

To consider

Sanctions Guidance for MPTS fitness to practise panels and GMC decision makers

Issue

- 1 Following a public consultation which concluded on 14 November 2014, we have updated the guidance used by Medical Practitioner Tribunal Service fitness to practise panels and GMC decision makers.

Recommendation

- 2 The Strategy and Policy Board is asked to agree the amendments to the Sanctions Guidance.

Sanctions Guidance for MPTS fitness to practise panels and GMC decision makers

Issue

- 3 Following a public consultation which ended on 14 November 2014, we have made revisions to the Sanctions Guidance, at Annex A.
- 4 The Sanctions Guidance has been updated in line with the recommendations agreed by the Strategy and Policy Board on 3 February 2015, and Council on 24 February 2015.

Proposals not being taken forward

- 5 We proposed providing guidance on taking the appropriate action without being influenced by the personal consequences for the doctor. We have not taken this proposal forward but have clarified that, in considering the personal consequences for the doctor, Medical Practitioner Tribunal Service fitness to practise panels (MPTS FtP panels) should ensure that any sanction they impose provides the safeguard required to protect the public.
- 6 We have also not taken forward proposals for panels to direct an apology where a patient has been harmed. However, we have provided guidance on the extent to which an apology is evidence of insight.

Key changes made to the guidance

- 7 We have provided additional guidance to make clear that where a doctor's fitness to practise is found impaired it will only be in exceptional circumstances that a MPTS FtP panel would take no action.
- 8 We have provided a definition of remediation, and advised that in a small number of cases, concerns may be so serious or persistent that remediation is not possible and, notwithstanding steps taken subsequently by the doctor, action will be required to protect the public interest.
- 9 We have provided panels with further guidance on the cases which indicate more serious action is likely to be required, specifically where a doctor fails to raise concerns; fails to work collaboratively with colleagues; exhibits predatory behaviour; or discriminates against patients, colleagues and other people. The updated guidance also outlines the aggravating factors which indicate more serious action is required in cases involving addiction or misuse of alcohol or drugs.
- 10 The updated Sanctions Guidance details the factors which may lead to more serious action where certain issues arising in a doctor's personal life undermine the public's trust in doctors, for example misconduct involving violence or offences of a sexual nature.

- 11** We have provided a definition of insight in the updated guidance, and have set out behaviours that demonstrate insight. This includes apologising to complainants as soon as is practicable.
- 12** The updated guidance identifies the stage of a doctor's UK medical career and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently as a mitigating factor.
- 13** We have also expanded our guidance on the relevant factors to consider when deciding on the length of a doctor's suspension, highlighting that the risk to patient safety and seriousness of the concerns is the primary consideration. This will support consistent decisions on length of suspension.

Further changes to be implemented

- 14** We intend to develop work to progress further changes during 2015 and will bring these to the Strategy and Policy Board in due course. These will include:
 - a** Exploring our role in facilitating meetings between doctors and patients in appropriate cases.
 - b** Developing our model of warnings to ensure a proportionate approach and address gaps in our ability to take action.
 - c** Introducing a robust verification process to check the authenticity of testimonials, and providing guidance on the factors that increase the relevance of testimonials to a panel decision.
 - d** Developing a process for routinely requesting a statement from a doctor's responsible officer for panels to consider at a hearing.
 - e** Providing supplementary guidance on how doctors should keep their clinical skills up to date when not working.
 - f** Considering the type of cases where a previous interim suspension order may be relevant to a panel's decision on substantive suspension.

Next steps

- 15** The revised Sanctions Guidance will be brought to Council for approval at its meeting on 23 April 2015, with a view to implementation in August 2015.
- 16** There is a GMC commissioned review underway on whistleblowing and proposals for a review by Professor Sir Bruce Keogh, Medical Director of NHS England, as an outcome of the Morecambe Bay Investigation. The Sanctions Guidance will be reviewed in the future should either of those reviews identify the need for further changes.

Supporting information

How this issue relates to the corporate strategy and business plan

- 17** Strategic Aim 2: to give all our key interest groups confidence that doctors are fit to practise. To achieve this, it is crucial that the action we take in response to concerns about doctors is perceived as fair, proportionate and adequate to protect the public and maintain confidence in the medical profession

How the issues support the principles of better regulation

- 18** The guidance used by MPTS FtP panels supports transparent and consistent decision making. The development of new guidance is expected to help to ensure the action we take is targeted and proportionate.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

- 19** This work was taken forward by a project board chaired by the Chair of the MPTS and included staff from the MPTS and other parts of the GMC. MPTS panellists and GMC/MPTS staff were provided with an opportunity to input via a series of policy workshops, drop-in sessions, webinars, teleconferences and a survey during 2014.
- 20** During the consultation we hosted a microsite on the website using case studies to gather views from respondents on the key themes in the consultation. 1600 responded to the case scenarios on the microsite. We held five national stakeholder events (London, Edinburgh, Manchester, Belfast and Cardiff), introduced by the Chair of the MPTS reaching around 120 people, and our Regional Liaison Service organised 16 further events across the country, obtaining the views of around 225 people. In addition to this, we engaged with 42 Responsible Officers through the Responsible Officer Reference Group to seek their views.

What equality and diversity considerations relate to this issue

- 21** We have considered the three aims of the equality duty at each stage of updating the guidance.
- 22** We have considered the potential impact of the updated guidance on people from protected groups. The changes may have a disproportionate impact on groups of doctors who are already overrepresented in our procedures, for example, male doctors, doctors who qualified overseas, doctors from a BME background, and older doctors. Some of these changes will be helpful to those groups, for example the guidance to panels to consider the stage of a doctor's UK medical career as a mitigating factor. Other changes may have a less favourable impact on these groups, for example:

- a** Guidance on the cases where more serious action is likely to be required.
 - b** Taking action to protect public confidence where necessary, notwithstanding any remediation.
 - c** Taking action where certain issues arise in a doctor's personal life.
- 23** We have given this careful consideration, but in view of the nature of these concerns, we consider that any potential impact is justified by the role this will play in protecting patient safety and public confidence in doctors.
- 24** We also recognise that some of these changes may have a disproportionate impact on unrepresented doctors, many of whom share a number of the characteristics that increase the likelihood of a doctor being involved in our fitness to practise procedures. To mitigate the impact on this group, we will work closely with the MPTS to ensure that unrepresented doctors are provided with detailed guidance to support them through the hearing process.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director of Policy, Business Transformation and Safeguarding, arowland@gmc-uk.org, 020 7189 5077.

**7 - Sanctions Guidance for MPTS fitness to practise panels
and GMC decision makers**

**General
Medical
Council**

Annex A

Revised Sanctions Guidance

Sanctions Guidance for the Fitness to Practise Panel

(August 2015)

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Introduction

Role and status of the Sanctions Guidance

1 This guidance has been approved by the Council of the General Medical Council (GMC). The steering group which developed the amended guidance was chaired by His Honour David Pearl, Chair of the Medical Practitioner Tribunal Service (MPTS) and involved staff from the MPTS and the GMC's Fitness to Practise directorate. It is for use by fitness to practise panels in cases that have been referred to the MPTS for a hearing when considering what sanction to impose following a finding that the doctor's fitness to practise is impaired. It also contains guidance on the issue of warnings where a panel has concluded that the doctor's fitness to practise is not impaired. It outlines the purpose of sanctions and the factors to be considered. The Sanctions Guidance is an authoritative statement of the GMC's approach to sanctions issues.

2 The guidance is also available to our other decision makers when deciding whether to refer a case to a hearing.

3 The guidance is a 'living document', which will be updated and revised as the need arises.

The GMC's statutory purpose

4 The statutory purpose of the GMC is to protect, promote and maintain the health and safety of the public. It does this through the four main functions given to it under the Medical Act 1983 as amended (the Act):

- keeping up-to-date registers of qualified doctors
- fostering *Good medical practice*
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC's role in setting standards

5 The GMC has a statutory role in advising doctors on standards of professional conduct, performance and medical ethics. Its core guidance, *Good medical*

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*practice*¹, sets out the principles and values which society and the profession expects of all doctors throughout their careers.

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6 *Good medical practice* is supported by a range of explanatory guidance², which expands on one or more of its high level principles. The explanatory guidance includes guidance on fundamental ethical principles that most doctors will use every day, like consent and confidentiality. It also includes guidance that every doctor needs to know about and follow, even though they may not use it regularly in their day to day work, on areas such as end of life care, leadership and management, raising concerns and children/young people. We also have a range of shorter guidance documents that may be more relevant to doctors working in certain specialties, or about specific situations some doctors may face during the course of their career.

