Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide: a draft for consultation

Have your say

Background and consultation questions

General Medical Council

Regulating doctors
Ensuring good medical practice

Please return your responses by 4 May 2012 to:

Consultation on Assisting Suicide Allegations Guidance
Standards and Ethics Team
General Medical Council
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Telephone: 020 7189 5404
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Other formats

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To request an alternative format or language, please call us on 0161 923 6602 or email us at **publications@gmc-uk.org**.

Freedom of information

The GMC is covered by the Freedom of Information Act 2000. This means that, if somebody asks us to give them information under the terms of the Act, we may have to disclose the answers you give in this questionnaire. However, you can tell us that you would prefer your answers to remain confidential. In that case, we would take this into account if we are asked to disclose this information (because some information given in confidence does not always have be disclosed under the Act).

If you would like your answers to remain confidential, please tick here ☐

About this **consultation**

The General Medical Council is holding this consultation to find out your views about our new draft *Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide*.

This draft guidance is for the Investigation Committee and case examiners, and will be published on our website. We will review and revise it in light of the responses we receive to the consultation.

Assisting or encouraging a suicide remains against the law and this guidance does not change that. Neither does it mean that doctors are now allowed to encourage or assist a person who wants to commit suicide.

We have written this guidance to help us to examine, fairly and consistently, any allegations that we receive about a doctor's involvement in encouraging or assisting suicide.

The guidance sets out:

- the law on assisting suicide
- the ethical principles which underpin all our guidance to doctors
- the test that our decision-makers must apply when they consider such allegations
- the types of cases and the factors that may be relevant to their consideration.

We welcome responses from anyone who has a view about this draft guidance and are particularly keen to hear from people who are affected by the issues it raises.

This is your chance to have your say.

The consultation runs from **6 February** to **4 May 2012**. We will use your responses to help us produce the final version of the guidance in Summer 2012.

In this document:

- when we mention our **'decision-makers'**, we mean our Investigation Committee and case examiners. If you want to know more about what they do and the way we deal with allegations about doctors, please visit our website at **www.gmc-uk.org/concerns/the_investigation_process.asp**.
- when we use the phrase 'assist[ing] suicide', we mean 'encouraging or assisting a suicide' as defined in Section 2 (1) of the Suicide Act 1961 as amended by the Coroners and Justice Act 2009.

The GMC issues guidance to doctors on the standards of professional conduct, performance and medical ethics that patients, the public and the profession expect of them.

Good Medical Practice (2006) is our current core guidance for doctors. It describes what is expected of all doctors registered with the GMC. To support *Good Medical Practice*, we publish additional guidance which provides more detail on specific issues, such as caring for patients towards the end of their lives, consent, and confidentiality. You can read all our guidance on our website at **www.gmc-uk.org**.

This guidance

This guidance is for the Investigation Committee and case examiners to use when considering allegations about a doctor's involvement in encouraging or assisting a suicide. We will incorporate it into our existing guidance for decision-makers at the investigation stage of our fitness to practise procedures. The guidance is not addressed to doctors but we realise that it may be of interest to them and to others.

We set up a working group to oversee the text of the draft guidance. The working group looked at the cases of assisting suicide that we have dealt with over the past ten years and considered how we should apply ethical principles to this subject. The draft guidance was approved for consultation by our Council in December 2011.

How to take part

- Take part online using our consultation website: **https://gmc.e-consultation.net/econsult**.
- Download a pdf from our website (**www.gmc-uk.org**) and post it to us (address on page 1) or email it to standards.consult@gmc-uk.org with 'Assisting Suicide Allegations Guidance' in the subject line.
- Contact us if you would like a printed copy (contact details on page 1) and return your completed response to us at the same address.

After you've taken part

When the consultation closes on **4 May 2012**, we will review the responses and use them to finalise the draft guidance.

We will publish a summary of responses, and how we used them, when we publish the final version of the guidance in summer 2012.

Questions about the draft guidance

There are 17 questions in this questionnaire about the scope, detail and style of the draft guidance.

The questions are based on the draft guidance, so we recommend that you read it before answering the questions. We do not ask questions about every single paragraph, but there is space for you to comment on every section.

