

To consider

Review of our Indicative Sanctions Guidance, the role of apology and warnings

Issue

- 1** We are holding a public consultation in the summer of 2014 on the guidance used by the Medical Practitioners Tribunal Service fitness to practise panels. This will include the Indicative Sanctions Guidance and the role of apology and warnings in our procedures.

Recommendations

- 2** Council is asked to:
 - a** Consider if we should consult on the issue of whether any previous interim order should influence a decisions to suspend solely to uphold public confidence in the profession.
 - b** Agree our proposals for consultation.

Review of our Indicative Sanctions Guidance, the role of apology and warnings

Issue

- 3 We recently ran a public consultation on our core guidance on standards for doctors, *Good medical practice* (GMP), to ensure it is up to date and reflects what doctors and patients think are the important values and principles of good care. A new version of GMP was introduced in April 2013.
- 4 To make sure the new standards are properly maintained and that our guidance is up to date, we now need to modernise the guidance which the Medical Practitioners Tribunal Service (MPTS) fitness to practise panels use to decide what sanction to impose.
- 5 At its meeting on 2 April 2014, Council held a seminar to consider the principles which underpin our Indicative Sanctions Guidance. At its meeting on 1 April 2014, the Strategy and Policy Board also considered our proposals to hold a public consultation to encourage key interest groups to share their views on our Indicative Sanctions Guidance and the role of apologies, and warnings in our fitness to practise procedures. This paper sets out the key principles on which we propose to consult.

Background

The role of our Indicative Sanctions Guidance

- 6 Our current Indicative Sanctions Guidance, at Annex A, is used by MPTS fitness to practise panels to decide what sanction, if any, to impose on a doctor at a hearing following a finding of impairment. It is published on the MPTS website.
- 7 The law requires us to investigate concerns about a doctor's fitness to practise and take action where necessary for protection of the public and to maintain confidence in the medical profession. The MPTS holds hearings to consider serious concerns about doctors to ensure separation between our investigation and adjudication roles and to give confidence in the impartiality of hearings. At a hearing, the MPTS fitness to practise panels are responsible for making decisions about the appropriate action to take when a doctor's fitness to practise is found to be impaired.
- 8 Where a doctor's fitness to practise is found impaired an MPTS fitness to practise panel can take no action, impose conditions, agree undertakings, suspend or remove the doctor from the medical register. Where necessary, an MPTS fitness to practise panel or interim orders panel (IOP) can also take immediate action to protect the public by imposing an interim order pending the outcome of our investigation and adjudication process. Where a doctor's fitness to practise is found to be not impaired an MPTS fitness to practise panel can

consider whether a warning is appropriate and, if they decide it is not, the case will be concluded with no action.

History and background

- 9** We first issued Indicative Sanctions Guidance for the then Professional Conduct Committee in November 2001. At that time, we had separate processes for health, performance and conduct issues and the guidance was intended for use in conduct cases only. The following year, a staff survey was conducted to inform further development of the key principles. Council approved the Guidance in May 2003 as 'an authoritative statement of Council's approach to sanction issues in conduct and conviction cases'.
- 10** Since then, our fitness to practise procedures have undergone major structural reform. The separate health, performance and conduct committees were replaced by a single fitness to practise panel in 2004. Our Indicative Sanctions Guidance was subsequently updated to reflect a more holistic approach to fitness to practise. The current version was issued in April 2009, following an internal review and engagement exercise involving key external interests including medical defence organisations. MPTS fitness to practise panels began using the Indicative Sanctions Guidance on its inception in 2012. During this period, the Guidance has also been amended to reflect various changes to legislation.

Key principles

- 11** Our Indicative Sanctions Guidance sets out the principles which underpin the decisions made by MPTS fitness to practise panels when deciding the appropriate sanction to impose in a case. This includes the purpose of sanctions and the role of the public interest, proportionality, aggravating and mitigating factors, expressions of regret and apology, testimonials and other issues. It also provides specific guidance on determining the seriousness of certain types of conduct, such as criminal convictions and cautions, dishonesty and sexual misconduct.

Proposals for consultation

- 12** We will be holding a public consultation to ensure our Indicative Sanctions Guidance reflects what doctors and patients think are the important values and principles of good care as set out in *Good medical practice*. The key themes for discussion include the purpose of sanctions, remediation and public confidence issues, the role of apology and warnings in our procedures, seriousness of concerns and length of suspension. Our proposals for consultation are set out at Annex B. An outline of the issues related to the role of apology and insight in our procedures is at Annex C.
- 13** An overview of the issues that relate to the length of suspension is at Annex D. Council is asked to consider if we should consult on the issue of whether any

previous interim order should influence a decision to suspend solely to uphold public confidence in the profession.

- 14** We also plan to consult on whether or not our current system of warnings is working as we intended and review their purpose. We will also ask if warnings could be used effectively in both impairment and no impairment cases, if appropriate terminology was introduced to distinguish between them. Finally, we will consider the case for introducing an escalation mechanism where a doctor repeats unacceptable behaviour after a warning is issued.