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7 *Good medical practice*, together with the explanatory guidance on specific issues (for example consent, prescribing, acting as an expert witness, personal beliefs etc.) underpins the GMC's functions and the current structures and processes for healthcare regulation, service provision and inspection.

8 Doctors are responsible for being familiar with and following the guidance and must use their judgement to apply the principles to the various situations they will face as doctors, whether or not they hold a licence to practise, whatever field of medicine they work in and whether or not they routinely see patients. Doctors must be prepared to explain and justify their decisions and actions. Failure to follow the guidance could put a doctor's registration at risk.

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9 Failure to follow *Good medical practice* does not automatically mean we will take action. The standards guidance sets out the principles of good practice, not thresholds at which we think a doctor is unsafe to work.

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10 If a concern is raised about a doctor, we use *Good medical practice* and any supplementary guidance as a benchmark and consider any mitigating or aggravating factors. We take action where a serious or persistent breach of the guidance has put patients at risk or undermined public confidence in doctors. The purpose of any action taken is to protect the public by helping to make sure doctors on our register provide safe care and to uphold public confidence in doctors. It is not our role to punish or discipline doctors.

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¹ http://www.gmc-uk.org/guidance/good_medical_practice/index.asp. Previous and no longer current editions of *Good medical practice* are at <http://www.gmc-uk.org/guidance/archive/index.asp>

² http://www.gmc-uk.org/guidance/ethical_guidance/index.asp

11 The role of this guidance is to ensure a consistent approach by panels to dealing with concerns. It provides a crucial link between two key regulatory roles of the GMC: that of setting standards for the profession; and of taking action when a doctor's fitness to practise is called into question because those standards have not been met. It also ensures that the parties are aware from the outset of the approach to be taken by a fitness to practise panel to the question of sanction.

12 The medical and lay panellists appointed to sit on panels exercise their own judgement in making decisions, but must base their decisions on the standards of good practice the GMC has established. Decisions taken by panellists in relation to sanction are at their discretion, however, in making those decisions they take account of the advice provided in this guidance.

The GMC's role in maintaining public confidence in the profession⁴

13 Patients must be able to trust doctors with their lives and health, so doctors must ensure that their conduct justifies their patient's trust in them and the public's trust in the profession (see *Good medical practice*, paragraph 65). Although panels should ensure the sanction they impose is appropriate and proportionate, the reputation of the profession as a whole is more important than any individual doctor⁵.

Equality and Diversity

14 The GMC and the MPTS have statutory obligations to ensure that our fitness to practise activities are fair. Anyone who is acting for the GMC and MPTS is expected to be aware of, and adhere to, the spirit and letter of equality and human rights legislation. Decision making should be consistent and impartial, and comply with the aims of the public sector equality duty.

15 Doctors must treat both colleagues and patients fairly, whatever their life choices and beliefs. Our guidance on this is at paragraphs 48, 54, 57 and of *Good medical practice*. Further guidance on the approach which should be taken where a doctor has unfairly discriminated against a person can be found at paragraphs 97-99 below.

⁴ This section will be updated with the new overarching objective, currently being progressed by the DH

⁵ Bolton v The Law Society [1993] EWCA Civ 32

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The GMC also publishes supplementary ethical guidance

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The GMC's responsibilities¶

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Publication of outcomes

16 All restrictions or requirements placed on a doctor, (with the exception of restrictions or requirements that relate to a doctor's health) are published on the GMC's website via the List of Registered Medical Practitioners⁷. Copies of the record of determinations of fitness to practise panel hearings held in public are also available on the MPTS website for approximately twelve months after the conclusion of the hearing.

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General principles regarding sanctions

The purpose of sanctions and the public interest

17 The purpose of sanctions is to, amongst other things:

- a protect the public
- b maintain public confidence in the profession
- c declare and uphold proper standards of conduct and behaviour.

18 The purpose of sanctions is therefore not to be punitive but to protect patients and the wider public interest, although they may have a punitive effect.

Proportionality

19 In deciding what sanction, if any, to impose the panel should consider the sanctions available starting with the least restrictive and have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. Sanctions can sometimes have an unintended punitive effect on an individual doctor and the personal consequences for the doctor will be one of a number of factors panels take into account. However ensuring that a sanction provides the minimum safeguard necessary to protect the public will be a priority.

20 Any sanction and the period for which it is imposed must be necessary to protect the public interest (see paragraphs 17-18). In making their decision on the appropriate sanction, panels need to be mindful that they do not give undue weight to whether or not a doctor has previously been subject to an interim order for conditions or suspension imposed by the interim orders

⁷ <http://www.gmc-uk.org/register/search/index.asp>

panel, or the period for which that order has been effective. Panels need to bear in mind that the interim orders panel makes no findings of fact and that its test for considering whether or not to impose an interim order is entirely different from the criteria used by fitness to practise panels when considering the appropriate sanction. It is for this reason that an interim order and the length of that order are unlikely to be of much significance for panels. Further detail about the test applied when considering the imposition of interim orders is set out in the [guidance for imposing interim orders](#)¹².

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21 These factors should be taken into account when considering the appropriate sanction to impose on a doctor's registration. While there may be a public interest in enabling a doctor's return to safe practice, and this should be facilitated where appropriate, the primary concern of a panel is the protection of the public and the wider public interest (i.e. maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour).

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22 Further guidance on the factors to bear in mind when considering specific sanctions is set out in paragraphs 50-139.

Aggravating and mitigating factors

23 In any case before them, the panel will need to have due regard to any evidence presented by way of mitigation by the doctor. Mitigation might be considered in five categories:

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a evidence of the doctor's understanding of the problem or insight, and his/her attempts to address or remediate it. This could include admission of the facts relating to the case, any apology by the doctor to the complainant/person in question (see also paragraphs 38-43), his/her efforts to prevent such behaviour recurring or efforts made to correct any deficiencies in performance or knowledge of English.

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b evidence of the doctor's overall adherence to important principles of good practice (i.e. keeping up to date, working within his/her area of competence etc. - see also paragraph 26) and the character and previous history of the doctor. This could also include evidence that the doctor has not previously had a finding made against him/her by a previous panel or by any of the Council's previous committees.

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¹² http://www.gmc-uk.org/Imposing_Interim_Orders_Guidance_for_the_Interim_Orders_Panel_and_the_Fitness_to_Practise_Panel.pdf_28443349.pdf

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c mitigation relating to the circumstances leading up to the incidents (for example, inexperience (see paragraphs 28-30), or a lack of training and supervision at work).

d matters of personal and professional mitigation which may be advanced such as personal hardship and work related stress

e lapse of time since an incident occurred.

24 Any mitigation should be considered and balanced carefully against the central aim of sanctions; that is the protection of the public and the maintenance of standards and public confidence in the profession. The panel's ability to take personal mitigation into account is less where there is a concern about patient safety as opposed to a concern about public confidence in the profession. Similarly, where the concerns are of a more serious nature, the panel's ability to take account of personal mitigation will be reduced.

25 The GMC may wish to draw attention to aggravating factors relating to the facts found proved by the panel (and the finding of impairment), such as the circumstances surrounding the events that took place. For example, if a doctor has abused their position of trust by taking advantage of a vulnerable person (breaching paragraphs 53 and 54 of *Good medical practice*) this would be an aggravating factor. The panel should also take into account any previous findings and substantive sanctions imposed on the doctor's registration either by the GMC or any other regulator.

26 *Good medical practice* sets out what is expected of doctors and this includes being competent in all areas of their practice, keeping knowledge and skills up to date, establishing and maintaining good relationships with patients and colleagues (including those who are not doctors), being trustworthy and acting with integrity and within the law. It also requires them to be willing to take responsibility if problems arise, learn from mistakes, and work effectively as part of a team. Panellists may wish to see evidence to support a doctor's contention that he/she has taken steps to mitigate his/her actions or to prevent problems arising. Panellists may wish to note in this respect that *Good medical practice* states that doctors should (this list is not exhaustive):

a raise concerns if patients are at risk because of inadequate premises, equipment or other resources, policies or systems and put matters right where possible (*Good medical practice*, paragraph 25(b))

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b ask for advice from a colleague, defence body or the GMC if a doctor has concerns that a colleague may not be fit to practise and may be putting patients at risk. If the doctor remains concerned, he/she must report this in line with our guidance and any relevant work place policy, making a note of steps taken (Good medical practice, paragraph 25(c))

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c be open and honest with patients if things go wrong and respond promptly, fully and honestly to complaints and apologise where appropriate. Doctors must not allow a patient's complaint to adversely affect the care or treatment they provide or arrange (Good Medical Practice, paragraphs 55 and 61)

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d cooperate with any complaints procedure and/or formal inquiry into the treatment of a patient disclosing information relevant to an investigation to anyone entitled to it (Good medical practice, paragraphs 72-74)

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e keep their knowledge and skills up to date and work with colleagues and patients to improve the quality of their work and promote patient safety (Good medical practice, paragraphs 8-13 and 22-23)

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f have the necessary knowledge of English to provide a good standard of practice and care (Good medical practice, paragraph 14.1)

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27 Further guidance on considering references and testimonials and on expressions of regret and apology is set out at paragraphs 34-37.

