Imposing Interim Orders

Guidance for the Interim Orders Panel and the Fitness to Practise Panel

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Introduction

1. This guidance is for use by Interim Orders Panels (IOP). It will also be of assistance to:

- Doctors whose cases are referred to an IOP
- Barristers or solicitors who represent doctors or the GMC before an IOP
- A Fitness to Practise Panel (FTP Panel), when considering whether to impose an interim order on a doctor's registration.
- Legal assessors advising IOPs and FTP Panels

2. The aim of the guidance is to promote consistency and transparency in decision making relating to interim orders. The guidance is a 'living document' and will be revised as the need arises.

The role and functions of the IOP

3. The role of the IOP is to consider whether a doctor's registration should be restricted on an interim basis, either by suspension or by imposing conditions on their registration. Cases considered by an IOP are heard in private although they may be heard in public in certain circumstances e.g. the doctor requests a public hearing or the IOP considers it appropriate.[1]

4. Section 41A of the Medical Act 1983, as amended, provides for an IOP, or a FTP Panel, to make an order, either suspending or imposing conditions upon a doctor's registration, for a period of up to 18 months. In practice, the vast majority of interim orders will be imposed by an IOP. A FTP Panel may, however, impose such orders and is likely to do so if, for example, it adjourns a case and considers that it is necessary to do so pending its resumed consideration of the matter. Further guidance on when it may be necessary for a FTP Panel to consider the imposition of an interim order is set out in paragraphs 41 - 44 below.

Referral process

5. The Registrar may refer a case to the IOP at any stage if he or she is of the opinion that the IOP should consider making an interim order.[2] Case examiners and the Investigation Committee also have powers to direct the Registrar to refer a case to the IOP.[3] Cases should be referred to an IOP where the doctor faces allegations of such a nature that it may be necessary for the protection of members of the public, or otherwise be in the public interest or in the interests of the doctor, for the doctor's registration to be restricted whilst

those allegations are investigated. This category also includes cases of doctors who have appeared before a Fitness to Practise Panel, had their registration either made subject to conditions, but without immediate conditions being imposed, or suspended or erased but without immediate suspension being imposed **and** we receive new information which was not available at the time of the original determination, which suggests that the doctor poses an immediate risk to patients, or that the wider public interest or the interests of the doctor (for example his/her health) may be adversely affected. Further guidance on the circumstances in which cases should be referred is provided at Annex A. [4]

Powers of the IOP

6. An IOP may make an order when it considers it necessary to do so for the protection of members of the public or it is otherwise desirable in the public interest to maintain public confidence and uphold proper standards of conduct and behaviour. The IOP may also make orders where it is in the interests of the doctor.

7. An IOP does not make findings of fact or determine the allegations against the doctor.

Review of interim orders

8. Except in the circumstances referred to in paragraph 9 below, any order imposed must be reviewed by an IOP within six months of the order being made, and thereafter every six months. However, following a first or subsequent review of an order, the doctor may request an early review. If three months have elapsed since the date of the immediately preceding review, then the order shall be reviewed as soon as practicable after receipt of a request for an early review. An order may also be reviewed at any time when new evidence relevant to the order becomes available, which may affect the order in place.[5] If the GMC wishes to extend an order beyond the period initially set, then it must apply to the relevant Court[6] to extend the order. Each extension will be for a maximum period of 12 months, however there is no limit on the number of extensions which may be granted.

9. There are, however, three instances where a review must take place within three months of the first or any subsequent order having taken place:

a. Where an order for interim conditions has been replaced with an order for interim suspension.

b. Where an order for interim suspension has been replaced with an order for interim conditions.

c. Where the High Court has extended an order beyond the period initially set.

