General Medical Council

# What we mean by fitness to practise

1. Fitness to practise is an assessment of a doctor's ability to practise safely and effectively. It includes considering a doctor's overall ability to perform their individual role, their professional and personal behaviour, and the impact of any health condition on their ability to provide safe care.
2. Decisions about fitness to practise are made throughout an individual's medical education and career. We have responsibility for assessing fitness to practise at the point of registration, during revalidation and where a concern arises about a doctor who is on the medical register.
3. We are legally required to make sure that our decisions protect the public. It's also vital that both the public and doctors trust us to make the right decisions. So, when we assess a concern about a doctor, we follow the guiding principles set out in *Decision making principles in fitness to practise*.
4. *What we mean by fitness to practice* describes:
    a. What decisions are made about a doctor's fitness to practise
    b. How we assess fitness to practise, and
    c. What might be a fitness to practise concern, and why.

# a. What decisions are made about a doctor's fitness to practise

## Fitness to practise and medical students

**5.** The nature of UK medical studies puts medical students in contact with patients and members of the public. Because of this, we expect medical students to display standards of competence and behaviour that are different from those expected of other students who are not training to join a regulated profession.

**6.** Medical students are expected to follow the standards of professional behaviour set out in *Achieving good medical practice: guidance for medical students*.

**7.** UK medical schools and educators are responsible for giving their students opportunities to learn, understand and practise the standards we expect of them. Where a medical student's behaviour, performance or health condition becomes a cause for concern, a medical school may follow fitness to practise procedures. Once this process has been completed and if a student has not improved, then they may not be allowed to graduate when they had initially planned, or at all.

**8.** To encourage a consistent framework, in our guidance *Professional behaviour and fitness to practise* we give advice to medical schools and educators on managing processes for student fitness to practise.

## Fitness to practise at the point of registration

**9.** Fitness to practise at the point of registration is an assessment of whether a medical graduate can join the medical register.

**10.** The medical register is there to give confidence that doctors who hold registration with the GMC* have the knowledge, skills and experience needed to meet the standards expected of them. When an individual applies to join the medical register, we need to be satisfied they can communicate effectively in English and that their behaviour, performance and health will not pose a risk to public protection.

**11.** We can only grant an individual registration if their fitness to practise is not impaired ie they do not pose a current and ongoing risk to public protection. Whether a doctor's fitness to practise is impaired at the point of registration is a binary decision as registration is either granted or refused. Decisions are made in line with *GDM4 The test of fitness to practise at the point of registration*.

* To practise medicine in the UK, a doctor must be registered with the GMC and hold a licence to practise. Some doctors who practise medicine outside of the UK are required by the legal framework governing that jurisdiction to hold registration with a licence to practise with the GMC, for example the Crown Dependencies of Jersey, Guernsey and the Isle of Man and some British Overseas Territories.

## Fitness to practise of a registered doctor

**12.** Fitness to practise of a registered doctor is an assessment of that doctor's ability to practise safely and effectively. It includes considering a doctor's performance, behaviour and / or the impact of a health condition on their ability to provide safe care. Different organisations and individuals have roles to play in ensuring that doctors are fit to practise and that the public is protected from those that are not.

### The role of local systems

**13.** Organisations who employ, or contract services from, doctors have important roles to play in ensuring doctors are fit to practise. For example, all doctors should participate in ongoing activities that assess their skills, allow them to receive feedback and support them to develop, such as annual appraisals.

**14.** Responsible officers are usually senior doctors within a healthcare organisation. They have statutory responsibilities* that include making sure systems are in place to evaluate doctors' fitness to practise on an ongoing basis. Where there are concerns about a doctor's fitness to practise, responsible officers have a duty to ensure that appropriate action is taken. This may include taking steps locally to support the doctor or limit their practice, or, where necessary, by making a referral to us.

### The role of the regulator

- ***The role of revalidation***

**15.** Doctors who hold a licence to practise† must take part in a process called revalidation to show they are keeping their knowledge up to date and are fit to practise.

**16.** Most doctors revalidate through a process of annual appraisals based on *Good medical practice* and a recommendation to the GMC from their responsible officer or suitable person‡. The recommendation is based on the outputs from appraisals and clinical governance information. Further information about revalidation is set out in *Guidance for doctors: requirements for revalidation and maintaining your licence*.

**17.** Revalidation is not a way to raise or address concerns about a doctor's fitness to practise. Concerns should be raised when they arise, through relevant local governance processes and not only through appraisal.

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* Under The Medical Profession (Responsible Officers) Regulations 2010 (as amended by Medical Profession (Responsible Officers) (Amendment) Regulations 2013) and The Medical Profession (Responsible Officers) Regulations (Northern Ireland) 2010.

† Licence to practise - information for doctors on the register

‡A suitable person is a licensed doctor approved by the GMC to make a recommendation to us about revalidation for a doctor who does not have a responsible officer.

- ***Concerns about a doctor's fitness to practise***

**18.** We – the GMC – make revalidation decisions[*] about doctors based on the recommendation from their responsible officer or suitable person along with other relevant information available to us. Where we decide to revalidate a doctor, this means we are satisfied they have demonstrated they are up to date and fit to practise and the doctor may continue to practise medicine as usual. If a doctor does not meet the requirements for revalidation, we may need to withdraw their licence to practise.

