

Guidance on Charge Drafting for Notices of Hearing

Introduction

Purpose and status of guidance

1. This guidance has been drafted to promote consistency of approach to presenting charges in notices for hearings in fitness to practise cases to assist the GMC and defence counsel, practitioners and panellists.
2. The guidance and the attached schedule of summary clauses are indicative and their application will need to be considered in each case.
3. Under the General Medical Council (Fitness to Practise) Rules 2004, the GMC will be alleging that a practitioner's fitness to practise is impaired by one or more of the following reasons (listed in section 35C(2) of the Medical Act 1983):
 - a. misconduct;
 - b. deficient professional performance;
 - c. a conviction or caution;
 - d. adverse physical or mental health;
 - e. a determination by a regulatory body.

The purpose of charges

4. Under Rule 15, the Notice of Hearing must particularise the allegation and the facts on which it is based. The notice should enable the practitioner to know exactly what is being alleged against him/her, and it should form the basis for the Panel to make structured findings of fact on these issues. The practitioner or Panel should not need to ask for further or better particulars.

5. The overall charge should be a basic outline of the case against the doctor so that anyone reading it knows immediately the identity of the doctor and what he/she is alleged to have done.
6. The charges should be based on those allegations referred by the Case Examiners. It is common, however, after referral of an allegation by the Case Examiners to a Panel, for new information (not considered by them) to emerge from the investigation performed by the GMC in preparation for the Panel hearing. Accordingly, charges not included in the Rule 7 letter may be added to the Notice of Hearing, provided that their inclusion would not be unfairly prejudicial to the practitioner.
7. The Case Presentation Team has developed specific guidance on the addition of further charges. It distinguishes between the addition, for example, of further examples of the same alleged pattern of misconduct identified in the Rule 7 letter and the addition of further misconduct, but that which is of a fundamentally different type. Generally, the latter would need to be included in a further Rule 7 letter, rather than being added as further particularisation in the Notice of Hearing under rule 15. You should refer to the specific guidance for more detail on this issue.
8. It is important to ensure that the charges identify the core areas of concern, and relate to matters which are serious enough to justify impairment proceedings. Impairment of fitness to practise is judged 'in the round', so it may be necessary to look at the cumulative effect of a series of faults. However, drafters should consider carefully whether each incident relied on should genuinely attract criticism. The Courts have been critical of unnecessary allegations which add little to the overall complaint (see, for example, the criticism in paragraph 143 of the judgment of Mr Justice Davis in *Williams v GMC* [2007] EWHC 2603 (Admin), of allegations which could be said to be 'sweeping up' charges or add little to the overall complaint; and *Misra v General Medical Council* [2003] UKPC, where the Privy Council criticised as unnecessary and oppressive charges based on a doctor's response to a GMC investigation).

General principles of drafting

9. The charge needs to be sufficiently particularised as to the basis of the alleged impairment, but drafters should beware of including unnecessary detail. The notice is not a narrative of the case, a summary of the evidence, or the equivalent of the GMC's opening statement of case. However, it should set out the facts which you say indicate impairment.
10. The charge should be unambiguously drafted. To achieve this you should:
 - f. Be as concise as possible – avoid sub clauses;
 - g. Use succinct, plain language; and
 - h. Say what you mean e.g. if you are alleging a doctor has been dishonest you need to say so (unless the alleged misconduct is obviously

dishonest – for example there is no need to charge dishonesty where it is alleged the doctor stole from a patient).

Structuring a charge

11. The best way of achieving a clear and sufficiently particularised charge is to make it chronological so that key events appear in their normal time frame.

12. In practical terms a charge can be sub-divided as follows:

a. First identify and describe the doctor's practice at the relevant time together with its location:

(for example) "in August 2004 you were practising as a Consultant Psychiatrist at the Maudsley Hospital in South London".

From this the Panel know the time frame with which they are concerned, the speciality of the doctor, his/her status and his/her location of practice.

The phrase "*at the material time*" should not be used as it should be possible to specify the time frame involved in most cases. If the allegations span a long period of time it should be possible to specify time as "*between X and Y*" date.

b. Go on to describe the key factual elements of what the doctor has done, avoiding unnecessary narrative detail:

e.g. when he/she saw the patient and what treatment he/she gave, how a relationship came to be formed etc.

c. Then indicate what is being criticised and precisely in what way it is being criticised. An expert's report may guide you as to the nature of what a doctor has done wrong; otherwise you can look at wording in the relevant edition of *Good Medical Practice* or other specific guidance issued by the GMC. It is not however necessary to tie allegations to specific provisions in such guidance.

d. Finish by stating:

"and that in relation to the facts alleged your fitness to practise is impaired by reason of... (set out the s35(C)(2) reason(s) relied on)".