Future publication

- 15** We aim to update the Indicative Sanctions Guidance to reflect the outcome of our public consultation and re-publish in May 2015. The new version will provide more detailed guidance on the principles and factors which MPTS fitness to practise panels should consider in making decisions. Our guidance for decision makers on warnings and undertakings at the end of an investigation will be consolidated in the revised edition. It is envisaged that MPTS fitness to practise panels will use a separate online tool to access the most recent legal case law. We are also looking at alternative means to communicate procedural issues.

Review of our restriction banks

- 16** Sometimes concerns about doctors are dealt with by imposing or agreeing limits on their right to work. This is done by placing conditions or undertakings on the doctor's registration to mitigate the risk to the public while they take steps to retrain or improve the way they work. Where there are very serious concerns about a doctor, we may impose an interim order to suspend or restrict their ability to work pending the outcome of our investigation.
- 17** In making decisions, MPTS fitness to practise panels may refer to separate guidance on restricting a doctor's registration by agreeing undertakings, or imposing conditions or interim orders. To help MPTS fitness to practise panels decide which restrictions are suitable for use in different circumstances, we issue and maintain a bank of undertakings, conditions and interim orders and a glossary of terms. To ensure these are appropriate in the modern environment in which doctors work we intend to undertake targeted engagement with stakeholders with a specific interest, e.g. employers and Responsible Officers. This work will be completed alongside the public consultation on the Indicative Sanctions Guidance.

Next steps

- 18** The outcome of Council's views on the proposals for consultation will help to inform a discussion on the way forward at the Strategy and Policy Board meeting on 22 May 2014. A draft consultation paper will then be circulated to the Strategy and Policy Board for comment, and to Council for approval in early

June 2014. We propose to launch a three month public consultation on 1 August 2014. The revised Guidance is expected to be launched for use by MPTS fitness to practise panels in July 2015.

Supporting information

How this issue relates to the corporate strategy and business plan

- 19** Strategic Aim 2 of our 2014 Business Plan is 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

- 20** The guidance used by MPTS fitness to practise panels supports transparent and consistent decision making. The public consultation on the guidance is expected to promote accountability in the way we work and 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)

- 21** This work is being taken forward by a project board which includes the Chair of the MPTS, colleagues from the MPTS and the Fitness to Practise, Registration and Revalidation, Education and Standards, and Strategy and Communication directorates. 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 2013.
- 22** Completed external engagement activities include notifying the Professional Standards Authority, government officials in the four countries, other UK health regulators and medical defence organisations. A communication and engagement plan has been produced.

How the issues differ across the four UK countries

- 23** The structure of the health service and oversight bodies differ across the four UK countries and our Guidance for panellists will be updated to reflect this.

What equality and diversity considerations relate to this issue

- 24** An equality analysis will be published alongside the consultation document in August 2014.

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Annex A

Indicative Sanctions Guidance, 2009

General Medical Council

Regulating doctors
Ensuring good medical practice

Indicative Sanctions Guidance for the Fitness to Practise Panel

April 2009
**(with 7 August 2009 revisions, March 2012
revisions and March 2013 revisions)**

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Introduction

Role and status of the Indicative Sanctions Guidance

1. This guidance has been developed by the General Medical Council (GMC). It is for use by fitness to practise panels in cases that have been referred to the Medical Practitioners Tribunal Service 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 decision-making process and factors to be considered. The Indicative Sanctions Guidance is an authoritative statement of the GMC's approach to sanctions issues.

2. The guidance is a 'living document', which will be updated and revised as the need arises. Please email any comments or suggestions for further revisions to pandevteam@mpts-uk.org.

The GMC's statutory purpose

3. 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

4. The GMC has a statutory role in providing guidance to doctors on standards of professional conduct, performance and medical ethics. Its guidance booklet [Good medical practice](#)¹, which has been drawn up after wide consultation, sets out the principles and values on which *Good medical practice* is founded, and the standards which society and the profession expects of all doctors (irrespective of their area of practice) throughout their careers.

5. The GMC also publishes [supplementary ethical guidance](#)², which expands on the principles in [Good medical practice](#), providing more detail on how to comply with them. This supplementary guidance is published in six additional booklets (on consent, confidentiality, end-of life care, research, management and children) as well

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

as a range of shorter statements – from writing references to reporting gunshot wounds – all of which can be found on the GMC’s website. When viewing [Good medical practice](#) on-line there are direct links through to the supplementary guidance and other information from the relevant paragraphs.

6. [Good medical practice](#), together with the [supplementary ethical guidance](#) on specific issues (for example consent, prescribing, acting as an expert witness, personal beliefs etc.) has therefore become a pivotal reference point in the current structures and processes for healthcare regulation, service provision and inspection, and underpins all the GMC's functions.

7. As confirmed in the introductory statements to *Good medical practice* (“Professionalism in Action” on page 4) outlining the context in which the guidance should be read, it is the responsibility of doctors to follow the guidance, exercising their judgement in any given circumstance, and being prepared to explain and justify decisions and actions. As the guidance warns doctors: *“serious or persistent failure to follow this guidance will put your registration at risk”*.

