

# 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 detailed 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 and GMC decision makers.

## 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.

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# 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 of doctors do 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 their 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

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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. 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 health
  - a determination by a regulatory body responsible for the regulation of health and social care, either in the United Kingdom 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 above 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

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does not remove the requirement to investigate and respond to concerns about a doctor's fitness to practise.

- 22.** Where the doctor 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 it appears to the case examiners 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 published and 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 departure from the professional standards, that there will be a presumption of an issue of impaired fitness to practise. These tend to fall within seven main headings:
- a. sexual assault or indecency
  - b. sexual or improper emotional relationships with a patient or someone close to them
  - c. violence
  - d. dishonesty
  - e. unlawfully discriminating in relation to characteristics protected by law
  - f. knowingly practising without a licence
  - g. gross negligence or recklessness about a risk of serious harm to patients.
- 25.** Where allegations fall under one of the seven headings, there is a presumption of impaired fitness to practise. This means that, where there is evidence to support the allegations, in order to avoid a referral to a medical practitioners tribunal the presumption of impairment must be rebutted.
- 26.** The presumption of impairment may be rebutted in violence and dishonesty cases, where the nature of the conduct is such that the doctor would not pose a risk to patients, to public confidence or to proper professional standards and conduct ie it is at the lower end of the spectrum of seriousness.
- 27.** In light of the particular issues that arise in cases involving a doctor who is unwell, issues relating to a doctor's health may in some circumstances amount to exceptional reasons for concluding that a referral to tribunal of an allegation that carries a presumption of impairment is not necessary but would not always do so. This means the fact an allegation has a presumption of impairment does not preclude the agreement of undertakings where

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there is cogent evidence the conduct is closely linked to health concerns. A close link between the doctor's health and an allegation with a presumption of impairment, where any risk to patients and public confidence in the medical profession would be addressed by agreeing undertakings in relation to the doctor's health, can be a proportionate way to address a matter as long as the misconduct is at the lower end of the spectrum of seriousness (see guidance on Health and Misconduct).

- 28.** In all presumption of impairment cases there may be exceptional reasons for concluding that a referral to tribunal is not necessary.
- 29.** 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 not done so.
- 30.** There may be instances where, following a full investigation, 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. Case examiners should consider seeking legal advice, in these circumstances, if it has not already been provided.

## Considering relevant context and evidence of insight and remediation

- 31.** Relevant context is the specific setting or circumstances surrounding a concern. It may be relevant in all cases to the assessment of whether a doctor poses any current and ongoing risk to public protection ie whether a doctor's fitness to practise is impaired, where it has influenced the doctor's performance, behaviour or health. Any such influence can be in a positive or negative way.
- 32.** Types of relevant context include the working environment in which a doctor was practising (systems and interpersonal factors) a doctor's role and experience and personal context. Further explanation about each type of relevant context can be found in the explanatory guidance What we mean by fitness to practise.
- 33.** When considering whether the realistic prospect test is met, case examiners will take into account any relevant context evidenced on the papers which they consider is relevant to their decision, along with evidence relating to the doctor's response to the concern, such as insight and remediation.
- 34.** Personal factors context is distinct from the doctor's character and good standing, the impact on the doctor's career and/or on health services. These factors will usually only be relevant when a tribunal is deciding what is a proportionate sanction to impose following a finding of impaired fitness to practise or, in the case of the doctor's character and good standing in the community, when case examiners have decided that the realistic prospect test has not been met and are considering whether a warning would be appropriate\*.

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\* Separate [guidance on Warnings can be found here](#).

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- 35.** Where the allegations fall within one of the categories where there is a presumption of impaired fitness to practise, the case examiners should be mindful that evidence of relevant context that may reduce the risk to public protection posed by the doctor, will carry less weight.
- 36.** Evidence of insight and remediation will also carry less weight in such cases. The case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin) (see paragraph 93 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.
- 37.** In some cases, where the alleged conduct falls within a presumption of impairment category, it will also result in a criminal conviction. Guidance on handling convictions is 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.)