**19.** Where there are concerns about a doctor's fitness to practise, we work closely with employers and responsible officers through our Outreach Team[†]. Working together allows us to help resolve concerns locally, where possible. This reduces the negative effects for doctors of duplication across local and national complaints processes and achieves more timely resolution of complaints for patients.

**20.** However, local resolution will not be suitable for all concerns and some matters will need to be referred to us to consider if regulatory action[‡] is required.

**21.** Through regulatory action, a doctor can be warned about their performance or behaviour, or have restrictions put on their registration. This means for a period of time, their practice may be limited or supervised, or they may not be able to practise. In a very small number of cases, we may remove a doctor's registration. This type of action is rare and is reserved for the most serious cases.

[*] How we decide whether to revalidate you
[†] How we work: Outreach
[‡] Regulatory action includes a warning or restrictive action of undertakings, conditions, suspension or erasure / removal from the medical register.

# b. How we assess fitness to practise

**22.** GMC decision makers and MPTS* tribunals can only assess a doctor's fitness to practise where there is a legal basis† for doing so. Where the concern is supported by evidence, an assessment will need to be made about whether the doctor poses any risk to one or more of the three parts of public protection.


**23.** This assessment of risk includes considering:

- the seriousness of the concern
- any relevant context, and
- how the doctor has responded to the concern.

An explanation of each follows below.

## The seriousness of the concern

**24.** The seriousness of the concern relates to the extent of the doctor's departure from the professional standards and / or impact of a health condition on the doctor's ability to practise safely.

### Extent of the departure from the professional standards

**25.** *Good Medical Practice*‡ sets out the principles, values, and standards of care and professional behaviour expected of all doctors registered with the GMC. It is an ethical framework, which supports doctors to deliver safe care to a good standard, in the

* The Medical Practitioner Tribunals Service (MPTS) is the tribunals service for doctors in the UK. The MPTS run hearings which make independent decisions about whether doctors are fit to practise medicine.
† A concern must fall under one or more of the categories of impairment set out in Section 35C of the Medical Act 1983.
‡ Specific references made throughout this publication to *Good medical practice* are to the version that will come into effect on 30 January 2024. Until then, the current version of Good medical practice continues to apply to doctors.

interests of patients. *Good medical practice* is supported by a range of more detailed guidance which expands on some of the standards it sets out.

**26.** Doctors are expected to practise in line with the professional standards and use their judgement to apply them in practice. *Good medical practice* is not a set of rules and not every departure from the professional standards will be considered serious. However, if a doctor does seriously depart from the standards, it can mean they pose a current and ongoing risk to public protection.

**27.** GMC decision makers and MPTS tribunals assess how serious a concern is by looking at the extent of the doctor's departure from the professional standards along with any specific factors that may impact on seriousness. This includes, if the concern is an isolated incident or has been repeated, whether it was premeditated or persistent, or whether it was an abuse of power.

### Impact of a health condition

**28.** It's important for doctors to look after their health and well-being and to get the right support when they may be unwell. Having a health condition does not mean that a doctor will present any risk to public protection.

**29.** The impact of a doctor's health condition will only be serious where the health condition is not managed and poses a risk to patients because the doctor is working or likely to work. This also applies where there are also concerns about the doctor's performance or behaviour and their health condition may be a contributory factor.

## Relevant context

**30.** Context is the specific setting or circumstances surrounding a concern. There are different types of context, described below, and one or more types may be seen in a case. Context may be relevant to the assessment of risk where it has influenced the doctor's performance, behaviour or health. Any such influence can be in a positive or negative way.

### Working environment

**31.** The environment in which a doctor is practising can influence their performance, behaviour or health. For example, systems failures or issues with organisational culture that the doctor can't control.

**32.** Working environments can be positive and supportive or they might present challenges that make it difficult for a doctor to deliver good medical practice. Sometimes those challenges can have negative consequences and may make errors more likely. They may also impact on how a doctor responds when something goes wrong in a patient's care.

**33.** Patient care and other clinical practice usually involves working with a range of health and social care professionals within multidisciplinary teams and/or across different organisations and care providers. Effective cultures, team working, communication and referral channels, good quality inductions, mentoring schemes and access to other support mechanisms are important ways of making sure doctors can deliver safe and

effective care to patients. However, barriers to this can be toxic cultures, breakdowns in team working, ineffective communication and referral channels and lack of support.

**34.** Where there are issues with the environment that a doctor is working in, they have a responsibility to raise concerns* where they believe that patient safety or care is being compromised. They must also encourage and support a culture in which staff can raise concerns openly and safely. The extent to which a doctor has met these requirements, or tried to meet these requirements, is likely to impact on the weight given to any working environment context that has influenced their performance, behaviour or health.