Absence of the doctor

10. The absence of the doctor does not preclude the proceedings from taking place. An IOP may, however, only make an order if the doctor has been given an opportunity to attend and be heard on the question of whether such an order should be made.[7]

11. If the doctor does not appear and is not represented before it, the Panel should proceed if it is satisfied that all reasonable efforts have been made to serve the doctor with notice of the proceedings. The Rules[8] require that notice of the hearing be served "**in such time before the hearing as is reasonable in the circumstances of the case**" [emphasis added]. In practice, doctors will normally receive at least seven days' notice of the hearing, but in cases of exceptional urgency the period of notice may be shorter. Notice of the hearing must be sent to the doctor at his/her registered address or last known address and if the doctor is represented by a solicitor or trade union or defence organisation, the Notice can also be served on the representative provided they have 'gone on record' as acting for the doctor.[9] Service of any notice may be proved by:

a. Confirmation of posting

b. A signed statement from any person serving the Notice confirming that the Notice was delivered to, sent to or left at

i. the doctor's registered address or last known address

ii. the business or electronic email address of the doctor's solicitor, trade union or defence organisation.[10]

12. An IOP does not have to be satisfied that the doctor is aware of the proceedings only that all reasonable efforts have been made to serve the doctor with notice of the proceedings.[11] It is the doctor's responsibility to maintain an effective registered address.

Applications for adjournment

13. The Rules[12] provide that an IOP may, at any stage in its proceedings, whether of its own motion or upon the application of either party, adjourn the hearing, but it can **only** do so where the hearing has **commenced** (i.e. where it has opened the hearing by recording the doctor's name, his/her registration number, the parties present and the type of case to be considered). Under the provisions of Rule 29(1) the IOP cannot consider any applications for the postponement of a hearing. Applications for postponements can only be made **before** the opening of a hearing and are considered by a member of the Investigation Committee. Where a doctor's application for a postponement has been rejected, the doctor may make an application for adjournment at the hearing. While the grounds of such an application may be similar, it is for the IOP to consider the matter afresh.

14. In the event that an application for adjournment is made, an IOP should, having formally opened the hearing, carefully consider the submissions made and invite the other party also to make submissions on whether the case should be adjourned. It is vital that in accordance with Rule 29(3) both parties should be given reasonable opportunity to make their representations; but, where necessary, parties should be reminded of the importance of keeping submissions brief, addressing the reasons why an adjournment is considered necessary (or the reasons why it is opposed) and that they should not enter into presentation of the issues of the case.

15. Having heard the submissions made by each party and where appropriate sought advice from the legal assessor the IOP should consider the matter in the absence of the parties. It is for the IOP to decide whether, in the circumstances of the case, it is appropriate to grant the application. In doing so the panel will need to balance fairness to the applicant with the potential risk, resulting from any adjournment, to the public, the wider public interest or the doctor.

Information available to the IOP

16. Prior to the hearing, papers and supporting documents are sent to the IOP, the doctor and the parties' legal representatives, and the legal assessor. Due to the nature of the IOP's work, documents may be received at the last moment; those documents are tabled on the day of the meeting and must, where possible, be read by panellists before they hear any submissions on the case. However, every effort should be made by all parties to ensure that documents are submitted in advance of the hearing to enable panels to consider them. Where documents are to be tabled by either party on the day of the

hearing, the IOP may request of the relevant party that the bundle is indexed and paginated. Where the size of the bundle is substantial, parties should highlight key documents for consideration by the panel.

17. Both the GMC's representative and the doctor or their representative may make submissions and adduce documentary evidence. Those submissions are limited to the question whether, given the circumstances of the case, it is necessary to impose/maintain an order either imposing interim conditions or interim suspension on the doctor's registration. It is important to keep in mind that the IOP does **not** make findings of fact or to resolve disputes of fact. For this reason, the Rules provide[13] that no person may give oral evidence before an IOP unless the Panel is satisfied that 'such evidence is desirable to enable it to discharge its functions'. In the past the IOP have rarely found it necessary to hear oral evidence from witnesses, but each case must be considered on its own merits. However, the IOP will always hear from the doctor, if s/he wishes to give evidence.

Test applied

18. The IOP must consider, in accordance with section 41A, whether to impose an interim order. If the IOP is satisfied that:

> a. in all the circumstances that there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public, or may adversely affect the public interest or the interests of the practitioner;
>
> **and**
>
> b. after balancing the interests of the doctor and the interests of the public, that an interim order is necessary to guard against such risk,

the appropriate order should be made.