The GMC's remit is UK-wide, so our guidance needs to take into account the different legal systems of Scotland, Northern Ireland, England and Wales. Please bear this in mind when you respond.

Thank you

Thank you for taking part in our consultation. We value your responses.

Equality and diversity

We have produced a draft equality analysis which sets out the work we are doing to understand the equality implications of this guidance. You can read this alongside the questionnaire and guidance on our consultation website (**https://gmc.e-consultation.net/econsult**).

We welcome your comments on whether any areas of the guidance need to be strengthened from an equality and diversity perspective. Please bear this in mind as you make your way through the questionnaire.

We will build on what we learn from this consultation as we develop our equality analysis.

The **guidance**

Who this guidance is for and when it should be used

1 This guidance is for the Investigation Committee and case examiners when they are considering allegations about a doctor's involvement in encouraging or assisting suicide.

Legal context

2 In the United Kingdom, it is a criminal offence to encourage or assist a person to commit or attempt suicide.[*] Suicide itself is not a crime.

3 In England, Wales and Northern Ireland, a prosecution cannot be brought without the consent of the Director of Public Prosecutions (DPP). But it has long been recognised that the DPP has discretion. Even if there is sufficient evidence to justify a prosecution, one will be brought only if required in the public interest. In February 2010, as required by the House of Lords judgment in R (Purdy) v DPP, the DPP for England and Wales issued guidance setting out the factors to be considered (for and against prosecution) when exercising that discretion. That guidance has been adopted by the DPP in Northern Ireland.

4 In Scotland, the Lord Advocate has decided not to issue guidance, but has said that a person encouraging or assisting a suicide could be guilty of culpable homicide.

Ethical guidance and principles

5 A central part of our role is to give advice to doctors on standards of professional conduct, performance and medical ethics.[†] We do this to protect, promote and maintain the health and safety of the public.[‡] The main way we do so is through our core guidance, *Good Medical Practice*, and its supporting booklets.

6 We develop our guidance through extensive consultation with the profession and the public. It reflects ethical and legal principles, including the rights set out in the European Convention on Human Rights.

7 In our guidance we make clear that doctors must:

- **a** show respect for human life
- **b** make the care of their patient their first concern
- **c** follow the law that affects their practice and ensure that their conduct at all times justifies their patients' trust in them and public trust in the profession
- **d** listen to patients and respect their views about their health

* In England, Wales and Northern Ireland, the full offence is set out in section 2 (1) of the Suicide Act 1961 as amended by the Coroners and Justice Act 2009. In Scotland, although there is no specific statute relating to assisting suicide, it is likely that encouraging or assisting suicide would constitute culpable homicide (see paragraph 4).

† Section 35 Medical Act 1983.

‡ Section 1 (1A) Medical Act 1983.

e provide patients with the information they want or need so they can make decisions about their health or healthcare, and answer patients' questions honestly and, as far as is practical, as fully as patients wish

f treat patients as individuals and respect their privacy and dignity

g respect competent patients' right to make decisions about their care, including their right to refuse treatment, even if this will lead to their death*

h providing good clinical care, including treatment to address patients' pain and other distressing symptoms.

8 We provide more detailed guidance about doctors' responsibilities in this area in our booklets *Consent: patients and doctors making decisions together* and *Treatment and care towards the end of life*. These include the obligation to discuss with patients their treatment options (including the option of no treatment) and plans for future treatment. This includes the kinds of treatment or care patients would want – or would not want – when they can no longer make or express their own decisions. We encourage doctors to create opportunities for patients to raise concerns and fears about the progression of their disease and about their death and to express their wishes. Listening to patients, providing them with information, and respecting their decisions to accept or refuse treatment offered to them, are integral parts of good practice.

9 Where patients raise the issue of assisted suicide, or ask for information that might encourage or assist them in ending their lives, doctors should explain that they cannot do so because providing this information would mean breaking the criminal law. Similarly, in respecting a patient's decision, doctors are not required to provide treatments which they consider will not be of overall benefit to the patient, or which will harm the patient. Respect for a patient's autonomy cannot justify illegal action.