- ***Systems factors***

**35.** Systems factors relate to the physical working environment where the doctor is practising. There are a range of systems factors which can directly or indirectly affect a doctor's performance, behaviour or health. These include, but are not limited to:

a. their immediate workplace, including the systems and processes that exist and the associated training they've received to understand their responsibilities within them, including:
   - the quality of induction– this will be particularly relevant where the doctor is transitioning to new social, cultural and professional environments
   - workload issues, such as unmitigated gaps in resources, a crisis or unexpected surge in demand
   - service delivery requirements to work in unfamiliar roles, teams and/or environments at short notice so the doctor has been unable to adequately prepare

b. the impact of technologies or other physical influences

c. a lack of, or conflicting, clinical practice guidance

d. the availability or effectiveness of reasonable adjustments for disabled doctors

e. working in a setting or situation where the requirements of patient care are unpredictable or new to the doctor.

- ***Interpersonal factors***

**36.** Interpersonal factors relate to the values and interests of the organisation or team within which the doctor is working, and the relationships between individuals in that working environment. There are a range of interpersonal factors which can directly or indirectly

* The GMC and NMC's joint guidance *Openness and honesty when things go wrong: the professional duty of candour* sets out further information about our expectations of how doctors can meet the requirements of the duty of candour.

affect a doctor's behaviour, performance or health. These include, but are not limited to:

a. the culture of the organisation, or the specific team or area of practice within the organisation, such as:
   - how engaged, positive and accessible the leadership team is
   - how they respond when things go wrong (blame versus learning culture)
   - how they encourage an inclusive and fair working environment, including their approach to identifying insider / outsider groups* and addressing associated risks

b. the support, supervision and learning experiences provided, or made available, to the doctor, including from more senior doctors, other healthcare professionals or relevant staff

c. the approach to giving and receiving effective, honest and timely feedback to help the doctor address any concerns early and for them not to develop further.

**Role and experience**

**37.** Doctors work across a wide range of contexts and roles which require different skills, knowledge and experience. Our professional standards apply to all doctors registered with the GMC, in all fields of practice, in NHS and independent care settings, whether or not a doctor routinely sees patients.

**38.** Practical experience of working in the relevant health and care system and setting plays a key role in a doctor's development.

**39.** Where a concern arises about a doctor's fitness to practise, their performance or behaviour will be judged against the standards expected of a reasonably competent doctor working within a similar setting and the same role. This includes grade and specialty.

**40.** Doctors in leadership positions have specific standards set out in *Good medical practice* and other detailed professional guidance that they're expected to practice in line with. Where a doctor is in a senior or leading role, the additional impact their poor performance or behaviour has had, or could have had, can be considered.

**Likelihood of medical professional continuing in, or returning to, medical practice**

**41.** A doctor may choose to retire or take a break from active medical practice at any stage in their career. Where a concern is raised about a doctor who has, or has stated an intention to, retire or take a break from active medical practice, this does not circumvent the need

* In groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). Members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping. (Fair to Refer? June 2019)

to assess if they pose any current and ongoing risk to public protection if they still hold GMC registration. This is because they may later choose to return to medical practice, or not go through with their plan to retire or take a break from active medical practice.

### Personal context

**42.** Personal context relates only to the individual doctor's circumstances. It is distinct from information about the doctor's good character and standing. Personal context can directly or indirectly affect a doctor's performance, behaviour or health condition and includes matters such as a personal emergency.

**43.** Where a doctor is aware of personal context that may impact on their performance, behaviour or health at work, they should raise this and seek appropriate support. However, some types of personal context can arise suddenly or cannot be predicted, which may put them outside the doctor's immediate control. This may present challenges that make it difficult for the doctor to deliver good medical practice.

## How the doctor has responded to the concern

**44.** To actively address concerns about their performance, behaviour or impact of a health condition, a doctor must first recognise there is a concern and try to understand how it arose. They must then take steps to address the concern and learn from it with the aim of mitigating against the likelihood of repetition.

**45.** The likelihood of repetition will be relevant to deciding if a doctor poses any current and ongoing risk to public protection. Evidence a doctor has insight, has taken steps to remediate, has been keeping their knowledge and skills up to date and has been working within their area of competence is all relevant to the assessment of risk and what action, if any, may be needed to protect the public.

### Insight

**46.** For a doctor to take effective steps to reduce the level of any risk they pose to public protection, they must have insight. This means recognising there is a concern, understanding how it arose, and understanding how it can be addressed.

**47.** Where the concern relates to a doctor's poor performance or behaviour, it is crucial that the doctor has insight into what went wrong and appreciates what should have been done differently. They must also show they understand how they should act differently in the future to avoid a similar concern occurring again.

**48.** Where the concern relates to a doctor's health condition, it's important they're aware of the impact their condition could have on patient safety. The doctor should only work if it is safe to do so because any impact is being effectively managed. Where the doctor is working, they should be seeking and following treatment and advice and taking steps locally to manage any potential risk to patients.

- ***Apologies***

**49.** A doctor must be open and honest if things go wrong. In cases where a patient has suffered harm or distress a doctor should offer an apology*. The apology should demonstrate sincere regret that something has gone wrong and be tailored to the individual patient.

**50.** For the purposes of decisions made about a doctor's fitness to practise, an apology by itself will not be treated as an admission of fault†. Whether it will be treated in this way in other legal proceedings will be determined by the relevant UK law applying to those proceedings.