19. In reaching a decision whether to impose an interim order an IOP should consider the following issues:

> a. The seriousness of risk to members of the public if the doctor continues to hold unrestricted registration. In assessing this risk the IOP should consider the seriousness of the allegations, the weight of the information, including information about the likelihood of a further incident or incidents occurring during the relevant period.

b. Whether public confidence in the medical profession is likely to be seriously damaged if the doctor continues to hold unrestricted registration during the relevant period.

c. Whether it is in the doctor's interests to hold unrestricted registration. For example, the doctor may clearly lack insight and need to be protected from him or herself.

20. In weighing up these factors, the IOP must carefully consider the proportionality of their response in dealing with the risk to the public interest (including patient safety and public confidence) and the adverse consequences of any action on the doctor's own interests.

21. In assessing whether or not it is appropriate to take action, the IOP should consider the seriousness of any police charges and the acceptability of their decision on interim action should the doctor later be convicted or acquitted (including public confidence issues as above).

22. When considering whether or not to make an interim order, the IOP cannot accept any undertakings given by the doctor as it has no power to accept them and they are, in any event, unenforceable.

Allegations of sexual misconduct

23. In general, where allegations involve sexually inappropriate behaviour towards patients or the doctor is under police investigation for a sexual criminal offence, particular consideration should be given to the impact on public confidence if the doctor were to continue working unrestricted in the meantime.

The following factors are likely to indicate, balanced alongside other considerations, that a case is likely to raise significant public confidence issues if no interim action is taken.

a. Information that a doctor is under investigation by police in connection to serious offences such as rape or attempted rape, sexual assault or attempted sexual assault or sexual abuse of children.

b. Allegations that a doctor exhibited predatory behaviour in seeking or establishing an inappropriate sexual or emotional relationship with a vulnerable patient.

c. Serious concerns about a doctor's sexualised behaviour towards a patient in a single episode.

d. Allegations of a pattern of sexually motivated behaviour towards patients.

Other serious criminal offences

24. Where a doctor is under investigation for any other serious criminal offence, particular consideration should be given to the impact on public confidence if the doctor were to continue working unrestricted in the meantime.

Doctor's health

25. Where there are issues about the doctor's health, the IOP should bear in mind that its primary duty is to protect members of the public and the wider public interest, and not to assume responsibility for, or give priority to, the treatment or rehabilitation of the doctor. However, where the IOP considers it appropriate to make an order for interim conditions, these may include conditions relating to the ongoing treatment and supervision of the doctor.

Interim conditions or interim suspension?

26. The IOP shall first consider whether it is necessary to impose an interim order to protect patients and or desirable to maintain public confidence and uphold proper standards of behaviour. If it decides that an order is appropriate, it must consider whether to impose interim conditions on the doctor's registration. If it considers an interim order for conditions inappropriate, it must consider whether to suspend the doctor's registration.

27. In deciding the appropriate action, the Panel must very carefully consider the issue of proportionality in weighing the significance of any risk to patient safety or public confidence, for example in not suspending the doctor against the damage to him by preventing him from practising. *[Sandler 2010]*

28. Under s41A(1) Medical Act 1983 the suspension of a doctor on 'public protection' grounds can only be done if it is necessary but there is no such qualification on suspension where it is desirable in the 'public interest' to maintain public confidence. *[Sandler 2010]*

29. When considering the imposition of conditions the IOP must ensure that any conditions imposed are workable, enforceable and will protect the public, the wider public interest or the doctor's own interests. Conditions should normally follow the format of conditions set out in the IOP conditions bank.

30. The following factors may also be relevant:

a. Whether the practitioner has complied with any undertaking given to the GMC or conditions previously imposed under GMC fitness to practise procedures.

b. The practitioner's history with the GMC (if any).

Sexual misconduct

31. Where allegations involve sexual misconduct, there may be a significant risk to patient safety and public confidence in the profession if decisions at the interim stage are not seen to reflect the seriousness of the individual case.

Workability and effectiveness of conditions

32. In cases involving allegations of sexual misconduct, one or more of the following factors are a strong indicator that conditions requiring the use of a chaperone may not be workable or effective:

a. Any serious concerns that the doctor has not complied with existing chaperoning arrangements at their place of work.

b. Allegations that a doctor asked a chaperone to leave the room during an intimate examination.

c. Allegations that a doctor exhibited sexually indicated behaviour towards patients in the presence of a chaperone.