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Considering the stage of a doctor's UK medical career

28 When a newly qualified graduate is first accepted onto the UK medical register and begins working as a doctor in the UK, they may well experience a steep learning curve as they take on new responsibilities. As a doctor's medical career progresses, panels would expect their understanding of: the social and cultural context of their work; appropriate standards; and national laws and regulations that apply to their area of work, to increase.

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29 Many doctors joining the register have previously worked, lived or were educated overseas, where different professional standards and social, ethnic or cultural norms may apply. Doctors are expected to familiarise themselves with the standards and ethical guidance that apply to practising in the UK before taking up employment, although it is recognised that experience of working as a doctor in the UK also plays a key role in their development.

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30 Panels may consider the stage of a doctor's UK medical career, and whether they are new to the UK register, when making decisions. Whether they have gained insight (see paragraphs 38-43) once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience, may be a mitigating factor. However, in cases involving serious concerns about a doctor's performance or conduct (for example, predatory behaviour to establish a relationship with a patient (see paragraphs 105-106), or serious dishonesty (see paragraphs 129-136)), the stage of a doctor's UK medical career will have limited influence on a panel's decision on what action to take. Serious poor practice or misconduct is not acceptable simply because the doctor is inexperienced.

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Remediation

31 Remediation is the process of addressing concerns (knowledge, skills, conduct, behaviour). Remediation can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive).

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32 In most cases, where a doctor has successfully remediated concerns, and has made sure they do not pose a risk to future patients or confidence in the profession, further action is unlikely to be necessary. However, there are a small minority of very serious cases where a doctor's failings may be so serious or persistent that, notwithstanding steps subsequently taken, remediation is not possible and action will need to be taken to protect the public interest. In these cases, where the doctor knew, or should have known, that they were causing harm to patients and taken steps earlier to prevent this, the panel should consider action to maintain public confidence.

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33 In such cases the panel must fully and clearly explain:

a the extent to which the concerns are capable of being remediated

b the steps the doctor has taken

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c how the seriousness of the concerns, including failure to take steps earlier, justifies taking action, notwithstanding the steps subsequently taken.

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References and testimonials

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34 The doctor may present references and testimonials as to his/her standing in the community or profession. Panels should consider, where these have been provided in advance of the hearing, whether the authors are aware of the

events leading to the hearing and what weight, if any, to give to these documents.

- 35** As with other mitigating or aggravating factors, any references and testimonials will need to be weighed appropriately against the nature of the facts found proved. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend on the standing of a practitioner. There may be cultural reasons for not requesting them and the panel should also be aware of this. In addition, acquiring references and testimonials may pose a difficulty for doctors who qualified outside the UK, and who are newly arrived in the UK. The panel will need to consider all such factors when looking at references and testimonials.

Expressions of regret and apology

- 36** When things go wrong and a patient under a doctor's care has suffered harm or distress there are a number of expectations on behalf of the profession and the public (*Good medical practice, paragraphs 55 and 61*); that doctors should:

- a** take steps to prevent similar events reoccurring,
- b** take positive steps to learn from their mistakes, and
- c** be open and honest and apologise when things go wrong.

- 37** Apologising does not of itself amount to an admission of legal liability or breach of statutory duty (*Section 2, Compensation Act 2006¹³*).

Insight

- 38** Expressing insight involves a demonstration of genuine reflection and remediation.

- 39** A doctor is likely to have insight if they:

- a** accept they should have behaved differently (showing empathy and understanding)

¹³ <http://www.legislation.gov.uk/ukpga/2006/29/contents>

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Deleted: *Good medical practice* provides the following guidance at paragraph 55 and 61 to doctors when things go wrong:¶
<#>¶
<#>"55 . You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress you should:¶
<#>¶
<#>put matters right (if that is possible)¶
<#>¶
<#>offer an apology¶
<#>¶
<#>explain fully and promptly what has happened and the likely short-term and long-term effects¶
<#>¶
<#>61 . You must respond promptly, fully and honestly to complaints and apologise when appropriate.¶
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This reflects

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Deleted: <#>The duty to "offer an apology" where appropriate reflects that, in our society, it is almost always expected that a person will apologise when things go wrong. . However, to some individuals (and this may or may not depend on the ...

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b take timely steps to remediate (see paragraphs 31-33) and apologise at an early stage before the hearing, and

Deleted: that it is expected that he/she will

c consistently demonstrate insight.

Deleted: prevent a reoccurrence - is an important factor in a hearing.

40 A doctor is likely to lack insight if they:

a refuse to apologise or accept their mistakes

b promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing

c do not consistently demonstrate insight, or

d fail to tell the truth during the hearing.

Deleted: When assessing whether a doctor has insight the panel will need to take into account whether he/she has demonstrated insight consistently throughout the hearing, eg has not given any untruthful evidence to the panel or falsified documents. But

41 However, the panel should be aware that there may be cultural differences in the way that insight is expressed. For example, how an apology or expression of regret is framed and delivered and the process of communication. This may also be affected by the doctor's circumstances, for example, their ill health.

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¶ <#>how a doctor frames his/her 'insight'¶

¶ <#>whether or how a doctor offers an apology, and¶

¶ the doctor's demeanour and attitude during the hearing.

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42 Cross-cultural communication studies show that there are significant variations in the way that individuals from different cultures and language groups communicate. This is particularly the case when using a second language, where speakers may use the conventions of their first language to frame and structure sentences, often translating as they speak. this may be reflected in the intonation adopted. As a result, the language convention, subtleties or nuances of the second language may not be reflected. In addition, there may be differences in the way that individuals use non-verbal cues to convey a message, including eye contact, gestures, facial expressions and touch.

43 Awareness of, and sensitivity to, these issues are important in determining how a doctor frames his/her insight.

Doctors' lives outside medicine

44 Doctors must make sure their conduct justifies their patients' trust in them and the public's trust in the profession (Good medical practice, paragraph 65). Doctors are expected to act with honesty and integrity and uphold the law and any serious or persistent failure in this regard will put their

Deleted: <#>The main consideration for the panel therefore, is to be satisfied about patient protection and the wider public interest and that the doctor has recognised that steps need to be taken, and not the form in which this insight may be expressed.¶

registration at risk. Set out below are aggravating factors in relation to a doctor's conduct in their personal life that is likely to lead the panel to consider taking more serious action (this list is not exhaustive):

Deleted: Where the following factors arise in a doctor's

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a misconduct involving violence or offences of a sexual nature (see paragraphs 107-108)

b concerns about their behaviour towards children or vulnerable adults (see paragraphs 103-104 and 109-117)

c concerns about probity (being honest and trustworthy and acting with integrity) (see paragraphs 129-136)

d misuse of alcohol or drugs leading to a criminal conviction or caution (see paragraphs 118-120)

e a doctor unfairly discriminating in relation to characteristics protected by law: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation. (see paragraphs 97-99).

Where no impairment is found

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45 Where a panel finds a doctor's fitness to practise is **not** impaired, the following options are available:

f no action

g issue a warning.

Warnings

Comment [KT3]: Move to benchbook

46 If the panel finds that the doctor's fitness to practise is not impaired, it may issue the doctor with a warning as to his/her future conduct or performance, with reference to the facts found proved. A warning may be issued where there has been a significant departure from *Good medical practice*. Warnings are not appropriate in cases relating solely to a doctor's health and/or knowledge of English, but may be issued in multi-factorial cases in which health or knowledge of English is raised as one the issues.

Deleted: <#> In the interests of fairness to both parties, panels should invite submissions from the GMC and the doctor on whether a warning should be issued before considering whether to conclude the case with no action or a warning. ¶

Deleted: ; or there is a significant cause for concern following an assessment of the doctor's performance or knowledge of English

47 Further guidance on the purpose of warnings, the factors to take into account when considering whether to impose a warning and the

circumstances in which a warning might be appropriate is set out in the Guidance on Warnings¹⁵.

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48 When considering the wording of a warning, panels should have regard to the Guidance on Warnings.