Deciding what facts to include

13. Only include what you can prove from admissible evidence: see Rule 34(1) and (2). As a guide rely on the "best evidence" rule – i.e. the evidence that carries the most weight is direct evidence, not hearsay, along with evidence that is supported by another witness or by documentation.

14. The Panel has the power to amend a charge (rule 17(3)) but can only do so if the amendment can be made “without injustice”.

Specific issues

The use of “*failed*” versus “*did not*”

15. The construction ‘*you failed,*’ used to state, for example, that a doctor ‘*failed to examine Patient A*’ means that we have to prove not only that the practitioner did not examine Patient A, but that he or she should have done so. This approach should be adopted where the *failure to examine* is core to the allegation; otherwise the wording should be “*You did not examine Patient A*”.

Allegations of dishonesty, sexual misconduct and states of mind

16. If the GMC considers that the doctor’s conduct was dishonest (as opposed to some lesser degree of culpability) it is essential that this is specifically pleaded in the allegation. A failure to include such an allegation if the facts may properly support such an inference can amount to a procedural error or ‘under-prosecution’ on the part of the GMC (see *R (Council for the Regulation of Healthcare Professionals) v Nursing and Midwifery Council* [2007] ACD 79). That said, it is not necessary to allege dishonesty if the allegation is already clearly contained in the words used: e.g. “you stole a bag ...” Any other conclusions upon a doctor’s motives or state of mind which the Panel may be asked to reach should be clearly pleaded: e.g. ‘deliberately misleading’ etc.

17. We can allege ‘indecenty’ even where the doctor has been acquitted of indecent assault. When alleging indecenty, the preferred approach is to charge that the Doctor’s actions were ‘sexually motivated,’ not least because there is an element of subjective judgement in the meaning of the term ‘indecent’. See further the Guidance on the Use of Summary Clauses.

18. If in a relevant case, for example of improper intimate examination, we do not allege either that the actions were indecent and/or sexually motivated, this should be as a result of a conscious decision not to do so, preferably supported by written Counsel’s advice. Cases should always be prosecuted at the highest level which can be supported by the evidence.

19. It may also be necessary to include lesser alternatives in cases where a range of possible interpretations can be drawn on the reasons for conduct. If only the most serious allegation is set out, there is a risk that the defence may claim injustice if they were not aware that less serious alternatives also had to be rebutted. See for example *R (Farag) v GMC* [2009], where a Panel’s finding of dishonesty was quashed and a submission that the defence was never given an opportunity to answer an alternative and lesser case was accepted. This implies that in, for example, a dishonesty case, it may be appropriate to allege that a statement was: (a) misleading; (b) intended to mislead and (c) dishonest.

20. However, there is a need to balance the inclusion of lesser alternatives against the “kitchen sink” approach to drafting, e.g. where we include every potential failing in the charges, rather than limiting the charges to the most serious allegations.

21. Further guidance on the suggested meaning of adjectives commonly used to describe a doctor’s conduct is contained in the Guidance on Use of Summary Clauses, attached to this document. Drafters should use it to ensure that terms are used consistently when drafting charges, as well as when presenting cases on behalf of the Council.

The use of summary clauses

22. There are two distinct types of summary clause, ‘specific aggravating factors’ and ‘generic summary clauses’.

23. Summary clauses are likely to be required when specific factual findings need to be made which may be aggravating features of the alleged misconduct, e.g. when the allegations describe the doctor’s misconduct as dishonest, misleading or sexually motivated. These may be described as ‘specific aggravating factors’. These are factual issues which require proof to the requisite standard in stage one. The use of such clauses is supported by case law.

24. In contrast, terms such as ‘inappropriate’, ‘inadequate’ or ‘not of the standard expected of a registered medical practitioner’ (described as ‘generic summary clauses’) are not factual matters requiring specific factual findings at stage one. Alternatively, generic summary clauses go to the exercise of judgement at the impairment stage of the hearings procedure (stage two).

25. The inclusion of generic summary clauses in the charges risks unnecessarily complicating the exercise by the Panel of its judgement on impairment, by implying that, since they form part of the charges, there is a requirement on the Panel to make a finding on the issue to the civil standard of proof at stage one. As stated above, generic clauses are matters of judgement for stage two of the procedure.