**Remediation**

**51.** Remediation is where a doctor actively addresses concerns about their behaviour, performance, or the impact of a health condition. Remediation can take several forms and, where successful, will make it less likely that regulatory action is needed to address any unmitigated risk. For remediation to be successful it needs to focus on activities that reduce the level of any risk posed to one or more parts of public protection.

**52.** Whilst responsible officers, employers and training bodies should provide appropriate support, efforts to remediate should be driven by the doctor with a focus on learning and impact on their future practice or behaviour.

**53.** Because of their specific role and responsibilities, a doctor's responsible officer may be asked to provide us with information about the doctor's current medical practice, involvement and cooperation with any local investigation, details of any apology and details of any practical steps taken to address the concern.

* *Good medical practice 2024* paragraph 45

† In England and Wales the Compensation Act 2006 provides that an apology, an offer of treatment or redress shall not by itself amount to an admission of negligence or breach of statutory duty. In Scotland, the Apologies (Scotland) Act 2016 provides that an apology is not admissible as evidence of liability in civil proceedings. This is subject to a number of exceptions, which includes the GMC's fitness to practise proceedings. There is not currently equivalent legislation in Northern Ireland.

# c. What may be a fitness to practise concern, and why

**54.** There is a wide range of information about a doctor that's capable of amounting to a fitness to practise concern. When considering the relevant information that's available, GMC decision makers and MPTS tribunals will need to identify how it relates to the professional standards that doctors are expected to meet.

**55.** To help with understanding of what may be a fitness to practise concern, there are descriptions below of some types of cases seen in the fitness to practise process and how those cases relate to *Good medical practice*[*] and the more detailed guidance on professional standards. These are:

1) Sexual misconduct
2) Dishonesty
3) Violent or abusive behaviour
4) Discrimination
5) Clinical concerns
6) Impact of a health condition
7) Insufficient knowledge of English language
8) Criminal convictions and cautions and determinations by another body responsible for the regulation of a health or social care profession

**56.** In some cases, the doctor's behaviour may amount to a criminal offence for which they have been convicted or received a caution. However, there may be cases which were not prosecuted, or which did not result in a conviction or caution, in which the risk to public protection will still need to be considered.

## 1) Sexual misconduct

**57.** Sexual misconduct may take the form of uninvited or unwelcome behaviour of a sexual nature - or which can be reasonably interpreted as sexual – that offends, embarrasses, harms, humiliates or intimidates an individual. It encompasses elements of harassment and abuse, can be physical, verbal or visual. It can be carried out, and experienced by, anyone regardless of socioeconomic background or protected characteristics.

**58.** Sexual misconduct may be sexually motivated, meaning it could be for the doctor's gratification, but won't always be.

**59.** Behaviour amounting to sexual misconduct can arise inside or outside a doctor's working life. When sexual misconduct arises in a doctor's working life, their behaviour may be

[*] Specific references made throughout this publication to *Good medical practice* are to the version that will come into effect on 30 January 2024. Until then, the current version of *Good medical practice* continues to apply to doctors.

directed towards patients, former patients, relatives of patients or colleagues*.

**60.** Consensual and reciprocated sexual attraction and relationships between colleagues are not sexual misconduct. But a relationship, or pursuit of a relationship, between colleagues may be inappropriate where there is a significant difference in power levels, or where training and career progression opportunities could be affected, and that is misused.

**61.** Outside a doctor's working life, sexual misconduct may be directed at any member of the public, including the doctor's partner or a family member.

**The professional standards doctors are expected to meet**

**62.** Doctors work in close contact with others, including patients, relatives of patients and colleagues. In doing so, they must treat patients as individuals and recognise and respect their dignity and right to privacy†, and treat colleagues with kindness, courtesy and respect‡. They must be aware of how their behaviours may influence others§.

**63.** Most patients interacting with health services are likely to feel vulnerable to some extent, and some patients are at increased risk of harm due to having a specific vulnerability or because of their individual circumstances. It is essential that doctors make sure their conduct justifies their patients' trust in them and the public's trust in the profession**, including by following the law††. They should protect people who are at risk of harm and must consider the needs and welfare of adults, children and young people who may be vulnerable and offer them help if they think their rights are being abused or denied‡‡.

**64.** Doctors must not act in a sexual way towards patients or use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them§§. To maintain the trust of patients and the public, doctors must never make a sexual advance, or display sexual behaviour, towards a patient ***.

**65.** Doctors must not abuse, discriminate against, bully or harass anyone†††.They must not act in a sexual way towards patients or colleagues with the effect or purpose of causing offence, embarrassment, humiliation or distress‡‡‡.

**66.** If a doctor is told by a patient about a breach of sexual boundaries, or has other reasons

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* Colleagues include anyone a doctor works with, whether or not they are medical professionals.
† *Good medical practice 2024* paragraph 16.
‡ *Good medical practice 2024* paragraph 48.
§ *Good medical practice 2024* paragraph 53.
** *Good medical practice 2024* paragraph 81.
†† *Good medical practice 2024* paragraph 4.
‡‡ *Good medical practice 2024* paragraph 41.
§§ *Good medical practice 2024* paragraph 86. *Maintaining a professional boundary between you and your patient* explains how doctors can put this principle into practice.
*** *Sexual behaviour and your duty to report colleagues*, paragraph 3.
††† *Good medical practice 2024* paragraph 56.
‡‡‡ *Good medical practice 2024* paragraphs 57 and 86.

to believe a colleague has, or may have, displayed sexual behaviour towards a patient, they must report those concerns. The police should be told where it is suspected a doctor has committed sexual assault or other criminal activity*.