10 Doctors should continue to provide care for patients in these circumstances, and will face challenges in ensuring that patients do not feel abandoned, while ensuring that their advice does not encourage or assist suicide. The Investigation Committee and case examiners will need to bear this in mind where there is evidence that a doctor's actions or advice may have encouraged or assisted suicide. They should also consider the whole context and the nature of the support or information sought by a patient from a doctor, before deciding whether the doctor's actions raise a question of impaired fitness to practise.

* A patient who dies as a result of the natural progression of their disease, following the refusal of life-prolonging treatment, does not commit suicide.

Status of this guidance

11 Nothing in this guidance changes the law on assisting suicide; neither should it be taken to imply that the GMC supports or opposes a change in that law.

12 This guidance does not replace any other GMC guidance. It should be read alongside all existing guidance for the Investigation Committee and case examiners, operational guidance and guidance on standards of professional conduct and medical ethics. This includes but is not limited to:

- *Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and Case Examiners*
- *Guidance on convictions, cautions and determinations*
- *The realistic prospect test*
- *The meaning of fitness to practise*
- *Good Medical Practice*
- *Treatment and care towards the end of life: good practice in decision making*
- *Good practice in prescribing*
- *Consent: patients and doctors making decisions together*

Equality and diversity

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

The test to be applied

14 When considering any allegation, the Investigation Committee or case examiner must decide whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on their registration.* In making this decision they must have in mind the GMC's duty to act in the public interest. The public interest comprises:

a protecting patients

b maintaining public confidence in the profession, and

c declaring and upholding proper standards of conduct and behaviour.

In applying this test, decision-makers must consider the intensity of the encouragement or assistance: whether it was persistent, active and instrumental, or minor and peripheral.

* *Making decisions on cases at the end of the investigation stage: guidance for Investigation Committee and Case Examiners* and *The realistic prospect test*

Cases involving convictions, cautions or determinations

15 Any case in which a doctor has been convicted of encouraging or assisting suicide should be referred directly to a fitness to practise panel.* Direct referrals should also usually be made where a doctor has accepted a caution and/or has been the subject of an adverse determination by another regulatory body for encouraging or assisting suicide.

Other cases

Presumption of impaired fitness to practise

16 There are certain categories of case (such as violence and sexual assault or improper relationships with patients) where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors that there is a presumption of impaired fitness to practise. Such cases should normally be referred to a fitness to practise panel. Exceptions will arise, for example, if, following the investigation of the case, the case examiners decide that the case does not meet the investigation stage test because there is no realistic prospect of establishing the case evidentially.

17 In the context of encouraging or assisting suicide, it is more difficult to lay down hard and fast rules and this guidance is not intended to fetter the discretion of the Investigation Committee or case examiners. Each case will depend on its own specific facts. But, as a guide, allegations of encouraging or assisting suicide will normally give rise to a presumption of impaired fitness to practise where:

- **a** the doctor's encouragement or assistance depended upon the use of privileges conferred by a licence to practise medicine (such as prescribing) or took place in the context of a doctor-patient relationship (as distinct from providing advice or support for family members, see paragraph 21b), and
- **b** the doctor knew, or should reasonably have known, that their actions would encourage or assist suicide, or
- **c** the doctor acted with intent to encourage or assist suicide.

18 Examples of where such encouragement or assistance might arise include where a doctor has prescribed medication that:

- **a** was not clinically indicated, after a patient had expressed or implied a wish or intention to commit suicide, or their intention was clear from the circumstances

* Rule 5 of the Fitness to Practise rules directs the Registrar to refer convictions to a fitness to practise panel in some circumstances, without first being considered by any case examiner. See also the GMC's *Guidance on convictions, cautions and determinations* http://www.gmc-uk.org/guidance_convictions_cautions_and_determinations.pdf_25416518.pdf.

b was not clinically indicated, and the medicine would cause death if taken at the prescribed dose or according to the doctor's instructions

c could be used to commit suicide together with anti-emetics which had been also prescribed by, or recommended by, the doctor.

