

Registrar
The Registrar is the statutory officer of the GMC responsible for maintaining the relevant registers of regulated professionals and exercising certain regulatory powers under the Medical Act and the Anaesthesia Associates and Physician Associates Order 2024. Many of these powers may be delegated to other authorised decision-makers, including Assistant Registrars.

Responsible officer
A responsible officer is a senior doctor within an organisation who has statutory responsibilities in relation to doctors' professional practice. Responsible officers may provide information to the GMC during investigations or receive concerns that the GMC has redirected to them for local consideration.

Suspension
Suspension is an outcome imposed by a tribunal and results in a professional being removed from the register for a specified period. During this period the professional cannot practise.

Threshold
The point at which a concern is considered serious enough to require regulatory action. Assessing whether a concern meets the threshold means considering whether the information suggests a potential risk to public protection, including patient safety, public confidence in the profession, or proper professional standards.

Undertaking
Undertakings are agreed restrictions on a professional's practice that are put in place to address concerns about their fitness to practise. They are agreed between the professional and the GMC and allow certain types of cases to be resolved without referral to a tribunal run by the MPTS.

Voluntary erasure
Voluntary erasure occurs when a professional asks to have their name removed from the relevant register, and this may happen while a fitness to practise investigation is ongoing. The request must be approved by the GMC and may be accepted where this is considered sufficient to protect patient safety and maintain public confidence.

Warning
A warning is issued by the GMC where concerns about a professional's fitness to practise are found but are not serious enough to require us to restrict or remove their registration. A warning remains on the professional's registration record for a specified period but does not restrict their ability to practise.

Email: **gmc@gmc-uk.org**
Website: **gmc-uk.org**
Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service.

Join the conversation

instagram.com/gmcuk/
facebook.com/gmcuk
linkd.in/gmcuk
youtube.com/gmcuktv

To ask for this publication in another format or language, please call us on **0161 923 6602** or email us at **gmc@gmc-uk.org**.

I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

Published July 2026

Code: GMC/CFTPASR25/0726