8. The Indicative Sanctions Guidance provides a crucial link between two key regulatory roles of the GMC: that of setting standards for the profession and of taking action on registration when a doctor’s fitness to practise is called into question because those standards have not been met. Although GMC members do not sit on fitness to practise panels, the GMC is responsible – under the Medical Act 1983, as amended (the Act) – for all decisions taken by the panels. The medical and lay panellists appointed to sit on panels exercise their own judgements in making decisions, but must take into consideration the standards of good practice the GMC has established. Decisions taken by panellists in relation to sanction are at their discretion, however, panellists are expected to refer to this guidance and to confirm that it has been followed or, if not, to explain why not.

9. The Indicative Sanctions Guidance aims to promote consistency and transparency in decision-making. It ensures that all parties are aware from the outset of the approach to be taken by a Fitness to Practise Panel to the question of sanction. It has received strong endorsement from the judiciary, and Mr Justice Collins in the case of *CRHP -v- (1) GMC (2) Leeper [2004] EWHC 1850* recorded that:

“It helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The [panel] must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff”.

10. Mr Justice Newman, in *R (on the application of Abrahaem) v GMC [2004]* described the Indicative Sanctions Guidance as

“Those are very useful guidelines and they form a framework which enables any tribunal, including this court, to focus its attention on the relevant issues. But one has to come back to the essential exercise which the law now requires in what lies behind the purpose of sanctions, which, as I have already pointed

out, is not to be punitive but to protect the public interest; public interest is a label which gives rise to separate areas of consideration.

Equality and Diversity Statement

The GMC's responsibilities

11. Doctors practise medicine to serve patients. It is a central function of the GMC, through the Medical Practitioners Tribunal Service fitness to practise panels, to promote the interests of patients and to protect them by ensuring a good standard in the practice of medicine by doctors who are fit to practise.

12. The GMC is committed to valuing diversity and promoting equality throughout the GMC, ensuring that our processes and procedures are fair, objective, transparent and free from unlawful discrimination. Promoting equality is also a requirement under current and emerging equality legislation. Everyone who is acting for the GMC is expected to adhere to the spirit and letter of this legislation. The GMC has published an [equality scheme](#)³, which will help to embed further the promotion of equality and diversity into our work.

The Doctors' responsibilities

13. Doctors are required to treat both colleagues and patients fairly, to the best of their ability and without discrimination. Fuller guidance is contained in *Good medical practice* (in paragraphs 48, 54, 57 and 59).

Publication of Outcomes

14. All restrictions placed on a doctor's registration (with the exception of restrictions that relate to a doctor's health) are published on the GMC's website via the [List of Registered Medical Practitioners](#)⁴. Copies of the minutes of Fitness to Practise Panel hearings held in public are also available on the MPTS [website for approximately twelve months after the date of the hearing](#).

³ http://www.gmc-uk.org/about/equality_scheme/index.asp

⁴ <http://www.gmc-uk.org/register/search/index.asp#>

Some general principles regarding sanctions

Role of the Panel and the three-stage process

15. Rule 17(2) of the Fitness to Practise Rules⁵ (the Rules) provides for a three-stage process before a panel reaches a determination on sanction. The panel has to decide in turn:

- a. Whether the facts alleged have been found proved;
- b. Whether, on the basis of the facts found proved, the doctor's fitness to practise is impaired;
- c. If so, whether any action should be taken against the doctor's registration; if the panel has not found the doctor's fitness to practise impaired, whether a warning should be issued.

16. In the interests of fairness to both parties, the panel should invite evidence and/or submissions from the GMC and the doctor at each stage of the proceedings. When considering the options available the panel should take account of the submissions made.

17. The Court of Appeal in Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460 made it plain that the functions of a Panel are quite different from those of "a court imposing retributive punishment."⁶

The purpose of sanctions and the public interest

18. The Merrison Report⁷ stated that 'the GMC should be able to take action in relation to the registration of a doctor..... in the interests of the public', and that the public interest had 'two closely woven strands', namely the particular need to protect the individual patient, and the collective need to maintain the confidence of the public in their doctors.

19. Since then a number of judgments have made it clear that the public interest includes, amongst other things:

- a. Protection of patients
- b. Maintenance of public confidence in the profession

⁵ The General Medical Council (Fitness to Practise) Rules Order of Council 2004 as amended by The General Medical Council (Fitness to Practise) (Amendment in Relation to Standard of Proof) Rules Order of Council 2008 (2008 No.1256) and The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009 (2009 No. 1913)

⁶ Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460, at paragraph 16

⁷ Report of the Committee of Inquiry into the Regulation of the Medical Profession (1975)

- c. Declaring and upholding proper standards of conduct and behaviour.

20. The purpose of the sanctions is therefore not to be punitive but to protect patients and the wider public interest, although they may have a punitive effect. This was confirmed in the judgment of Laws LJ in the case of Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460 in which he stated:

“The Sanel then is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor.”⁸

He referred to the earlier Privy Council decision in Gupta v The General Medical Council [2002] 1 WLR 1691 which stated

“It has frequently been observed that, where professional discipline is at stake, the relevant committee is not concerned exclusively, or even primarily, with the punishment of the practitioner concerned. Their Lordships refer, for example, to the judgment of Sir Thomas Bingham MR in Bolton v Law Society [1994] 1 WLR 512, 517-519 where his Lordship set out the general approach that has to be adopted. In particular he pointed out that, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension that the practitioner may be unable to re-establish his practice when the period has passed.”

