Reform of the fitness to practise procedures at the GMC

Changes to the way we deal with cases at the end of an investigation

A paper for consultation
Contents

Foreword 4

Executive summary 6
  How to comment 7
  Further information 7

Introduction 8

Our fitness to practise procedures 11
  Background 11
  Our current fitness to practise procedures 12
  The purpose of our fitness to practise procedures 12
  Are our fitness to practise procedures overly punitive? 13
  Are our fitness to practise procedures appropriate given the increased volumes of complaints received about doctors? 14
  What changes are we proposing? 17
  How will we maintain public confidence? 21
  How will we maintain high standards of public protection? 22
  What cases will still go to a hearing? 23
  Other changes to increase our efficiency 24
  What is the impact of these changes likely to be on different groups? 26

Consultation questions 27

Annex A – Our current fitness to practise procedures 28

Annex B – Equality impact assessment 29
Foreword

Fitness to practise is the most contentious and high profile area of our work. Maintaining a register of fit and proper individuals to practise medicine requires us at times to remove or restrict a doctor’s registration. However, the purpose of our fitness to practise work is not to punish doctors but above all to protect patients and to provide opportunities to remediate and rehabilitate doctors.

In early 2000, we developed fundamental reforms to our fitness to practise procedures which were introduced in 2004. These have brought significant improvements to the way we handle cases and we believe they have also underpinned public confidence in medical regulation. They simplified our procedures, separated our investigation and adjudication functions, improved the quality and consistency of decisions and established closer links with employers of doctors. Now, ten years on, we believe further change is needed.

During those ten years, there have been large scale changes to the environment in which we work. A number of court decisions have had an impact on our approach to fitness to practise cases. In particular, in Cohen v GMC [2008] All ER 307 in 2008, the High Court in England clarified that we must focus on doctors’ current and future fitness to practise and not on disciplining them for past misconduct.

We are creating much closer relationships with employers through the establishment of a new liaison service which builds on the links we have developed in recent years. A specialist fitness to practise adviser will work with employers within every region in England and in Scotland, Wales and Northern Ireland to improve the handling of concerns about doctors.

Last year we worked closely with the Office for the Health Professions Adjudicator (OHPA) to plan for the transfer of our adjudication model. Following consultation, the Government recently announced that adjudication should remain with the GMC and we are embarking on a programme of work to ensure independence of our adjudication procedures and to modernise the way in which hearings are conducted.

We have also seen significant changes in the number and complexity of the cases we receive and in those who refer cases to us. In the last three years, complaints about doctors have risen by 35%, referrals from employers and the police have risen by 117% and the number of hearing days has increased by 66%. We now run 17 concurrent hearings every day.

Together, these changes require us to consider carefully whether our current approach remains the most appropriate way to manage fitness to practise cases. Under the current arrangements, there are only certain types of cases where doctors can cooperate with us to achieve a consensual outcome.
The result is that most cases go to a public hearing, even if the doctor would be willing to accept our proposed sanction. Public hearings often result in a great deal of stress and anxiety for both the doctors involved and the witnesses. In some cases, allegations are reported in the press which later turn out to be unfounded. Hearings are also extremely costly and, even with careful case management, it takes several months to bring a case to a hearing.

We believe our approach to fitness to practise cases should prioritise public protection and fairness for doctors. We also need to ensure that we deliver value for money. It is therefore questionable whether cases should be referred for a public hearing if we can deliver fast and effective public protection without the need for one. Where a doctor is willing to accept the GMC’s proposed sanction – for example, the removal of their name from the register – the case for a public hearing is hard to make. Accordingly, we believe a new phase of reform is now needed – one that ensures our procedures deliver fast and effective public protection in a way that is fair and sensitive to all involved, and which at the same time delivers value for money.

However, we do need to consider the implications for the role that hearings may play in maintaining public confidence in the profession. Even under the current system, when we hold a public hearing, complainants can find it difficult to accept that our role has to be concerned with the doctor’s current and future fitness to practise and not about punishing them for past conduct. This mismatch of expectations may be exacerbated in cases which conclude with a doctor’s cooperation without a public hearing.

We are anxious to ensure that our fitness to practise procedures continue to be as robust as we can make them, and that they are fair to doctors and, above all, protect patients. This consultation brings forward proposals that aim to achieve this. It examines the role that public hearings play in maintaining public confidence, whether our current approach remains appropriate and how, moving forward, we can develop a more proportionate, streamlined process.

Our aim is to achieve procedures that are effective, sensitive to those involved and maintain public confidence in the profession and the GMC as the regulator of doctors in the UK.

We are consulting for 12 weeks until 11 April 2011. This consultation raises issues that are fundamental to the way we approach fitness to practise cases and we understand that this is a sensitive area which can be very emotive. We want to hear from a wide range of individuals and groups and to encourage as much participation in this debate as possible. During the consultation period we will be holding a series of events to discuss these changes with a range of different groups in order to stimulate discussion.

We believe our approach to fitness to practise cases should prioritise public protection and fairness for doctors. We also need to ensure that we deliver value for money.
Executive summary

Our purpose is to protect patients and, where possible, support the rehabilitation of doctors. A number of court decisions have clarified that our proper focus is the current and future fitness to practise of doctors and not punishing doctors for past misconduct.*

This document sets out our proposals for changes to our fitness to practise procedures to introduce a more proportionate approach.

Our present fitness to practise procedures dictate a cautious approach to cooperating with doctors to put in place measures that protect patients. As a result, the majority of cases are referred for a public hearing, even where a doctor is willing to accept our proposed sanction. The view of doctors and those who represent doctors is that this approach is overly punitive in that public hearings are stressful for all involved and often result in media coverage of the allegations which may later prove to be unfounded.

We are exploring alternative means to deliver patient protection, in cases where there is no significant dispute about the facts, other than sending cases to a public hearing.

