

Agenda item:	14
Report title:	Changes to guidance for decision makers at the end of the investigation stage
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Action:	To note

Executive summary

The Senior Management Team (SMT) at a meeting on 7 August 2017 reviewed our case examiner guidance and agreed that violence should continue to carry a presumption of impairment and that we should provide more guidance on application of the presumption.

It was also agreed that, given the range of conduct that can result in a criminal conviction, a criminal conviction, in and of itself, should not carry a presumption of impairment and should be a matter for case examiner discretion on a case by case basis with more detailed guidance to be provided to ensure consistency of approach.

Recommendation

The Executive Board is asked to note the changes to the guidance.

Background

- 1 We have not consulted on the case examiner guidance since it was introduced in 2004. We have, however, conducted a high profile consultation on the Sanctions

Guidance used by tribunals when determining sanction and reflected in the guidance for case examiners when applying the realistic prospect test (the prospect of a tribunal finding a doctor impaired).

- 2 When we consulted on the sanctions guidance we asked about the factors in a doctor's private life that should result in action. The consultation proposed that the following factors should result in more serious action:
 - misconduct involving violence or offences of a sexual nature
 - concerns about their behaviour towards children or vulnerable adults
 - concerns about probity (being honest and trustworthy and acting with integrity)
 - misuse of alcohol or drugs leading to a criminal conviction or caution
 - unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation
 - any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings.
- 3 Responses to the consultation gave support for this proposal from the majority of respondents (76% patients, 49% doctors).
- 4 Changes to the categories of presumed impairment were agreed at the Executive Board in June and are included in the attached guidance at Annex A. It was agreed at that meeting that further discussion was needed about the threshold for impairment for conduct involving violence and conduct resulting in a criminal conviction or caution. These sections of the guidance are highlighted.

Criminal convictions and cautions – no presumption of impairment

- 5 The conduct that can result in a conviction or caution covers a great range from:
 - Very serious offences such as murder, rape, sexual assault or indecency, burglary and grievous bodily harm; to
 - Less serious offences such as driving without car tax or insurance (where no dishonesty involved) or drink driving (non-health). Currently this latter group would usually not lead to a finding of impairment unless there were aggravating factors but would result in a warning.

- 6 Criminal convictions and cautions are not currently included in the list of conduct that carries a presumption or impairment although much of the conduct that is included in that list will often involve a criminal conviction.
- 7 In terms of the standard of conduct expected of doctors, a conviction or caution for a criminal offence is clearly a serious departure from that standard. If we were to include convictions in the category that carries a presumption of impairment, the convictions or cautions listed in the second category at paragraph 5 above would generally result in referral to a tribunal and, if impairment is found, a suspension.
- 8 In light of this, the SMT agreed that a criminal conviction, in and of itself should not carry a presumption of impairment, and we should give more detailed guidance on the convictions that should lead to a finding of impairment.

Violence – a presumption of impairment

- 9 In the current guidance, violence is listed as conduct that carries a presumption of impairment. A presumption of impairment means that, unless exceptional circumstances exist (unusual, special or uncommon), a proven allegation will result in a finding of impairment and in most cases a referral to a tribunal. A review of our decisions shows that this standard is not consistently applied. The SMT discussed and agreed that violence is conduct that poses a risk to confidence in the medical profession and should continue to be listed as conduct that carries a presumption of impairment. It was agreed that more guidance should be provided to support improved consistency of application.