Proportionality

21. In deciding what sanction, if any, to impose the panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. The panel should consider the sanctions available starting with the least restrictive.

22. Any sanction and the period for which it is imposed must be necessary to protect the public interest (see paragraphs 18 – 20). 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 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 the 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

⁸ Raschid and Fatnani v The General Medical Council [2007] 1 WLR 1460, at paragraph 18

about the test applied when considering the imposition of interim orders is set out in the GMC's [Guidance for imposing interim orders](#)⁹.

23. The panel must keep the factors set out above at the forefront of their mind when considering the appropriate sanction to impose on a doctor's registration. Whilst there may be a public interest in enabling a doctor's return to **safe** practice, and panellists should facilitate this where appropriate in the decisions they reach, they should bear in mind that the protection of patients and the wider public interest (i.e. maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour) is their primary concern.

24. Further guidance on the factors to bear in mind when considering each of those sanctions is set out in paragraphs 45 - 113 below.

Aggravating and mitigating factors

25. 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 two categories:

a. *Evidence of the doctor's understanding of the problem, and his/her attempts to address it.* This could include admission of the facts relating to the case, any apologies by the doctor to the complainant/person in question (see also paragraphs 32 - 37 below), his/her efforts to prevent such behaviour recurring or efforts made to correct any deficiencies in performance;

and

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 28 below). Mitigation could also relate to the circumstances leading up to the incidents as well as 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 or her by a previous panel or by any of the Council's previous committees.

26. The panel should also take into account matters of personal and professional mitigation which may be advanced such as testimonials, personal hardship and work related stress. Without purporting in any way to be exhaustive, other factors might include matters such as lapse of time since an incident occurred, inexperience or a lack of training and supervision at work. Features such as these 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.

⁹ http://www.gmc-uk.org/Imposing_Interim_Orders___Guidance_for_the_Interim_Orders_Panel_and_the_Fitness_to_Practise_Panel.pdf_28443349.pdf

27. The GMC may wish to draw attention to aggravating factors relating to the facts found proved by the panel, for example the circumstances surrounding the events that took place, eg whether the doctor has abused their position of trust by taking advantage of a vulnerable person (breaching paragraphs 53 and 54 of *Good medical practice*). The panel should also take into account any previous findings and sanctions imposed on the doctor's registration either by the GMC or any other regulator.

28. The principles in *Good medical practice* emphasise that doctors should take a mature and responsible approach to their career; being personally accountable for problems that arise, learning from mistakes, and working as 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:

- a. raise concerns where he/she has good reason to think that patient safety may be seriously compromised by inadequate premises, equipment or other resources, and should put matters right where possible (*Good medical practice*, paragraphs 24 and 25);
- b. protect patients from risk of harm posed by another colleague's conduct, performance or health (*Good medical practice*, paragraph 25c);
- c. be open and honest with patients if things go wrong (*Good Medical Practice* paragraphs 55 and 61);
- 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 to 74);
- 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 to 13 and 22 to 23).

29. Further guidance on considering references and testimonials and on expressions of regret and apology is set out below at paragraphs 30 - 37.

Guidance on considering references and testimonials

30. 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.

31. 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 United Kingdom 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

32. *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;
- a. put matters right (if that is possible)
 - b. offer an apology
 - c. 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

This reflects a number of expectations on behalf of the profession and the public, including that:

- a. patients should be protected from similar events reoccurring, and
- b. doctors should take positive steps to learn from their mistakes, or when things go wrong.

33. 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 their culture), offering an apology amounts to an acceptance of personal guilt which, depending on the facts, a doctor may regard as inappropriate or excessive. It is also possible that occasionally a doctor may be constrained by issues involving legal liability, for example a criminal investigation, and/or legal advice and therefore does not offer an apology.

34. This 'insight' - the expectation that a doctor will be able to stand back and accept that, with hindsight, they should have behaved differently, and that it is expected that he/she will take steps to prevent a reoccurrence - is an important factor in a hearing. 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 the panel should be aware that there may be cultural differences in the way that insight is expressed, for example, whether or how an apology or expression of regret is framed and delivered and the process of communication, and that this may be affected by the doctor's circumstances, for example, their ill health.

35. Cross-cultural communication studies show that there are great variations in the way that individuals from different cultures and language groups use language to code and de-code messages. 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 and may also 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.

36. Awareness of and sensitivity to these issues are important in determining the following:

- a. How a doctor frames his/her 'insight'.
- b. Whether or how a doctor offers an apology.
- c. The doctor's demeanour and attitude during the hearing.

37. 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.

Where no impairment is found

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

- a. No action;
- b. Issue a warning.

39. 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.

Warnings

40. 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](#); or there is a significant cause for concern following an assessment of the doctor's performance. Warnings are not appropriate in cases relating solely to a doctor's health, but may be issued in multi-factorial cases in which health is raised as one of the issues.