The environment in which we work has changed significantly. In the last three years the number of complaints has risen by 35%, with an increase in those referred by employers of doctors and the police. This has led to a 66% increase in the number of hearing days. There can be little doubt that hearings are not the most efficient way to protect the public in relation to the fitness to practise of doctors. Even with careful case management, it can take several months to prepare a case for a hearing.

This consultation contains proposals for a more proportionate way to protect patients than our current approach of sending the majority of cases to a public hearing. We are proposing to introduce greater discussion with doctors to encourage them to accept the measures necessary to protect the public, without the need to refer the case to a public hearing.

We are conscious that complainants have a range of reasons for making a complaint about a doctor and sometimes want a doctor punished or their complaint aired at a public hearing. Our procedures should focus on protecting patients and such concerns can be pursued in other ways such as the NHS complaints procedure or in the civil courts. Nonetheless, we are conscious that public hearings may play a role in maintaining public confidence and we explore this issue later in this paper.

* See page 13 (paragraph 3)
We have set out a number of proposals for change to our procedures to address the issues mentioned above. These include:

a. encouraging doctors to accept our proposed sanction in all cases, including suspension and erasure, without the need to refer the case for a public hearing

b. the introduction of greater discussion with doctors, including, in some cases, meetings with doctors at the end of the investigation stage

c. the introduction of a presumption of erasure for certain criminal convictions where the conduct which led to the conviction is incompatible with registration as a doctor

d. the introduction of automatic suspension for doctors who refuse to comply with a fitness to practise investigation.

These proposals raise a range of issues which are discussed in detail in the paper. These include:

a. whether doctors should be able to disclose information on a ‘without prejudice’ basis (which means we could not later use it at a hearing if it was not possible to reach an outcome through cooperation)

b. how best to facilitate meetings with doctors to support a constructive dialogue

c. how best to communicate the outcome of discussions with doctors to complainants

d. whether there are cases that should be referred for a public hearing on public interest grounds, even when a doctor is willing to accept our proposed sanction

e. how to maintain transparency of decision making if we do not refer cases for a public hearing. In particular, what terminology we should use to describe consensual arrangements and what we should publish about those arrangements

f. how to address the risk that witness evidence may deteriorate in conduct cases where a doctor accepts our proposed sanction of erasure and later seeks to be restored to the register

g. the types of convictions to be covered by a presumption of erasure from the register.

Our approach is designed to achieve an effective, proportionate approach to fitness to practise which is fair and sensitive to the needs of all involved, while ensuring that we continue to protect patients appropriately.

How to comment

You can take part in an online version of the consultation:

www.gmc-uk.org/ftppreformconsultation

Or you can download the main consultation document and respond in writing, either by emailing or by sending your response to:

Claire Kilner
Policy and Planning Manager — Fitness to Practise
The General Medical Council
350 Euston Road
London NW1 3JN

email: ftpconsultation@gmc-uk.org

This consultation runs from 17 January – 11 April 2011.

Further information

Further information about the fitness to practise procedures can be found on the GMC’s website:

www.gmc-uk.org

If you have any questions about the consultation please contact Claire Kilner on 020 7189 5167 or by email at ftpconsultation@gmc-uk.org.
Introduction

We are consulting on proposals to change some aspects of the way we deal with cases involving concerns about the fitness to practise of doctors. This consultation focuses on how we deal with cases at the end of an investigation into a doctor’s fitness to practise and, in particular, whether a public hearing is required.

Our role

The GMC is the independent regulator for doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do this in four ways by:

a. controlling entry to and maintaining the list of registered and licensed medical practitioners
b. setting the educational standards for medical schools and postgraduate medical education
c. determining the principles and values that underpin our guidance for doctors Good Medical Practice
d. taking firm but fair action against a doctor’s registration where the standards of Good Medical Practice have not been met.

This consultation contains proposals for reform of our fitness to practise procedures which are the mechanism by which we deliver point d above and, in particular, how we deal with cases at the end of an investigation.

We will be consulting separately on proposals to ensure the independence of the panels who conduct fitness to practise hearings.

How does our role fit into the wider healthcare environment?

There must be coherence in the way that professional regulation connects with the wider regulatory environment. Our description of a four-layer model of medical regulation has been widely supported. It comprises the following.

a. Personal regulation: doctors are expected to behave with professional integrity, to take responsibility for their clinical and ethical practice and to recognise the limits of their competence.

b. Team based regulation: doctors in clinical practice work within teams, and each member of those teams has a responsibility for ensuring that their colleagues act appropriately and that any risk to patients posed by any member of the team is identified early and addressed.

c. Local regulation: employers should have systems in place for ensuring that the doctors they employ or contract with comply with required standards. Employers should have adequate clinical governance arrangements for ensuring that doctors are competent and fit to practise and that any concerns are identified and addressed as quickly as possible. They should
deal with lower level concerns about doctors as part of these clinical governance arrangements which play an important role in protecting patients and ensuring appropriate standards of care.

d. **National regulation:** at national level the GMC focuses on the most serious concerns about doctors. Concerns need only be referred to the GMC when they involve a serious or persistent breach of our guidance *Good Medical Practice*. These are concerns that call into question a doctor’s right to practise medicine at all, or in some limited way.

When a concern is referred to us, we assess the seriousness of what is alleged to decide whether we need to take action on the doctor’s registration. If so, we carry out an investigation, seeking comments from the doctor’s employer. If the allegations on their own would not require us to take action, but might do so if they were part of a wider pattern of behaviour, we rely on the employer of the doctor to identify if any other concerns exist – in such cases we would only investigate if further concerns are raised. Where there are no further concerns, we refer the matter back to the employer, who then has responsibility for dealing with the initial low-level concern. During this process, we have powers to suspend or limit a doctor’s practice on a temporary basis while we investigate if we think a doctor may pose an immediate risk to patients.