Other serious or persistent failures to comply with the principles set out in *Good Medical Practice* or other GMC guidance

19 Doctors' conduct may also raise a question of impaired fitness to practise by:

a encouraging a person to commit suicide, for example by suggesting it (whether prompted or unprompted) as a 'treatment' option in dealing with the person's disease or condition

b providing practical assistance, for example by helping a person who wishes to commit suicide to travel to the place where they will be assisted to do so

c assessing a person's physical health or mental capacity and/or writing reports knowing, or having reason to suspect, that the assessments and/or reports would be used to enable the person to obtain encouragement or assistance in committing suicide

d providing information or advice about other sources of information about assisted suicide

e providing information or advice about methods of committing suicide, and what each method involves from a medical perspective.

20 In each case, the prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration must be considered and must proceed on the basis of the individual circumstances of the case and in the light of the GMC's duty to act in the public interest (see paragraph 14). Each act undertaken by the doctor may be considered either separately or together with other allied acts (though see paragraph 22b for exceptions relating to the disclosure of records) but always within the overall context.

21 A number of factors may be helpful in applying the realistic prospect test (see paragraph 14). These include:

a whether the allegation relates to an isolated action or is part of a wider pattern of behaviour

A 'one-off' action may suggest that the doctor does not pose a risk to patient safety in the future. However, isolated actions may in themselves still undermine public confidence in the profession or contravene the proper standards of conduct expected of a doctor.

b whether the doctor was acting in a professional or personal capacity

Actions to assist suicide undertaken in a professional capacity will always raise questions about the protection of patients, trust in the profession and proper standards of professional conduct.

If the doctor's actions concern a close relative or partner, for example, it is less likely that they would repeat their actions or pose a danger to patient safety. However, such actions may still undermine public confidence in the profession or contravene the proper standards of conduct expected of a doctor.

c whether the doctor intended to encourage or assist the person seeking to commit suicide or whether the doctor knew (or should have known) that their actions could or would have the effect of encouraging or assisting a person in committing suicide

A doctor may provide information or advice which a patient uses to commit suicide, but the doctor could not reasonably have foreseen this outcome.

d whether the doctor has acted honestly and openly; for example, whether they have kept an accurate record of their prescribing and/or the advice or information provided

Dishonesty is in itself a serious matter. However, in cases involving encouraging or assisting suicide records may also indicate whether a doctor knew or should have known the patient's intentions when providing treatment or advice.

e whether the person who has been encouraged or offered assistance was under 18 years of age

f whether the person who has been encouraged or offered assistance had mental capacity* to decide to take their own life

g whether the doctor benefits, financially or otherwise, from the death or from the encouragement or assistance itself (and the extent to which gain was part of the motive)

h whether the person has reached and communicated a clear, voluntary, settled and informed decision to commit suicide or whether there was evidence of threats or pressure to commit suicide, which the doctor knew about, or should reasonably have known about

i whether the encouragement or assistance was intended (or known to be likely) to have a significant impact on the person's decision or ability to commit suicide.

* As defined in the Mental Capacity Act 2005 or the Adults with Incapacity (Scotland) Act 2000. There is no primary legislation defining how capacity should be assessed in Northern Ireland; follow UK case law – Re C (Adult: Refusal of Medical Treatment) [1994] 1 All ER 819.

Allegations that will not normally give rise to a question of impaired fitness to practise

22 Some actions related to a person's decision to, or ability to, commit suicide are lawful, or will be too distant from the encouragement or assistance to raise a question about a doctor's fitness to practise. These include:

- **a** providing advice or information limited to the law relating to encouraging or assisting suicide
- **b** providing access to a patient's records in compliance with a valid subject access request under the Data Protection Act 1998
- **c** providing information or evidence for, or otherwise assisting in, the preparation, pursuit or defence of legal proceedings regarding encouraging or assisting suicide (limited to the information, evidence or assistance necessary for those purposes).

Questions about the guidance

Legal context (paragraphs 2–4)

In paragraphs 2–4 we set out the current law in the United Kingdom on encouraging or assisting suicide.

