

Making decisions on cases at the end of the investigation stage: Guidance for Case Examiners and the Investigation Committee

Introduction

1. This guidance looks at the types of practice or behaviour which may result in a finding of impaired fitness to practise by the GMC or result in a warning.
2. The guidance aims to help case examiners and the Investigation Committee decide the appropriate outcome for a case at the end of an investigation into a doctor's fitness to practise. While we recognise that individual cases have to be decided on their own merits, the purpose of the guidance is to encourage consistent and criteria-based decision-making.
3. The guidance is a 'living document' which will be updated and revised as the need arises.
4. Case examiners and members of the Investigation Committee are obliged to exercise their own judgement in making decisions but within a framework set by the Council. This framework is reflected in this guidance. It refers, where necessary to *Good Medical Practice* and other core GMC guidance.
5. Any examples provided in this document are intended to form guidance only, and are not exhaustive, but will provide a benchmark in identifying the kinds of cases which are likely to result in a finding of impaired fitness to practise. In considering an appropriate outcome, the case examiners and members of the Investigation Committee should refer to the guidance in this document, but will also need to take account of the guidance in *Good Medical Practice*, other more specific guidance produced by our Standards and Ethics section and any relevant guidance produced by the royal colleges and other bodies. They should also consult the Indicative Sanctions Guidance which the GMC has prepared for the use of FTP panels.

Equality and Diversity Statement

6. The GMC is committed to promoting equality and valuing diversity and to operating procedures and processes which are fair, objective, transparent and free from unlawful discrimination.

The GMC's Fitness to Practise procedures

The process

7. By far the great majority of doctors deliver good quality healthcare, often in difficult and demanding situations. However, a small proportion do not and concerns about their practice must be investigated under our fitness to practise procedures.

8. Any doctor wanting to practise medicine in the UK must, by law, be both registered and hold a licence to practise. Our fitness to practise powers extend to all registered doctors, whether or not they hold a licence to practise. Following the introduction of licensing, the GMC's Fitness to Practise sanctions continues to attach to a doctor's registration. Where a doctor's name is suspended or erased from the Register by a Fitness to Practise Panel, we will automatically withdraw a doctor's licence. Where a doctor's registration is subject to conditions or undertakings which restrict their practice they will still be entitled to hold a licence but must continue to comply with any conditions or undertakings on their registration. If they do not, their registration and licence may be at risk.

9. Information concerning a doctor's fitness to practise may be received from a complainant or a person acting in a public capacity, or may otherwise come to the attention of the GMC.

10. At any time, the Registrar (on his own motion or where requested by a case examiner or the Investigation Committee) may refer an allegation to an Interim Orders Panel. Guidance on referrals to an IOP is attached at Annex C.

11. Initial investigations will be carried out by the Registrar's staff (with the assistance of lawyers where required), for example, where there is insufficient information to establish whether the allegation falls within the GMC's jurisdiction, or where further information is required to see if a pattern of behaviour may be established. These may include making enquiries of the doctor's employer, colleagues or others, or obtaining medical records or other documentation.

12. Convictions resulting in a custodial sentence are referred direct by the Registrar to a Fitness to Practise (FTP) Panel. There is a presumption that the same will apply to cautions, non-custodial convictions, and determinations of other regulatory bodies. However, in some cases a warning will be the appropriate response. There are also a number of minor offences (such as parking offences) where no formal GMC action will be required. Guidance on the handling of convictions and determinations is attached at Annex D.

13. The decision at the end of the investigation stage is to be taken unanimously by a medical and a lay case examiner. Case examiners have been appointed by the Registrar following a rigorous, competency-based, recruitment process designed to assess their decision-making competencies and skills. Where they do not agree, the matter is decided by the Investigation Committee.

14. The case examiners will apply the following test at the conclusion of the investigation stage:

‘The Investigation Committee or case examiner must have in mind the GMC’s duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor’s fitness to practise is impaired to a degree justifying action on registration’

15. At any stage, the Registrar’s staff or the case examiners may refer the case to the police for investigation where the allegations appear to disclose the commission of a criminal offence and where the police appear to have had no previous involvement in the matter.

16. A note on the meaning of fitness to practise, approved by Council, is attached at Annex A. Further legal guidance on the ‘realistic prospect’ test is attached at Annex B by way of an aide memoire.