9 – Introduction of a new webpage for case examiner decisions

9 – Annex A

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

Introduction

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

Equality and Diversity Statement

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

The GMC's Fitness to Practise procedures

The process

- 7 By far the great majority of doctors deliver good quality healthcare, often in difficult and demanding situations. However, a small proportion does not and concerns about their practice must be investigated under our fitness to practise procedures.
- 8 Any doctor wanting to practise medicine in the UK must, by law, be both registered and hold a licence to practise. Our fitness to practise powers extend to all registered doctors, whether or not they hold a licence to practise. Following the introduction of licensing, the GMC's Fitness to Practise sanctions continue to attach to a doctor's registration. Where a doctor's name is suspended or erased from the Register by a medical practitioners tribunal, we will automatically withdraw a doctor's licence. Where a doctor's registration is subject to conditions or undertakings which restrict their practice they will still be entitled to hold a licence but must continue to comply with any conditions or undertakings on their registration. If they do not, their registration and licence may be at risk.
- 9 Information concerning a doctor's fitness to practise may be received from a complainant or a person acting in a public capacity, or may otherwise come to the attention of the GMC.
- 10 At any time, the Registrar (on his own motion or where requested by a case examiner or the Investigation Committee) may refer an allegation to an interim orders tribunal. Guidance on referrals to an interim orders tribunal is attached at [Annex C](#).
- 11 Initial investigations will be carried out by the Registrar's staff (with the assistance of lawyers where required), for example, where there is insufficient information to establish whether the allegation falls within the GMC's jurisdiction, or where further information is required to see if a pattern of behaviour may be established. These may include making enquiries of the doctor's employer, colleagues or others, or obtaining medical records or other documentation.
- 12 Convictions resulting in a custodial sentence are referred direct by the Registrar to a medical practitioners tribunal. There is a presumption that the same will apply to cautions, non-custodial convictions, and determinations of other regulatory bodies. However, in some cases a warning will be the appropriate response. There are also a number of minor offences (such as parking offences) where no formal GMC action will be required. Guidance on the handling of convictions and determinations is attached at [Annex D](#).

- 13** The decision at the end of the investigation stage is to be taken unanimously by a medical and a lay case examiner. Case examiners have been appointed by the Registrar following a rigorous, competency-based, recruitment process designed to assess their decision-making competencies and skills. Where they do not agree, the matter is decided by the Investigation Committee.
- 14** The case examiners will apply the following test at the conclusion of the investigation stage:
- The investigation committee or case examiner must have in mind the GMC's duty to protect the public which includes promoting and maintaining the health, and safety and well-being of the public; public confidence in the profession; and, proper standards and conduct for doctors, in considering whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration.
- 15** At any stage a case may be referred to the police for investigation where the allegations appear to disclose the commission of a criminal offence and where the police appear to have had no previous involvement in the matter.
- 16** A note on the meaning of fitness to practise, approved by Council, is attached at [Annex A](#). Further legal guidance on the 'realistic prospect' test is attached at [Annex B](#) by way of an aide memoire.
- 17** Under section 35C(2) of the Medical Act 1983 (the Act), impairment can only be by reason of any or all of the following:
- misconduct
 - deficient professional performance
 - a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales)
 - adverse physical or mental ill-health
 - a determination by a regulatory body either in the British Isles or overseas.
 - not having the necessary knowledge of English.
- 18** Members of the Investigation Committee and case examiners must not consider the categories set out in paragraph 17 as separate issues. There may be cases that involve concerns about a number of aspects of a doctor's fitness to practise. In making a decision, it is the cumulative effect of all impairing factors that must be taken into account. Health, performance and language assessments are part of the process of

collecting evidence. 'Passing' an assessment will not necessarily mean that no action will be taken, as there may be other issues for the case examiner to consider.

- 19** There will also be cases that demonstrate significant departures from *Good medical practice* or a significant cause for concern on assessment. These cases may not be so serious as to warrant action on a doctor's registration but may require a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response in these types of cases will be a warning. A warning should only be considered where the case examiners or the Investigation Committee have already decided that there is no realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration.
- 20** At the end of the investigation there are a number of options open to the case examiners:
- a** refer the case to a medical practitioners tribunal
 - b** agree undertakings
 - c** issue a warning (or refer the matter to the Investigation Committee for a hearing regarding whether to issue a warning)
 - d** conclude the case with no further action.
- 21** Our fitness to practise procedures apply equally to all registered doctors whether or not they hold a licence to practise. All doctors on the register are expected to meet the standards in *Good medical practice*. The fact that a doctor does not currently hold a licence to practise does not remove the requirement to investigate and respond to concerns about a doctor's fitness to practise.
- 22** Where the practitioner chooses not to comment or does not dispute the facts alleged, and where a medical and lay case examiner agree to do so, a warning may be issued. In all other cases in which the case examiners feel a warning may be appropriate, the matter will proceed to an oral hearing before the Investigation Committee to decide whether a warning should be issued. The practitioner has a right to request such an oral hearing to be held. Where new evidence at the hearing casts a fresh light on the case, the Investigation Committee may refer the matter to a medical practitioners tribunal.
- 23** Undertakings may only be agreed where the case examiners have decided that the doctor's fitness to practise is impaired (or is likely to be, on recurrence of a medical condition), where to do so would provide sufficient protection to the public and where there is no possibility of erasure should the matter proceed to a medical practitioners tribunal. The restrictions imposed as a result of the undertakings (save for those

relating solely to the doctor's health) will be disclosed on enquiry. Guidance in relation to directing assessments and agreeing undertakings is attached at [Annex F](#).