49 It is important that panels give clear reasons for issuing, or for not issuing, a warning.

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Where impairment is found

Comment [KT4]: Move to benchbook

50 Where a panel finds a doctor's fitness to practise is impaired, the following options are available to the panel:

Deleted: <#>Warnings are disclosed to any person or body who brought the allegation to the attention of the GMC, the practitioner's employer, and any other enquirer. They are published via the GMC's website on the List of Registered Medical Practitioners for a five-year period.¶

a take no action (see paragraph 52)

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b impose conditions on the doctor's registration for a period up to three years (see paragraphs 60-71)

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c direct that the doctor's registration be suspended for up to 12 months (see paragraphs 72-85)

Deleted: 69 - 76

d direct erasure of the doctor's name from the register, except in cases that relate solely to a doctor's health and/or knowledge of English language (see paragraphs 86-90).

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e Panels may agree as an alternative to imposing any sanction any written undertakings (including any limitations on his/her practice) offered by the doctor (see paragraphs 55-59).

Comment [KT5]: Move to benchbook

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¶ Before moving to a vote the panel should ensure that it fully discusses the case, the submissions made by both parties as to the appropriate sanction and all the options available to it. The submissions made by both parties are just that, submissions; the final decision as to the appropriate sanction is for the panel alone to make operating within the relevant legislation

51 It is important that the panel's determination on sanction makes clear that it has considered all the options and provides clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. This is particularly important, where it is lower, or higher, than that suggested by this guidance and where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why a particular period of sanction was considered necessary.

Deleted: ¹⁶ and the framework set out by the Indicative Sanctions Guidance.¶
¶

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Deleted: http://www.gmc-uk.org/Guidance_on_Warnings.pdf_27286909.pdf

¹⁵ http://www.gmc-uk.org/Guidance_on_Warnings.pdf_25416870.pdf,

No action

52 Where a doctor's fitness to practise is impaired there is an expectation that action will be taken in order to protect the public interest (protection of patients, maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour, see paragraphs 17-18).

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Exceptional circumstances

53 There may be exceptional circumstances in which a panel might be justified in taking no action. Exceptional circumstances will be those which are unusual, special or uncommon. Such cases are therefore likely to be very rare. Where a panel has made a finding of impairment, they will have taken account of a doctor's level of insight, any remediation, and mitigation. These factors must be present when a panel decides to take no action, but as they are not unusual, special or uncommon, they are unlikely on their own to justify a panel's reasons for taking no action

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54 In cases where a panel decides not to take action following a finding of impairment, based on exceptional circumstances, the panel's determination must fully and clearly explain:

a what the exceptional circumstances are

b why the circumstances are exceptional, and

c how the exceptional circumstances justify taking no further action.

Undertakings

55 The Rules¹⁷ provide that a panel may agree, as an alternative to imposing any sanction, written undertakings offered by the doctor. These undertakings must be sufficient to protect patients and the public interest, and the doctor must agree that the Registrar may disclose the undertakings (except those relating exclusively to the doctor's health) to:

a his/her employer or anyone with whom he/she is contracted or has an arrangement to provide medical services

¹⁷ Rule 17(2)(m) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

- b anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and
- c any other person enquiring.

56 Undertakings may include restrictions on the doctor's practice or behaviour, or the commitment to undergo medical supervision or re-training. As with conditions (see paragraphs 60-71), they are likely to be appropriate where the doctor has the insight to limit his/her practice and the concerns about the doctor's practice are such that a period of retraining, and/or supervision is likely to be the most appropriate way of addressing them.

57 Undertakings will only be appropriate where the panel is satisfied that the doctor has shown insight and will comply with them, and the doctor has the potential for remediation. The panel may wish to see evidence that the doctor has taken responsibility for his/her own actions and/or otherwise taken steps to mitigate his/her actions (see also paragraphs 23-33, above).

58 The GMC has published separate guidance, 'Undertakings at FTP hearings',¹⁸ which panels should consider when deciding whether to accept undertakings.

59 Panellists should ensure that any undertakings are appropriate, proportionate, are sufficient to protect patients and the public, and are an effective way of addressing the concerns about the doctor. Undertakings should normally follow the format of the standard undertakings in the bank of undertakings¹⁹.

Conditional registration (maximum 3 years)

60 Conditions may be imposed up to a maximum of three years in the first instance, renewable in periods up to 36 months thereafter. This sanction allows a doctor to practise subject to certain restrictions or requirements (for example, restriction to NHS posts or no longer carrying out a particular procedure). Conditions are likely to be appropriate where the concerns about the doctor's practice are such that a period of retraining and/or supervision is likely to be the most appropriate way of addressing them.

61 Conditions might be most appropriate in cases involving the doctor's health, performance, following a single clinical incident where there is evidence of shortcomings in a specific area or areas of the doctor's practice, or where a

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Deleted: <#> Undertakings relating to a doctor's practice are published on the List of Registered Medical Practitioners on the GMC's website (save those relating exclusively to the doctor's health).¶

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Deleted: , or where the doctor has the insight to limit his/her practice

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Deleted: The bank comprises standard sets of undertakings, which allow for effective monitoring by the GMC and disclosure of information to any person requesting information about his/her registration status.

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Deleted: ¶ <#> Where a panel accepts undertakings, the Registrar will monitor the doctor's progress and consider any new information received in relation to them, including representations from the doctor or otherwise to suggest that the undertakings are no longer appropriate. The Registrar will consider any breaches of undertakings or information indicating further concerns about the doctor's fitness to practise and will refer for a review hearing if appropriate. Further detail about the post-hearing procedure is provided in the guidance on Undertakings at FTP hearings and also the separate ...

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¹⁸ http://www.gmc-uk.org/Undertakings_at_FTP_Panel_hearings_Aug_09.pdf 26870331.pdf

¹⁹ http://www.gmc-uk.org/Undertakings_Bank.pdf 25416205.pdf

doctor lacks the necessary knowledge of English to practise medicine without direct supervision. Panels will need to be satisfied that the doctor has displayed insight into his/her problems, and that there is potential for the doctor to respond positively to remediation/retraining and to supervision of his/her work.

62 The purpose of conditions is to enable doctor to deal with his/her health issues and/or remedy any deficiencies in his/her practice or knowledge of English while, in the meantime protecting patients from harm. In such circumstances, conditions might include requirements to work under supervision.

63 When assessing whether remedial training is possible, the panel will need to consider any objective evidence submitted, For example, reports on the assessment of the doctor's performance, health, or knowledge of English or evidence submitted on behalf of the doctor, or that is otherwise available to them, about the doctor's practice, health or knowledge of English.

64 The objectives of any conditions should be made clear so that the doctor knows what is expected of him/her and so that a panel, at any future review hearing, is able to ascertain the original shortcomings and the exact proposals for their correction. Only with these established will it be able to evaluate whether they have been achieved. Any conditions should be appropriate, proportionate, workable and measurable.

65 When deciding whether conditions might be appropriate the panel will need to satisfy itself that most or all of the following factors (where applicable) are present (having regard to the type of case: health; language; performance; misconduct etc.) This list is not exhaustive:

- a** no evidence of harmful deep-seated personality or attitudinal problems
- b** identifiable areas of the doctor's practice in need of assessment or retraining
- c** potential and willingness to respond positively to retraining, in particular evidence of the doctor's commitment to keeping his/her knowledge and skills up to date throughout his/her working life, improving the quality of his/her work and promoting patient safety (*Good medical practice*, paragraphs 7-13 "Knowledge, Skills and Performance" and 22-23 regarding "Safety and Quality")
- d** willingness to be open and honest with patients if things go wrong (*Good*

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Deleted: ²², Panels will need to take this guidance into account bearing in mind that where the issues relate to misconduct or a criminal conviction, knowledge of English or untreated health problems, signposting a doctor to seek support from their Responsible Officer is not an appropriate way forward as they are not able to provide remedial help in such circumstances.¶
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Before imposing conditions the panel should satisfy itself that:¶
<#>¶
<#>the problem is amenable to improvement through conditions or, in cases involving the doctor's health, whether his/her medical condition can be appropriately managed¶
<#>¶
<#>a future panel will be readily able to determine whether the objective has ...

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medical practice, paragraphs 55 and 61)

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e in cases involving health issues, evidence that the doctor has insight into any health problems, has been compliant with the GMC's guidance on health (*Good medical practice*, paragraphs 28-30) and that he/she will abide by conditions relating to his/her medical condition(s), treatment and supervision

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f patients will not be put in danger either directly or indirectly as a result of conditional registration itself

g it is possible to formulate appropriate and practical conditions to impose on registration.

66 Where a panel has found a doctor's fitness to practise impaired by reason of adverse physical or mental health the conditions should include medical supervision of the doctor as well as supervision at his/her place of employment. Generally, it is inappropriate to impose conditions regarding medical supervision if the doctor's fitness to practise has not been found impaired by reason of adverse physical or mental health. An exception would be a case where a doctor has refused to undergo a health assessment.