Public confidence

33. The public has a right to know about a doctor's fitness to practise history to enable them to make an informed choice about where to seek treatment. To balance this with fairness to the doctor, allegations leading to the imposition of interim conditions are not published or disclosed to general enquirers. It is therefore the responsibility of the IOP to consider whether, if allegations are later proved, it will damage public confidence to learn the doctor continued working with patients while the matter was investigated.

34. With this in mind, the presence of one or more of the following factors are a strong indicator that conditions may not be adequate to maintain public confidence in the profession or the medical regulator.

a. Information that a doctor has been charged by police in connection to serious offences such as rape or attempted rape, sexual assault or

attempted sexual assault or sexual abuse of children.

b. Allegations of a pattern of sexually inappropriate conduct towards patients.

In exercising their discretion in relation to the particular facts of each case the IOP should also consider any immediate risk to patient safety [*Yeong 2009*]. However, there are circumstances in which it is necessary to take action to protect public confidence even where there is no immediate risk to patients.

Criminal Charges

35. Where the allegations involve serious criminal charges the panel should consider recent case law in relation to the proportionality of their response.

> 'The statutory test is there, and that is the one to be applied. One would like, all the same, to think that in all these kinds of cases of potential interim suspension an interim orders panel would at least be asking itself, as part of its thought process, the following: will it be acceptable for us not to suspend in a case of this kind if at the end of the day the charges are proved and the guilt of the applicant is established? That is one aspect. Another part of the thought process should be: will it be acceptable for us to suspend an applicant in a case of this kind if, at the end of the day, the applicant may be acquitted of all charges? Those considerations should form at least part of the thinking of an interim orders panel...' [*Sosanya 2009*]

36. It is incumbent on the panel to consider the individual features of each case and the particular facts of the criminal charges. In evaluating the acceptability of intervening or declining to do so, the IOP should have in mind the ultimate possibilities of both the practitioner's acquittal and his/her conviction of the particular charges.

Period of order

37. Where it imposes an interim order an IOP must specify the length of the order. The maximum period for which an initial order may be imposed is 18 months. It is important to bear in mind that if the IOP wishes to extend an order beyond the period initially set, the GMC will need to apply to the relevant Court to do so.

38. In considering the period for which an order should be imposed an IOP should bear in mind the time that is likely to be needed before the matter is resolved (for example, the time needed to complete any investigation into

allegations regarding the doctor's fitness to practise, including obtaining assessments of the doctor's health and/or performance, and for the case to be listed for hearing by a FTP Panel). The IOP should also bear in mind that there is provision[14] enabling it, or a FTP Panel, to revoke, vary or replace an interim order on review (see paragraphs 37 and 38 below).

Review of interim orders

39. With the exception of the circumstances mentioned in paragraph 9 above, the IOP must review an interim order within six months of the order being imposed, and thereafter, at intervals of no more than six months during the lifetime of the order. A review of an order may also be held **at any time** when new evidence relevant to the order becomes available. Further, following a first or subsequent review of the order, the doctor may also request an earlier review, which shall be heard as soon as practicable after three months from the date of the immediately preceding order (see also paragraph 9 above).

40. When reviewing interim orders an IOP must fully consider all the circumstances relating to the case, including any new information. It must decide whether the order should be maintained, varied, replaced or revoked. In doing so the IOP should apply the same test and take account of the same factors as set out in paragraphs 18-23 above.

Reasons for decisions

41. Rule 27(4)(g) of the Rules makes clear that when announcing its decision the IOP "**shall** give its reasons for that decision" [emphasis added]. An IOP must therefore ensure that reasons are given for any decisions taken, including decisions not to impose an order. The courts do not expect an IOP to give long detailed reasons but the reasons given must be clear and explain how the decisions were reached, including identifying the interest(s) for which the order is considered necessary.

42. Although IOP decisions should be fairly concise, they must include the following information with specific reference to the distinct features and particular facts of each individual case.

a. The risk to patients should be clearly identified to support the proportionality of any action it was necessary to take.

b. The risk to public confidence in the profession if the doctor continued working without restriction on their registration and the allegations are later proved, to support the proportionality of any interim action taken.

c. Where an order is made primarily because it is desirable in the public interest to uphold public confidence and there are no concerns about clinical practice specific reasons should be given for why this is appropriate.

d. Reasons for the initial period of time for which an interim order is imposed.

e. Where no order is imposed, clear reasons must be given.

