General Medical Council

Response from the General Medical Council (GMC) to the Health & Care Professions Council's (HCPC) consultation on updates to their sanctions policy

About us

We are the regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs).

We work with doctors, PAs and AAs, those they care for and other stakeholders to support good, safe patient care across the UK. Further information about how we do this can be found on our website under Our mandate - GMC.

We have a legal duty to protect the public as set out in the *Medical Act 1983* ('the Act'). The Act in conjunction with the Anaesthesia Associates and Physician Associates Order 2024 ('AAPA Order 2024') splits public protection into three distinct parts. It says that we must act in a way that:

- protects, promotes and maintains the health, safety and well-being of the public ('patient safety')
- promotes and maintains public confidence in the professions ('public confidence'), and
- promotes and maintains proper professional standards and conduct for members of those professions ('uphold professional standards').

To protect the public, we must consider the relevance of, and impact on, each of the three parts of public protection when we make decisions about a doctor, PA or AA's fitness to practise.

We can only assess a doctor, PA or AA's fitness to practise when they are registered with us and there is a legal basis for doing so. The legal bases are referred to as the grounds of impairment.

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

- misconduct
- deficient professional performance
- a conviction or caution
- adverse physical or mental health
- not having the necessary knowledge of English, and
- a determination by another regulatory body to the effect the doctor's fitness to practise is impaired.

The grounds of impairment under the AAPA Order 2024 for PAs and AAs are:

- misconduct, and

- an inability to provide care to a sufficient standard.

Further detail on these grounds are included in our guidance *Decision on whether regulatory action is required (PAs and AAs)*.

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

There are some differences in the fitness to practise process we operate for doctors compared to PAs and AAs due to there being two separate legal frameworks setting out our duties and powers. However, the fundamental principles that inform the decisions we make in fitness to practise are largely consistent. As we only started regulating PAs and AAs in December 2024, these principles are primarily based on our experience of, and learnings from, regulating doctors.

Our response

As your consultation is about the policy which will be used by your fitness to practise panels (panels) when deciding on an appropriate sanction, we have focused our response on the guidance used by a medical practitioners tribunal (MPT) when making decisions about doctors, except where otherwise stated. The reason for this is that the way in which MPTs operate, and the decisions they make, are similar to your panels.

One outcome at the end of an investigation into a doctor's fitness to practise is that a case could be referred to a hearing. At an MPT hearing, the role of the tribunal is to consider whether the allegations presented against the doctor by the GMC are proved and if so, whether the doctor's fitness to practise is impaired as a result.

The MPT will only make a finding of impairment where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response. This assessment is made with reference to the facts found proved at the hearing and any further relevant evidence presented to the MPT.

To assess whether that doctor poses any current and ongoing risk to public protection, the MPT will consider:

- the seriousness of the facts found proved,
- any relevant context known about the doctor and / or their working environment, and
- how the doctor has responded to the allegation(s).

The MPT will also decide, based on the proven allegations, what action, if any, is needed to protect the public. If the doctor's fitness to practise is found to be impaired, a sanction of conditions, suspension or erasure may be required. Where the doctor's fitness to practise is found not to be impaired, in some instances a warning may be given.

An updated suite of decision-making guidance for MPTS tribunals was published on 30 September 2025. It will come into effect in hearings on Monday 24 November 2025. This guidance implements the fitness to practise decision making principles that we publicly consulted on in March 2024 and presents existing guidance in a more accessible format.

The guidance has four sections as follows:

1. Introduction - this section explains the GMC and MPTS' legal duty to protect the public and the decision-making principles of being proportionate, transparent and fair. It also explains how tribunals may need to act to protect the public in eight specific case types when making decisions on interim orders, impairment, warnings and sanction.
2. Procedural matters - this section explains the procedural matters that relate to MPTS hearings and gives guidance to tribunals on how to exercise their discretion in respect of those matters, where appropriate.
3. Interim Order Tribunal hearings - this section gives guidance on imposing interim orders at new and review hearings.
4. MPT hearings - this section gives guidance on the facts, impairment and sanction stages of an MPT hearing. It includes new sanctions bandings for eight specific case types and also provides guidance on when warnings are a proportionate response.