This approach was introduced in 2004 to make certain that concerns are dealt with proportionately at the appropriate level.

The development of revalidation will further change our relationship with employers. For the first time, employers, through responsible officers, will be required to make a positive statement about the fitness to practise of the doctors they employ.

As such, employers have a vital role in dealing with concerns about doctors and ensuring they are competent and fit to practise. With their new responsibilities for overseeing revalidation, they are now more important than ever in promoting high standards of medical practice. For the GMC,

The development of revalidation will further change our relationship with employers. For the first time, employers, through responsible officers, will be required to make a positive statement about the fitness to practise of the doctors they employ.
What is this consultation about?

The proposals in this document deal with our approach to cases about a doctor’s fitness to practise. They set out a possible new approach which would involve entering into discussions with doctors who are referred to the GMC in an attempt to gain their cooperation to putting the necessary patient protection in place. If adequate patient protection can be achieved by consent, further action by the GMC would not be required. In particular, if patients and the public are protected, there should be no need for a public hearing.

Why are we making changes now?

Our current fitness to practise procedures were introduced in 2004 following a substantial period of development and consultation. Many of the ideas were first mooted in 2001 and it is nearly ten years since they were first developed. Our experience of operating these procedures, feedback from those involved and changes to the healthcare environment, lead us to believe that this is the time for further reform. We now believe we need to make further changes to make sure our procedures reflect our purpose of protecting patients in a way that is proportionate and fair.

In particular, there are concerns that our current approach may be overly punitive and is not the most proportionate way to deliver patient protection. In proposing changes, we are seeking to ensure that our fitness to practise procedures continue to reflect the principles of good regulation and are transparent, proportionate, accountable, consistent and targeted.

Our objective is to develop a way of handling concerns about doctors which will protect the public, inspire public confidence, represent good value for money and deliver robust decisions as quickly as possible.
Our fitness to practise procedures

This section sets out why we need to review our fitness to practise procedures and what the proposed changes are. It also includes the questions that we would like you to answer about each proposal.

Background

The GMC was established in 1858 to enable the public to identify doctors who were acceptably qualified as opposed to the one in three doctors then thought to be practising without qualification. For much of its history, the GMC has been primarily a standards and education body – fitness to practise featured little in our activities.

Between 1990 and 2000, the volume of fitness to practise cases trebled and, towards the end of the 1990s, we concluded that our fitness to practise procedures were no longer fit for purpose. We began a fundamental review, which culminated in a public consultation proposing radical reform in 2001.

A key concern was that the fitness to practise procedures at that time were subject to three separate legal processes to which cases were allocated at an early stage, depending on whether the allegations related to health, conduct or performance.

The reforms proposed during the consultation attracted widespread support both from patient groups and representatives of the profession. It led to the creation of a new set of rules, the Fitness to Practise Rules 2004, which fundamentally changed the way in which we handled concerns about doctors. The changes introduced included:

a. a new approach to concerns about a doctor, bringing together the three separate procedures (conduct, performance and health) with a single test of impaired fitness to practise

b. a streamlined process for managing cases with a separation between the investigation and adjudication stages

c. the employment of professional decision makers (case examiners) at the investigation stage

d. linking with wider systems of quality assurance, recognising that many concerns are best dealt with locally

e. a new response to concerns which fall short of the most serious by issuing warnings.
Our current fitness to practise procedures

The legislative framework which governs the GMC’s current fitness to practise procedures is largely contained in the Medical Act 1983, as amended, and the Fitness to Practise Rules 2004. The procedures are divided into three stages: initial assessment, the investigation stage and the hearing stage. A brief summary of these stages is contained in Annex A.

The procedures dictate a cautious approach to cooperation with doctors, which means that most cases where we believe a doctor’s fitness to practise is impaired are referred for a public hearing. At the end of an investigation, in health or performance cases, we may agree undertakings with a doctor where there is evidence that the doctor has insight. We may also agree that a doctor may have their name voluntarily removed from the register (voluntary erasure) in some circumstances. All other cases, where we believe the doctor’s fitness to practise may be impaired, are referred for a hearing by a fitness to practise panel.

The purpose of our fitness to practise procedures

Doctors hold a special position in society. They command a high level of trust and respect which is essential to enable us to entrust them with our health and wellbeing. Membership of the profession confers a number of benefits and the price doctors pay for those benefits is that they are expected to meet the high standards of personal and professional conduct contained in our guidance Good Medical Practice. When they breach those standards, it can put patients at serious risk and public confidence can be affected.

Our fitness to practise procedures provide a mechanism to address such breaches. Their main purpose is to enable us to take action in relation to a doctor’s registration in order to protect patients and the public.

However, they are also intended to serve a number of secondary functions which include:

- providing an opportunity to rehabilitate and remediate doctors whose fitness to practise is impaired
- a means by which we can protect the reputation of the profession and maintain public confidence in doctors
- acting as a deterrent to doctors thereby improving the conduct and performance of the profession as a whole in a way that benefits patients.
A fitness to practise investigation is usually instigated by a complaint being made. Complainants can be motivated by a variety of factors including a determination to avoid a repetition of the problem or the wish for an apology. In the case of patients or relatives who feel they have been harmed by a doctor, there may be an understandable wish to ensure that the doctor is punished in some way or to seek some form of compensation or redress. However, that is not, and has never been, the purpose behind our procedures and there are other ways to pursue doctors in those circumstances such as the NHS complaints procedures as well as in the civil and criminal courts.

The GMC’s purpose is to ensure that doctors who practise are fit to do so. In the 1970s, the Merrison Committee, which conducted an inquiry into the regulation of the medical profession, took pains to emphasise that words like ‘discipline’, ‘punishment’ and ‘offence’ should be avoided.