## Sexual assault or indecency

- 38.** This encompasses a wide range of behaviour including allegations of sexual assault and abuse, allegations in relation to indecent images of children and allegations of sexual harassment in the workplace. This category also includes misconduct within a clinical setting where there is an allegation the doctor's behaviour was sexually motivated. For example, performing an intimate examination with no clinical justification or failing to maintain professional boundaries when treating a patient by making a remark of a sexual or inappropriate personal nature.
- 39.** 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.

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## Sexual or improper emotional relationships with a patient or someone close to them

**40.** A finding of a sexual or improper emotional relationship with a patient, or someone close to them, is a very serious departure from the professional standards. *Good medical practice* states:

‘You must not act in a sexual way towards patients or use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. You must follow our more detailed guidance on *Maintaining personal and professional boundaries*.’

(GMP paragraph 86)

**41.** [Maintaining personal and professional boundaries](#) provides more detailed guidance on the issue of sexual and improper emotional relationships with current and former patients.

## Violence

**42.** Evidence a doctor has been violent can represent a very serious departure from the professional standards and poses a risk to confidence in the medical profession. Many allegations of violence will result in a conviction. However, there may be cases which were not prosecuted or which did 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 the workplace. Allegations which arose in the context of a doctor’s professional environment are likely to increase the risk the doctor poses to public protection.

## Considering risk

**43.** Violence carries a presumption of impaired fitness to practise. However, it can involve a range of behaviour and case examiners will need to have regard to where on the spectrum of seriousness the doctor’s alleged departure from the professional standards sits. The presumption of impairment is likely to be rebutted in cases at the lower end of the spectrum where the doctor’s behaviour does not pose a risk to public protection. These cases can be concluded with a warning, advice or no action.

**44.** In assessing risk, case examiners should consider the individual circumstances of the allegation and weigh all the available evidence. In doing so, they should bear in mind each of the three distinct parts of public protection and carefully consider whether the doctor poses a risk to patients, to public confidence in the profession or to proper professional standards and conduct.

**45.** Depending on the circumstances, the risk posed by the doctor’s behaviour is likely to be lower where the violence:

- a. was limited in nature rather than a sustained or repeated assault
- b. caused no physical injuries or they were very minor in nature. Case examiners should bear in mind that violence can also result in emotional or psychological harm. Where this harm was significant, this may increase the risk to public protection.

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- c. occurred outside the context of the doctor's professional role.
- 46.** Case examiners should however be alert to any factors which would increase the overall risk. Although this is not an exhaustive list, the risk posed by the doctor is likely to be higher where one or more of the following factors apply.

The violence:

- a. was sustained or repeated
- b. resulted in physical injuries that were more than very minor in nature or caused significant emotional or psychological harm
- c. occurred in the context of the doctor's professional role
- d. was directed towards a vulnerable person\*
- e. was motivated by hostility towards someone's race, sexual orientation, disability, sex, gender, religion, age or the doctor's assumptions about the alleged victim's protected characteristics.

Other relevant factors likely to increase the risk posed by the doctor's behaviour include:

- a. the doctor having a history of violent behaviour and there being a likelihood of repetition. Case examiners should refer to our guidance on taking a doctor's previous history into account.
  - b. a lack of insight from the doctor in relation to their violent conduct. This may increase the likelihood of future repetition and the overall risk posed by the doctor.
- 47.** If, having considered all the circumstances, case examiners are satisfied the RPT is not met, they should consider whether it is appropriate to issue a warning<sup>†</sup>. Warnings allow us to indicate to a doctor that their behaviour represents a significant departure from the standards set out in Good medical practice and should not be repeated.
- 48.** In some cases, where the violence is at the lower end of the spectrum of seriousness and/or there is significant evidence of relevant context and/or evidence of insight and remediation that reduces the risk to public protection, a warning may be disproportionate and the case can be concluded with no action or advice. Case examiners should refer to the [Warnings guidance](#) for examples of factors that are relevant to whether a warning is appropriate.

## Dishonesty

- 49.** Case law has established that because of the privileged and trusted role doctors have, society expects higher standards of them. Maintaining patients' confidence in the professionals that treat them is more important than the interests of an individual doctor. Evidence a doctor has
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\* Vulnerability can be permanent or temporary and caused by matters such as age (children and young people younger than 18 years should be considered vulnerable), frailty, disability, illness, or current circumstances such as bereavement or redundancy.