Presumption of impaired fitness to practise

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

a. sexual assault or indecency

b. violence

c. improper sexual/emotional relationships

d. knowingly practising without a licence

e. unlawfully discriminating in relation to characteristics protected by law

f. Dishonesty

g. Gross negligence or recklessness about a risk of serious harm to patients.

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

(The decision in *R v Metropolitan Police Commissioner ex parte Redgrave* (2003) 1 WLR 1136, as subsequently applied and clarified in cases such as *Bhatt v General Medical Council* [2011] EWHC 783 (Admin) and *Ashraf v General Dental Council* [2014] EWHC 2618 (Admin), indicates that the GMC may take action on a case against a doctor on the same issues as a previous criminal prosecution, notwithstanding that the doctor was acquitted by the criminal process.)

26 Where allegations fall under one of the eight headings, there is a presumption of impaired fitness to practise. **Unless there are exceptional reasons for not doing so**, the case examiners and Investigation Committee will normally refer the case to a medical practitioners tribunal. In light of the particular issues that arise in cases involving a doctor who is unwell, this does not preclude the agreement of undertakings in cases where conduct is closely linked to health concerns and any risk to patients and public confidence in the medical profession would be addressed by agreeing undertakings in relation to the doctor's health (see guidance on Health and Misconduct link). Where the case examiners do not refer the case to a medical practitioners

tribunal, they will need to be particularly careful to record detailed reasons for having done so.

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

28 Where the allegations fall within one of the categories where there is a presumption of impaired fitness to practise, the case examiners should not normally consider any arguments in mitigation made by the doctor. Mitigation should only be considered following a finding of fact by a medical practitioners tribunal. The case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) (see paragraph 62 for further details) established that evidence that a failing is remediable and has been remedied by a doctor is relevant to consideration of impairment. Cases in which there is a presumption of impaired fitness to practise, however, are unlikely to fall into the category of cases that are easily remediable.

Sexual assault or indecency (para 24a)

29 This encompasses a wide range of conduct from allegations of sexual assault and sexual abuse to allegations in relation to indecent images of children.

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

Violence (para 24b)

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

Improper sexual/emotional relationships (para 24c)

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

'You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them'.

(GMP paragraph 53)

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

Knowingly practising without a licence (para 24d)

- 34** Following the introduction of the licence to practise, it is the licence to practise that confers all the privileges that were previously associated with registration. It will be a criminal offence for a doctor who is registered but who does not hold a licence or for any other person to pretend to have a licence. However, when the allegations relate to a doctor who holds registration but who does not hold a licence we can also take the case forward under our fitness to practise procedures.
- 35** Each case will need to be considered on its own facts but if a doctor has deliberately misled patients or others about his/her licensing status, there is a presumption the case should be referred forward to a medical practitioners tribunal hearing.

Unlawful discrimination in relation to characteristics protected by law (para 24e)

- 36** Doctors must treat their colleagues and patients fairly, whatever their life choices and beliefs. The guidance on this can be found in paragraphs 45, 54 and 57 of *Good medical practice*.
- 37** Doctors must not 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 legislation (*Good medical practice*, paragraph 59) however where discrimination relates to characteristics protected by legislation and is therefore unlawful this will give rise to a presumption of impairment.
- 38** 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 the explanatory guidance *Personal beliefs and medical practice*¹)
- 39** *Good medical practice* and the documents it links to including explanatory GMC guidance provide a more complete picture of behaviour of this kind, but even it is not exhaustive.