17. Under section 35C(2) of the Medical Act 1983 (the Act), impairment can be by reason of any or all of the following:

- Misconduct
- Deficient performance
- A criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales)
- Physical or mental ill-health
- A determination by a regulatory body either in the British Isles or overseas

18. Case examiners and members of the Investigation Committee must not consider the categories set out in paragraph 17 as separate issues. There may be cases that involve concerns about a number of aspects of a doctor’s fitness to practise. In making a decision, it is the cumulative effect of all impairing factors that must be taken into account. Health and performance assessments are part of the process of collecting evidence. ‘Passing’ an assessment will not necessarily mean that no action will be taken, as there may be other issues for the case examiner to consider.

19. There will also be cases that demonstrate significant departures from *Good Medical Practice* or a significant cause for concern on assessment. These cases may not be so serious as to warrant action on a doctor’s registration but may require a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response

in these types of cases will be a warning. A warning should only be considered where the case examiners or the Investigation Committee have already decided that there is no realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration.

20. At the end of the investigation there are a number of options open to the case examiners:

- a. Refer the case to a Fitness to Practise panel.
- b. Agree undertakings on health and performance issues following a health examination or a performance assessment.
- c. Issue a warning (or refer the matter to the Investigation Committee for a hearing regarding whether to issue a warning).
- d. Conclude the case with no further action.

21. Our fitness to practise procedures apply equally to all registered doctors whether or not they hold a licence to practise. All doctors on the register are expected to meet the standards in *Good Medical Practice*. The fact that a doctor does not currently hold a licence to practise does not remove the requirement to investigate and respond to concerns about a doctor's fitness to practise.

22. Where the practitioner chooses not to comment or does not dispute the facts alleged, and where a medical and lay case examiner agree to do so, a warning may be issued. In all other cases in which the case examiners feel a warning may be appropriate, the matter will proceed to an oral hearing before the Committee to decide whether a warning should be issued. The practitioner has a right to request such an oral hearing to be held. Where new evidence at the hearing casts a fresh light on the case, the Committee may refer the matter to a FTP Panel.

23. Undertakings may only be agreed where the case examiners have decided that the doctor's fitness to practise is impaired (or is likely to be, on recurrence of a medical condition), where to do so would provide sufficient protection to the public and where there is no possibility of erasure should the matter proceed to a FTP Panel. The restrictions imposed as a result of the undertakings (save for those relating solely to the doctor's health) will be disclosed on enquiry. Guidance in relation to directing assessments and agreeing undertakings is attached at Annex E.

Presumption of Impaired Fitness to Practise

24. There are certain categories of case where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise. These tend to fall within three main headings:

- Sexual assault or indecency
- Violence
- Improper sexual/emotional relationships

25. In many cases, where the alleged conduct falls within one of these categories, it will result in a criminal conviction. Guidance on handling convictions is attached at Annex D. However, there will be cases which are not prosecuted or which do not result in a conviction, but will nevertheless warrant investigation and action by the GMC.

(The decision in R v Metropolitan Police Commissioner ex parte Redgrave (2003) 1 WLR 1136 indicates that the GMC may take action on a case against a doctor on the same issues as a previous criminal prosecution, notwithstanding that the doctor was acquitted by the criminal process.)

26. Where allegations fall under one of the three headings, there is a presumption of impaired fitness to practise. The case examiners and Investigation Committee will normally refer the case to a Fitness to Practise panel, unless there are exceptional reasons for not doing so. Where the case examiners do not refer the case to a Fitness to Practise Panel, they will need to be particularly careful to record full reasons for having done so.

27. There may be instances where, following the investigation of the case, the case examiners decide that the case does not meet the investigation stage test because there is no realistic prospect of establishing the case evidentially. If the case examiners decide to close a case on these grounds, detailed reasons should be provided on the decision making form. Case examiners should consider seeking legal advice, in these circumstances, if it has not already been provided. The case examiners should record the reasons for the decision, referring specifically to any legal advice that has been obtained.

28. Where the allegations fall within one of the categories where there is a presumption of impaired fitness to practise, the case examiners should not normally consider any arguments in mitigation made by the doctor. Mitigation should only be considered following a finding of fact by a Fitness to Practise panel. The case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)* (see paragraph 59 for further details) established that evidence that a failing is remediable and has been remedied by a doctor is relevant to consideration of impairment. Cases in which there is a presumption of impaired fitness to practise, however, are unlikely to fall into the category of cases that are easily remediable.

Sexual assault or indecency

29. This encompasses a wide range of conduct from allegations of sexual assault and sexual abuse to allegations in relation to child pornography.