The view that the role of the GMC is not punishment of doctors but protection of patients and of the reputation of the profession was confirmed by the Privy Council in Gupta v General Medical Council [2002] 1 WLR 1691. More recently it was reflected in the Court of Appeal case of Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460. In a number of rulings starting in 2008 the courts have clarified that the GMC must be concerned with a medical practitioner’s current and future fitness to practise and whether they pose an unacceptable future risk and not with disciplining doctors for past conduct (see, for example, Cohen v GMC [2008] All ER 307). In view of this, any action taken by the GMC must be proportionate. To act otherwise would be inappropriate and unlawful. When a panel issues a sanction at a hearing, it must be the minimum sanction necessary to protect the public.

Nevertheless, there can be a mismatch between the expectations of complainants who may feel that the doctor should be punished or disciplined for their actions. This in turn can create a level of dissatisfaction and misunderstanding with complainants engaged in our fitness to practise process.

Are our fitness to practise procedures overly punitive?

Some doctors, and those representing them, believe that the GMC’s fitness to practise procedures can appear overly punitive. One of the reasons cited is our policy of sending most cases to a public hearing where we believe the doctor’s fitness to practise is impaired. At the hearing, the allegations are read out in public, except where they relate solely to a doctor’s health. The GMC and the doctor’s defence team present their cases, including the details of the alleged facts, and this is followed by a full examination of the evidence, including examination and cross examination of witnesses. The hearings are open to the public and journalists are often present. As a result, allegations which the panel may later conclude to be unfounded are sometimes published in the media. In short, the requirement to take part in a public hearing is itself perceived as a form of punishment.

Hearings are mainly intended as a mechanism to establish disputed facts, but currently we do refer some cases to a hearing where the significant facts are not disputed. The justification for this is to maintain public confidence – by testing the evidence and making the determination in public, we maximise the transparency of our decision making process.

However, public hearings are costly and, even with careful case management, it takes several months to bring a case to a hearing. They also create significant stress for the doctors, complainants and witnesses involved. Given that our core role is to provide public protection, we are considering whether there are other ways to achieve that goal, proportionately and expeditiously, without referring most cases to a public hearing.
Are our fitness to practise procedures appropriate given the increased volumes of complaints received about doctors?

In the last ten years, the number of complaints or referrals we receive about doctors has increased and both the profile of those who refer doctors and the nature of the cases have changed.

**Number of complaints/referrals**

In 2000, we received 4,141 complaints about doctors compared with 7,022 projected for 2010. The number of complaints we receive has increased by 35% over the last three years. See figure 1 below.

It should be noted that data in this section will differ slightly from the annual statistics report which will be published in 2011. This is because the 2010 figures in this consultation are based on data extracted from our system at the end of November 2010 and therefore include projections for December 2010.

**Figure 1 Complaints/referrals**

<table>
<thead>
<tr>
<th>Enquiry year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints/referrals</td>
<td>4,141</td>
<td>4,219</td>
<td>3,723</td>
<td>3,821</td>
<td>4,444</td>
<td>4,941</td>
<td>5,087</td>
<td>5,230</td>
<td>5,220</td>
<td>5,692</td>
<td>7,022</td>
</tr>
</tbody>
</table>
Who makes complaints/referrals?
The profile of those who refer cases has also changed. The number of referrals we receive from persons acting in a public capacity (PAPC), for example, employers of doctors and the police, has increased from 656 in 2000 to 1,367 in 2010 and has increased by 117% in the last three years. See figure 2 below.

![Figure 2 PAPC complaints/referrals](image)

<table>
<thead>
<tr>
<th>Enquiry year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAPC</td>
<td>656</td>
<td>640</td>
<td>568</td>
<td>578</td>
<td>703</td>
<td>808</td>
<td>395</td>
<td>492</td>
<td>630</td>
<td>1,048</td>
<td>1,367</td>
</tr>
</tbody>
</table>

We have commissioned research to try to understand why the number of enquiries has risen and, in particular, why there has been such a large increase in referrals from PAPC.

The types of cases we receive from PAPC tend to be more serious. As a result, interim orders have increased by 42% in the last three years. See figure 3 below.

![Figure 3 IOP Hearings](image)

<table>
<thead>
<tr>
<th>Enquiry year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of doctors</td>
<td>33</td>
<td>154</td>
<td>136</td>
<td>127</td>
<td>167</td>
<td>274</td>
<td>259</td>
<td>346</td>
<td>329</td>
<td>427</td>
<td>468</td>
</tr>
</tbody>
</table>

Comment: Prior to the introduction of Interim Orders Panels in 2004, the Interim Orders Committee was responsible for the same process (introduced late 2000, hence low figures for that year)
Number of hearing days and concurrent hearings
The impact of these changes on the volume and profile of complaints is that the number of hearing days and the number of concurrent hearings we run has increased significantly. In 2000 there were 333 hearing days – by 2010 that had risen to 3,493 hearing days. In the last three years, the number of hearing days has increased by 66%. As a result, the number of concurrent hearings we run has increased. See figures 4–5 below.

![Figure 4 Total hearing days](image1)

![Figure 5 Concurrent hearings](image2)
The cost of fitness to practise
This increase in activity has inevitably led to increasing cost. In 2000, the GMC spent just under £15 million on its fitness to practise activities and, in 2010, this has risen to just under £44 million.

Despite making considerable efficiency savings, the cost of fitness to practise has increased by 50% since 2004. See figure 6 below.

Figure 6 Cost of fitness to practise

<table>
<thead>
<tr>
<th>Enquiry year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost (£000)</td>
<td>14,720</td>
<td>20,672</td>
<td>28,082</td>
<td>26,896</td>
<td>29,207</td>
<td>41,380</td>
<td>47,122</td>
<td>49,130</td>
<td>47,550</td>
<td>51,140</td>
<td>43,877</td>
</tr>
</tbody>
</table>

Clearly, public protection and fairness rather than cost should determine the way in which we handle these matters. Nevertheless, we are obliged to demonstrate that we provide value for money and the case for requiring a public hearing when it could be avoided is hard to make. Where a doctor is willing to accept the GMC’s proposed sanction, for example, removal of their name from the register, referring a case to a public hearing does not appear to be an appropriate or proportionate response. This does, however, raise questions about the role that public hearings may play in maintaining public confidence which need to be carefully considered and which we look at in more detail below.