The full suite of guidance can be accessed on the MPTS website here.

Q1. To what extent do you agree or disagree with the proposed changes on suspension orders?

~~Strongly agree / Agree / Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We agree with the principle that before imposing a sanction of suspension, the panel should assess whether erasure is the most proportionate response. However, we do not fully agree with the way this principle has been reflected in the sanctions policy and query whether, by stating the principle at the outset of paragraph 145 prior to setting out the factors that may make suspension appropriate, it risks driving panels towards imposing a striking off order without fully considering if suspension is proportionate first.

In Part C of Section three: MPT hearings (the sanctions guidance) we explain that "In the context of deciding what sanction, if any, is required to address the level of current and ongoing risk to public protection posed by a doctor (low, medium or high), being proportionate means:

- When deciding what is required but no more than necessary to achieve public protection, approaching the question by considering if the least restrictive action is appropriate, and not making a final decision until the options immediately above and below the action the MPT is minded to take, have also been assessed.

- …"

We have also moved away from using the terminology "fundamentally incompatible" when describing decisions to suspend or erase a doctor, PA or AA. This is because we consider that through the introduction of a requirement to automatically remove a PA or AA who is convicted of a listed offence from the register as soon as reasonably practicable (Article 9(1)(c) of the AAPA Order 2024), the government have set a specific threshold in relation to matters that are so serious that they should be regarded as "fundamentally incompatible" with registration.

In the sanctions guidance for MPTs we have therefore set out considerations relevant to suspension being proportionate before dealing with erasure. First, we explain that "Suspension is for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period, with the aim they should be able to safely return to unrestricted practice in the future."

We go on to say that a decision to suspend a doctor will be a proportionate response where:

a. conditions are not appropriate, measurable and / or workable

b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and / or

c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and / or maintain professional standards.

The sanctions guidance then explains that erasure is "…action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise."*

The following examples are given for when erasure may be the proportionate response:

a. conditions are not appropriate, measurable and / or workable and suspension is not sufficient to protect the public

b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place

c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and / or

d. the seriousness of the facts found proven and / or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.

Q2. To what extent do you agree or disagree with the proposed changes on interim orders?

~~Strongly agree /~~ Agree ~~/ Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We agree that where a registrant has been subject to an interim order this may be a relevant factor for a panel to consider when making a decision on the length of a substantive sanction. However, we query whether the guidance given at paragraphs 27 to 30 fully reflects all relevant case law on this matter.

The sanctions guidance for MPTs makes it clear that any time spent under an interim order of conditions or suspension is unlikely to be relevant to deciding the appropriate length of conditions or suspension that are imposed following a finding of impairment. This is because the type of action and the length of time that conditions or suspensions are put in place need to adequately address the finding of impairment based on the decision that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response.

It also reflects the reminders you have provided that interim orders serve a very different purpose to sanctions and when imposing an interim order, panels are not making findings of fact. The sanctions guidance confirms that the test for considering whether to impose an interim order is entirely different from the criteria that applies when considering what, if any, is an appropriate sanction to impose following a finding of impairment.

* Where the risk to public protection relates solely to the impact of a health condition, erasure from the medical register is not an option.

We agree that it's important to set out that if the panel was to take into account previous time spent under an interim order before any decision to impose a sanction of conditions or suspension is made, it would likely leave a public protection gap. And deducting or discounting the time a registrant has spent under an interim order from the length of time that any sanction is put in place for, would not wholly reflect the assessment of the level of current and ongoing risk to public protection posed by the registrant resulting in the finding that their fitness to practise is impaired.

However, the sanctions guidance for MPTs makes an additional point that you may consider is also relevant to your sanctions policy. Specifically, how time spent under an interim order of suspension may be relevant when determining the proportionate period of suspension to be imposed purely on the grounds of public confidence (Kamberova v Nursing and Midwifery Council (2016) [2016] EWCA Crim 2955). The sanctions guidance explains that in many of these cases, given the different purposes of interim orders and sanctions, a previous interim order of suspension is unlikely to have a significant impact. Nevertheless, it must still be considered.

Q3. To what extent do you agree or disagree with the proposed changes on apologies?