41. 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 GMC's [Guidance on Warnings](#)¹⁰.

42. When considering the wording of a warning, panels should have regard to the [Guidance on Warnings](#).

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

44. 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.

¹⁰ http://www.gmc-uk.org/Guidance_on_Warnings.pdf_27286909.pdf

Where impairment is found

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

- a. No action (see paragraph 48);
- b. Impose conditions on the doctor's registration for a period up to three years (see paragraphs 56 - 68);
- c. Direct that the doctor's registration be suspended for up to 12 months (see paragraphs 69 - 76);
- d. Direct erasure of the doctor's name from the register, except in cases that relate **solely** to a doctor's health (see paragraphs 77 - 84).

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 49 – 55).

46. 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 legislation¹¹ and the framework set out by the Indicative Sanctions Guidance.

47. 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, especially 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.

¹¹ eg Medical Act 1983 as amended, General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended) and various other Rules

No action

48. Where a doctor's fitness to practise is impaired the Council expects that MPTS panels will take action against the doctor's registration 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 18 - 24). There may, however, be **exceptional** circumstances in which a panel might be justified in taking no action against a doctor's registration. Such cases are, however, likely to be very rare. No action might be appropriate in cases where the doctor has demonstrated considerable insight into his/her behaviour **and** has already embarked on, and completed, any remedial action the panel would otherwise require him/her to undertake. The panel may wish to see evidence to show that the doctor has taken steps to mitigate his/her actions – see paragraphs 25 - 29 above. In such cases it is particularly important that the panel's determination sets out very clearly the reasons why it considered it appropriate to take no action notwithstanding the fact that the doctor's fitness to practise was found to be impaired.

Undertakings

49. The Rules¹² provide that a panel may agree as an alternative to imposing any sanction **written** undertakings offered by the doctor provided that the doctor agrees 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,
- 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.

50. 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).

51. Undertakings may include restrictions on the doctor's practice or behaviour, or the commitment to undergo medical supervision or retraining. As with conditions (see paragraphs 56 – 68), they 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, or where the doctor has the insight to limit his/her practice.

52. Undertakings will only be appropriate where the panel is satisfied that the doctor will comply with them, for example, because the doctor has shown genuine insight into his/her problems/deficiencies and 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 25 - 29 above).

53. The GMC has published separate guidance, [Undertakings at FTP hearings](#)¹³ which panels should follow if considering whether to accept undertakings.

54. 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 undertakings](#)¹⁴. 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.

¹² Rule 17(2)(m) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

¹³ http://www.gmc-uk.org/Undertakings_at_FTP_Panel_hearings_Aug_09.pdf_26870331.pdf

¹⁴ http://www.gmc-uk.org/Undertakings_Bank.pdf_25416205.pdf

55. 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 [Guidance on dealing with breaches of undertakings and criteria referral to Fitness to Practise Panels](#).¹⁵

¹⁵ http://www.gmc-uk.org/Guidance_on_dealing_with_breaches_of_undertakings_and_criteria_referral_to_a_Fitness_to_Practise_Panel.pdf_25416200.pdf

Conditional registration (maximum 3 years)

56. 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 (eg 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.

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

58. The purpose of conditions is to enable the doctor to deal with his/her health issues and/or remedy any deficiencies in his/her practice whilst in the meantime protecting patients from harm. In such circumstances, conditions might include requirements to work with the Postgraduate Dean or GP Director.

59. The GMC has published separate [guidance about making referrals to the Postgraduate Dean or GP Director](#)¹⁶ along with information about the [medical career structure of doctors](#)¹⁷. Panels will need to take this guidance into account bearing in mind that where the issues relate to misconduct or a criminal conviction, or to untreated health problems, referral to a Postgraduate Dean is not an appropriate way forward as they are not able to provide remedial help in such circumstances.

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

61. The objectives of any conditions should be made clear so that the doctor knows what is expected of him or 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, and in practical terms should be discussed fully by the panel before voting. Before imposing conditions the panel should satisfy itself that:

- a. 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.

¹⁶ http://www.gmc-uk.org/Guidance_for_making_referrals_to_the_Postgraduate_Dean.pdf_25416687.pdf

¹⁷ http://www.gmc-uk.org/Medical_career_structure__doctors_in_training.pdf_25417075.pdf

- b. The objectives of the conditions are clear.
- c. A future panel will be readily able to determine whether the objective has been achieved and whether patients will or will not be at risk.

62. 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 apparent having regard to the type of case (health, performance, misconduct etc.) This list is not exhaustive:

- No evidence of harmful deep-seated personality or attitudinal problems.
- Identifiable areas of the doctor's practice in need of assessment or retraining.
- 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 to 13 "Knowledge, Skills and Performance" and 22 to 23 regarding "Safety and Quality").
- Willingness to be open and honest with patients if things go wrong (*Good Medical Practice*, paragraphs 55 and 61).
- In cases involving health issues, evidence that the doctor has genuine insight into any health problems, has been compliant with the GMC's guidance on health (*Good medical practice*, paragraphs 28 to 30) and that he/she will abide by conditions relating to his/her medical condition(s), treatment and supervision.
- Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.
- It is possible to formulate appropriate and practical conditions to impose on registration.