## 2) Dishonesty

**67.** Honesty is a basic quality expected of members of society based on shared moral values. It involves being truthful about important matters and respecting the property rights of others. Dishonesty is a disregard for this shared moral value and can be used to describe a lack of probity, cheating, lying or deliberately withholding information.

**68.** Whether behaviour is dishonest is judged by considering what is known about a doctor's knowledge or belief of what they were doing and assessing if that is dishonest by the standards of ordinary decent people. There is no additional requirement that the doctor must appreciate that what they have done is, by those standards, dishonest.

**69.** Dishonest behaviour can include a wide range of actions or omissions which may arise inside or outside a doctor's working life. When dishonesty arises in a doctor's working life, their behaviour may be directed towards patients, former patients, relatives of patients, colleagues†,the organisation the doctor is working for or their professional regulator(s). Outside a doctor's working life, dishonesty may be directed at any person or organisation.

**The professional standards doctors are expected to meet**

**70.** Honesty is at the heart of medical professionalism and is essential for the public to have trust in doctors and the systems they work in. Doctors must make sure their conduct justifies their patients' trust in them and the public's trust in the profession‡. They must follow the law§ and always be honest about their experience, qualifications and current role**.

**71.** Good doctors are open and honest with patients if things have gone wrong. Doctors must respond promptly, fully and honestly to complaints and apologise when appropriate††.

**72.** Documents made by doctors to formally record their work (including patients' medical records) must be clear, accurate, contemporaneous and legible‡‡. When writing references and when appraising or assessing the performance of colleagues, doctors must be accurate, fair and objective§§.

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* *Sexual behaviour and your duty to report colleagues*, paragraph 4.
† Colleagues include anyone a medical professional works with, whether or not they are medical professionals.
‡ *Good medical practice 2024* paragraph 81.
§ *Good medical practice 2024* paragraph 4.
** *Good medical practice 2024* paragraph 82.
†† *Good medical practice 2024* paragraph 46.
‡‡ *Good medical practice 2024* paragraph 69.
§§ *Good medical practice 2024* paragraph 62.

**73.** Doctors must be honest and trustworthy when writing reports; completing or signing forms, reports and other documents; and when giving evidence to courts and tribunals. They must make sure that any information they communicate is not false or misleading. Doctors must take reasonable steps to check the information is correct, must not deliberately leave out relevant information or present opinion as established fact*.

**74.** When communicating publicly as a doctor, they must be honest and trustworthy, not exploit people's lack of medical knowledge and declare any conflicts of interest†.

**75.** Conflicts of interest may arise in a range of situations. They are not confined to financial interests and may also include other personal or professional interests. Doctors must not allow any interests they have to affect, or be seen to affect, the way they propose, provide or prescribe treatments, refer patients or commission services‡. Nor must they ask for, accept or offer an incentive which may affect, or be seen to affect, these things§.

**76.** When designing, organising or carrying out research, doctors must put the interests of participants first, act with honesty, follow national research governance guidelines and GMC guidance**.

## 3) Violent or abusive behaviour

**77.** Violent or abusive behaviour describes behaviour that may be aggressive, coercive, controlling, destructive, harassing, intimidating, isolating or threatening. It can be demonstrated through physical acts or omissions, or verbally.

**78.** Physical abuse often occurs when physical force is used in a way that injures or endangers another person. Emotional abuse may include verbal abuse such as yelling, name-calling, blaming and shaming. Isolation, intimidation, and controlling behaviour – such as rigidly controlling finances, withholding necessities (food, clothes, medication, shelter), preventing someone from working or seeing friends or family - are also forms of emotional abuse.

**79.** Violent or abusive behaviour may include aggressive or physically threatening behaviour to colleagues or patients, or more specific incidents of violence outside the workplace. It may also include stalking and harassment.

**80.** When violent or abusive behaviour arises in a doctor's working life, the doctor's behaviour may be directed towards patients, former patients, relatives of patients or colleagues††. In addition to the direct impact it will have on the recipient, violent or abusive behaviour can impact other individuals, such as those who witness the behaviour,

* *Good medical practice 2024* paragraph 89.
† *Good medical practice2024* paragraph 90.
‡ *Good medical practice 2024* paragraph 94.
§ *Good medical practice 2024* paragraph 95.
** *Good medical practice 2024* paragraph 85.
†† Colleagues include anyone a doctor works with, whether or not they are doctors.

and on the working environment.

**81.** Outside a doctor's working life, violent or abusive behaviour may be directed at any person, including the doctor's partner or a family member.

**The professional standards doctors are expected to meet**

**82.** Doctors must protect and promote the health and safety of patients and the public and make sure their conduct justifies their patients' trust in them and the public's trust in the profession*. They must treat colleagues and patients with kindness, courtesy and respect†.

**83.** Doctors must be aware of how their attitudes and behaviours may influence or affect others‡. They should help to create a culture that is respectful, fair, supportive and compassionate by role modelling behaviours consistent with these values§.