~~Strongly agree /~~ Agree / ~~Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We agree with the key points you have made in the sanctions policy in relation to apologies. However, in the sanctions guidance for MPTs we set out some additional principles that you may also wish to consider.

Firstly, we have made it clear that doctors have the right to advance a robust defence to an allegation. This includes requiring the regulator to prove their case and bring witnesses to hearings. As a result, an apology from the doctor may not be forthcoming until after a witness has engaged in the hearing. In other cases, if the defence put forward by the doctor is not successful, it may be unrealistic to expect them to immediately accept every finding, in a fully sincere manner, or apologise.

Secondly, we expand the point that panels should consider the reasons why an apology may not have been given to include consideration of circumstances where there is evidence that a doctor wanted to apologise sooner but has been prevented from doing so by systems or procedures, such as governance or ongoing litigation, or the culture, in their place of work. MPTs will also need to consider how any differences in culture, faith and communication that are known about the doctor may have impacted on the quality of evidence, such as how the doctor has expressed insight, or framed and communicated an apology. This evidence will be relevant to the weight an MPT gives to information about a doctor not apologising sooner or at all.

Q4. To what extent do you agree or disagree with the proposed changes on strike-off where concerns are so serious, they are incompatible with continued registration?

~~Strongly agree /~~ Agree ~~/ Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We agree the changes made to the sanctions policy provide clarity that there may be some cases in which a decision to strike a registrant off the register **may** be the only proportionate sanction to ensure that the public are protected.

However, please also note our response to question one which provides related information about how we have presented the principle of proportionality and set out the circumstances in which erasure may be the only proportionate response. We would also suggest that the opening sentence in paragraph 155 of the policy is amended to read 'A striking off order may be appropriate…' rather than '…will be appropriate…' as not all serious, persistent, deliberate or reckless acts will result in strike off.

Q5. To what extent do you agree or disagree with the proposed changes on assessing seriousness and culpability?

~~Strongly agree / Agree / Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

Although we agree with some aspects of the content on seriousness, there are specific areas of this part of the policy that we don't agree with and so on balance, we have responded disagree to this question.

Assessing seriousness

We note the section on seriousness (paragraph 31) starts by saying "Panels need to assess seriousness at various stages in their decision making, including when deciding what sanction, if any, to impose and the length of that sanction." We don't agree that seriousness should be assessed at various stages of panel decision making. This is because to revisit or reassess the panel's view on seriousness at various stages of the hearing risks introducing inconsistency in decision-making in terms of how the same features of the case are considered.

The approach taken in Part B of Section three: MPT hearings (the impairment guidance) is that an MPT will reach a view on seriousness based on the facts found proved when reaching a view on whether the doctor poses any current and ongoing risk to public protection requiring restrictive action in response i.e. when making a decision on impairment. The decision on impairment will then directly inform the decision on sanction. The only additional evidence that needs to be considered at the sanction stage is evidence about the impact that taking a specific type of action may have on patients or members of the public, or the doctor themselves and references and testimonials about the doctor's character. The MPT's earlier view on seriousness does not need to be, and should not be, revisited. It should simply be applied to the decision on sanction.

At paragraph 33 of the policy, you refer to how some conduct may be considered fundamentally incompatible with continued registration because it represents a particularly serious departure

from the standards required of HCPC registrants. Please see our response to question one regarding use of the term "fundamentally incompatible". We do however agree that there are certain types of behaviour or poor performance that represent such a significant departure from the professional standards meaning they will usually fall at the higher end of the spectrum of seriousness. This is often because the departure from the professional standards amounts to an abuse of, or interference with an individual's dignity, and / or breaches the fundamental tenets of the professions to act with honesty, integrity and uphold the law.

We note at paragraph 34 of the policy you refer to an important part of assessing seriousness as being considering aggravating and mitigating features. We thought it would be helpful to share that the impairment guidance for MPTs does not make explicit reference to aggravating or mitigating features when assessing the seriousness of an allegation. This is intentional and we have chosen to use language that focuses on risk because we consider this better reflects the purpose of professional regulation. However, the factors that increase or decrease risk are akin to those that you describe as aggravating or mitigating factors.