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67 Conditions should normally follow the format of conditions as set out in the FTP Conditions Bank²³. Panellists may also find it helpful to refer to the definitions of the roles of individuals involved in doctors' supervision in the Glossary of terms [that accompanies the conditions and undertakings banks](#)²⁴.

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68 The ~~Conditions Bank~~ has been developed to indicate appropriate wording for restrictions ~~or requirements on~~ a doctor's practice (which are published) and for their treatment (which are not published). It is important that panels follow the suggested wording in the bank, where possible, and to maintain a clear distinction between practice and treatment conditions. If practice conditions are imposed that contain a reference to the treatment of a doctor's health, real practical difficulties are caused by the conflict between the GMC's duty to publish practice restrictions ~~and requirements~~ and the desirability of maintaining medical confidentiality for the doctor.

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69 It is, of course, open to panels to impose conditions that are not set out in the conditions bank, as appropriate, in the circumstances of the particular case while taking account of the general principles outlined above.

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²³ http://www.gmc-uk.org/FTPP_Conditions_Bank.pdf_25415696.pdf

²⁴ http://www.gmc-uk.org/Glossary_of_Terms_used_in_Fitness_to_Practise_Actions.dot.pdf_25416199.pdf

70 As any conditions will need to be reviewed, a review hearing should be directed where conditions are imposed. Further guidance about review hearings is set out at paragraphs 140-144.

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71 Panels should also consider, as required by Rule 17(2)(o)²⁵, whether the conditions imposed should take effect immediately. When doing so panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Panels should explain fully the reasons for any decision reached. Further guidance on when an immediate order might be appropriate is set out at paragraphs 145-149.

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Suspension (up to 12 months but may be indefinite in certain circumstances in health and/or knowledge of English only cases)

72 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbecoming a registered medical practitioner. Suspension from the register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension, although this is not its intention.

73 Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate because the panel considers that the doctor should not practise again either for public safety reasons or in order to protect the reputation of the profession). Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the panel is satisfied that the behaviour or incident is unlikely to be repeated. The panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions (see paragraphs 23-33).

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74 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that he/she has gained insight into the deficiencies and has the potential to remediate if prepared to undergo a rehabilitation or retraining programme. In such cases, to protect patients and the public interest, the panel might wish to impose a period of

²⁵ General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

suspension. ~~The suspension will need to be reviewed and therefore, a review hearing should be directed. Such a direction should~~ indicate in broad terms the type of ~~action and evidence of remediation, (such as complying with any invitations from the GMC to undergo a performance assessment or English Language assessment)~~ which, if undertaken during the period of suspension, may help the panel's evaluation at any subsequent review hearing. The panel should, however, bear in mind that during the period of suspension the doctor will not be able to practise.

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75 ~~The doctor~~ may, however, have contact with patients similar to that of a final year medical student, i.e. under the supervision of a fully registered medical practitioner, **and** provided that the patients have been informed of the doctor's registration status, the events which resulted in the suspension of the doctor's registration and have given their full consent.

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Determining the length of suspension

76 The length of the suspension may be up to 12 months and is a matter for the panel's discretion, depending on the gravity of the particular case.

77 ~~The following factors will be relevant when determining the length of suspension:~~

Deleted: Panels should consider the following

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a ~~the risk to patient safety~~

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b ~~the seriousness of the concerns and any mitigating or aggravating factors (as set out in paragraphs 23-33)~~

c ~~ensuring the doctor has adequate time to remediate~~

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78 The Panel's primary consideration should be the ~~risk to patient safety and the seriousness of the concerns. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a~~ factor.

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79 ~~The table below sets out examples of aggravating factors that will also be relevant to the length of suspension, under broad categories, depending on the nature of the case:~~

Deleted: As detailed above, when determining the seriousness of the concerns, panels should consider any aggravating factors.

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Knowledge, skills and performance

- The extent of the doctor's reckless behaviour
- The extent to which the doctor departed from principles of *Good medical practice*
- Whether the doctor is reluctant to take remedial action

Communication, partnership and teamwork

- Whether the doctor is reluctant to apologise
- The extent to which the doctor failed to comply with restrictions/requirements

Safety and quality

- The extent to which the doctor failed to address serious concerns over a period of time
- The extent to which the doctor failed to take prompt action when patient safety, dignity or comfort was seriously compromised
- Whether the doctor showed a lack of responsibility toward clinical duties/patient care
- Whether the doctor showed a deliberate disregard for restrictions/requirements

Maintaining Trust

- The extent to which the doctor's actions risked patient safety or public confidence
- The extent of the doctor's significant or sustained acts of dishonesty or misconduct
- Whether the doctor failed to be open and honest with GMC and local investigations
- The seriousness of the doctor's inappropriate behaviour
- The extent of the doctor's predatory behaviour
- The impact that the doctor's actions had on vulnerable people and the risk of harm

80 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

- a serious breach of *Good medical practice* where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public interest
- in cases involving deficient performance where there is a risk to patient safety if the doctor's registration were not suspended and where the doctor demonstrates potential for remediation or retraining

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Deleted: when some or all of the following factors are apparent (this list is not exhaustive):

c in cases which relate to the doctor's health, where the doctor's judgement may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions or the doctor has failed to comply with restrictions or requirements.

d in cases which relate to knowledge of English, where the doctor's language skills impact on his/her ability to practise and there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions

e no evidence of harmful, deep-seated personality or attitudinal problems

f no evidence of repetition of similar behaviour since incident

g the panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour.

Deleted: <#>in cases which relate to the doctor's health, and where the doctor has failed to comply with any restrictions/requirements on their registration¶

81 Panels must also consider, as required by Rule 17(2)(o)²⁶, whether to direct that the doctor's registration be suspended with immediate effect. When doing so panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 145-149.

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82 Where a doctor is suspended due to concerns about their knowledge of English, a six month period of suspension is likely to be needed in the first instance. This is to provide the doctor with sufficient time to improve their language skills, and take an IELTS assessment. In cases which relate solely to either health or knowledge of English, where erasure is not available as a sanction, there are provisions to suspend a doctor's registration indefinitely where necessary– see paragraph 84.

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83 For doctors with serious health problems or insufficient knowledge of English, erasure is only an available sanction if there are also other factors (such as a conviction, misconduct or deficient performance), which have resulted in the finding of impaired fitness to practise. Suspension is appropriate where the doctor's health or knowledge of English is such that he/she cannot practise safely even under conditions. In such cases, the panel may direct a review hearing to obtain further information as to whether the doctor is then fit to resume practice either under conditions or unrestricted.

²⁶ General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

- 84** In cases which relate solely to a doctor's health or language, it is open to the panel, if the doctor's registration has been suspended for at least two years because of two or more successive periods of suspension, to suspend the doctor's registration indefinitely. If the panel decides to direct indefinite suspension there is no automatic further hearing of the case, although it is open to the doctor to request a review after a period of two years has elapsed from the date when the indefinite suspension took effect.
- 85** Panels must provide reasons for the period of suspension chosen, including the factors that led them to conclude that the particular period of suspension, whether the maximum available or a shorter period, was appropriate.

Erasure

- 86** The Panel may erase a doctor from the register in any case - except one which relates solely to the doctor's health and/or knowledge of English - where this is the only means of protecting patients and the wider public interest, which includes maintaining public trust and confidence in the profession.
- 87** Erasure may be appropriate even where the doctor doesn't present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example if a doctor has shown a blatant disregard for the safeguards designed to protect patients and maintain high standards within the profession that is incompatible with continued registration as a doctor²⁷.
- 88** Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive):
- a** a particularly serious departure from the principles set out in *Good medical practice* – the behaviour fundamentally incompatible with being a doctor
 - b** a reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
 - c** doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs [137-139](#) regarding failure to provide an acceptable level of treatment/care)

²⁷ [Gupta v GMC \(Privy Council Appeal No. 44 of 2001\)](#)

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<#>Lord Bingham, Master of the Rolls, in the case of *Bolton v The Law Society*²⁸, stated that:¶

¶

"Because orders made by the tribunal are not primarily punitive, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases. It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend again. On applying for restoration after striking off, all these points may be made, and the former solicitor may also be able to point to real efforts made to re-establish himself and redeem his reputation. All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness. Thus it can never be an objection to an order of suspension in an appropriate case that the solicitor may be unable to re-establish his practice when the period of suspension is past. If that proves, or appears likely to be, so the consequence for the individual and his family may be deeply unfortunate and

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d abuse of position/trust (see *Good medical practice*, paragraph 65 “you must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession”)

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e violation of a patient’s rights/exploiting vulnerable persons (see for example *Good medical practice*, paragraph 27 on children and young people, paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services)

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f offences of a sexual nature, including involvement in child pornography (see further guidance below at paragraphs 109-117)

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g offences involving violence

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h dishonesty, especially where persistent and/or covered up (see further guidance at paragraphs 129-136)

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i putting own interests before those of patients (see *Good medical practice* – “Make the care of your patient your first concern” at paragraph 1 and paragraphs 77, to 80 regarding conflicts of interest)

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j persistent lack of insight into seriousness of actions or consequences.