Dishonesty (para 24f)

¹ http://www.gmc-uk.org/guidance/ethical_guidance/21171.asp (accessed 17/06/2015)

- 40** Dishonesty, if proven, will usually amount to such a serious failure to meet the standards required of doctors that there will be a presumption of impaired fitness to practise.
- 41** Good medical practice provides that 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.
- 42** Examples of dishonesty in professional practice include:

- defrauding an employer
- improperly amending patient records
- submitting or providing false references and information on a CV or application form or in an exam or appraisal
- research misconduct which incorporates a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and the profession have in medicine as a science, regardless of whether this leads to direct harm to patients. Because it has the potential to have far reaching consequences, this type of dishonesty is particularly serious. Allegations in this category may also include false claims as to qualifications/experience and forgery or improper alterations of documents.

- 43** Examples outside professional practice include:

- fraud
- mishandling charitable funds
- theft
- forging signatures or documents.

- 44** *Good medical practice* provides as follows:

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

(GMP paragraph 67)

- 45** *Good Practice in Research*² provides more detailed guidance on the principles of good research practice which must be followed.
- 46** Although the GMC takes all allegations of dishonesty seriously, there will be cases alleging minor dishonesty which are not related to the doctor's professional practice and which are so minor in nature that taking action on a doctor's registration is unlikely to be a proportionate response. Examples of dishonesty that are likely to fall into this category might include:
- Travelling in Zone 3 with a Zone 2 travel ticket.
 - Parking in a disabled bay without being eligible.
 - Continuing to park after expiry of a parking permit.
 - Failing to declare when undercharged small sums.
- 47** In cases of this nature, it is unlikely that these allegations, by themselves, would satisfy the realistic prospect test of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. Nonetheless, the GMC does take all allegations of dishonesty seriously, and allegations of this nature, if admitted or proven, do warrant some action by the GMC. It is likely that the most appropriate response, in cases of this nature, will be a warning.

Gross negligence or recklessness about the risk of serious harm to patients (para 24g)

- 48** Where a matter does not fall within one of the other categories of presumed impairment but raises a question about a doctor's fitness to practise, a key factor in whether a doctor is found impaired will relate to how they have responded to the concern. Even where there has been a serious failing that may have harmed patients, if a doctor has been honest about the failing including apologising to any patient harmed, reflected on what happened, demonstrated insight, taken steps to put it right and repetition is unlikely, this is likely to address the risk of to the public.
- 49** However, whilst the absence of a risk of repetition is a key consideration in terms of protecting the public, determining whether a practitioner's fitness to practise is impaired by reason of misconduct, requires consideration not only of whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public

² http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp (accessed 17/06/2015)

confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances³

- 50** Where a doctor's failings amount to gross negligence or recklessness about a serious risk to patients then, notwithstanding steps taken to achieve personal remediation, public confidence would be damaged if we fail to take action. Examples of such cases include:
- Where a doctor has failed to address a serious failing or respond to concerns raised, when they knew or should have known that they were causing harm to patients and should have taken steps earlier to prevent this but failed to do so.
 - A one off failing where it was apparent or should have been apparent that the doctor's actions involved a serious risk of harm to patients.

Other serious or persistent failures to practise in accordance with the principles in *Good medical practice*

- 51** Other serious or persistent failures to practise in accordance with the principles in *Good medical practice* may also raise an issue of impaired fitness to practise. Most concerns about treatment or the standard of a doctor's clinical practice will fall into this category.
- 52** In deciding whether a complaint meets the realistic prospect test, the case examiners will need to consider both the nature and seriousness of the allegations and whether the issue is easily remediable and has been remediated. The following paragraphs and the examples provided will help the case examiners decide whether a complaint meets the realistic prospect test.