What changes are we proposing?

Greater opportunity for discussion with doctors about the nature of presenting concerns
Under the existing arrangements there is some scope for the GMC to reach agreement with doctors facing allegations that their fitness to practise is impaired. For example, we can agree undertakings in health and performance cases where the doctor shows insight. In a small number of cases we also agree with the doctor that his or her name should be removed from the register under our voluntary erasure provisions. However, we only agree undertakings or grant voluntary erasure in about 2% of fitness to practise cases a year.
Last year, we consulted on extending the use of voluntary erasure to some conduct cases such as dangerous driving or one-off clinical incidents where a doctor was willing to sign a statement of agreed facts. The proposals received strong support from those who responded to the consultation and were approved by our Council.

We now propose to seek cooperation from doctors in all cases where the doctor is willing to accept our proposed sanction. This would mean that in all cases, when we have established the nature of the allegations or at the end of our investigation, we would assess the evidence and consider the appropriate sanction to protect the public. We would then discuss this with the doctor with a view to agreeing that we proceed with the proposed sanction. In practice, this would mean that we would try to conclude cases where we think that conditions are the most appropriate sanction by agreeing undertakings. Where we regard suspension or erasure as the appropriate sanction we would seek the doctor’s cooperation that they should be suspended or that their name be removed from the register.

It is important to stress that we are not proposing that we should negotiate with doctors about the appropriate sanction to protect the public. In the future, as now, we must put in place the minimum sanction necessary to protect the public. In the criminal justice process, a system of ‘plea bargaining’ is sometimes used where the Crown Prosecution Service in England has discretion to accept a guilty plea for a lesser charge. This is not what we are proposing. However, we do believe that there is value in having a discussion with doctors so that, at an earlier stage, we can better understand the seriousness of the case in order to determine the appropriate sanction to protect the public. Clearly, were we to adopt this approach, it would require a change to our operational model.

Under our current process, there may be aspects of a case which only fully emerge at the hearing. It would make sense to encourage greater discussion with doctors to ensure that we are fully apprised of the facts of the case, that we have a better understanding of the nature and seriousness of the issues and to see if an appropriate sanction can be reached by cooperation. Any facts put forward by a doctor during these discussions would need to be supported by evidence.

**Question 1**

Do you agree that, where there is no significant dispute about the facts, we should explore alternative means to deliver patient protection other than sending cases to a public hearing? If you disagree, please give reasons for your answer.

**Question 2**

Do you agree that it would be appropriate for the GMC to have discussions with doctors in order to foster cooperation? If you disagree, please give reasons for your answer.
One of the key questions is whether doctors should be able to share information with us during discussions on a ‘without prejudice’ basis. If so, we would not be able to use that information as evidence should the case later go to a hearing.

This is a difficult issue. On the one hand, our purpose is to protect patients and the public and we would have concerns about not being able to use information that raises a concern about patient safety.

On the other hand, discussions with doctors are more likely to be constructive if doctors can share information with confidence that it will not be used against them should our attempts at cooperation fail. If doctors do not engage during these discussions, cooperation will be unlikely and many more cases will continue to be referred to public hearings as they are now.

There is a safeguard in that ‘without prejudice’ discussions cannot be used as a façade to conceal facts or evidence and, where this is the case, that information can be later referred to a panel.

Some regulators are not allowed to use any information provided on a ‘without prejudice’ basis in preliminary discussions as evidence at a later hearing, but they can initiate further investigation and use any information uncovered by such investigation.

Question 3

Do you think that doctors:

a. Should be able to share information on a ‘without prejudice’ basis?

b. Should not be able to share information on a ‘without prejudice’ basis?

c. Should be able to share information on a ‘without prejudice’ basis where the GMC cannot directly use that information in a later hearing but can conduct further investigation and use any information uncovered by such investigation?
Facilitation of meetings
We are considering ways to maximise the effectiveness of any meetings with doctors and to avoid situations where views become entrenched.

Mediation is used in the civil justice system. It involves the appointment of a trained neutral mediator who assists the parties to the dispute to narrow the differences between their stated positions and agree on a negotiated outcome. This outcome can often be a midway point between the parties’ two positions. Mediation is designed primarily for situations where the outcome is open to negotiation. We do not believe mediation is appropriate in meetings with doctors facing allegations that their fitness to practise is impaired. The sanction appropriate to protect the public should not be open to negotiation and it would be wrong for the GMC to agree a lesser sanction in exchange for a consensual outcome.

Given the nature of our discussions with doctors, where the focus will be the exchange of information and a discussion about the appropriate sanction to protect the public, we believe that facilitation rather than mediation skills would be most appropriate and effective. Facilitation differs from mediation in that the role of the mediator is to assist the parties to reach a negotiated settlement whereas the role of the facilitator would be to foster constructive dialogue without taking any active role in the outcome of the discussion.

One option would be to use independent facilitators, although that is likely to be costly. An alternative would be for the GMC to contract with an approved list of trained facilitators who would be available to facilitate meetings with doctors. This will also have a cost but would be more cost effective than using independent facilitators and we would expect the benefits to outweigh the costs.

Question 4
Do you agree that we should consider ways to access practical facilitation skills to support constructive discussions with doctors?

Communication with complainants
Meetings with doctors will focus on the seriousness of the issues, the available evidence and whether a doctor will accept the necessary sanction to protect the public. The participants at the meeting will be the GMC and the doctor.