30. While many allegations relating to sexual assault or indecency will result in a conviction and be referred direct by the Registrar to a Fitness to Practise Panel, there will be cases which are not prosecuted or which do not result in a conviction and which the case examiners will need to consider.

Violence

31. Many allegations of violence will result in a conviction. However, there may be cases which were not prosecuted or which do not result in a conviction. There may be allegations of aggressive or physically threatening behaviour to colleagues or patients or more specific incidents of violence outside of a doctor's professional environment.

Improper sexual/emotional relationships

32. This encompasses improper sexual and/or emotional relationships with patients or patients' relatives. *Good Medical Practice* states:

'You must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them'.
(Paragraph 32 GMP.)

'Maintaining Boundaries' provides more detailed guidance on the issue of sexual and improper emotional relationships with current and former patients.

Presumption that the GMC will take action

Dishonesty

33. Dishonesty, in any context, is serious as it may undermine trust in the profession. *Good Medical Practice*, states that doctors must be honest and trustworthy and act with integrity, as this is at the heart of medical professionalism. It also states:

'You must be honest and open in any financial arrangements with patients.

(GMP Paragraph 72a)

You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

b. if you manage finances, you must make sure the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.'

(GMP Paragraph 73b)

34. Paragraphs 72 to 73 of GMP provide more detailed guidance on financial and commercial dealings and on conflicts of interest. See also the more detailed GMC guidance on conflicts of interest (paragraphs 74-76).

35. There will be cases of dishonesty where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise. These types of cases are likely to fall into two categories:

- a. cases where the doctor's dishonesty puts patients at risk
- b. cases where the nature of the dishonesty is such that public confidence in doctors generally might be undermined if the GMC did not take action.

36. Examples in professional practice could include defrauding an employer, improperly amending patient records or submitting or providing false references and information on a CV. Examples outside professional practice might include defrauding the revenue or mishandling charitable funds.

37. Research misconduct is a further example. The term is used to describe a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and the profession have in medicine as a science, regardless of whether this leads to direct harm to patients. Because it has the potential to have far reaching consequences, this type of dishonesty is particularly serious. Allegations in this category may also include false claims as to qualifications/experience and forgery or improper alterations of documents.

38. Good Medical Practice provides as follows:

If you are involved in designing, organising or carrying out research, you must:

- (a) put the protection of the participants' interests first
- (b) act with honesty and integrity
- (c) follow the appropriate national research governance guidelines and the guidance in [GMC guidance] *Research: The role and responsibilities of doctors*.

(GMP Paragraphs 70 71)

39. However, although the GMC takes all allegations of dishonesty seriously, there will be cases alleging minor dishonesty which are not related to the doctor's professional practice and which are so minor in nature that taking action on a doctor's registration is unlikely to be a proportionate response. Examples of dishonesty that are likely to fall into this category might include a failure to pay for a ticket covering all or part of a journey on public transport.

40. In cases of this nature, it is unlikely that these allegations, by themselves, would satisfy the realistic prospect test of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. Nonetheless, the GMC does take all allegations of dishonesty seriously, and allegations of this nature, if admitted or proven, do warrant some action by the GMC. It is likely that the most appropriate response, in cases of this nature, will be a warning.

Practising without a licence

41. Following the introduction of the licence to practise, it is the licence to practise that confers all the privileges that were previously associated with registration. It will be a criminal offence for a doctor who is registered but who does not hold a licence or for any other person to pretend to have a licence. However, when the allegations relate to a doctor who holds registration but who does not hold a licence we can also take the case forward under our Fitness to Practise procedures.

42. Each case will need to be considered on its own facts but if a doctor has deliberately misled patients or others about his/her licensing status, there is a presumption the case should be referred forward to a Fitness to Practise panel hearing.

Other serious or persistent failures to practise in accordance with the principles in *Good Medical Practice*

43. Other serious or persistent failures to practise in accordance with the principles in *Good Medical Practice* may also raise an issue of impaired fitness to practise. Most concerns about treatment or the standard of a doctor's clinical practice will fall into this category.

44. In deciding whether a complaint meets the investigation stage test, the case examiners will need to consider both the nature and seriousness of the allegations and whether the issue is easily remediable and/or has been remediated. The following paragraphs and the examples provided will help the case examiners decide whether a complaint meets the investigation stage test.