Nature of Allegations:

- 53** Allegations of serious or persistent failures to practise in accordance with the principles set out in *Good medical practice* can be categorised under the following headings:
- a** Knowledge, skills and performance
 - b** Safety and quality
 - c** Communication, partnership and teamwork

³ See Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council & Anor [2011] EWHC 927 (Admin), Lang J at para 74.

d Maintaining trust

Seriousness of Allegations

- 54** Where the allegations indicate failures to practise in accordance with the principles set out in *Good medical practice*, the case examiners will need to proceed to consider how serious or persistent the failure or failures are. Whilst doctors are expected to comply with the standards in *Good medical practice*, not all failures to meet standards will amount to an issue of impaired fitness to practise to a degree justifying action on the doctor's registration. *Good medical practice* is guidance, not a statutory code, so doctors must use their judgement to apply the principles to the various situations they will face. Whether they choose to follow the guidance or not — they must always be prepared to explain and justify their decisions and actions. The guidance in the booklet focuses on a doctor's professional life. Behaviour that takes place outside a doctor's professional practice may lead to action on registration where public confidence in doctors generally might be undermined if the GMC did not take action.
- 55** *Good medical practice* states that 'serious or persistent failures to follow this guidance will put your registration at risk'. In some cases the concerns may arise from a series of episodes. There will, however, be cases that arise from a single clinical incident. Additional guidance on single clinical incidents is attached at [Annex H](#). A question of fitness to practise is likely to arise in the following circumstances:

Criminal convictions and cautions

- 56** A conviction that carries a custodial sentence must under our rules be referred directly by the Registrar for a hearing. Many of the concerns that fall within the category of a presumption of impairment will also involve a conviction and will, except in exceptional circumstances be referred for a hearing. When considering serious misconduct, the fact that the misconduct resulted in a criminal conviction or caution will be an aggravating factor. A conviction involving illegal drugs will be viewed seriously.
- 57** Any criminal conviction or caution is a serious matter and needs careful consideration. However, there will be some misconduct where, despite it having resulted in a conviction or a caution, it may not be proportionate to find a doctor's fitness to practise impaired. This would usually relate to matters such as drink driving where there are no aggravating features, or lower level misconduct that might in other circumstances result in a fixed penalty notice but on this occasion has led to a conviction or caution. Examples are urinating in public, kicking a car while drunk, having a row with a bouncer.

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

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

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

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

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

- 60** Conduct which shows that a doctor has acted without regard for patients' rights or feelings, or has abused their professional position as a doctor, will usually give rise to questions about a doctor's fitness to practise.
- 61** Examples of acting without regard for patients' rights or feelings would include failing to obtain appropriate consent or to provide adequate information to the patient. *Good medical practice* provides:

'You must be polite and considerate.

You must treat patients as individuals and respect their dignity and privacy.

You must treat patients fairly and with respect whatever their life choices and beliefs.

You must work in partnership with patients sharing with them the information they will need to make decisions about their care...

You must treat information about patients as confidential'.

(GMP paragraphs 46 to 50).

- 62** *Good medical practice* also explains that doctors must be mindful of the way they express their own personal beliefs to patients.

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

(GMP paragraph 54).

A doctor's health is compromising patient safety

63 The GMC does not necessarily need to be involved merely because a doctor is unwell, even if the illness is serious. However, a doctor's fitness to practise is brought into question if it appears that the doctor has a serious medical condition (including an addiction to drugs or alcohol) and the doctor does not appear to be following appropriate medical advice about modifying his or her practice as necessary in order to minimise risk to patients. Although intended for triage decisions, it may be helpful to refer to the *Guidance for decision makers on assessing risk in health cases*⁴.

64 *Good medical practice* provides:

'If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients.'

(GMP Paragraph 28)

65 The chart attached at [Annex G](#) provides further guidance and illustrative examples of how failures to meet the standards in Good medical practice may give rise to action on a doctor's registration.

A doctor's knowledge of English is compromising patient safety

66 Where a doctor lacks the necessary knowledge of English to practise medicine safely in the UK and there is a potential or actual risk to patients it is likely to be appropriate to take action on registration.

67 *Good medical practice* provides:

'You must have the necessary knowledge of English to provide a good standard of practice and care in the UK'.

(GMP Paragraph 14.1)

68 The guidance on directing language assessments at [Annex E](#) provides further guidance on relevant issues which may give rise to a serious concern.