**84.** Doctors must not abuse, discriminate against, bully or harass anyone**. This applies to all interactions, including on social media and networking sites. Doctors are expected to take action, or support others to take action, if they witness, or are made aware of, such behaviours††.

## 4) Discrimination

**85.** Discrimination describes the unfair or prejudicial treatment of individuals and groups based on characteristics. Unlawful discrimination may occur when that less favourable treatment relates to specific characteristics, recognised legally as 'protected characteristics'. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation‡‡.

**86.** Unlawful discrimination under the Equality Act 2010 can be direct or indirect. Direct discrimination may occur when an individual is treated worse or less favourably because:

a. of a protected characteristic they possess, or

b. someone thinks they have a protected characteristic, regardless of whether that perception is correct or not ('discriminaiton by perception'); or

c. the individual is connected to someone with a protected characteristic, such as a family member or colleague (discrimination by association').

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* *Good medical practice 2024* 'Behaviours of medical professionals registered with the GMC' and paragraph 81.
† *Good medical practice 2024* paragraphs 48 and 23.
‡ *Good medical practice 2024* paragraph 53.
§ *Good medical practice 2024* paragraph 52.
** *Good medical practice 2024* paragraph 56.
†† *Good medical practice 2024* paragraph 58.
‡‡ Equality Act 2010, Part 2, Chapter 1, Section 4.

**87.** Indirect discrimination is usually less obvious than direct discrimination. It happens when something is put in place that applies in the same way for everybody but disadvantages a group of people who share a protected characteristic and an individual is disadvantaged as part of this group. The person or organisation applying the policy or process must show there is a good reason for it.

**88.** Where harassment relates to certain protected characteristics it is a type of discrimination*. Harassment may take the form of unwanted behaviour which is intended to, or has the effect of, violating a person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment.

**89.** Victimisation is also a type of discrimination. It can occur where an individual is treated badly or suffers a detriment because they've complained, or supported a complaint, about discrimination, or it is suspected that they will. A detriment can include a loss, disadvantage, damage or harm, such as being left out, ignored or being denied training or promotion opportunities.

**90.** When discrimination arises in a doctor's working life, the doctor's behaviour may be directed towards patients, former patients, relatives of patients or colleagues†. Outside a doctor's working life, discrimination may be directed at any person.

**The professional standards doctors are expected to meet**

**91.** Doctors must treat patients fairly, not discriminate against them or let their personal views affect their relationship with them‡. They must treat colleagues and patients with kindness, courtesy and respect§.

**92.** Doctors must be aware of how their attitudes and behaviours may influence or affect others**. They must show respect for, and sensitivity towards, others' life experience, cultures and beliefs†† and not express their personal beliefs to patients in ways that exploit their vulnerability or could reasonably cause them distress‡‡.

**93.** If a doctor has a conscientious objection to a particular procedure, they must make sure the way they manage this doesn't act as a barrier to a patient's access to appropriate care to meet their needs§§. They must not refuse or delay treatment because they believe a patient's actions or choices contributed to their condition***.

**94.** Doctors must consider and respond to the needs of patients with impairments or

* A criminal offence of harassment can also be pursed under the Protection from Harassment Act 1997.
† Colleagues include anyone a doctor works with, whether or not they are doctors.
‡ *Good medical practice 2024* paragraph 19.
§ *Good medical practice 2024* paragraphs 48 and 23.
** *Good medical practice 2024* paragraph 53.
†† *Good medical practice 2024* paragraph 55.
‡‡ *Good medical practice 2024* paragraph 87.
§§ *Good medical practice 2024* paragraph 21.
*** *Good medical practice 2024* paragraph 19.

disabilities. They should offer reasonable adjustments that are proportionate to the circumstances*.

**95.** A doctor should end a professional relationship with a patient only when the breakdown of trust means they cannot continue to provide good clinical care to them†.

**96.** When writing references, and when appraising or assessing the performance of colleagues and students, doctors must be accurate, fair and objective‡. They should be aware of the risk of bias and consider how their own life experience, culture and beliefs influence their interactions with others§.

**97.** Doctors must help to create a culture that is respectful, fair, supportive, and compassionate by role modelling behaviours consistent with these values**. Doctors with additional leadership and management responsibilities must actively advance equality and diversity by creating or maintaining a positive working environment free from discrimination, bullying and harassment, and ensure their organisation's policies on employment and equality and diversity are up to date and reflect the law††.

**98.** Doctors should take action, or support others to take action, if they witness, or are made aware of, discrimination‡‡.

## 5) Clinical concerns

**99.** Clinical concerns usually arise in a doctor's working life. A clinical concern describes behaviour or poor performance relating to a doctor's clinical practice or how they discharge a specific role for which they require or use their clinical knowledge, skills or experience. This includes a wide range of activities such as delivering patient care, acting as a clinical lead, conducting research, setting up local clinical governance arrangements, performing audits and acting as an expert witness.

**100.** It's possible for a clinical concern to arise outside a doctor's working life where they use their clinical knowledge, skills or experience in a way that is not intended to deliver patient care in accordance with Good medical practice. This includes prescribing for themselves or a family member where this could have been reasonably avoided.