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89 When directing erasure, panels must also consider, as required by Rule 17(2)(o)³², whether to make an order suspending the doctor’s registration with immediate effect. When doing so panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 145-149.

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Erasure is not available in cases where the only issue relates to the doctor’s health or knowledge of English.¶

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90 A doctor who has been erased cannot apply to be restored to the register until five years have elapsed³³. At that stage the panel will have to decide whether the doctor is fit to resume unrestricted practice. Further guidance on doctors’ restoration to the register is provided in the Guidance for doctors on registration following erasure by a Fitness to Practise Panel³⁴.

³² General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

³³ Section 41(2)(a) Medical Act 1983 as amended

³⁴ http://www.gmc-uk.org/Guidance_for_doctors_on_restoration_following_erasure_by_a_Fitness_to_Practise_Panel.pdf_25416789.pdf

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Cases that indicate more serious action is likely to be required

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Failure to raise concerns

91 All doctors have a responsibility to promote and encourage a culture that allows all staff to raise concerns openly and safely. Doctors' duties to raise concerns are set out in *Good medical practice* (paragraphs 24-25) and in our explanatory guidance *Raising and acting on concerns about patient safety*. These duties apply to all doctors and not just those with specific management or leadership responsibilities.

92 More serious outcomes are likely to be appropriate if a doctor has concerns that they failed to raise, where:

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a there is reason to believe a colleague's fitness to practise is impaired and may present a risk of harm to patients (*Good medical practice*, paragraph 25(c))

b a patient is not receiving basic care to meet their needs (*Good medical practice*, paragraph 25(a))

c patients are at risk because of inadequate premises, equipment or other resources, policies or systems (*Good medical practice*, paragraph 25(b))

93 Where the doctor has repeatedly failed to raise concerns over an extended period of time, and/or has failed to raise concerns which present a serious risk to patient safety, panels should consider whether or not it is appropriate to remove or suspend the doctor to maintain public confidence.

Failure to work collaboratively with colleagues

94 Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in *Good medical practice* (paragraphs 35-37).

95 Colleagues include anyone a doctor works with, whether or not they are also doctors.

96 More serious outcomes are likely to be appropriate if there are serious concerns which involve:

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- [a bullying](#)
- [b sexual harassment](#)
- [c physical violence towards colleagues, or](#)
- [d unlawful discrimination \(see paragraphs 97-99\)](#)

Discrimination against patients, colleagues and other people

97 Doctors must not unlawfully discriminate against patients or colleagues by allowing their personal views to affect their professional relationships or the treatment they provide or arrange. This includes views about a patient's or colleague's lifestyle, culture, or their social or economic status, as well as the characteristics covered by equality legislation³⁵ (*Good medical practice*, paragraph 59).

98 Doctors may choose to opt out of providing a particular procedure because of their personal beliefs or values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients (see our explanatory guidance *Personal beliefs and medical practice*).

99 Discrimination is unacceptable in a modern society, undermines public confidence in doctors and is a serious risk to patient safety. **More serious outcomes are likely to be appropriate where a case involves discrimination against patients, colleagues or other people who share protected characteristics, in any circumstance, either within or outside their professional life.**

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Abuse of professional position

100 Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in *Good medical practice* (paragraph 53) and in our explanatory guidance *Maintaining a professional boundary between you and your patient* and *Ending your professional relationship with a patient*.

³⁵ The Equality Act 2010 specifies nine groups of individuals who have 'protected characteristics' which are covered by this legislation: age, disability, race, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief, sexual orientation.

101 Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them³⁶.

102 Personal relationships with former patients may also be inappropriate depending on:

- a the nature of the previous professional relationship
- a the length of time since it ended (doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them)
- b the vulnerability of the patient (see paragraphs 103-104), and
- c whether the doctor is caring for other members of the family.

Vulnerable patients

103 Where a patient is particularly vulnerable, there is an even greater onus on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:

- a presence of mental health issues
- b children and young people under 18
- c disability or frailty
- d bereavement
- e history of abuse or neglect.

104 Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient, is an aggravating factor that increases the gravity of the concern and is likely to require more serious action.

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³⁶ A definition of 'someone close to them' is provided in our explanatory guidance on maintaining a professional relationship between you and your patient (paragraph 6) available at www.gmc-uk.org/guidance/ethical_guidance/21170.asp.

Predatory behaviour

105 Where a doctor demonstrates predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):

a inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship

b use of personal contact details from medical records to approach a patient outside their doctor-patient relationship

c visiting a patient's home without an appointment or valid medical reason.

106 More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour, involves a vulnerable patient, or constitutes a criminal offence.

Sexual misconduct

107 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child pornography at paragraphs 109-117.

108 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.

Sex offenders and child pornography

109 Any doctor who has been convicted of, or has received a caution for a sexual offence listed in Schedule 3 of the Sexual Offences Act 2003 is required to notify the police ("register") under S80 of the Sexual Offences Act 2003 and may be required to undertake a programme of rehabilitation or treatment. Sexual offences include accessing and viewing or other involvement in child

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<#>Panels should note the principle set out in paragraph 53 of *Good medical practice* "You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them" and the separate guidance issued on *Maintaining Boundaries*³⁷. ¶

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*"The public, and in particular female patients, must have confidence in the medical profession whatever their state of health might be. The conduct as found proved against Dr Haikel undoubtedly undermines such confidence and a severe sanction was inevitable. Their Lordships are satisfied that erasure was neither unreasonable, excessive nor disproportionate but necessary in the ¶ public interest."*³⁸¶

pornography, which involves the exploitation or abuse of a child. Such offences seriously undermine patients' and the public's trust and confidence in the medical profession and breach a number of principles set out in *Good medical practice* (paragraph 65 regarding honesty and integrity, paragraphs 46-49 regarding establishing and maintaining partnerships with patients, particularly paragraph 47 regarding respecting their dignity, and paragraph 27 regarding children and young people).

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110 Taking, making, distributing or showing with a view to being distributed, to publish, or possession of an indecent photograph or pseudo-photograph of a child is illegal and regarded in UK society as morally unacceptable. For these reasons any involvement in child pornography by a registered medical practitioner raises the question whether the public interest demands that his/her registration be affected.

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111 While the courts properly distinguish between degrees of seriousness, any conviction for child pornography against a registered medical practitioner is a matter of grave concern because it involves such a fundamental breach of the public's trust in doctors and inevitably brings the profession into disrepute. It is therefore highly likely that in such a case, the only proportionate sanction will be erasure, but the panel should bear in mind paragraphs 19-22 and 52-90 of this guidance, which deal with the options available to the panel, and the issue of proportionality. If the panel decides to impose a sanction other than erasure, it is important that particular care is taken to explain fully the reasons and the thinking that has led it to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.

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112 The panel should be aware that any conviction relating to child pornography will lead to registration as a sex offender and possible inclusion on the Children's Barred List by the Disclosure and Barring Service under the Safeguarding Vulnerable Groups Act 2006 (as amended)³⁹. The Council has made it clear that no doctor registered as a sex offender should have unrestricted registration. The panel will therefore need to ensure that, in cases where it imposes a period of suspension, the case should be reviewed before the end of the period of suspension to consider whether a further period of suspension is appropriate or whether the doctor should be permitted to resume practice subject to conditions.

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³⁹ <http://www.legislation.gov.uk/ukpga/2006/47/contents>

113 In order to protect the public interest, the panel should consider whether any such conditions ought to include no direct contact with any patients during the period the doctor is registered as a sex offender. (Doctors may of course be registered as sex offenders following other sexual offences not related to child pornography.)

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114 The panel should also consider whether doctors registered as sex offenders should be required to undergo assessment, for example by a clinical psychologist, to assess the potential risk to patients before they may be permitted to resume any form of practice.

115 When panels are reviewing cases where the doctor has completed the prescribed period of registration as a sex offender (which is dependent on the nature and gravity of the offence) and is no longer required to register as a sex offender panels should take into account the following factors:

- a** the seriousness of the original offence
- b** evidence about the doctor's response to any treatment programme he/she has undertaken
- c** any insight shown by the doctor
- d** the likelihood of the doctor re-offending
- e** the possible risk to patients and the wider public if the doctor was allowed to resume unrestricted practice
- f** the possible damage to the public's trust in the profession if the doctor was allowed to resume unrestricted practice.