⁴ http://www.gmc-uk.org/DC4315_Guidance_for_decision_makers_on_assessing_risk_in_cases_involving_health_concerns_48690195.pdf (accessed 17/06/2015)

Remediation - whether the failing is easily remediable and has been remedied

- 69** In the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), Mr Justice Silber ruled that at the impairment stage, a tribunal ought to take account of evidence and/or submissions (in addition to those *deployed* at the fact-finding stage) from both the doctor and the GMC that the doctor's failing (as identified at the fact-finding stage):
- a** is easily remediable
 - b** and that it has already been remedied
 - c** and that it is highly unlikely to be repeated.
- 70** Ease of remediation, steps taken to remediate and the likelihood of repetition of the failing are all relevant in considering impairment. Ease of remediation and the steps taken are usually inter-related and normally occur together. It is likely that the more factors that are present, the more weight they will carry. But they may not occur together. For example, there may be evidence that, although the failing is easy to remedy, it has not actually been remedied. The case examiners or the Investigation Committee will need to decide what weight to give to the potentiality for remedy and its actuality: see paragraphs 68–72 below.
- 71** Evidence of the factors may include reports and submissions by the doctor concerning courses or training undertaken to remedy the failing and evidence of the doctor's previous fitness to practise history (which may be relevant to the likelihood of repetition). Mr Justice Silber indicated that evidence of easy remediation tends to favour the doctor, by helping him to negate impairment. Conversely, he indicated that psychiatric or psychological problems making it difficult or impossible for him to remedy the failing would point towards impairment.
- 72** In a few cases, a doctor's failings (including serious performance concerns) may be so serious or persistent, notwithstanding steps subsequently taken, that action is required to maintain public confidence and where personal remediation is not sufficient to address the damage to public confidence, for example, where a doctor has had a record of poor outcomes that involved patient harm and has persistently failed to address them prior to GMC involvement or a one off failing involving gross negligence or recklessness about a risk of serious harm. In deciding whether a case meets the realistic prospect test, the Investigation Committee or the case examiners will need to consider the possible impact on a tribunal at the impairment stage of material showing that a doctor's failing is easily remediable and has already been remedied and the level of the risk of repetition. This is likely to be most relevant in cases relating to performance or clinical misconduct.
- 73** Examples of appropriate evidence of remediation may include:

- a** Certificates from completed training modules
 - b** Professional Development documentation
 - c** Competency reports from supervising doctors
 - d** Evidence of participation in a College or Faculty run 'Continuing Professional Development' scheme or a personal development plan.
- 74** Personal statements ('self certification') are not considered appropriate evidence of remediation.
- 75** Such material may not always be available. Where it is available it may not be clear or determinative. But where it is available, it should be considered. Additionally, where evidence of remediation is available, if a doctor shows a lack of insight, this may be relevant to the third factor highlighted in the Cohen judgment; the likely risk of repetition and will therefore affect the weight attached to such evidence.
- 76** If the Investigation Committee or case examiners are satisfied that the failing is easily remediable and has been remedied and there is no likelihood of repetition, they may still decide that impairment could be established before a tribunal. The weight to be given to that factor, like any other, is a matter for the decision makers' discretion. The Cohen judgment recognises that there are cases that raise issues of public confidence where, regardless of whether the failing has been remedied, a case should be referred to a tribunal. These are likely to involve allegations which are very serious in nature and where there is a presumption of impairment.
- 77** The cases of Dr C T Yeong and The General Medical Council [2009] EWHC 1923 (Admin) and CHRE v Nursing and Midwifery Council & Paula Grant [2011] EWHC 927 (Admin) have also emphasised the importance of the wider public interest when considering the question of impairment, particularly maintaining public confidence in the profession, where misconduct has taken place over a prolonged period of time and reflects serious attitudinal or behavioural issues rather than of clinical competence. In these circumstances, evidence of remedial action may be far less significant and given considerably less weight.

Undertakings

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

- 79** When the case examiners have decided that a doctor's fitness to practise is impaired (or is likely to be in the event of the reoccurrence of a medical condition) and that undertakings will be an appropriate way forward, it will be irrelevant whether or not the doctor holds a licence to practise. Fitness to practise sanctions attached to registration and all doctors on the medical register are required to comply with *Good medical practice*. Even when the issues are practice related and the doctor has relinquished their licence to practise, practice related undertakings may still be the most appropriate approach, including a commitment to work under medical supervision or undergo retraining.
- 80** A registered doctor is entitled to apply for a licence at any time and that doctor's practice will only be restricted if action has been taken on their registration. If that doctor later obtains a licence, they will need to comply with any undertakings. Case examiners will need to consider in an individual case the most appropriate sanction keeping in mind the possibility of a doctor regaining their licence.
- 81** If on review, the doctor's unlicensed status remains unchanged the case examiners or tribunal will need to consider the most appropriate action to take. This could include discussing with the doctor the possibility of taking voluntary erasure from the register, a further period of undertakings or conditions or more robust action such as referring the case to a tribunal or suspending the doctor. Such decisions will need to be made on a case by case basis.