26. As a result, generic wrap up clauses should not generally be included in charges, except for when there is a specific need dictated by the circumstances of the case. For example, in performance cases it may be necessary to state, in stage one, just how far on the spectrum a doctor’s fitness to practise has fallen short of an accepted standard.

Multifactorial cases

27. The principle of the procedures introduced in November 2004 is that fitness to practise is to be judged ‘in the round’. The usual approach will therefore be to set out the alleged facts and then at the end of all the charges to conclude by alleging impaired fitness to practise by reason of whichever of the categories under section 35D of the Medical Act are said to apply. It is not necessary to link each head of charge to a specific category of impairment. See the suggested wording at paragraph 12(d) above.

Quotes

28. Panels have the power to find facts proved as amended. However, they have sometimes found difficulty in finding charges proved which refer to alleged spoken words if the evidence is that the precise words alleged in the charge were not those actually spoken. It is therefore usually advisable to add a rider of ‘...or words to that effect’ when alleging spoken words.

The Rule 7 letter

29. A Rule 7 letter is intended to inform the practitioner of the allegation and state the matters which appear to raise a question as to whether fitness to practise is impaired. Rule 7 gives the practitioner the opportunity to persuade the Case Examiners that the allegation, as then summarised in the rule 7 letter, should not be referred to a Panel.

30. In drafting charges, you should consider whether:

- a. The allegations which the GMC now wishes to proceed with were set out, in substance, in the Rule 7 letter. In some situations where new particulars or facts have come to light after the Rule 7 process is complete, it may be necessary to pass these new facts back through the Rule 7 and 8 processes. Whether fresh referral under rule 8 is necessary is dictated by the extent to which the new information changes the underlying nature of the alleged impaired fitness to practise. You should refer to the GMC’s policy on adding new particulars after an allegation has been referred to a Panel for more detailed guidance on these issues; and
- b. The charges can be framed so as to draw upon any admissions made by the doctor in response to the Rule 7 letter, so as to narrow the areas in dispute before the Panel.

Performance cases

31. In cases where a doctor’s performance is alleged to be deficient, it is common for a performance assessment team to undertake an assessment of the doctor’s performance, with a subsequent report outlining the team’s conclusions about the doctor’s performance. If a report indicates a doctor’s performance is deficient, and the matter is referred to a Panel, charges would be drafted based upon the report.

32. The favoured approach to pleading *performance cases* is to charge that:

“You underwent an assessment on (insert date); your performance was deficient in the following areas... (list areas of deficiency)”.

Using this approach, it is a matter for the Panel to determine, at stage 1, whether a performance deficiency exists (and thus to determine if the practitioner is impaired).

However, the conclusions of the assessment team will form a key component of the evidence upon which the allegation of deficient performance is based. Please refer to the template at Annex B which guides drafters on how to draft charges for performance related cases.

Health cases

33. In these cases, it is customary to set out any details of any condition from which the doctor may be suffering in a schedule on a separate sheet; this can then be treated as confidential.

Numbering the Heads of Charge

34. Use numbers at the top level, then letters for sub-headings and Roman numerals for sub-sub-headings. If any further subdivision is necessary, use double letters and Roman numerals alternatively for each subdivision.

35. Try to use one head of charge with subdivisions for a group of related allegations, such as the events during a single consultation.

Example:

1. "In December 2004 you were practising as a general practitioner at the Park Surgery, Manchester;
2. (a) On 2 December 2004 Mrs Mary Smith consulted you;
 - (b) i. You did not take an adequate history from Mrs Smith;
 - ii. a. You did not examine Mrs Smith;
b. You thereby did not place yourself in an adequate position in which to assess Mrs Smith's condition; and
 - iii. You did not refer Mrs Smith for further specialist investigation when her condition so required.
3. (a) On 3 December 2004, Mrs Smith again consulted you;
 - (b) i. You did not take an adequate history from Mrs Smith;
 - ii. (a) You did not examine Mrs Smith;
(b) You thereby did not place yourself in an adequate position in which to assess Mrs Smith's condition;
4. (a) On 4 December 2004, Mrs Elsie Jones consulted you, etc etc

And that in relation to the facts alleged your fitness to practise is impaired by reason of your misconduct".

36. Each sub-head is concluded with a comma. The end of each head of charge is concluded with a semi-colon; the end of the charge is concluded with a full stop.