<sup>†</sup> Separate [guidance on Warnings is here](#).

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been dishonest can represent a very serious breach of our professional standards and pose a risk to confidence in the medical profession, even where the dishonesty is unconnected with a doctor's clinical practice.

**50.** 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.

**51.** Examples of dishonesty in professional practice can 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.

**52.** Examples outside professional practice can include:

- fraud
- misuse of charitable funds
- theft including shoplifting
- forging signatures or documents.

**53.** *Good medical practice* provides as follows:

'When designing, organising or carrying out research, you must put the interests of participants first. You must act with honesty and integrity, and follow national research governance guidelines and our more detailed guidance on Good practice in research.' (GMP paragraph 85)

**54.** Good practice in research\* provides more detailed guidance on the principles of good research practice which must be followed.

## Considering risk

**55.** Dishonesty carries a presumption of impaired fitness to practise. However, it can encompass a wide range of behaviour, some of which is at the lower end of the spectrum of seriousness.

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\* [http://www.gmc-uk.org/guidance/ethical\\_guidance/5992.asp](http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp)

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- 56.** Case examiners should therefore consider where on the spectrum the doctor's alleged departure from the professional standards sits. The presumption of impairment is likely to be rebutted in cases at the lower end of the spectrum where the doctor's behaviour does not pose a risk to public protection. Some of these cases may be concluded with a warning but may also sometimes be closed with advice or no action.
- 57.** When considering an allegation of dishonesty, case examiners should weigh all the available evidence together with the individual circumstances of the case. In doing so, they should take into account each of the three parts of public protection and carefully consider whether the doctor poses a risk to patients, to public confidence in the profession or to proper professional standards and conduct.
- 58.** Depending on the circumstances, in cases involving dishonesty at the lower end of the spectrum, the risk posed by the doctor's behaviour is likely to be lower where:
- the dishonesty was not persistent or repeated over a period of time;
  - the value of the financial or other benefit derived by the doctor from the dishonesty was not significant;
  - the dishonesty occurred outside the context of the doctor's professional role.
- 59.** Even when one or more of the above factors is present, the realistic prospect test may still be met depending on the particular circumstances of the case.
- 60.** Case examiners should be alert to factors which would increase the overall risk. These may include one or more of the following, although this is not an exhaustive list.
- The dishonesty was persistent.
  - The value of the benefit was significant.
  - The dishonesty affected patient care, directly or indirectly, or had the potential to do so.
  - The dishonesty involved an attempt to conceal professional misconduct, clinical errors or deficiencies and/or to blame others.
  - The dishonesty undermined the integrity of a system designed to protect the public.
  - The dishonesty was directed towards a vulnerable person\*.
  - The doctor has a history of dishonest behaviour and there is a likelihood of repetition. Case examiners should refer to our [guidance on taking a doctor's previous history into account](#).
  - The doctor has demonstrated a lack of insight in relation to their dishonest behaviour. This may increase the likelihood of future repetition and the overall risk posed by the doctor.
- 61.** If, having considered all the circumstances, case examiners are satisfied the RPT is not met,
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\* Vulnerability can be permanent or temporary and caused by matters such as age (children and young people younger than 18 years should be considered vulnerable), frailty, disability, illness, or current circumstances such as bereavement or redundancy.

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they should consider whether it is appropriate to issue a warning\* to signify to the doctor that their behaviour was unacceptable and should not be repeated.

- 62.** Although the GMC takes all allegations of dishonesty seriously, there will be some cases alleging dishonesty which is minor in nature where issuing a warning is unlikely to be a proportionate response and closure with advice or no action is appropriate. Case examiners should refer to the Warnings guidance for examples of factors that are relevant to whether a warning is indicated.