63. Where a panel has found a doctor's fitness to practise impaired by reason of adverse physical or mental health the conditions should include conditions relating to the medical supervision of the doctor as well as conditions relating to 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.

64. Conditions should normally follow the format of conditions as set out in the [FTP Conditions Bank](#)¹⁸. Panellists may also find it helpful to refer to the definitions of the

¹⁸ http://www.gmc-uk.org/FTPP_Conditions_Bank.pdf_25415696.pdf

roles of individuals involved in doctors' supervision as provided by the GMC in the [Glossary of terms used in FTP actions](#)¹⁹.

65. The conditions bank has been developed to indicate appropriate wording for restrictions to 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 the desirability of maintaining medical confidentiality for the doctor.

66. 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 whilst taking account of the general principles outlined above.

67. If imposing conditions, it is also normally appropriate for panels to direct a review hearing. Further guidance about review hearings is set out at paragraphs 114 - 120 below.

68. Panels must also consider, as required by Rule 17(2)(o)²⁰, 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 121 - 126 below.

¹⁹ http://www.gmc-uk.org/Glossary_of_Terms_used_in_Fitness_to_Practise_Actions.dot.pdf_25416199.pdf
²⁰ General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

Suspension (up to 12 months but may be indefinite in certain circumstances in health only cases)

69. 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 unbefitting 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. 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. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that 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). This may be the case, 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 25 -29 above).

70. Suspension is also likely to be appropriate in a case of deficient performance 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 be rehabilitated if prepared to undergo a rehabilitation programme. In such cases, to protect patients and the public interest, the panel might wish to impose a period of suspension, direct a review hearing and to indicate in broad terms the type of remedial action 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. He/she 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.

71. 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. In health only cases, there are provisions to suspend a doctor's registration indefinitely – see paragraph 73 below.

72. As far as doctors with serious health problems are concerned, the option of erasure does not exist unless there are also other factors (such as a conviction, misconduct or deficient performance), which have resulted in the finding of impaired fitness to practise. In those cases, suspension is appropriate where the doctor's health 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.

73. In cases which relate solely to a doctor's health, 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.

74. 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.

75. This sanction may therefore be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- 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.
- 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.
- No evidence of harmful, deep-seated personality or attitudinal problems.
- No evidence of repetition of similar behaviour since incident.
- Panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour.

76. Panels must also consider, as required by Rule 17(2)(o)²¹, 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 121 - 126 below.

²¹ General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

Erasure

77. The Panel may erase a doctor from the register in any case - except one which relates solely to the doctor's health - where this is the only means of protecting patients and the wider public interest, which includes maintaining public trust and confidence in the profession.

78. Lord Bingham, Master of the Rolls, in the case of *Bolton v The Law Society*²², 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 unintended. But it does not make suspension the wrong order if it is otherwise right. The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.'** [our emphasis]*

79. The Gupta²³ judgment, which adopted the approach set out in *Bolton v The Law Society*, emphasised the GMC's role in maintaining justified confidence in the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk:

"..the appellant's behaviour demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession".

²² *Bolton v The Law Society* [1994] 1 WLR 512, [1993] EWCA Civ 32. The Court of Appeal's ruling in the case of *The Law Society v John Brendan Salsbury* [2008] EWCA Civ 1285 2008 WL4963085 endorsed this approach.

²³ *Dr Prabha Gupta v GMC* (Privy Council Appeal No. 44 of 2001)

80. In the case of *Bijl v the GMC*²⁴, which involved two **clinical** errors of judgement/mistakes relating to one operation performed by Dr Bijl, the Privy Council stated that [a Panel] should not feel it necessary to erase:

*“an otherwise competent and useful doctor who presents **no danger** to the public in order to satisfy [public] demand for blame and punishment [emphasis added].*

and drew attention to the statement that:

*“**honest failure** should not be responded to primarily by blame and retribution but by learning and by a drive to reduce risks for future patients” [emphasis added].*

81. There are some examples of misconduct where the Privy Council has upheld decisions to erase a doctor despite strong mitigation. This has been because it would not have been in the public interest to do otherwise given the circumstances concerned.

82. Erasure may well be appropriate when the behaviour involves **any** of the following factors (this list is not exhaustive):

- Particularly serious departure from the principles set out in *Good Medical Practice* i.e. behaviour fundamentally incompatible with being a doctor.
- A reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
- 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 112 - 113 regarding failure to provide an acceptable level of treatment/care).
- Abuse of position/trust (see *Good medical practice* paragraph 65 “you must make sure that your conduct at all times justifies your patients’ trust in you and the public’s trust in the profession”).
- Violation of a patient’s rights/exploiting vulnerable persons (see for example *Good medical practice* paragraph 27 regarding children and young people, paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services).
- Offences of a sexual nature, including involvement in child pornography (see further guidance below at paragraphs 92 - 104).
- Offences involving violence.