As explained above, in the impairment guidance for MPTs assessing seriousness is set out as one part of the assessment of current and ongoing risk to public protection. Features that may increase seriousness are set out at paragraph 36.

Assessing culpability

We note use of the term 'culpability' is often associated with blame and wrongdoing and we wonder if it correctly reflects that regulation is about assessing and managing risk to the public (including public confidence in the profession) rather than punishing for wrongdoing. Using the term may risk undermining the principle of a learning / no blame culture that is essential to compassionate and fair regulation.

As well as considering the seriousness of the allegation, to assess risk to public protection the impairment guidance directs MPTs to consider any relevant context known about the doctor and / or their working environment as well as the doctor's response to the allegation, including insight and remediation. It also explains how these factors may increase or decrease any risk the doctor poses to public protection (see paragraphs 45 to 73 on relevant context and paragraphs 74 to 118 on insight and remediation).

We do, however, agree the risk of harm to patients or service users is a relevant consideration when assessing risk to public protection. We make the following key points in the impairment guidance:

- that in all cases the extent of the departure from the professional standards and the consequences or outcome for an individual patient may not be directly related. A less serious departure from the professional standards can sometimes result in significant harm to, or the death of, a patient or member of the public. Alternatively, there can still be a satisfactory clinical outcome for a patient (no harm suffered at all) despite a significant departure from the professional standards expected having occurred.
- that the risk to patients and members of the public arising from the doctor's departure from the professional standards will, therefore, be the primary consideration to an MPT's assessment of seriousness. This means the actual consequences or outcome for an individual patient should not be considered in isolation and the MPT should attach more weight to evidence about the risk to patients and members of the public associated with

the specific departure from the professional standards.

Q6. To what extent do you agree or disagree with the proposed changes on concerns about discrimination?

~~Strongly agree /~~ Agree ~~/ Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We broadly agree with the approach you've taken to giving direction to panels on how to consider discrimination cases. In response to the specific changes you have made, we agree that it's useful to set out that all forms of unlawful discrimination are unacceptable and include the different types of discrimination. We agree that it's also helpful for panels to understand the impact when a registrant unfairly discriminates against individuals.

In the *Introduction* section to the MPTS Guidance for tribunals we have a section on discrimination which provides a narrative description, sets out the key professional standards that are relevant to this type of allegation, summarises the position on seriousness and explains how an allegation of unlawful discrimination may engage each of the three parts of public protection: patient safety, public confidence and upholding professional standards. This is to promote consistency in decision making. The guidance then goes on to summarise the approach to considering whether an interim order is needed, deciding impairment and following that, deciding whether a warning is required or what sanction to impose. The sanctions banding for discrimination is also set out here. You may wish to consider this content and whether there are any additional further points that are relevant to HCPC panel decision making that you could include in the policy.

Q7. To what extent do you agree or disagree with the proposed changes on dishonesty?

~~Strongly agree / Agree /~~ Neither agree nor disagree ~~/ Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

Although we agree with the positions in your policy at paragraphs 75 to 77, we are unsure as to whether they meet the aim stated in your consultation document to "make it easier to assess how the dishonest actions of registrants may affect trust or cause harm, leading to more informed and consistent decisions in serious cases." We consider there is an opportunity to give more detailed guidance in order to support fair and consistent decision making in dishonesty cases. We have sought to do this in a number of ways, explained below.

Before a case is referred to an MPT, when deciding how serious dishonest behaviour is, decision makers at the GMC will apply the *Supplementary guidance on violence and dishonesty that may represent a lower risk to public protection (Doctors).* This guidance sets out that a concern about a doctor's dishonest behaviour is less likely to pose any current and ongoing risk to public protection where certain features are present, for example:

- the alleged dishonesty was not persistent or repeated
- the value of the financial or other material benefit derived by the doctor from the alleged dishonesty was not significant

- the dishonesty did not affect patient care directly or indirectly, nor had the potential to do so.

This is not an exhaustive list and decision makers are guided to assess risk based on the individual circumstances of the case. Cases that are referred to an MPT at the end of an investigation will usually fall at the higher end of the spectrum of seriousness. However, a range of dishonest behaviour may still be seen. This is recognised in the impairment guidance and sanctions guidance, including within the sanction banding for dishonesty.