GMC Style Guide

37. You should apply the principles of the GMC Style Guide wherever possible. Key points include:

- a. Use Arial 12pt typeface. All drafts **MUST** be submitted in this format in a Word document;
- b. Date format should always be in the form of the number with suffix; for example '1 December 2002' not '1st December 2002' or 'December 1st 2002'. We usually refer to times by the 24 hour clock. An exception is if quoting from other documents such as medical records;
- c. Where possible try to use the active tense rather than the passive – for example, 'Mrs Smith consulted you' rather than 'you were consulted by Mrs Smith'; and
- d. Numbers within the heads of charge should be spelt out if whole numbers from zero to nine and should be in number format if fractions or from 10 upwards.

Annex A – Guidance on the use of summary clauses

Charge	Meaning	Suggested use
Inadequate	Insufficient	In the clinical context: when the doctor should have done something more. It is not a criticism of the actions that the doctor actually did take.
Inappropriate	Not suitable	When the doctor has done something that he should not have done. Used [not exclusively] in sexual misconduct cases. Not used in clinical cases where the charges should be ' <i>not clinically indicated</i> '.
Misleading	Leading someone to believe something is true when it is not.	Used in respect of statements made, documents submitted. Does not imply dishonesty or an intention to mislead.
Deliberately misleading	On purpose; consciously and intentionally misleading.	Consider carefully whether it is necessary to allege both this <u>and</u> dishonesty, or whether it is superfluous; there may be only a limited number of cases where statements were not made dishonestly but the conduct could still be judged to be deliberately misleading.
Intending to mislead	As above	As above.
Dishonest		Only where the charge may properly be found proved following a GHOSH advice from the legal adviser.
Not of the standard expected of a registered medical practitioner	Deficient performance	In clinical cases: equates to a breach of a duty of care in negligence. Also includes any conduct by the doctor which falls below the minimum acceptable standard of conduct – e.g. assault; inappropriate relationship.
Irresponsible	Deliberately failing to carry out a	When a doctor knew he should have done something but

Charge	Meaning	Suggested use
	responsibility.	deliberately chose not to – e.g. not ordering a scan, when he knew, or should have known a scan was needed.
Likely to put the public at risk	There must be an identifiable risk to the public.	When a risk to the public was a likely outcome of the doctor's action or inaction.
Abuse of your professional position	Where the doctor uses his professional position in an improper way [for advantage].	The opportunity for the conduct complained of should have arisen out of the doctor's professional position: e.g. encouraging/persuading an elderly vulnerable patient who the doctor is treating to leave their estate to the treating doctor.
Likely to bring the medical profession into disrepute	Likely to make the general public hold doctors in lower esteem	This is an objective test as to whether in fact the profession was likely to be brought into disrepute; but should only be charged where the doctor deliberately, recklessly or negligently brought about the likely outcome.
Sexually motivated	Where the doctor's reason for the conduct was sexual.	As a doctor's motive should never be sexual this can be charged in any instance where that motive exists, irrespective of whether the conduct would otherwise have been justified.
Not in the patient's best interests	Contrary to the patient's interest	Where the Doctor puts his/her interest ahead of the patient's, allows some other interest to take primacy, or acts in a way contrary to the patient's interests.
Not clinically justified/indicated	There was no clinical reason to do it	Does not necessarily imply an unacceptable practice. In reality, used as evidence of poor practice.

Annex B – Template draft allegations – performance cases

In the Fitness to Practise Panel of the

General Medical Council

Between

General Medical Council

and

Dr []

Draft Allegations

That being registered under the Medical Act 1983 (as amended);

1. By letter dated [], the General Medical Council (“GMC”) invited you to undergo an assessment of the standard of your professional performance (an “assessment”), to which you agreed.

2. That assessment took place on [].

3. Your professional performance was unacceptable in the following areas of Good Medical Practice;
 - (a) []

 - (b) []

 - (c) []

 - (d) []

 - (e) []

4. Your professional performance was a cause for concern in the following areas of Good Medical Practice;
 - []

 - []

 - []

 - []

 - []

5. In the [] Core Knowledge Test you scored [below the minimum acceptable standard].
6. In the [] Knowledge test your performance was [unacceptable or cause for concern] in [*domains*].
7. In the Tests of Communication skills your overall performance was [unacceptable / cause for concern].
8. In the Practical Tests of [] you scored [below the minimum acceptable standard].