## Unlawful discrimination in relation to characteristics protected by law

- 63.** Doctors must treat their colleagues and patients fairly, whatever their life choices and beliefs. The guidance on this can be found in paragraphs 19, 33 and 56 of Good medical practice.
- 64.** 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 56.) However where discrimination relates to characteristics protected by legislation, and is therefore unlawful, this will give rise to a presumption of impairment.
- 65.** Doctors who unlawfully discriminate against members of the public will have departed from the professional standards on two counts: firstly, the duty to act within the law (Good medical practice, paragraph 4); and also the duty to make sure their conduct justifies patients' trust in them and the public's trust in the medical profession (Good medical practice, paragraph 81).
- 66.** 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 more detailed guidance Personal beliefs and medical practice).
- 67.** Good medical practice and the documents it links to including the more detailed guidance provide a more complete picture of behaviour of this kind, but even it is not exhaustive.

## Knowingly practising without a licence

- 68.** 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.

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\* Separate [guidance on Warnings is here](#)

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**69.** Each case will need to be considered on its own facts but if a doctor has deliberately misled patients or others about their licensing status, there is a presumption the case should be referred forward to a medical practitioners tribunal hearing.

## **Gross negligence or recklessness about the risk of serious harm to patients**

**70.** Where there is evidence of a departure from the professional standards that 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 clinical 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 to the public.

**71.** 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 their current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.\*

**72.** Where a doctor's clinical failings amount to gross negligence or recklessness about a serious risk to patients then, notwithstanding steps taken to seek personal remediation, public confidence would be damaged if we did not act. 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, as a result of the doctor's actions, a serious risk of harm to patients was likely.

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

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## Other departures from the professional standards

- 73.** Other departures from the professional standards that do not carry a presumption of impairment, 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.
- 74.** For these cases, in deciding whether evidence of a departure from the professional standards meets the realistic prospect test, the case examiners will need to consider both the nature and seriousness of the allegations to which the evidence relates 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 evidence of a departure meets the realistic prospect test.

### Seriousness of allegations

- 75.** Where there is evidence of a departure from the professional standards, the case examiners will need to proceed to consider how serious it is. Whilst doctors are expected to comply with the standards in Good medical practice, not all departures from the standards will pose a risk to public protection and 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.
- 76.** 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 act.
- 77.** Good medical practice states that if a doctor seriously departs from the standards, it can mean that they pose a current and ongoing risk to public protection. 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.

### Sexual misconduct

- 78.** Sexual misconduct encompasses a wide range of unacceptable sexual behaviours that may vary in nature and severity, and some of which constitute a criminal offence. Although some of the most serious types of sexual misconduct allegations carry a presumption of impaired fitness to practise, allegations which do not fall within these categories can still have a devastating impact on individuals, teams and patient safety and constitute a very serious departure from our professional standards as set out in Good medical practice which states:
- 'You must not act in a sexual way towards patients or use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them. You must follow our more detailed guidance on Maintaining personal and professional boundaries.'

(GMP paragraph 86)

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‘You must not act in a sexual way towards colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress. What we mean by acting ‘in a sexual way’ can include – but isn’t limited to – verbal or written comments, displaying or sharing images, as well as unwelcome physical contact. You must follow our more detailed guidance on Maintaining personal and professional boundaries.’

(GMP paragraph 57)

- 79.** When considering sexual misconduct allegations and how they engage the professional standards that doctors are expected to meet as well as the extent of the departure from the standards, case examiners should also be referring to our more detailed guidance Maintaining personal and professional boundaries. The guidance sets out our expectations in relation to personal and professional boundaries, respect for others, trust and vulnerabilities such as differences in power levels.

## Criminal convictions and cautions

- 80.** 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 increase the seriousness and overall level of risk to public protection posed by the doctor. A conviction involving illegal drugs will be viewed seriously.
- 81.** 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 factors that increase seriousness, 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, a conviction for verbal abuse during a row with a bouncer (as long as there are no factors that increase seriousness, for example racial abuse).

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

- 82.** 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

- 83.** 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

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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**

**84.** 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.

**85.** 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 treat patients with kindness, courtesy and respect. This doesn't mean agreeing to every request (see paragraph 7d) or withholding relevant information that may be upsetting or unwelcome (see paragraph 28). It means:

- a. communicating sensitively and considerately, particularly when you're sharing potentially distressing issues about the patient's prognosis and care
- b. listening to patients, recognising their knowledge and experience of their health, and acknowledging their concerns
- c. trying not to make assumptions about what a patient will consider significant or the importance they will attach to different outcomes.'