Cases where a FTP Panel considers imposing an interim order

43. The imposition of interim orders will normally be considered by the IOP. A FTP Panel may also impose an interim order (section 41A of the Medical Act) but this is only likely to occur in a relatively small number of cases where, for example, a case has been referred to a FTP Panel but adjourned and the FTP Panel considers that the imposition of such an order may be necessary in the interim, pending its further consideration of the matter.

44. FTP Panels will need to bear in mind that the notice of hearing sent to doctors who are not already subject to an interim order, does not only notify them of the details of their hearing into allegations against them by a FTP Panel but also includes a reference to the Panel's powers under section 41A of the

Medical Act to place an interim order of conditions or suspension on their registration under the circumstances described at paragraph 30 above. It also informs them that any such order would be reviewed after six months, and at regular intervals thereafter, as set out in Section 41A(2).

45. If the doctor is present and/or legally represented the FTP Panel should proceed to hear submissions by both parties (the doctor and/or his representative and Counsel for the GMC) on whether an interim order should be imposed following the procedure set out in paragraph 44 below. In fairness both to the doctor and the GMC, the FTP Panel should notify them that they wish to consider whether an interim order should be imposed and allow them a short period to obtain instructions and prepare their submissions. If, however, the doctor is not present or not represented he or she will not be able to make submissions on this question. However, as outlined in paragraph 42 above, the doctor will have had notice of the Panel's powers in this regard. Therefore the requirement that no interim order "shall be made ....unless he has been afforded an opportunity of appearing before the Panel and being heard on the question of whether such an order should be made in his case;" will have been met.

46. When considering whether to impose an interim order, a FTP Panel should:

a. Consider the matter in private, unless the doctor requests that the matter be considered in public.

b. Follow the procedure set out in Rule 27 of the General Medical Council (Fitness to Practise) Rules 2004; and

c. Apply the same test and follow the same advice set out above for the IOP.

Annex A

Guidance on referral to an Interim Orders Panel

The following examples are illustrative of cases which, depending on all the circumstances, may suggest that referral to an Interim Orders Panel is appropriate. The list is not exhaustive and there may be others where referral would be appropriate.

Risk to patients: clinical issues

1. This category concerns cases where, if the allegations are substantiated, there is an ongoing risk to patients from the doctor's clinical practice. Such cases will normally involve either a series of failures to provide a proper standard of care, or one particularly serious failure. Allegations indicating a serious lack of basic medical knowledge or skills, may well require referral to an Interim Orders Panel.

2. This category also includes cases of doctors who have appeared before a Fitness to Practise panel and had their registration either suspended or erased but without immediate suspension being imposed, but where we receive new information which was not available at the time of the original determination that the doctor poses an immediate risk to patients.

Risk to patients/public confidence: non-clinical issues

3. These are cases not directly related to clinical practice but where, if the allegations are substantiated, the doctor poses a risk to patients or public confidence in the profession if allowed to continue in unrestricted practice.

4. This category includes cases where the doctor faces allegations of a nature so serious that it would not be in the public interest for the doctor to hold unrestricted registration whilst the allegations are resolved even though there may be no evidence of a direct risk to patients. The question would be whether public confidence in the profession may be seriously damaged by the doctor concerned holding unrestricted registration whilst the allegations are resolved.

5. Matters of this kind, which would normally already be under investigation by the police, would include very serious alleged offences including murder, attempted murder, human trafficking, blackmail, manslaughter, rape, attempted rape, sexual assault and sexual abuse of children. Relevant offences may include abuse of children through grooming, prostitution or pornography and any offence by an adult relating to a child under 13 or person with a mental disorder impeding choice under the Sexual Offences Act 2003, Sexual Offences Act

(Scotland 2010) and Sexual Offences (Northern Ireland) Order 2008. Police investigations into other matters may also suggest that a referral to an Interim Orders Panel is appropriate, depending on the individual circumstances of the case.

