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Regulatory Briefing

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Georgina Goring is a highly respected specialist in professional discipline, inquests and inquiries. Georgina is an outstanding advocate and is well known for her personable nature, attention to detail and ability to advise clients regarding complex issues.

The New Medical Practitioners' Tribunal Guidance

New guidance has been published by the Medical Practitioners' Tribunal Service ('MPTS') which came into effect on 24 November 2025 ('the Guidance') and applies to all doctor's fitness to practise hearings that commence after that date.

All practitioners appearing before a MPT will be expected to be familiar with, and make specific representations on the Guidance in submissions on impairment and sanction, as Tribunals will use the Guidance as their touchstone in proceedings.

The objective of the Guidance is to assist Tribunals in reaching consistent and well-reasoned decisions and provide all MPTS's stakeholders, including the public, with clarity on how decisions are made and the range of outcomes which can be expected in any individual case.

The Guidance is divided into three substantive sections – procedural matters, interim order hearings and Medical Practitioners Tribunal Hearings. This article will focus on the latter and will provide a whistle-stop tour.

Access to all the guidance can be found here: https://www.mpts-uk.org/parties-and-representatives/guidance-for-tribunals/tribunal-guidance-for-doctors-hearings

Medical Practitioners Tribunal Hearings Guidance (Section three)

Part A: the facts

This provides guidance in relation to several key evidential considerations and includes specific guidance in assessing witness evidence, hearsay evidence, inferences/adverse inferences and convictions/cautions. The Guidance reinforces parts of the GMC FTP Rules, for instance Rule 34(1) 'fairness and relevance' remain central considerations and Rule 34(4) - a certificate of conviction is conclusive evidence of the conviction itself.

Part B: stage two - impairment

This section provides Tribunals with detailed guidance for the impairment stage of proceedings. It outlines 5 stages:

1. Is there a legal basis for impairment?

   a. This reflects the heads of impairment set out at Section 35C(2) of the Medical Act - misconduct, deficient professional performance, a conviction or caution, adverse physical or mental health, not having the necessary knowledge of English and a determination from another health regulatory body either in the UK or overseas.

2. Where on the spectrum of seriousness do the facts lie?

   a. Tribunals are invited to make a finding of low, medium or high and record this in their written determination.

   b. A number of examples are given in relation to cases falling at the lower end of the spectrum of seriousness, such as clinical failings where a doctor has not acted with willful disregard to patients' wishes, dishonesty which is limited in nature and limited impact, incidents of discriminatory behaviour which are limited in nature and impact and are not unlawful.

   c. A number of examples are given in relation to cases falling at the higher end of the spectrum of seriousness, such as sexual assault, indecency or sexual harassment, an improper or sexual relationship with a patient or a colleague, persistent and sustained dishonesty and a criminal conviction resulting in a custodial sentence.

   d. Once a starting point is established, Tribunals are invited to consider further factors which may increase the seriousness such as predatory or premeditated behaviour.

3. The impact of "any relevant context" and the impact that may have on the level of risk?

   a. This can include context about the wider working environment, context of the doctor's role and experience and personal context.

   b. For personal context to be relevant to the assessment of current and ongoing risk to public protection, there must be a direct link between it and the doctor's behaviour, performance or health. Personal context will carry less weight if the case is at the higher end of the spectrum of seriousness.

4. How the doctor has responded to allegations?

   a. Insight - The Guidance contains particular factors the doctor should demonstrate for the Tribunal to find insight and factors where a Tribunal may conclude that the doctor lacks genuine insight.

   b. Similarly, in relation to remediation - examples of remediation are provided - Tribunals are invited to consider whether the remediation displayed by doctors is relevant, measurable and effective.

   c. This provides a helpful tool for those defending doctors (and indeed those defending in front of other regulators) and should be considered at an early stage in preparations, allowing the doctor to be able to provide best evidence in relation to this critical stage.

5. Finally, taking into account their conclusions, the Tribunal must decide if the doctor poses any current ongoing risk to public protection and make a finding on impairment.

Part C – stage three: sanction

Practitioners should have in mind throughout the facts and impairment stage the new bandings and sanction ranges within the Guidance, as it may inform the way in which parties conduct their case at the first two stages.

The Guidance replaces previous sanction guidance and includes eight sanction bandings for specific case types, examples of which are:

Case type	**Lower level of risk to public protection**	**Medium level of risk to public protection**	**Higher level of risk to public protection**
Sexual misconduct	Suspension up to 6 months	Suspension 6 to 12 months	Suspension 12 months to Erasure
Clinical concerns	Conditions 12 to 24 months	Conditions 24 to 36 months to suspension 6 months	Suspension 6 months to Erasure

Criminal practitioners will recognise similarities between these guidelines and those developed by the Sentencing Council and used in criminal courts.

Detailed guidance is also provided in relation to:

1. Proportionality;
2. Sanctions available - taking no action (only in exceptional circumstances), conditions (can be imposed for a maximum of three years - conditions imposed must be appropriate, workable and measurable), suspension (for a maximum of 12 months) or erasure from the medical register; and
3. Additional evidence which is relevant to sanction stage - testimonials, the impact a specific sanction may have on patients or the doctor themselves.

Looking ahead…

In the recent judgment of GMC v Gilbert & PSA [2026] EWCA Civ 33, the Court of Appeal rejected appeals by both the GMC and the PSA which challenged a decision by the MPT in relation to sanction. Whilst the Court was considering the old GMC's Sanction Guidance (February 2024) rather than this new Guidance, the judgment perhaps serves as a timely reminder as Tribunals move to utilise this new Guidance.

The Court of Appeal emphatically rejected the GMC's challenge, which was described as a "tick box" or "score sheet" approach to the Sanction Guidance. The Court reiterated what matters most is that Tribunals should assess the seriousness of a practitioner's conduct which demands "an evaluation of the overall gravity of the matter". This serves as an important reminder to Tribunals who may be tempted to apply an overly rigid approach to Guidance rather than undertaking a holistic assessment of the overall seriousness of the conduct in light of the particular circumstances of the case. To adopt a cliché from the Crown Court, these are Guidelines not tramlines, they are meant to inform the Tribunal's decision-making, rather than establishing inflexible rules to be followed without deviation.

The MPTS new guidance does not stop there – further guidance is expected in 2026 in relation to voluntary erasure applications, restoration hearing and non-compliance hearings.