Nature of Allegations:

45. Allegations of serious or persistent failures to practise in accordance with the principles set out in *Good Medical Practice*, can be categorised under the following headings:

- Good Clinical Care
- Maintaining Good Medical Practice
- Teaching and Training, Appraising and Assessing
- Relationships with patients
- Working with colleagues
- Probity
- Health

Seriousness of Allegations

46. Where the allegations indicate failures to practise in accordance with the principles set out in *Good Medical Practice*, the case examiners will need to proceed to consider how serious or persistent the failure or failures are. Whilst doctors are expected to comply with the standards in *Good Medical Practice*, not all failures to meet standards will amount to an issue of impaired fitness to practise

to a degree justifying action on the doctor's registration. *Good Medical Practice* is guidance, not a statutory code, so doctors must use their judgement to apply the principles to the various situations they will face. Whether they choose to follow the guidance or not – they must always be prepared to explain and justify their decisions and actions. The guidance in the booklet focuses on a doctor's professional life. Behaviour that takes place outside a doctor's professional practice may lead to action on registration where public confidence in doctors generally might be undermined if the GMC did not take action.

47. *Good Medical Practice* states that 'serious or persistent failures to follow this guidance will put your registration at risk'. In some cases the concerns may arise from a series of episodes. There will, however, be cases that arise from a single clinical incident. Additional guidance on single clinical incidents is attached at Annex H. A question of fitness to practise is likely to arise in the following circumstances:

A doctor's performance has harmed patients or put patients at risk of harm

48. A risk of harm will usually be demonstrated by a series of incidents that cause concern locally. These incidents will indicate persistent technical failings or other repeated departures from good practice which are not being, or cannot be, safely managed locally or local management has been tried and failed.

A doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients

49. An isolated lapse from high standards of conduct – such as an atypical rude outburst – would not normally, in itself, suggest that the doctor's fitness to practise should be in question. The sort of misconduct, whether criminal or not, which may however, indicate a lack of integrity, an unwillingness to practise ethically or responsibly or a serious lack of insight into obvious problems of poor practice will bring a doctor's registration into question.

A doctor has abused a patient's trust or violated a patient's autonomy or other fundamental rights

50. Conduct which shows that a doctor has acted without regard for patients' rights or feelings, or has abused their professional position as a doctor, will usually give rise to questions about a doctor's fitness to practise.

51. Examples of acting without regard for patients' rights or feelings would include failing to obtain appropriate consent or to provide adequate information to the patient. *Good Medical Practice* provides:

'Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs.'

'To fulfil your role in the doctor-patient partnership you must:

- (a) be polite, considerate and honest
- (b) treat patients with dignity
- (c) treat each patient as an individual
- (d) respect patients' privacy and right to confidentiality
- (e) support patients in caring for themselves to improve and maintain their health
- (f) encourage patients who have knowledge about their condition to use this when they are making decisions about their care.

(GMP Paragraphs 20-21)

Good Medical Practice also explains that doctors must be mindful of the way they express their own personal beliefs to patients.

'You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.'

(GMP Paragraph 33)

A doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others

52. Cases of dishonesty or fraud on the part of the doctor are likely to fall within the category of Dishonesty where there is a presumption that the doctor's fitness to practise is impaired. However, there may be cases where the doctor's actions might not have been strictly dishonest but they may have been designed to mislead others by omission. This might occur in circumstances where a misleading report or reference is provided.

53. *Good Medical Practice* states that:

'You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.'

You must always be honest about your experience, qualifications and position, particularly when applying for posts.

You must do your best to make sure that any documents you write or sign are not false or misleading. This means that you must take reasonable steps to verify the information in the documents, and that you must not deliberately leave out relevant information.

If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.

If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written

statements. You must make clear the limits of your knowledge or competence.

You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure that applies to your work. You must disclose to anyone entitled to ask for it any information relevant to an investigation into your own or a colleague's conduct, performance or health. In doing so, you must follow the guidance in *Confidentiality: Protecting and providing information*.

You must assist the coroner or procurator fiscal in an inquest or inquiry into a patient's death by responding to their enquiries and by offering all relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you.'

(GMP Paragraphs 63-69)

The doctor's behaviour was such that public confidence in doctors generally might be undermined if the GMC did not take action.

54. This will include behaviour that takes place outside a doctor's professional practice. Many cases of this nature will involve a conviction or a police caution. Guidance on dealing with cases of this nature is at Annex D. Paragraph 58 of *Good Medical Practice* requires doctors to notify the GMC if, anywhere in the world, they have accepted a caution, been charged with or found guilty of a criminal offence, or if another professional body has made a finding against their registration as a result of fitness to practise procedures.

55. *Good Medical Practice* also makes it clear that conduct outside a doctor's professional practice may, nonetheless, affect their fitness to practise.