6. It may also be in the interests of public safety and public confidence to refer matters to the IOP where a doctor is alleged to have breached the guidance on relationships with patients in Good Medical Practice. Where there is evidence to suggest a doctor has used their professional position to establish or pursue a sexual or improper relationship with a patient or someone close to them (paragraph 32, GMP) this is a strong indicator that a referral is appropriate.

7, There are also circumstances in which failure to comply with the GMC's Guidance for Doctors on Maintaining Boundaries (2006) may suggest that it is necessary to refer the doctor to the IOP, depending on the individual circumstances of the case. A referral is very likely to be indicated if the initial allegations feature one or more of the following factors:

a. Failure to obtain informed consent before undertaking an intimate examination, particularly where the examination is not clinically indicated.

b. Failure to offer a chaperone for an intimate examination or failure to make arrangements to ensure a chaperone is present throughout, where this has been requested by the patient.

c. Failure to maintain professional boundaries when undertaking an examination which the patient may perceive to be intimate particularly where this involves examination of breasts, genitalia and rectum but depending on the circumstances may also include any examination where it is necessary to touch or even be close to the patient.

d. Failure to treat the patient with dignity or allow them privacy when getting dressed or undressed, including unnecessary personal comments, particularly where this has been perceived to be sexually motivated.

e. Sexualised behaviour towards the patient including any acts, words or behaviour designed to arouse or gratify sexual impulses and desires.

f. Pursuing a sexual relationship with a former patient, where at the time of the professional relationship the patient was vulnerable, for example because of their mental health problems or lack of maturity.

6. The point at which doctors who are the subject of criminal investigations should be referred to an Interim Orders Panel is flexible and will depend on all the circumstances of the case.

Cases involving a breach of conditional registration or of undertakings to limit practice

7. These are cases where the doctor has breached restrictions imposed on his or her registration or has broken undertakings to the GMC to limit his or her practice. Examples would include:

a. The doctor breaches conditions imposed by the Fitness to Practise panel or the IOP.

b. The doctor breaches agreed undertakings.

c. The doctor refuses to co-operate with a performance or health assessment, or prevaricates or falls ill temporarily so that completion of the assessment or medical examination is delayed.

8. The Interim Orders Panel has a duty to act to protect members of the public and the wider public interest. It is therefore important that cases are referred as soon as information becomes available suggesting that the doctor's registration needs to be restricted on an interim basis. It will not always be possible to gather all the evidence that might potentially be available before referring the matter to a panel.

9. The Interim Orders Panel will make no finding of fact but the complaint must be credible and backed up where possible by corroborative evidence although the lack of corroborative evidence should not be a bar in itself to a referral to an Interim Orders Panel. The complainant may not be in a position to provide such evidence at this early stage.

[1] Rules 41(3), (4) and (6) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 as amended by The General Medical Council (Fitness to Practise) (Amendment in Relation to Standard of Proof) Rules Order of Council 2008 and The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009 (also referred to as the "Rules")

[2] Rule 6 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

[3] Rule 8(6) of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended and section 35C(8) of the Medical Act 1983, as amended

[4] The guidance set out in the Annex was developed, and agreed by the Fitness to Practise Committee, to assist Case Examiners in deciding whether a case should be referred to the IOP.

[5] S41(2) Medical Act 1983 as amended

[6] The relevant Court means the Court of Session where a doctor's registered address is in Scotland, the High Court in Northern Ireland where a doctor's registered address is in Northern Ireland and the High Court in England and Wales for all others Where reference is made to the High Court in this document it includes the Court of Session and the High Court in Northern Ireland.

[7] Section 41A(4) of the Medical Act 1983 as amended

[8] Rule 26(1) of the The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

[9] Rule 40 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended) and Paragraph 8 of Schedule 4 to the Medical Act 1983, as amended

[10] Rule 40 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

[11] Rule 31 of The General Medical Council (Fitness to Practise Rules Order of Council 2004 (as amended)
Subsequent reviews normally take place every six months. The Panel may, however, impose a shorter period of time within which a review must be heard, if it considers it appropriate in all the circumstances of the case.

[12] Rule 29(2) and (3) of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

[13] Rule 27(2) of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

[14] Section 41A(3) of the Medical Act 1983, as amended.