**101.** Whether the doctor's performance or behaviour amounts to a clinical concern will be judged by considering whether there has been a departure from the professional standards and if so, the extent of that departure.

**102.** A clinical concern can incorporate a wide range of actions or omissions and the doctor's

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* *Good medical practice 2024* paragraph 33.
† *Good medical practice 2024*paragraph 47.
‡ *Good medical practice 2024* paragraph 62.
§ *Good medical practice 2024* paragraph 54.
** *Good medical practice 2024* paragraph 52.
†† *Leadership and management for all doctors* paragraph 9.
‡‡ *Good medical practice 2024* paragraph 58.

poor performance or behaviour may be directed towards or impact patients, former patients, relatives of patients or colleagues*.

**The professional standards doctors are expected to meet**

**103.** Good doctors make the care of patients their first concern, work effectively with colleagues, provide a good standard of practice and care and are open and honest when things go wrong. They work within their competence, keep their knowledge and skills up to date and demonstrate leadership within their role†.

**104.** Doctors must provide a good standard of practice and care‡. They must recognise and respect every patient's dignity and privacy§. They must treat patients with kindness, courtesy and respect**. Doctors must listen to patients and encourage an open dialogue about their health, asking questions and responding honestly to their questions††. They must work in partnership with patients to assess their needs and priorities‡‡, giving them the information they want or need in a way they can understand§§.

**105.** To develop and maintain effective teamworking and interpersonal relationships, doctors must listen to colleagues, communicate clearly, politely and considerately, recognize and show respect for colleagues' skills and contributions and work collaboratively***.

**106.** Doctors must contribute to continuity of patient care†††. When delegating tasks or duties, doctors must be confident the person they are delegating to has the necessary knowledge, skills and training to carry them out‡‡‡. If a task is delegated to them but the doctor is not confident they have the necessary knowledge, skills and training to carry it out safely, they must prioritise patient safety and seek help§§§.

**107.** Documents that doctors make to formally record their work, including patient records, must be clear, accurate contemporaneous and legible****.

**108.** Doctors should be familiar with, and use, the clinical governance and risk management structures and processes in the organisations where they work or are contracted to††††. They must act promptly if they think patient safety or dignity is, or may be, seriously

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* Colleagues include anyone a doctor works with, whether or not they are doctors.
† *Good medical practice*, 'Behaviours of medical professionals registered with the GMC'.
‡ *Good medical practice 2024* paragraph 6.
§ *Good medical practice 2024* paragraph 16.
** *Good medical practice 2024* paragraph 23.
†† *Good medical practice 2024* paragraph 29.
‡‡ *Good medical practice 2024* paragraph 6.
§§ *Good medical practice 2024* paragraph 28.
*** *Good medical practice 2024* paragraph 49.
††† *Good medical practice 2024* paragraph 66.
‡‡‡ *Good medical practice 2024* paragraph 66.
§§§ *Good medical practice 2024* paragraph 67.
**** *Good medical practice 2024* paragraph 69.
†††† *Good medical practice 2024* paragraph 72.

compromised* and be open and honest with patients if things go wrong†. Doctors in a formal leadership or management role must take active steps to create an environment in which people can talk about errors and concerns safely‡.

**109.** Patient safety may be affected if there is not enough cover. A doctor must therefore take up any post they have accepted, work any shift they have agreed to, and work their contractual notice period before leaving a job, unless the employer has reasonable time to make other arrangements or their personal circumstances prevent this§.

**110.** Doctors must be competent in all aspects of their work, including, where applicable, formal leadership roles, management, research and teaching. They must recognise and work within the limits of their competence and keep up to date with guidelines and developments that affect their work**.

**111.** Medical professionals with additional leadership and management responsibilities must make sure that systems are in place to identify any failure, or potential failure, in the clinical performance of individuals or teams and must make sure any failure is dealt with quickly and effectively††. They should also make sure systems are in place to monitor, review and improve the quality of their team's work and that teams are appropriately supported and developed‡‡.

## 6) Impact of a health condition

**112.** A health condition is a physical or mental condition, injury, or impairment that may be categorised as acute or chronic.

**113.** A health condition may also be classified as a disability but should not automatically be regarded in this way. For example, multiple sclerosis is both a health condition and a disability, but alcohol addiction is a health condition and not a disability. Equally, not all disabilities are a health condition. For example, there is no medical health element attributed to dyslexia.

**114.** A health concern does not automatically arise because a doctor has a health condition and / or a disability. There are many doctors with a health condition and / or disability that we will never need to know about because it has no impact on that individual's ability to provide safe care.

**115.** A health condition will only amount to a health concern where it's impact on the doctor poses a risk to patients. Health concerns may arise in isolation but will often be seen

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* *Good medical practice 2024* paragraph 75.
† *Good medical practice 2024* paragraph 45.
‡ *Good medical practice 2024* paragraph 76.
§ *Good medical practice 2024* paragraph 74.
** *Good medical practice 2024* paragraphs 1, 2 and 3.
†† *Leadership and management for all doctors* paragraph 28.
‡‡ *Leadership and management for all doctors* paragraph 29.

alongside and / or as a contributory factor in other types of cases.