Warnings

- 82** There will also be cases that demonstrate significant departures from *Good medical practice*, not so serious as to warrant action on a doctor's registration but requiring a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response in these types of cases will be a warning. A warning may also be appropriate where a performance assessment indicates a significant cause for concern. A warning will not affect a doctor's registration or right to hold a licence to practise.
- 83** Case examiners and the Investigation Committee will first need to apply the realistic prospect test as set out in paragraph 14 of this guidance. A warning should only be considered where the case examiners or the Investigation Committee have already decided that there is no realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration. The question of whether a warning might be appropriate must be considered in all cases where the case examiners or Investigation Committee decide that the realistic prospect test has not been met.
- 84** In many cases, determining whether allegations about treatment and clinical practice are serious enough to meet the realistic prospect test will be very complex and will depend on a range of factors. These might include the seniority of the doctor, the level of supervision, the effect of external factors such as systems failures and any

remediation undertaken by the doctor. Where the case examiners consider that the allegations are on the borderline between action on registration and a warning, the presumption should be that the case progresses to a medical practitioners tribunal

- 85** Once it has been established that the realistic prospect test has not been met, for whatever reason, the case examiners should consider all the evidence, including arguments in mitigation, when considering whether or not to issue a warning.
- 86** Although a warning does not affect a doctor's registration or licence, it will appear on the register during the 5-year period that it remains valid and will be disclosed on enquiry at any time.

Case Examiner decisions following withdrawal of a matter under rule 28

- 87** Rules 28(2) and (3) of the Fitness to Practise Rules allow a case examiner to withdraw a matter which has been referred to a medical practitioners tribunal or to refer the case back for consideration by the case examiners under Rule 10 or 11. (See separate guidance on the cancellation of hearings under Rule 28.)
- 88** When a case is referred back to the case examiners under Rule 28(2)(b), the options open to the case examiners are restricted to considering undertakings under Rule 10 or a warning under Rule 11. It is not open to them to consider other options, such as carrying out further enquiries.
- 89** The decision that the case examiners will be asked to make will depend on the grounds for withdrawing the matter referred to a hearing. This should be recorded in the referral from the Case Presentation Team.

Undertakings

- 90** Case examiners may be asked to consider agreeing undertakings where, following referral, while the doctor's fitness to practise appears to be impaired, undertakings appear to be an appropriate way of concluding the case.
- 91** The case examiners' decision should take account of the guidance in paragraph 73–76 above and in the guidance on undertakings in [Annex F](#).
- 92** When the case examiners decide that it is appropriate to invite the doctor to agree undertakings, the case should progress in accordance with the standard process for agreeing undertakings.

Warnings

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

- 94** In considering whether a warning is appropriate in these circumstances, the case examiners should apply the guidance in paragraphs 77-81 above and in the separate guidance on issuing warnings.
- 95** When a case is referred back to the case examiners in these circumstances on the basis that there is no longer a realistic prospect of establishing that the doctor's fitness to practise is impaired, the case examiners' options will be restricted to considering whether it is appropriate issue a warning; it will not be open to them to consider inviting the doctor to accept undertakings.
- 96** When the case examiners decide that it is appropriate to issue a warning, the case should progress in accordance with the standard process for issuing warnings.

Recording Decisions

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

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

- Annex A: Council's policy statement on the meaning of Fitness to Practise
- Annex B: Aide Memoire on the 'realistic prospect test'
- Annex C: Guidance on referral to an Interim Orders Tribunal
- Annex D: Guidance on dealing with convictions, cautions and determinations
- Annex E: Guidance on directing a language assessment
- Annex F: Guidance on agreeing undertakings
- Annex G: Illustrative examples
- Annex H: Guidance on single clinical incidents
- Annex I: Guidance on considering applications for voluntary erasure

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