'You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession.'

(GMP Paragraph 57)

A doctor's health is compromising patient safety

56. The GMC *does* not necessarily need to be involved merely because a doctor is unwell, even if the illness is serious. However, a doctor's fitness to practise is brought into question if it appears that the doctor has a serious medical condition (including an addiction to drugs or alcohol) and the doctor does not appear to be following appropriate medical advice about modifying his or her practice as necessary in order to minimise risk to patients.

Good Medical Practice provides:

If you know that you have, or think that you might have, a serious condition that you could pass on to patients, or if your judgement or

performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

(GMP Paragraph 79.)

57. This *advice* is only illustrative of the sort of behaviour which could call registration into question. *Good Medical Practice* and the documents it links to including supplementary GMC guidance provide a more complete picture of behaviour of this kind, but even it is not exhaustive.

58. The chart attached a Annex F provides further guidance and illustrative examples of how failures to meet the standards in *Good Medical Practice* may give rise to action on a doctor's registration.

Whether the failing is easily remediable and/or has been remedied

59. In the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), Mr Justice Silber ruled that at the impairment stage, a panel ought to take account of evidence and/or submissions (in addition to those deployed at the fact-finding stage) from both the doctor and the GMC that the doctor's failing (as identified at the fact-finding stage) is easily remediable and/or has already been remedied by him. This was considered to be a factor closely linked to the risk of repetition of that failing.

60. Ease of remediation, steps taken to remediate and the likelihood of repetition of the failing are all relevant in considering impairment. All three factors are usually inter-related and normally occur together. It is likely that the more factors that are present, the more weight they will carry. But they may not occur together. For example, there may be evidence that, although the failing is easy to remedy, it has not actually been remedied. The case examiners or the Investigation Committee will need to decide what weight to give to the potentiality for remedy and/or its actuality: see paragraph 65 below.

61. Evidence of the factors may include reports and submissions by the doctor concerning courses or training undertaken to remedy the failing and evidence of the doctor's previous fitness to practise history (which may be relevant to the likelihood of repetition). Mr Justice Silber indicated that evidence of easy remediation tends to favour the doctor, by helping him to negate impairment. Conversely, he indicated that psychiatric or psychological problems making it difficult or impossible for him to remedy the failing would point towards impairment.

62. In deciding whether a case meets the investigation stage test, case examiners or the Investigation Committee will need to consider the possible impact on a panel at the impairment stage of material showing that a doctor's failing is easily remediable and/or has already been remedied and/or the level of the risk of repetition.

63. Such material may not always be available. Where it is available it may not be clear or determinative. But where it is available, it should be considered.

64. If case examiners or the Investigation Committee are satisfied that the failing is easily remediable and has been remedied, they may still decide that impairment could be established before a panel. The weight to be given to that factor, like any other, is a matter for the case examiners' discretion. The Cohen judgment recognises that there are cases that raise issues of public confidence where, regardless of whether the failing has been remedied, a case should be referred to a panel. These are likely to involve allegations which are very serious in nature and where there is a presumption of impairment.

Undertakings

65. Undertakings may only be agreed where the case examiners have decided that the doctor's fitness to practise is impaired (or is likely to be, on recurrence of a medical condition), where to do so would provide sufficient protection to the public and where there is no possibility of erasure should the matter proceed to a FTP Panel. Guidance in relation to directing assessments and agreeing undertakings is attached at Annex E.

66. When the case examiners have decided that a doctor's fitness to practise is impaired (or is likely to be in the event of the reoccurrence of a medical condition) and that undertakings will be an appropriate way forward, it will be irrelevant whether or not the doctor holds a licence to practise. Fitness to practise sanctions attach to registration and all doctors on the medical register are required to comply with *Good Medical Practice*. Even when the issues are practice related and the doctor has relinquished their licence to practise, practice related undertakings may still be the most appropriate approach, including a commitment to work under medical supervision or undergo retraining.

67. A registered doctor is entitled to apply for a licence at any time and that doctor's practice will only be restricted if action has been taken on their registration. If that doctor later obtains a Licence, they will need to comply with any undertakings. Case examiners will need to consider in an individual case the most appropriate sanction keeping in mind the possibility of a doctor regaining their licence.

68. Such undertakings should be imposed for a specified period of time and be subject to review. The sanction period should be the same for an unlicensed doctor as for a licensed doctor.