1 **Do you think paragraphs 2-4 set out the legal context clearly?**

☐ Yes ☐ No ☐ Not sure

Comments

Ethical guidance and principles (paragraphs 5–10)

In this section, we describe the role of the GMC and remind decision-makers of the ethical principles that underpin this and our other guidance documents.

2 **Do you think this explanation of the ethical principles is helpful?**

☐ Yes ☐ No ☐ Not sure

Comments

In paragraphs 9 and 10, we discuss the implications of the some of the ethical principles in the context of assisting suicide. We aren't sure whether these paragraphs belong in this section.

3 Do you find these paragraphs helpful?

☐ Yes ☐ No ☐ Not sure

Comments

Equality and diversity analysis (paragraph 13)

4 Are there any parts of this guidance which could result in discrimination against any of the groups of people with protected characteristics under the Equality Act 2010?

(The protected characteristics are: age, disability, gender reassignment/transgender, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation).

☐ Yes ☐ No ☐ Not sure

Comments

Types of case: cases involving convictions, cautions and determinations (paragraph 15)

In paragraph 15 we remind the decision-maker of the current guidance they should follow when dealing with allegations in which doctors have been convicted, received a caution and/or have been the subject of a determination by another regulatory body in relation to allegations that he or she has assisted a suicide. We say that in these circumstances, the doctor should be referred directly to a fitness to practise panel.

5 **For each of the following, please indicate whether you agree, disagree or are not sure that a doctor should be referred directly to a fitness to practise panel:**

	Agree	Disagree	Not sure
1 When the doctor has been convicted			
2 When the doctor has received a caution			
3 When the doctor has been the subject of a determination by another regulatory body			

Comments

Presumption of impaired fitness to practise
(Paragraphs 16–18)

In paragraph 17 we have outlined what we see as the circumstances in which there is a presumption of impaired fitness to practise. This list is not intended to be exhaustive.

6 Should we add any other circumstances to the list in paragraph 17?

☐ Yes ☐ No ☐ Not sure

If yes, please say what.

In paragraph 18 we have provided examples of assisting suicide which relate to the prescribing of medication.

7 Are there any other examples that could usefully be added to the list at paragraph 18?

☐ Yes ☐ No ☐ Not sure

If yes, please say what.

Other serious or persistent failures to comply with GMC guidance (paragraphs 19–21)

This section lists some of the actions a doctor might take that could be seen as assisting a suicide and we remind the decision-maker of the test that he or she must apply. We also give the decision-maker a list of factors that might be relevant when assessing whether or not there is a public interest in taking further action.

8 Are there any other examples that we should include in paragraph 19?

☐ Yes ☐ No ☐ Not sure

If yes, please say what.

9 Are there any other factors which we should include in paragraph 21 that could help a decision-maker to decide whether there may be a public interest in taking further action?

☐ Yes ☐ No ☐ Not sure

If yes, please say what.

Allegations that do not raise a question of impaired fitness to practise (paragraph 22)

In paragraph 22 we set out examples of things a doctor might do relating to encouraging or assisting a suicide that would not normally raise a question of impaired fitness to practise, either because they are done to comply with a legal requirement, or because they are not closely enough related to the person's suicide to warrant action on a doctor's registration.

10 Do you agree that the examples provided in paragraph 22 should not normally raise a question of impaired fitness to practise?

☐ Yes ☐ No ☐ Not sure

Comments (please state which action(s) you are referring to)

11 Are there any other things a doctor might do relating to assisting suicide that should not normally raise a question of impaired fitness to practise?

☐ Yes ☐ No ☐ Not sure

If yes, please say what.

General questions about the draft guidance

12 Should the GMC give advice to the Investigation Committee and case examiners on this issue?

☐ Yes ☐ No ☐ Not sure

Comments

13 Is the draft guidance detailed enough?

☐ Too detailed ☐ About right ☐ Not detailed enough

Comments

14 Is the guidance clear?

- [ ] Very clear
- [ ] Quite clear
- [ ] Neutral
- [ ] Quite unclear
- [ ] Very unclear

Comments

15 Do you have any other comments on the draft guidance?

- [ ] Yes
- [ ] No
- [ ] Not sure

Comments (please indicate paragraph/s).