(GMP paragraph 23)

'You must recognise and respect every patient's dignity and right to privacy.'

(GMP paragraph 16)

'You must treat patients fairly. You must not discriminate against them or allow your personal views to affect your relationship with them, or the treatment you provide or arrange. You must not refuse or delay treatment because you believe that a patient's actions or choices contributed to their condition.'

(GMP paragraph 19)

'The exchange of information between medical professionals and patients is central to good decision making. You must give patients the information they want or need in a way they can understand. This includes information about:

- a. their condition(s), likely progression, and any uncertainties about diagnosis and prognosis
- b. the options for treating or managing the condition(s), including the option to take no action
- c. the potential benefits, risks of harm, uncertainties about, and likelihood of success for each option.'

(GMP paragraph 28)

'You must treat information about patients as confidential, including after a patient has died.'

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You must follow our more detailed guidance on Confidentiality: good practice in handling patient information.'

(GMP paragraph 22)

- 86.** *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 and moral beliefs) to patients in ways that exploit their vulnerability or could reasonably cause them distress. You must follow our more detailed guidance on *Personal beliefs and medical practice*.'

(GMP paragraph 87).

## A doctor's health is compromising patient safety

- 87.** The GMC does not necessarily need to be involved because a doctor is unwell, even if the illness is *serious*. However, we need to consider the impact of a doctor's health condition in the following circumstances.

- There are also concerns about their conduct that puts patients or public confidence in the profession at risk and their health condition may be a contributory factor. This includes where there are concerns amounting to serious misconduct and criminal offences involving drugs.
- The doctor is working or likely to work and:
- there are, or have been, serious concerns about the clinical care the doctor has provided and a health condition may have been a contributory factor the nature of the doctor's health condition may affect their conduct or the clinical care they provide and the doctor is not seeking and/or following treatment and advice, and/or is not engaging with local support and steps put in place to manage any risks to patients. This suggests the doctor may lack insight into any risk, or potential risks, their health condition poses, or
- the doctor's health condition has only recently been diagnosed, is not well controlled and it is too soon to know if risks to patients can be appropriately managed by the doctor seeking and following treatment and advice and/or engaging with local support and steps to manage risk.

- 88.** Although intended for triage decisions, it may be helpful to refer to additional guidance for decision makers on assessing risk in health cases attached at Annex J.

- 89.** *Good medical practice* provides:

'You must consult a suitably qualified professional and follow their advice about any changes to your practice they consider necessary if:

- a. you know or suspect that you have a serious condition that you could pass on to patients
- b. your judgement or performance could be affected by a condition or its treatment.

You must not rely on your own assessment of the risk to patients.'

(GMP Paragraph 79)

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

## A doctor's knowledge of English is compromising patient safety

91. 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.
92. 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 5)
93. The guidance on directing language assessments at Annex E provides further guidance on relevant issues which may give rise to a serious concern.

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

94. 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):
- is easily remediable
  - and that it has already been remedied
  - and that it is highly unlikely to be repeated.
95. 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 below.*
96. *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.*
97. In a few cases, a doctor's departure from the professional standards (including serious performance concerns) may be so serious that, regardless of any attempts at personal

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remediation made by the doctor, action must be taken to address the damage that has been done to public confidence. One example of this might be 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. Another example is a one off failing involving gross negligence or recklessness about a risk of serious harm. A finding of this kind carries a presumption of impairment (see above).

- 98.** *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 the poor performance or behaviour that amounted to a departure from the professional standards 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.*
- 99.** *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.
- 100.** *Personal statements ('self certification') are not considered appropriate evidence of remediation.*
- 101.** 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.
- 102.** If the Investigation Committee or case examiners are satisfied that the poor performance or behaviour that amounted to a departure from the professional standards 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 poor performance or behaviour 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.
- 103.** 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.