69. If on review, the doctor's unlicensed status remains unchanged the case examiners or panel will need to consider the most appropriate action to take. This could include discussing with the doctor the possibility of taking voluntary erasure from the register, a further period of undertakings or conditions or more robust action such as referring the case to a panel or suspending the doctor. Such decisions will need to be made on a case by case basis.

Warnings

70. There will also be cases that demonstrate significant departures from *Good Medical Practice*, not so serious as to warrant action on a doctor's registration but requiring a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response in these types of cases will be a warning. A warning may also be appropriate where a performance assessment indicates a significant cause for concern. A warning will not affect a doctor's registration or right to hold a licence to practise.

71. Case examiners and the Investigation Committee will first need to apply the investigation stage test as set out in paragraph 14 of this guidance. A warning should only be considered where the case examiners or the Investigation Committee have already decided that there is no realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration. The question of whether a warning might be appropriate must be considered in all cases where the case examiners or Investigation Committee decide that the investigation stage test has not been met.

72. In many cases, determining whether allegations about treatment and clinical practice are serious enough to meet the investigation stage test will be very complex and will depend on a range of factors. These might include the seniority of the doctor, the level of supervision, the effect of external factors such as systems failures and any remediation undertaken by the doctor. Where the case examiners consider that the allegations are on the borderline between action on registration and a warning, the presumption should be that the case progresses to a Fitness to Practise panel.

73. Once it has been established that the investigation stage test has not been met, for whatever reason, the case examiners should consider all the evidence, including arguments in mitigation, when considering whether or not to issue a warning.

74. Although a warning does not affect a doctor's registration or licence, it will appear on the register during the 5-year period that it remains valid and will be disclosed on enquiry at any time.

Case Examiner decisions following cancellation of a hearing under rule 28

73. Rule 28(3)(c) of the Fitness to Practise Rules allows a member of the Investigation Committee to cancel a hearing and to refer the case back for consideration by the case examiners under Rules 10 and 11. (See separate guidance on the cancellation of hearings under Rule 28.)

74. When a case is referred back to the case examiners under Rule 28(3)(c), the options open to the case examiners are restricted to considering undertakings under Rule 10 or a warning under Rule 11. It is not open them to consider other options, such as carrying out further enquiries.

75. The decision that the case examiners will be asked to make will depend on the grounds for cancelling the hearing. This should be recorded in the referral from the Case Presentation Team.

Undertakings

76. Case examiners may be asked to consider agreeing undertakings where, following referral, while the doctor's fitness to practise appears to be impaired, undertakings appear to be an appropriate way of concluding the case.

77. The case examiners' decision should take account of the guidance in paragraph 58 above and in the guidance on undertakings in Annex E.

78. When the case examiners decide that it is appropriate to invite the doctor to agree undertakings, the case should progress in accordance with the standard process for agreeing undertakings.

Warnings

79. Case examiners may be asked to consider issuing a warning when, following referral, it appears that, while there is no longer a realistic prospect of establishing that the doctor's fitness to practise is impaired, there are nonetheless concerns which may warrant a warning.

80. In considering whether a warning is appropriate in these circumstances, the case examiners should apply the guidance in paragraphs 59 to 63 above and in the separate guidance on issuing warnings.

81. When a case is referred back to the case examiners in these circumstances on the basis that there is no longer a realistic prospect of establishing that the doctor's fitness to practise is impaired, the case examiners' options will be restricted to considering whether it is appropriate issue a warning; it will not be open to them to consider inviting the doctor to accept undertakings.

82. When the case examiners decide that it is appropriate to issue a warning, the case should progress in accordance with the standard process for issuing warnings.

Recording Decisions

83. Decisions agreed by case examiners must be recorded on the file. All parties should be able to understand why a decision has been taken, even if they do not agree with the decision. Decisions should be recorded using the Case Examiner Decision Form. A copy of the CEDF is attached at Annex G. It is important that case examiners provide a detailed record of the reasons for their decisions.

Annexes (not attached but available on www.gmc-uk.org)

- Annex A: [Council's policy statement on the meaning of Fitness to Practise](#)
- Annex B: [Aide Memoire on the 'realistic prospect test'](#)
- Annex C: [Guidance on referral to an Interim Orders Panel](#)
- Annex D: [Guidance on dealing with convictions, cautions and determinations](#)
- Annex E: [Guidance on agreeing undertakings](#)
- Annex F: [Illustrative examples](#)
- Annex G: [Case Examiner Decision Form](#)
- Annex H: [Guidance on Single Clinical Incidents](#)
- Annex I: [Guidance on considering applications for Voluntary Erasure](#)

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