The meetings will not be about resolving the complainant’s concerns or providing any form of redress. This is not currently the purpose of our fitness to practise procedures. Accordingly, it is not being proposed that complainants should be present at these meetings with doctors, although we recognise that they have a significant interest in the case. As such, it will be vital to communicate effectively with complainants about the nature and outcome of these meetings.

We are proposing that we would write to the complainant prior to a meeting to notify the complainant that we are proposing to encourage the doctor to accept our proposed sanction. We would also write to the complainant following such a meeting to confirm the outcome. As is our current policy, we should communicate in a way that is accessible and easily understood by the complainant and takes account of any special needs they may have.
How will we maintain public confidence?

Anecdotally, we believe that confidence in medical regulation is relatively high, both among doctors and members of the public. The level of transparency in our work is an important factor in sustaining that confidence. We demonstrate transparency in a number of ways. We publish all sanctions on a doctor’s registration on the online medical register through our website and respond to telephone queries about the fitness to practise of individual doctors. Public hearings may also play a part in demonstrating transparency and we publish a full record of all fitness to practise hearings where we make findings against a doctor. That said, it is also possible that they may give the false impression that a large proportion of doctors behave inappropriately. Media coverage inevitably highlights the most serious cases and sometimes includes serious allegations about doctors which subsequently prove to be unsubstantiated.

Nevertheless, if fewer cases are subject to a public hearing, it will be important to ensure that we maintain transparency and ensure that public confidence is not undermined. In particular, we will need to guard against the perception that agreements with doctors behind closed doors are in any way compromising patient safety.

We therefore propose to bolster public confidence by:

a. Ensuring that, as now, the sanction accepted by the doctor is the sanction appropriate to protect the public. We will not negotiate a lesser sanction to encourage doctors to accept a settlement and we will undertake internal quality assurance monitoring and take part in independent audit of our decision making to ensure that sanctions reached through cooperation are consistent and adequate.

b. Ensuring that the way we describe the outcome of discussions with doctors accurately reflects that outcome. We will no longer use the term voluntary erasure where we remove a doctor’s name from the register in fitness to practise cases. That description does not reflect the fact that, in such cases, the GMC believes it is appropriate that the doctor’s registration is restricted or removed and the doctor accepts our proposal. An alternative would be to record that a doctor’s name has been ‘erased by mutual agreement’.

c. Ensuring that the sanction accepted by the doctor is published in full on our website. We also propose to publish a description of the issues which were put to the doctor and any mitigation (information provided by the doctor that reduces the seriousness of the apparent concern) supported by evidence that we have taken into account.

We are interested in your views on whether these measures will maintain public confidence in the profession and the GMC.

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**Question 5**

_Do you agree with the approach outlined for communicating with complainants about our discussions with doctors? Please give reasons for your answer._
How will we maintain high standards of public protection?

Greater discussion with doctors offers an opportunity to deliver fast, effective and proportionate public protection. In particular, in cases where a doctor accepts that we remove them from the register, they will no longer be able to practise as a doctor and this is the strongest possible form of public protection we can deliver. However, in cases disposed of in this way, the evidence will not have been tested at a hearing. A potential risk arises where a doctor accepts that we remove them from the register and later applies for restoration to the register.

In health and performance cases we can, and do, require a doctor to undergo a health or performance assessment before agreeing to restore them to the register to ensure they are fit to practise. In conduct cases, the evidence to support our case is often primarily evidence from witnesses to specific events. If some time has elapsed, the evidence may no longer be accessible or as robust because the witnesses are no longer available, or because memories have faded.

In order to minimise this risk, in cases involving misconduct we propose to require doctors who wish to agree to have their name removed from the register to sign a statement of agreed facts. The document will require the doctor to state that they are signing the statement freely and without undue pressure, that they understand the implications of signing the statement and that they have taken legal advice. We will need to consider how we will ensure that unrepresented doctors fully understand the implications of signing such statements before accepting a sanction proposed by us. We are interested in your views on how we might do this.

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Question 6

Do you think the term ‘by mutual agreement’ correctly reflects the outcome of discussions with doctors? If not, what term would you prefer and why?

Question 7

Do you think that publication of the sanction accepted by the doctor will maintain public confidence in the profession? If not, are there other steps we should take?

Question 8

Do you believe we should publish a description of the issues put to the doctor? What other information (mitigation taken into account, etc) should we publish?
Doctors who accept that they should be erased or suspended from the register will be subject to the same provisions as doctors who are erased or suspended by panels. Doctors who accept that they should be erased will not be allowed to apply for restoration for at least five years and, should they apply, will have to satisfy us that they are up to date and fit to practise. Where a doctor accepts that they should be suspended from the register, we will review the case at the end of the period of suspension to ensure that the doctor does not pose a continuing risk to patients that would require their registration to be subject to further restrictions or limitations. These provisions mirror the provisions for doctors who are erased or suspended by fitness to practise panels.

What cases will still go to a hearing?

Cases where the doctor does not accept our proposed sanction or where there is a significant dispute about the evidence will continue to go to a hearing.

We have considered whether there are any cases in which a doctor is willing to accept our proposed sanction where we should insist on referring the case to a hearing on public interest grounds. We have not so far been able to identify any categories of case where such a public interest exists.

As we discussed earlier, our purpose is to protect patients by ensuring that doctors on the register do not pose a risk to patients. It is not to conduct inquiries into failings within the healthcare system or otherwise provide an avenue for complainants to ventilate their concerns where there are other vehicles for this.

Question 9

Do you think our proposals above are a reasonable way to deal with any risk of deterioration of evidence? Do you have any other suggestions?

Question 10

How do you think we might ensure that unrepresented doctors fully understand the implications of signing a statement of agreed facts?