116 Each case should be considered on its merits and decisions taken in the light of the particular circumstances relating to the case.

117 Where panels have doubt about whether a doctor, no longer required to register as a sex offender, should resume unrestricted practice, the doctor should not be granted unrestricted registration.

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Drug and alcohol misuse linked to misconduct or criminal offences

- 118 Doctors are expected to act with honesty and integrity and uphold the law and any serious or persistent failure in this regard will put their registration at risk.
- 119 When a doctor is unwell, including because of drug or alcohol addiction, they must take appropriate steps to make sure this does not affect patient safety. This includes regularly reflecting on their standard of practice and the care they provide (*Good medical practice* paragraph 22(b)).
- 120 Set out below are aggravating factors in cases relating to drugs or alcohol that is likely to lead the panel to consider taking more serious action (this list is not exhaustive)
- a intoxication in the workplace or while on duty
 - b misuse of alcohol or drugs that has impacted on the doctor's clinical performance and caused serious harm to patients or put public safety at serious risk
 - c misuse of alcohol or drugs that has resulted in violence, bullying or misconduct of a sexual nature (see paragraphs 107-108)
 - d misuse of alcohol or drugs that led to a criminal conviction, particularly where a custodial sentence was imposed (see paragraphs 121-128)

Deleted: <#>Some issues relating to drug and alcohol misuse are more serious and have aggravating features, particularly where a doctor has shown a reckless disregard for patient safety. ¶
<#>Panels should consider more serious action in cases involving the following factors:¶

Other issues relevant to sanction

Considering conviction, caution or determination allegations

- 121** Convictions refer to a decision by a criminal court in the British Isles, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence.
- 122** Cautions refer to offences committed in the British Isles or elsewhere but where no court proceedings took place because the doctor has admitted the offence and criminal proceedings were considered unnecessary.
- 123** Determinations refer to decisions by another health or social care regulatory body, in the United Kingdom or elsewhere, which has made a determination

that the fitness to practise of the doctor as a member of that profession is impaired or an equivalent finding.

124 Where the panel receives in evidence a signed certificate of the conviction or determination, unless it also receives evidence to the effect that the doctor is not the person referred to in the conviction or determination, then the panel is bound to accept the certificate as conclusive evidence of the offence having been committed or the facts found by the determination. In accepting a caution, the doctor will have admitted committing the offence.

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125 The purpose of the hearing is not to punish the doctor a second time for the offences for which he/she was found guilty. The purpose is to consider whether the doctor's fitness to practise is impaired as a result and, if so, whether there is a need to restrict his/her registration in order to protect the public who might come to the doctor as patients and to maintain the high standards and good reputation of the profession. Panellists will be aware of the paragraphs in *Good medical practice* regarding the need to be honest and trustworthy, and to act with integrity (paragraphs [65-67](#)).

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126 The panel should, however, bear in mind that the sentence or sanction previously imposed is not necessarily a definitive guide to the seriousness of the offence. There may have been personal circumstances that led the court or regulatory body to be lenient. For example, the court may have expressed an expectation that the regulatory body would erase the doctor. Similarly, the range of sanctions and how they are applied may vary significantly amongst other regulatory bodies.

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127 Panels may wish to note that *Good medical practice* ([paragraph 75](#)) imposes a duty on doctors to "tell us without delay if, anywhere in the world, [they] (a) have accepted a caution from the police or been criticised by an official inquiry (b) been charged with or found guilty of a criminal offence, (c) another professional body has made a finding against [their] registration as a result of fitness to practise procedures."

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128 As a general principle, where a doctor has been convicted of a serious criminal offence or offences, they should not be permitted to resume their practice until they have satisfactorily completed their sentence⁴³.

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⁴³ **The Council for the Regulation of Health Care Professionals v General Dental Council [2005] EWHC 87 (Admin)**

Dishonesty

129 *Good medical practice*, states that registered doctors must be honest and trustworthy, and must **make sure that their conduct justifies** their patients' trust in them **and** the public's trust in the profession

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130 In relation to financial and commercial dealings *Good medical practice* also sets out that:

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"You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession." (*Good medical practice* paragraph 65)¶

"You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals" (*Good medical practice* paragraph 77)

131 *Good medical practice* (paragraphs 78-80) and our separate guidance on *Financial and commercial arrangements and conflicts of interest*⁴⁵, further emphasises the duty to avoid conflicts of interest.

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132 In relation to providing and publishing information about their services *Good medical practice* (paragraph 70) advises doctors that:

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"When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge".

133 Dishonesty, even where it does not result in direct harm to patients but is **instead** related to matters outside the doctor's clinical responsibility, **(for example, providing false statements or fraudulent claims for monies)** is particularly serious because it can undermine the trust the public place in the profession. **Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate dishonesty which is serious and/or persistent.**

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134 Examples of dishonesty in professional practice could include defrauding an employer, falsifying or improperly amending patient records or submitting or providing false references, inaccurate or misleading information on a CV and failing to take reasonable steps to ensure that statements made in formal documents are accurate. (See *Good medical practice* paragraphs 19-21 on the duty to keep clear, accurate and legible records, and paragraphs 71-74 regarding writing reports and CVs, giving evidence and signing documents;

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"...Health Authorities must be able to place complete reliance on the integrity of practitioners; and the Committee is entitled to regard conduct which ¶ undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole."⁴⁶¶

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⁴⁵ http://www.gmc-uk.org/guidance/current/library/conflicts_of_interest.asp

see also separate guidance on writing references and *Acting as a witness in legal proceedings*⁴⁷).

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135 Research misconduct is a further example of dishonesty and can include 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. Paragraph 67 of *Good medical practice* states that:

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‘You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance’.

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(see also separate guidance on *Research: Good practice in research and Consent to research*)

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136 Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 88, above).

Failing to provide an acceptable level of treatment/care

137 Cases in this category are those where a practitioner has not acted in a patient’s best interests and has failed to provide an adequate level of care, falling well below expected professional standards (set out in domains one and four of *Good medical practice* on knowledge, skills and performance and maintaining trust). In particular where a reckless disregard for patient safety or a breach of the fundamental duty of doctors to “Make the care of your patient your first concern” has been demonstrated.

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<#>Cases in this category are ones where a practitioner has not acted in a patient’s best interests and has failed to provide an adequate level of care, falling well below expected professional standards (please refer to the guidance set out at paragraphs 14 to 21, 24 to 26, 51 and 56 to 59 of *Good medical practice*, particularly where a reckless disregard for patient safety or a breach of the fundamental duty of doctors to “Make the care of your patient your first concern” have been demonstrated.¶

138 A particularly important consideration in such cases is whether or not a doctor has, or has the potential to develop, insight into these failures. Where this is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

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139 In most cases, where a doctor has successfully remediated the concerns raised about their practice, and has made sure they do not pose a risk to future patients, further action is unlikely to be necessary. However, there are a small minority of very serious cases where a doctor’s failings may be so serious or persistent as to be irremediable, even if they have subsequently

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⁴⁷ http://www.gmc-uk.org/guidance/current/library/writing_references.asp

[taken steps to try to address the concerns. In these cases, where the doctor knew, or should have known, that they were causing harm to patients and taken steps earlier to prevent this, the panel should consider action to maintain public confidence.](#)

Review hearings

140 It is important that no doctor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the panel considers that he/she is safe to do so. In some misconduct cases it may be self-evident that following a short period of suspension, there will be no value in a review hearing. In most cases, however, where a period of suspension is imposed and in all cases where conditions have been imposed the panel will need to be reassured that the doctor is fit to resume practice either unrestricted or with conditions or further conditions. The panel will also need to satisfy itself that the doctor has fully appreciated the gravity of the offence, has not reoffended, and has maintained his/her skills and knowledge and that patients will not be placed at risk by resumption of practice or by the imposition of conditional registration. [In light of that a review directed by the panel will be necessary and at the review hearing whether the doctor has produced any information/objective evidence regarding these matters will be key to the panel's decision.](#)

141 Where a panel has found that the doctor has not complied with the conditions on his/her registration⁵². The panel will need to consider carefully whether the breach was wilful, i.e. the doctor is culpable. If it finds that the breach was wilful [a more serious outcome is likely to be appropriate.](#)⁵³

142 Where a doctor's registration is suspended, the panel may direct that the current period of suspension be extended (up to 12 months), that the doctor's name be erased from the register (except in a health only case) or impose a period of conditions (up to three years)⁵⁴. In cases involving solely the doctor's health or language, it is also open to the panel to suspend the doctor's registration indefinitely⁵⁵ (see [paragraph 86](#)).