²⁴ Dr Willem Bijl v GMC (Privy Council appeal No. 78 of 2000)

- Dishonesty, especially where persistent and/or covered up (see further guidance at paragraphs 105 - 111 below)²⁵.
- Putting own interests before those of patients (see *Good medical practice* – “Make the care of your patient your first concern” on the inside cover and paragraphs 78 to 80 regarding conflicts of interest).
- Persistent lack of insight into seriousness of actions or consequences.

Erasure is **not** available in cases where the **only** issue relates to the doctor’s health.

83. When directing erasure, panels must also consider, as required by Rule 17(2)(o)²⁶, 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 121 - 126 below.

84. A doctor who has been erased cannot apply to be restored to the register until five years have elapsed²⁷. 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 Panel](#).²⁸

²⁵ The Law Society v John Brendan Salisbury [2008] EWCA Civ 1285 2008 WL4963085.

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

²⁷ Section 41(2)(a) Medical Act 1983 as amended

²⁸ http://www.gmc-uk.org/Guidance_for_doctors_on_restoration_following_erasure_by_a_Fitness_to_Practise_Panel.pdf_25416789.pdf

Other issues relevant to sanction

Considering conviction, caution or determination allegations

85. 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.

86. 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.

87. 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.

88. 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.²⁹ In accepting a caution, the doctor will have admitted committing the offence.

89. 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.³⁰ 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 56 to 57).

90. 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 circumstances³¹ 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.

91. Panels may wish to note that *Good medical practice* 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

²⁹ Rule 34(3) and (4) General Medical Council (Fitness to Practise) Rules Order of Council 2004

³⁰ Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001).

³¹ *CHRP v (1) GDC and (2) Mr Fleischmann* [2005] EWHC 87 (Admin)

professional body has made a finding against [their] registration as a result of fitness to practise procedures.” (*Good medical practice* paragraph 75).

Sexual misconduct

92. 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 or patients’ relatives. See further guidance on sex offenders and child pornography at paragraphs 95 - 104 below.

93. 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](#)³².

94. 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 which a doctor occupies, or where a doctor has been required to register as a sex offender. The risk to patients is important. In such cases erasure has therefore been judged the appropriate sanction:

*‘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.’*³³

Sex offenders and child pornography

95. 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 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 honest and integrity, paragraphs 46 to 49 regarding establishing and maintaining partnerships with patients, particularly paragraph 47 regarding respecting their dignity, and paragraph 27 regarding children and young people).

³² http://www.gmc-uk.org/guidance/current/library/maintaining_boundaries.asp

³³ *Dr Mohamed Shaker Haikel v General Medical Council* (Privy Council Appeal No. 69 of 2001). See also *Dr Ali Abdul Razak v General Medical Council* [2004] EWHC205 (Admin).

96. In the case of *CHRP v (1) GDC and (2) Mr Fleischmann* [2005] EWHC 87 (Admin) the Court gave some guidance on the handling of cases involving Internet child pornography.

97. 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.

98. Whilst the courts properly distinguish between degrees of seriousness, the Council considers any conviction for child pornography against a registered medical practitioner to be a matter of grave concern because it involves such a fundamental breach of patients' 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 15- 4 and 45-113 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.

99. The panel should be aware that any conviction relating to child pornography will lead to registration as a sex offender and possibly to court ordered disqualification from working with children. **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.

100. The Council has also expressed the view that, 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.)

101. 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.

102. 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.

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

104. 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.

Dishonesty

105. The GMC's guidance, *Good medical practice*, states that registered doctors must be honest and trustworthy, and must never abuse their patients' trust in them or the public's trust in the profession.

"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)

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

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

The GMC's guidance further emphasises the duty to avoid conflicts of interest (see *Good medical practice* paragraphs 78 to 80 and our separate guidance on

Conflicts of Interest³⁴⁾

107. In relation to providing and publishing information about their services *Good Medical Practice* advises doctors that:

“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” (paragraph 70).

108. Dishonesty, even where it does not result in direct harm to patients but is for example related to matters outside the doctor’s clinical responsibility, e.g. providing false statements or fraudulent claims for monies, is particularly serious because it can undermine the trust the public place in the profession. The Privy Council has emphasised that:

‘...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.’³⁵

109. 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 to 21 regarding the duty to keep clear, accurate and legible records, and paragraphs 71 to 74 regarding writing reports and CVs, giving evidence and signing documents; see also our separate guidance on [writing references](#)³⁶).

110. Research misconduct is a further example. The term is used to describe a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and the profession have in medicine as a science, regardless of whether this leads to direct harm to patients. Because it has the potential to have far reaching consequences, this type of dishonesty is particularly serious. Paragraph 67 of *Good medical practice* states that:

³⁴ http://www.gmc-uk.org/guidance/current/library/conflicts_of_interest.asp

³⁵ Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001).

³⁶ http://www.gmc-uk.org/guidance/current/library/writing_references.asp

“You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance” (paragraph 67).

(see also our separate guidance on [Research: The Role and Responsibilities of Doctors](#)³⁷

111. Dishonesty, especially where persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 82 above).³⁸

Failing to provide an acceptable level of treatment/care

112. 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.