In terms of how dishonest actions may affect trust or cause harm, we cannot see this set out clearly in the policy. In the *Introduction* section of the MPTS Guidance for tribunals we explain how an allegation of dishonesty may engage each of the three parts of public protection: patient safety, public confidence and upholding professional standards. You may find the additional information here to be helpful.

Q8. To what extent do you agree or disagree with the proposed changes on sexually motivated misconduct?

~~Strongly agree /~~ Agree ~~/ Neither agree nor disagree / Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We support the changes that have been made to strengthen your position on sexual misconduct. We agree there is no place for sexual misconduct / sexually motivated misconduct in professional healthcare and that these concerns should be treated seriously. Further detail about our approach can be found in the *Introduction* section of the MPTS Guidance for tribunals.

Q9. To what extent do you agree or disagree with the proposed changes on professional boundaries?

~~Strongly agree / Agree /~~ Neither agree nor disagree ~~/ Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

We have responded that we neither agree nor disagree on the basis that we consider it is a matter for yourselves as to how you present content relevant to professional boundaries.

We have more detailed guidance for doctors, PAs and AAs on professional standards relating to maintaining personal and professional boundaries which covers the importance of maintaining respectful personal and professional boundaries with patients and colleagues. It covers unacceptable behaviours and the impacts these can have, both on individuals and patient safety. We agree that it is important for MPTs to be aware of this guidance when assessing the seriousness of a doctor, PA or AA's departure from the professional standards. However, we have chosen to reference this through the lens of specific case types, rather than consider professional boundaries to be its own category of case / allegation. In the *Introduction* section of the MPTS Guidance for tribunals, the key principles have therefore been included in the specific case types sections relating to sexual misconduct and dishonesty.

In addition, we have taken a different approach to positioning the relevance of predatory behaviour. We consider that predatory behaviour is a feature that may increase the seriousness in a range of allegation types. It is therefore listed in the *impairment guidance* with an explanation so that MPTs are encouraged to consider it more widely.

Q10. To what extent do you agree or disagree that the structural and editorial improvements are clear?

~~Strongly agree / Agree /~~ Neither agree nor disagree ~~/ Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer.

Overall, we consider the structure and layout of the guidance is a matter for you and so have responded that we neither agree nor disagree with the approach taken.

However, as mentioned in response to question 5, we do not agree that panels should repeat the exercise of assessing seriousness at different stages of their decision making. There is a risk that such an approach could result in inconsistencies. We note that the policy does not clearly explain how the panel's earlier decisions on facts and impairment inform or link to their panel's decision on sanction. This is something we consider would be helpful to set out.

We would be pleased to discuss how we have developed the new and updated MPTS Guidance for tribunals if that would be helpful.

Q11. To what extent do you agree or disagree with the proposed changes to our sanctions policy in general?

~~Strongly agree / Agree /~~ Neither agree nor disagree ~~/ Disagree / Strongly disagree / Don't know~~

Please provide reasons for your answer including your views on the substance of the changes.

We think that any changes to the policy should help support good decision about a registrant's fitness to practise which should:

- protect the public
- be proportionate
- be transparent, and
- be fair.

It's important that any policy on sanctions is accessible and supports fair and consistent decision making. We don't have any further general comments but as mentioned already, we'd be happy to discuss the approach we have taken to developing our MPTS Guidance for tribunals.

Q12. Are there any further changes we should consider to the sanctions policy?

We do not have any further specific comments on the policy.

Q13. Do you think the proposed changes have any positive or negative impacts on groups or individuals who share one or more of the protected characteristics under the Equality Act 2010 and equivalent Northern Ireland legislation?

If so, please provide details.

We have not seen an equalities impact assessment or details of what was considered to inform changes to the sanctions policy. We cannot therefore comment on whether the changes will have any positive or negative impacts on groups or individuals.

Q14. Are there any additional steps we should take to ensure the proposed changes do not unintentionally disadvantage any groups?

As stated in response to question 13, we have not seen an equalities impact assessment or any other relevant information so we cannot comment further in response to this question.

30 September 2025