143 Where a review hearing cannot be concluded before the expiry of the period of conditional registration or suspension, the panel may extend that period

⁵² Section 35D (9) and (10) Medical Act 1983 as amended
⁵³ Section 35D (11) and (12) Medical Act 1983 as amended
⁵⁴ Section 35D (5) Medical Act 1983 as amended
⁵⁵ Section 35D (6) Medical Act 1983 as amended

Comment [KT11]: Move to benchbook

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 <#>Rule 22 sets out the procedure a panel must follow at a review hearing. The panel will need to consider and make a finding as to whether the doctor's fitness to practise is impaired or he/she has failed to comply with any conditions imposed at the previous hearing (giving reasons for its decision)⁵¹ before determining whether to impose a further order. The panel's powers to impose orders at a review hearing are set out in section 35D of the Act. The guidance provided in this section applies in relation to orders at review hearings as well as regarding a panel's initial decision as to sanction.¶

¶
 <#>Where the panel decides that a period of conditional registration or suspension would be appropriate, it must decide whether or not to direct a review hearing, to be held shortly before the expiry of the period. The panel should give reasons for its decision whether to direct a review hearing or not so that it is clear that the matter has been considered and the basis on which the decision has been reached. Where the panel does not direct a review hearing, the reasons should include an explanation of the factors that led it to decide that the doctor would be fit to resume unrestricted practice following expiry of the period of conditions or suspension. Where the panel directs a review hearing, it may wish to make clear what it expects the doctor to do during the period of conditions/suspension and the information he/she should

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for a further short period⁵⁶ to allow for re-listing of the review hearing as soon as practicable, with the objective of preserving the status quo pending the outcome of the review hearing. It is advisable for panels to invite submissions from both parties as to the length of time they might require and determine the period of extension accordingly.

Comment [KT12]: Move to benchbook

144 The panel may, when considering sanction, take into account any written undertakings offered by the doctor, which it considers sufficient to protect patients and the public interest and provided that the doctor agrees that the Registrar may disclose the undertakings (except those relating exclusively to the doctor's health) to:

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a his/her employer or anyone with whom he/she is contracted or has an arrangement to provide medical services.

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b anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and

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c any other person enquiring.

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Immediate orders (suspension or conditions)

145 The panel may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is in the public interest, or is in the best interests of the practitioner⁵⁷. The interests of the practitioner include avoiding putting him or her in a position where he/she may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put him/her at risk of committing a criminal offence. These factors should be balanced against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require the imposition of an immediate order.

Comment [KT13]: Move to benchbook

Deleted: <#>The doctor is entitled to appeal against any substantive direction affecting his/her registration. The direction does not take effect during the appeal period (28 days) or, if an appeal is lodged, until that appeal has been disposed of. During this time, the doctor's registration remains fully effective unless the panel also imposes an immediate order.¶¶

146 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety, for example where he/she has provided poor clinical care (set out in domains one and four of *Good medical practice on knowledge, skills and performance and maintaining trust*) or abused a doctor's special position of trust (*Good medical practice* paragraphs 53, 65 and 75), or where immediate action is required to protect public confidence in the medical profession.

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⁵⁶ Section 35D (5) and (12) Medical Act 1983 as amended.

⁵⁷ Section 38 of the Medical Act 1983 as amended

Deleted: Under the provisions of Section 35D Medical Act 1983 as amended

147 It is sometimes argued by doctors, or their representatives, that no immediate order should be made as the doctor needs time to make arrangements for the care of his/her patients before the substantive order for suspension or erasure takes effect. In considering such arguments, panels will need to bear in mind that any doctor whose case is considered by a fitness to practise panel will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients prior to the hearing should the need arise. In any event, the GMC also notifies the doctor's employers, or in the case of general practitioners, the relevant body, of the date of the hearing and they have a duty to ensure that appropriate arrangements are in place for the care of the doctor's patients should an immediate order be imposed.

Deleted: Primary Care Trust

148 Where the panel has directed a period of conditional registration as the substantive outcome of the case, it may impose an immediate order of conditional registration. Where the panel has directed erasure or suspension as the substantive outcome of the case, it may impose an immediate order to suspend registration. ↓

Comment [KT14]: Move to benchbook

Deleted: Before making a decision the panel must consider any submission or evidence and will need to invite these from both parties in advance of making a decision.

149 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the panel based on the facts of each case. The panel should, however, have regard to the seriousness of the matter which led to the substantive direction and consider carefully whether it is appropriate for the doctor to continue in unrestricted practice pending the substantive order taking effect. ↓

Comment [KT15]: Move to benchbook

Deleted: The panel should consider the matter in camera and when announcing its decision whether or not to impose an immediate order, give reasons for the decision taken.

Annex A

List of other documents and guidance available to Panels

Medical Act 1983 (as amended)

General Medical Council (Constitution of Panels and Investigation Committee) Rules 2004

General Medical Council (Legal Assessors) Rules 2004

General Medical Council (Fitness to Practise) Rules 2004 (as amended)

Good medical practice – Current edition

(Previous and no longer current versions of Good medical practice, published in 2001, 1998 and 1995 respectively, can be downloaded from our archive section at <http://www.gmc-uk.org/guidance/archive/index.asp>)

Supplementary ethical guidance

Guidance to the Fitness to Practise Rules

Meaning of Fitness to Practise

Guidance on agreeing undertakings at the investigation stage (Consensual Disposal)

Pre-Adjudication Case Management Procedure Guidance Manual

Guidance for Specialist Advisers

Guidance on warnings

Undertakings at FTP Panel hearings – Procedure and guidance

Undertakings bank

Deleted: http://www.gmc-uk.org/about/legislation/medical_act.asp

Deleted: <http://www.opsi.gov.uk/si/si2004/20042611.htm>

Deleted: <http://www.opsi.gov.uk/si/si2004/20042625.htm>

Deleted: http://www.gmc-uk.org/consolidated_version_of_FTP_Rules.pdf_26875225.pdf

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Deleted: http://www.gmc-uk.org/guidance/ethical_guidance/index.asp

Deleted: http://www.gmc-uk.org/Guidance_to_the_FTP_Rules_2_.pdf_35398575.pdf

Deleted: http://www.gmc-uk.org/the_meaning_of_fitness_to_practise.pdf_25416562.pdf

Deleted: http://www.gmc-uk.org/Guidance_for_decision_makers_on_assessing_insight_when_considering_whether_undertakings_are_appropriate.pdf_32423692.pdf

Deleted: http://www.mpts-uk.org/static/documents/content/250a_Pre_hearing_case_management_procedure_post_1_Feb_2011.pdf_48760565.pdf

Deleted: http://www.gmc-uk.org/Guidance_for_specialist_advisers.pdf_27338610.pdf

Deleted: http://www.gmc-uk.org/Guidance_on_Warnings.pdf_27286909.pdf_36

Deleted: http://www.gmc-uk.org/Undertakings_at_FTP_Panel_hearings_Aug_09.pdf_26870331.pdf

Deleted: http://www.gmc-uk.org/Undertakings_Bank.pdf_25416205.pdf

FTP Conditions Bank

▼ Medical career structure – Doctors in training

▼ Glossary of terms used in FTP actions

▼ Guidance on the use of clinical attachments

▼ International Classification of Diseases (ICD10)

▼ Imposing Interim Orders – Guidance for IOP and FTP Panels

▼ IOP Conditions Bank

▼ Voluntary Erasure – Guidance for decision-makers

▼ Guidance for doctors on restoration following erasure by a Fitness to Practise Panel

▼ Managing Fitness to Practise Panel hearings – guidance for panel chairmen

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_25415696.pdf¶

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Guidance for making referrals to the Postgraduate Dean or GP Director ¶
http://www.mpts-uk.org/static/documents/content/Guidance_for_making_referrals_to_the_Postgraduate_Dean.pdf ¶_25416687.pdf¶

Deleted: http://www.mpts-uk.org/static/documents/content/Medical_career_structure_doctors_in_training.pdf ¶_25417075.pdf¶

Deleted: http://www.gmc-uk.org/Glossary_of_Terms_used_in_Fitness_to_Practise_Actions.dot.pdf ¶
_25416199.pdf¶

Deleted: http://www.gmc-uk.org/Clinical_attachments_guidance.pdf ¶_25416788.pdf¶

Deleted: <http://www.who.int/classifications/apps/icd/icd10online/> ¶

Deleted: http://www.gmc-uk.org/Imposing_Interim_Orders_Guidance_for_the_Interim_Orders_Panel_and_the_Fitness_to_Practise_Panel.pdf ¶
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