113. 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.³⁹

³⁷ http://www.gmc-uk.org/Research_the_role_and_responsibilities_of_doctors_2002.pdf_31588009.pdf

³⁸ Dr Jamal Abdi Farah v General Medical Council [2008] EWHC 731 Admin and Dr Sushant Varma v General Medical Council [2008] EWHC 753 Admin and The Law Society v John Brendan Salsbury [2008] EWCA Civ 1285 2008 WL4963085

³⁹ See judgment in the case of Dr Purabi Ghosh v General Medical Council (Privy Council Appeal No. 69 of 2000). Also Dr John Adrian Garfoot v General Medical Council (Privy Council Appeal No. 81 of 2001).

Review hearings

114. 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)⁴⁰ 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.

115. 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 submit in advance of the review hearing. This information will be helpful both to the doctor and to the panel considering the matter at the review hearing.

116. 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. The panel should consider whether the doctor has produced any information/objective evidence regarding these matters.

117. Where a panel has found that the doctor has not complied with the conditions on his/her registration it may direct erasure (except in a health only case) or suspension (up to 12 months)⁴¹. The panel will need to consider carefully whether the breach was wilful, ie the doctor is culpable. If it finds that the breach was **not** wilful and therefore does not constitute a failure to comply within the meaning of the Act and the Rules, but considers that the doctor's fitness to practise is impaired, it may direct

⁴⁰ Rule 22(f) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)

⁴¹ Section 35D (9) and (10) Medical Act 1983 as amended

erasure, suspension, extend the conditions for a period up to three years, revoke or vary any of the previous conditions.⁴²

118. 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)⁴³. In cases involving solely the doctor's health, it is also open to the panel to suspend the doctor's registration indefinitely⁴⁴ (see also paragraph 73 of this guidance).

119. Where a review hearing cannot be concluded before the expiry of the period of conditional registration or suspension, the panel may extend that period for a further short period⁴⁶ 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.

120. The panel may as an alternative to imposing any 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:

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

⁴² Section 35D (11) and (12) Medical Act 1983 as amended

⁴³ Section 35D (5) Medical Act 1983 as amended

⁴⁴ Section 35D (6) Medical Act 1983 as amended

⁴⁵ Under the provisions of Section 35D Medical Act 1983 as amended

Immediate orders (suspension or conditions)

121. 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.

122. 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 practitioner⁴⁶. 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 (eg irresponsible prescribing when the doctor is in prison, particularly of drugs of addiction; *Good medical practice*, paragraphs 16(a) and 19 to 21 and '[Good practice in prescribing medicines](#)')⁴⁷. 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.

123. 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 (ie breached paragraphs 14 to 21, 24 to 26, 51 and 56 to 59, *Good medical practice*) 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.

124. 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 Primary Care Trust, 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.

125. 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. 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.

⁴⁶ Section 38 of the Medical Act 1983 as amended

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

126. 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. 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.

List of other documents and guidance available to Panels

Medical Act 1983 (as amended):

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

General Medical Council (Constitution of Panels and Investigation Committee) Rules 2004: <http://www.opsi.gov.uk/si/si2004/20042611.htm>

General Medical Council (Legal Assessors) Rules 2004:
<http://www.opsi.gov.uk/si/si2004/20042625.htm>

General Medical Council (Fitness to Practise) Rules 2004 (as amended):
http://www.gmc-uk.org/consolidated_version_of_FTP_Rules.pdf_26875225.pdf

Good medical practice – Current edition

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

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

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

Guidance to the Fitness to Practise Rules:

http://www.gmc-uk.org/Guidance_to_the_FtP_Rules__2_.pdf_35398575.pdf

Meaning of Fitness to Practise:

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

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

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

Pre-Adjudication Case Management Procedure Guidance Manual

http://www.mpts-uk.org/static/documents/content/250a_Pre_hearing_case_management_procedure__post_1_Feb_2011.pdf_48760565.pdf

Guidance for Specialist Advisers

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

Guidance on warnings

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

Undertakings at FTP Panel hearings – Procedure and guidance

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

Undertakings bank

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

FTP Conditions Bank

http://www.mpts-uk.org/static/documents/content/FTPP_Conditions_Bank.pdf_25415696.pdf

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

Medical career structure – Doctors in training

http://www.mpts-uk.org/static/documents/content/Medical_career_structure___doctors_in_training.pdf_25417075.pdf

Glossary of terms used in FTP actions

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

Guidance on the use of clinical attachments

http://www.gmc-uk.org/Clinical_attachments_guidance.pdf_25416788.pdf

International Classification of Diseases (ICD10):

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

Imposing Interim Orders – Guidance for IOP and FTP Panels

http://www.gmc-uk.org/Imposing_Interim_Orders___Guidance_for_the_Interim_Orders_Panel_and_the_Fitness_to_Practise_Panel.pdf_28443349.pdf

IOP Conditions Bank

http://www.gmc-uk.org/IOP_Conditions_Bank.pdf_25416202.pdf

Voluntary Erasure – Guidance for decision-makers:

http://www.gmc-uk.org/voluntary_erasure_guidance.pdf_25416412.pdf

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

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

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

<http://www.mpts-uk.org/decisions/1655.asp>