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## Undertakings

- 104.** Undertakings may only be agreed where it appears to the case examiners that the doctor's fitness to practise is impaired (or is likely to be, on recurrence of a health 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.
- 105.** Where it appears to the case examiners that a doctor's fitness to practise is impaired (or is likely to be in the event of the recurrence of a health 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 attach 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.
- 106.** 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.
- 107.** 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

- 108.** 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.
- 109.** Case examiners and the Investigation Committee will first need to apply the realistic prospect test as set out above. 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.
- 110.** 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

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range of factors. This will include the impact of any relevant context known to us, such as the seniority of the doctor, the level of supervision and the effect of external factors such as systems failures, as well as how the doctor has responded to the allegation, including evidence of insight and remediation. 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.

- 111.** 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 available to them, when considering whether or not to issue a warning.
- 112.** When considering a warning, case examiners should take account of the separate guidance on issuing warnings.
- 113.** Although a warning does not affect a doctor's registration or licence, it will appear on the register during the 2-year period that it remains valid. After this time, while they will not be disclosed to general enquirers or prospective employers, they can be disclosed to a doctor's current employer indefinitely.

## Case Examiner decisions following withdrawal of a matter under rule 28

- 114.** Rule 28(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.)
- 115.** When a case is referred back to the case examiners under Rule 28(3)(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 them to consider other options, such as carrying out further enquiries.
- 116.** 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

- 117.** 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.
- 118.** The case examiners' decision should take account of the guidance in paragraph 103-106 above and in the guidance on undertakings in [Annex F](#).
- 119.** 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.

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## Warnings

120. 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.
121. In considering whether a warning is appropriate in these circumstances, the case examiners should apply the guidance above and in the separate [guidance on issuing warnings](#).
122. 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.
123. 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

124. 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.

## Doctors holding provisional registration

125. Rarely, case examiners will be asked to make a fitness to practise decision in relation to a doctor who holds provisional rather than full registration. A doctor's provisional registration will ordinarily automatically lapse on the expiry of their full allowance of 3 years and 30 days\*. However, where the doctor is subject to fitness to practise proceedings on or after the date their provisional registration would have lapsed, their provisional registration will not lapse until we complete those proceedings. This may be through a case examiner decision to close the case, issue a warning or once an MPT determination takes effect. It is important to note that provisional registration will also lapse upon the receipt of undertakings signed by the doctor.†
126. When considering whether the RPT is met, case examiners should assess the seriousness of the allegations and the strength of the evidence we hold in support of them in the usual way. However, the fact that the doctor's provisional registration will lapse on the completion of the fitness to practise proceedings is a relevant factor when considering whether action is proportionate and in the public interest. Where the allegations are very serious and public

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\* [The General Medical Council \(Maximum Period of Provisional Registration\) Regulations Order of Council 2015](#),

† Under regulation 4(2)(d) of [The General Medical Council \(Maximum Period of Provisional Registration\) Regulations Order of Council 2015](#)

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confidence in the profession would be undermined were they not fully considered at a public hearing, a referral to an MPT should be made.

- 127.** However, there may be some cases where it is not proportionate to refer a doctor with time limited provisional registration to tribunal even where the RPT is met. These may include cases involving violence and dishonesty at the lower end of the spectrum particularly where the events occurred in a doctor's personal life. For example, a police caution for theft of low value items or a minor assault following an altercation outside of the workplace. In addition, where a case involves clinical performance for example where a doctor has been referred to us following failure of their Foundation year, a referral to tribunal on the grounds of deficient performance is unlikely to be proportionate or in the public interest. Although our legal role to protect the public must take precedence, in deciding how this is best met case examiners are entitled to consider the specific circumstances of a doctor's case. These will include whether the doctor will continue to be registered following completion of the fitness to practise proceedings.
- 128.** It is important to note that in circumstances where a doctor holds provisional registration that will lapse on the completion of fitness to practise proceedings, the fitness to practise concern must reach a final outcome. Unlike circumstances where a doctor is granted voluntary erasure or administrative erasure is authorised, there is no specific power to revisit pre-existing fitness to practise concerns if a doctor were, at a future date, to apply for full registration.

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## Annexes

(not attached but available on [www.gmc-uk.org](http://www.gmc-uk.org))

- [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, varying and revoking undertakings
- [Annex G:](#) Illustrative examples
- [Annex H:](#) Guidance on single clinical incidents
- [Annex I:](#) Guidance on considering applications for voluntary erasure
- [Annex J:](#) Guidance for decision makers on assessing risk in health cases

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