**The professional standards doctors are expected to meet**

**116.** Doctors should try to take care of their own health and wellbeing, recognising that if they don't they may not be fit for work. They should seek independent professional advice about their fitness for work, rather than relying on their own assessment*. If a doctor knows or suspects they have a serious condition they could pass on to patients, or if their judgement or performance could be affected by a condition or its treatment, they must consult a suitably qualified professional and follow their advice about any changes to their practice†.

**117.** Doctors should be immunised against common serious communicable diseases unless contraindicated‡.

**118.** Doctors must be compassionate towards colleagues who have problems with their health§.

## 7) Knowledge of English language

**119.** To practise safely in the UK, a doctor must have the necessary knowledge of English language. This is because they need to be able to communicate effectively with patients and their relatives, work in partnership with other healthcare colleagues and clearly and accurately document their work.

**120.** Doctors must be able to show they can meet the minimum standards of speaking, listening, reading and writing set for individuals wishing to practise medicine in the UK.

**121.** Evidence of English language capability provided by doctors who qualified outside of the UK when they register with the GMC is assessed by considering if: it is recent, objective, independent and robust; it clearly demonstrates that a doctor can read, write and interact with patients, relatives and healthcare professionals in English; and it can reasonably be verified**.

**122.** A doctor's knowledge of English language will only amount to a concern where it poses a risk to patients. Concerns usually arise inside a doctor's professional practice and will relate to the doctor's knowledge of English language in one or more of the areas of speaking, listening, reading and writing. They can be seen in isolation but can also be seen alongside and / or as a contributory factor in other types of cases.

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* *Good medical practice 2024* paragraph 78.
† *Good medical practice 2024* paragraph 79.
‡ *Good medical practice 2024* paragraph 80.
§ *Good medical practice 2024* paragraph 51.
** GMC guidance: Evidence of English language skills

**The professional standards doctors are expected to meet**

**123.** Doctors must recognise and work within the limits of their competence[*] and must have the necessary knowledge of English language to provide a good standard of practice and care in the UK[†]. They must give patients the information they want or need to know in a way they can understand[‡]. Documents a medical professional makes to formally record their work, including patients' records, must be clear, accurate, contemporaneous and legible[§].

## 8) Criminal convictions and cautions and determinations by another body responsible for the regulation of a health or social care profession

**124.** Convictions and cautions are defined[**] as being a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England or Wales, would constitute a criminal offence.

**125.** A conviction may result in a custodial or non-custodial sentence. A custodial sentence is a period of imprisonment and can be immediate or suspended. It is given for the most serious types of criminal offences. A non-custodial sentence includes discharges, fines and community orders.

**126.** Discharges are given for the least serious types of offences and do not impose a punishment beyond having a criminal record. Fines are a form of financial penalty given for low-level types of offences, such as some motoring offences. Community orders are given to address the cause of offending in cases that are not serious enough to require a custodial sentence and can be made of different components, such as drugs rehabilitation, attendance on courses and unpaid work.

**127.** A conditional or absolute discharge may not be considered as a conviction for the purposes of our fitness to practise processes, but the doctor's underlying behaviour may still amount to a concern.

**128.** A bind over is a civil promise to keep the peace. It's not a criminal conviction in and of itself, although an individual may be bound over by a criminal court on being convicted of an offence. Again, the doctor's behaviour resulting in the bind over may still amount to a concern and need to be considered.

**129.** Cautions are a formal warning issued by the police to an individual who admits to committing a criminal offence. They are usually only given in response to low-level, first time, offences – for example low value theft, disorderly conduct or possession of cannabis - and can only be issued with the acceptance of the offender.

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[*] *Good medical practice 2024* paragraph 2.
[†] *Good medical practice 2024* paragraph 5.
[‡] *Good medical practice 2024* paragraph 28.
[§] *Good medical practice 2024* paragraph 69.
[**] Section 35C(2) of the Medical Act 1983

**130.** Convictions and cautions can be the result of a wide range of behaviour arising inside or outside a doctor's working life. Minor motoring offences arising in a doctor's private life, such as speeding, traffic light offences, not wearing a seatbelt and talking on a mobile phone will not usually amount to a fitness to practise concern.

**131.** A determination is defined* as a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect†.

**132.** A determination can be the result of a wide range of behaviour arising inside or outside a doctor's working life.

**The professional standards doctors are expected to meet**

**133.** Good doctors act with honesty and integrity and ensure their conduct justifies their patients' trust in them and the public's trust in their profession‡.

**134.** Doctors must tell the GMC without delay if, anywhere in the world: they have been charged with or found guilty of a criminal offence; they have accepted a caution from a prosecuting authority; they have been criticised by an official inquiry, including by a coroner at an inquest; another professional body has made a finding against their registration as a result of fitness to practise procedures§.

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* Section 35C(2) of the Medical Act 1983)

† This could include where a doctor is registered in the UK with another healthcare regulator, such as the General Dental Council, or with an overseas regulator because they also practise medicine outside of the UK.

‡ *Good medical practice 2024*, 'Behaviours of medical professionals registered with the GMC' and paragraph 81.

§ *Good medical practice 2024* paragraph 99.