Question 11

Are there cases which should be referred for a public hearing even where the doctor is willing to agree the sanction proposed by the GMC? If yes, what types of cases and what criteria should the GMC apply to identify such cases?
Other changes to increase our efficiency

There are two other measures which we believe would simplify and speed up our fitness to practise procedures.

**Serious convictions**

There are some types of convictions that are so serious that they are inherently incompatible with registration as a doctor. We currently operate a presumption that all cases involving a custodial sentence are referred for a hearing but even in cases involving the most serious convictions there is a hearing to consider whether the doctor’s fitness to practise is impaired and what the appropriate sanction should be. There is a strong argument that taking such cases to a hearing is a waste of resources.

We propose that receipt of a conviction certificate for such offences will trigger a presumption of erasure without the need for a hearing. We would make provision for the doctor to make written representations. Unless representations made by the doctor raise matters which need to be considered by a fitness to practise panel we would proceed to erase the doctor’s name from the register. This would enable the GMC to take swift and robust action in the most serious cases and could well boost public confidence in the regulatory process.

We have identified the following offences as offences that would fall into this category:

- murder
- rape
- sexual assault against an adult or child
- abuse of children through grooming, prostitution or pornography
- any offence under the Sexual Offences Act 2003 by an adult relating to a child under 13
- any offence under the Sexual Offences Act 2003 relating to a person with a mental disorder impeding choice
- trafficking people for exploitation
- blackmail.

We are interested in whether there are other offences which should also be in this category.

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**Question 12**

Do you agree that there are some convictions that are so serious that the behaviour is incompatible with continued registration as a doctor and that there should be a presumption that the doctor be erased?
Refusal to comply with a fitness to practise investigation

There is a cohort of doctors who are referred into our fitness to practise procedures who consistently refuse to engage with our investigation. This may involve failure to reply to any correspondence about their case or a refusal to undertake a health or performance assessment. In 2009, 20 doctors within our procedures refused to undertake a health or performance assessment. This significantly hampers our investigation to establish whether their fitness to practise is impaired and, given our public protection role, is unacceptable. It is also a breach of our professional guidance, Good Medical Practice, which requires doctors to cooperate fully with any formal inquiry into their treatment of a patient and with any complaints procedure that applies to their work (Good Medical Practice, paragraph 68).

We propose to make provisions for automatic suspension of doctors who are being investigated in our fitness to practise procedures and who then refuse to cooperate with our investigation. We would need to demonstrate that we had made every attempt to engage with the doctor before it would be appropriate to undertake such a course of action.

Question 13

Do you agree that the convictions we have identified are convictions which fall into this category?

Question 14

Are there any other convictions you think should fall into this category?

Question 15

Do you agree that doctors within our fitness to practise procedures who refuse to engage with our investigation, where we have made every attempt to seek their engagement, should be automatically suspended from the register?
What is the impact of these changes likely to be on different groups?

We have carried out an initial assessment of the likely impact of these proposals on different groups who are involved in our fitness to practise procedures including patients, doctors, complainants and witnesses and this is attached at Annex B.

We believe greater cooperation with doctors will, overall, be positive for complainants and witnesses, particularly more vulnerable witnesses, as they may not have the stress of giving evidence at a public hearing.

It is possible that doctors or complainants from different cultural backgrounds may react differently to this more consensual approach. If we do embark on these changes we will record the outcomes and monitor them to assess whether there are any unintended consequences for particular groups of doctors.

The proposal to introduce automatic suspension for non-compliance with a fitness to practise investigation could affect certain groups of doctors. Again we will carefully monitor the operation of these procedures on implementation with this in mind.

As part of this consultation we will engage with a diverse range of interest groups including doctors, patients and the public, witnesses and complainants.

Question 16
Do you think that these proposals will benefit or disadvantage any groups of people who are involved in our fitness to practise procedures?

Question 17
Do you think these proposals will impact on the confidence in our procedures of any particular groups of people? If so, which groups and why?
Consultation questions

Question 1
Do you agree that, where there is no significant dispute about the facts, we should explore alternative means to deliver patient protection other than sending cases to a public hearing? If you disagree, please give reasons for your answer.

Question 2
Do you agree that it would be appropriate for the GMC to have discussions with doctors in order to foster cooperation? If you disagree, please give reasons for your answer.

Question 3
Do you think that doctors:

a. Should be able to share information on a ‘without prejudice’ basis?

b. Should not be able to share information on a ‘without prejudice’ basis?

c. Should be able to share information on a ‘without prejudice’ basis where the GMC cannot directly use that information in a later hearing but can conduct further investigation and use any information uncovered by such investigation?

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Question 10
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Annex A

Our current fitness to practise procedures

Initial assessment
All complaints or queries we receive are considered by a senior member of GMC staff who has three options available: to close the case, to refer the case to the doctor’s employer or to begin an investigation. We close cases at this stage if the matters raised, even if proven, would not require us to take any action.

We refer cases to a doctor’s employer if the matters raised, in and of themselves, would not require us to take any action but might do so if they formed part of a wider pattern of behaviour. We ask the employer if they have any further information about the matters raised or any other cause for concern. Unless the employer raises further matters at this stage, we close the case.

The investigation stage
We conduct an investigation where the concerns, if proven, would require us to take action to protect patients. Evidence is gathered which may include reports from a doctor’s employer, an independent assessment of the doctor’s health or clinical performance, obtaining an expert opinion and gathering witness statements.

Once sufficient evidence is available, two case examiners (one of whom is medically qualified) consider the case and decide what action should be taken. They may decide that the evidence does not represent a serious or persistent breach of the standards expected of a doctor as specified in Good Medical Practice and that the doctor’s fitness to practise is not impaired. In such instances, the case examiners may decide to close the case with no action, issue advice to the doctor or issue a warning.