The consultation process

To help us continue to improve the way we consult, please tell us about your experience of taking part in this consultation.

16 Did you find the consultation document (the questionnaire and any associated instructions if completing it online) clear?

☐ Yes ☐ No ☐ Not sure

Comments

17 Were you able easily to access all the relevant documentation you needed to respond?

☐ Yes ☐ No ☐ Not sure

Comments

Thank you for taking the time to send us your comments – we are grateful for your input.

About you

Finally, we would appreciate you providing the following information about yourself to help us analyse the consultation responses.

Your details

Name

Job title (if responding as an organisation)

Organisation (if responding as an organisation)

Address (optional)

Email

Contact tel (optional)

Would you like to be contacted about General Medical Council (GMC) consultations in the future?

- [ ] Yes
- [ ] No

If you would like to know about upcoming GMC consultations, please let us know which of the areas of the GMC's work interest you:

- [ ] Education
- [ ] Standards and ethics
- [ ] Fitness to practise
- [ ] Registration
- [ ] Licensing and revalidation

Data protection

The information you supply will be stored and processed by the GMC in accordance with the Data Protection Act 1998 and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

Responding as an individual

Are you are responding as an individual?

☐ Yes ☐ No

If yes, please complete the following questions. **If not, please complete the 'responding as an organisation' section on page 29.**

Which of the following categories best describes you?

☐ Doctor
☐ Medical educator (teaching, delivering or administering)
☐ Medical student
☐ Member of the public
☐ Other healthcare professional
☐ Other (please give details) ______________________________

Doctors

For the purposes of analysis, it would be helpful for us to know a bit more about the doctors who respond to the consultation. If you are responding as an individual doctor, could you please tick the box below which most closely reflects your role?

☐ General practitioner
☐ Consultant
☐ Other hospital doctor
☐ Trainee doctor
☐ Medical director
☐ Other medical manager
☐ Staff and Associate Grade (SAS) doctor
☐ Sessional/Locum doctor
☐ Medical student
☐ Other (please give details)______________________________

If you are a doctor, do you work

☐ Full-time ☐ Part-time

What is your country of residence?

☐ England ☐ Northern Ireland ☐ Scotland ☐ Wales

☐ Other – European Economic Area

☐ Other – rest of the world (please say where) ______________________________

To help ensure that our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

What is your age?

☐ Under 25 ☐ 25–34 ☐ 35–44 ☐ 45–54 ☐ 55–64 ☐ 65 or over

Are you:

☐ Female ☐ Male

Would you describe yourself as having a disability?

☐ Yes ☐ No

What is your ethnic origin? (Please tick one)

Asian or Asian British

- ☐ Asian or Asian British
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background, please specify ______________________

Black or Black British

- ☐ Black or Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other Black background, please specify______________________

Chinese or other ethnic group

- ☐ Chinese
- ☐ Any other background, please specify______________________

Mixed

- ☐ White and Asian
- ☐ White and Black African
- ☐ White and Black Caribbean
- ☐ Any other mixed background, please specify______________________

White

- ☐ British
- ☐ Irish
- ☐ Any other white background, please specify ______________________

Responding as an organisation

Are you responding on behalf of an organisation?

- [ ] Yes
- [ ] No

If yes, please complete the following questions. **If not, please complete the 'responding as an individual' section on page 26.**

Which of the following categories best describes your organisation?

- [ ] Body representing doctors
- [ ] Body representing patients or public
- [ ] Government department
- [ ] Independent healthcare provider
- [ ] Medical school (undergraduate)
- [ ] Postgraduate medical institution
- [ ] NHS/HSC organisation
- [ ] Regulatory body
- [ ] Other (please give details) ______________________________

In which country is your organisation based?

- [ ] UK wide
- [ ] England
- [ ] Scotland
- [ ] Northern Ireland
- [ ] Wales
- [ ] Other (European Economic Area)
- [ ] Other (rest of the world)

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General Medical Council

Regulating doctors
Ensuring good medical practice