If, however, the case examiners consider that the evidence suggests that a doctor’s fitness to practise is impaired they may, in certain cases, invite the doctor to agree undertakings whereby the doctor agrees to limit their practice in some way to protect patients. This may include additional supervision, attending remedial training or not treating certain categories of patients. We only agree undertakings with doctors in certain circumstances and we provide comprehensive guidance to the case examiners on when to pursue this option.

Finally, if the case examiners consider that appropriate safeguards cannot be put in place through the agreement of undertakings, they will refer the case for a hearing. Once this referral has been made, the case enters the hearing stage of the procedure.

At any time, a case may be referred to an Interim Orders Panel. The remit of an Interim Orders Panel is to place restrictions on a doctor’s practice, if necessary, on an interim basis to protect patients while an investigation is being carried out or a case is being prepared for a hearing.

The hearing stage
Once a case has been referred for consideration by a fitness to practise panel, we prepare the case for a hearing. A fitness to practise panel is usually made up of a chair and two members, at least one of whom must be medical and one of who must be non-medical. A legal assessor, who must be a solicitor or barrister of at least ten years standing, will also be present to advise the panel on points of law. The doctor may be represented either by a solicitor or counsel, a representative from a professional organisation or, at the discretion of the Panel, a member of their family or other person. The GMC will be represented by a solicitor or counsel.

Our hearings have three stages; the fact finding stage, the finding of impairment stage and the sanction stage. If the panel find a doctor’s fitness to practise is not impaired they may close the case, with or without advice or issue a warning. If the panel finds a doctor’s fitness to practise is impaired they may agree undertakings, impose conditions, suspend the doctor or erase the doctor from the register.

Our guidance on when it is appropriate to issue a warning or agree undertakings at the hearing stage is the same as for the case examiners at the end of the investigation stage.
Annex B

Equality impact assessment

1. Screening impact

This table sets out our analysis of how the proposed reforms could impact positively, differentially or negatively on different groups of people.

Where a section is left blank, it is because we do not believe our proposals affect a particular group differently than the rest of the population.

<table>
<thead>
<tr>
<th>Positively</th>
<th>Differentially</th>
<th>Negative/adverse impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where the impact will improve equality and promote relations between groups</td>
<td>Do people from different communities or groups have different expectations, needs, experiences or attitudes in relation to the service we offer?</td>
<td>Where one or more groups are significantly disadvantaged by the impact</td>
</tr>
</tbody>
</table>

**General comments**

In general, a more consensual approach will be positive for doctors. Doctors and their representatives have told us they view our current approach of sending the majority of cases for a public hearing as overly punitive. Hearings are stressful for doctors and often result in media reporting of allegations that may later prove to be unfounded.

A more consensual approach will also, in general, be positive for complainants and witnesses who will not have the stress of a public hearing.

There may be circumstances in which individual complainants want a public hearing to ventilate their concerns but, as long as we ensure our proposals deliver robust public protection, there will be no disadvantage in real terms for complainants.

The introduction of a presumption of erasure for a limited category of convictions is unlikely to impact on specific groups. The numbers affected are likely to be small.

**Ethnic groups**

International medical graduates, doctors who have been qualified for more than 20 years and male doctors are over-represented in our procedures. Moving to a more consensual approach will benefit these groups proportionately as well as doctors in general.
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<tr>
<th></th>
<th>Positively</th>
<th>Differentially</th>
<th>Negative/Adverse Impact</th>
</tr>
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<tr>
<td></td>
<td>Where the impact will improve equality and promote relations between groups</td>
<td>Do people from different communities or groups have different expectations, needs, experiences or attitudes in relation to the service we offer?</td>
<td>Where one or more groups are significantly disadvantaged by the impact</td>
</tr>
<tr>
<td>Ethnic groups</td>
<td>In relation to international medical graduates, it is possible that there are cultural issues around consensual arrangements. For example, some cultures may be more comfortable with accepting fault in a professional sphere than others. We have no specific evidence about how this may affect different groups and will have to evaluate any changes carefully.</td>
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<tr>
<td>Men, women and transgender people</td>
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<tr>
<td>People with disabilities</td>
<td>The proposals to extend a consensual approach should be helpful for vulnerable witnesses in that, where a doctor accepts a sanction, they will not have the stress of giving evidence in a public hearing. Proposals to introduce automatic suspension for non-compliance with our procedures could affect people with mental health issues disproportionately. We will need to ensure a robust process to ensure we have made all efforts to engage with the doctor and monitor the impact of this proposal carefully.</td>
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<tr>
<td>All age groups</td>
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<tr>
<td>People who are lesbian, gay or bisexual</td>
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<tr>
<td>Religious or belief systems</td>
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<tr>
<td>People from disadvantaged socio/ economic groups</td>
<td></td>
<td>We will need to consider how we might ensure unrepresented doctors fully understand the implications of signing a statement of agreed facts.</td>
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</tr>
</tbody>
</table>
2. Gathering data and evidence

This table sets out how we have engaged with key diversity groups about our proposals. The consultation will enable us to identify better the potential impact of our proposals on different groups and where we need to take action to guard against this.

<table>
<thead>
<tr>
<th>Equality target group</th>
<th>Involvement and consultation</th>
<th>Data/information</th>
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</thead>
<tbody>
<tr>
<td>Ethnic groups</td>
<td>We are proposing to conduct a public consultation which will include questions about how the changes may affect different groups.</td>
<td></td>
</tr>
<tr>
<td>General comments</td>
<td>We intend the consultation to be proactive and we propose to hold workshops and events with different community groups to get views on their likely impact.</td>
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<tr>
<td>People with disabilities</td>
<td>Planned consultation workshops will include meeting with BME groups.</td>
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3. Monitoring and review

a) We have included in the consultation paper a number of proposals for ensuring that we maintain transparency in relation to consensual arrangements with doctors.

b) We will conduct a review after the first year to consider whether there are any adverse impacts on particular groups. The new procedures will be subject to ongoing internal monitoring and to internal and external audit procedures going forward.
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