Executive summary
We are modernising our investigations and adjudication processes to make sure that we can address patient safety concerns in the most efficient way.

As previously reported to the Board the Department of Health consulted on the changes to the Medical Act in summer 2014. We recently consulted on changes to the Fitness to Practise Rules to implement new powers introduced by a Section 60 Order approved by Parliament in March 2015 to establish the Medical Practitioners Tribunal Service in statute and improve our procedures. A summary of the Rule changes is at Annex J.

We have drafted guidance to support the changes and new processes, at Annexes A-I. A summary of the key criteria in the guidance is at Annex K.

Recommendations
The Strategy and Policy Board is asked to:

a Agree that, while costs orders will be published in hearing determinations, they should not be separately published against a doctor’s record on the List of Registered Medical Practitioners.

b Approve the draft guidance, at Annexes A-I.

c Note the summary of the Rule changes at Annex J.

d Note the summary of the key criteria in the guidance at Annex K.

e Note the Equality and Diversity considerations at Annex L.
Issue

1 Annexes A-I contain new or substantially revised guidance, to support changes to the Medical Act 1983 (as amended) and/or Rules following consultation. The key criteria in each piece of guidance, which was circulated to Council in August 2015, is set out at Annex K. Comments from Council have been taken into account in developing the attached drafts. The costs guidance was discussed with defence lawyers and medical defence organisations (MDOs) at the Case Management Group meeting on 8 September.

Changes to the Medical Act

Right of Appeal

2 New guidance for decision makers (Annex A) when considering the GMC right of appeal where the decision of the Medical Practitioners Tribunal (MPT) appears insufficient to protect the public and an appeal will support the GMC’s overarching objective of protecting the public and upholding confidence in doctors. Publicising the right of appeal will be considered as part of the wider work on publication and disclosure of fitness to practise information.

Five year rule

3 New guidance for decision makers (Annex B) when deciding to waive the five year rule because it is in the public interest for a case to proceed notwithstanding its age.

Reviews on the papers

4 New guidance for the tribunal (Annex C) includes guidance for the tribunal on dealing with unrepresented doctors, and doctors who are unwell.

Directing reviews

5 New guidance for decision makers (Annex D) on when to direct a review of a sanction where one has not been directed by a tribunal. In general, a review is expected to take place in all cases where a sanction has been imposed for six months or longer to provide assurance that a doctor is fit to practise before restrictions are removed.

6 We have also included within this guidance new powers to refer a doctor for a hearing where a doctor does not agree to our varying undertakings and to reflect a new power to refer a doctor to a hearing where English language skills have deteriorated or give rise to further fitness to practise concerns.
Change to the Medical Act and Rules

Case management and costs

7 New guidance for the tribunal (Annex E) and the Case Manager (Annex F) on making costs orders (against a doctor or the GMC) and assessing the amount of costs following a breach of directions and unreasonable conduct. The guidance will include how to decide that conduct is unreasonable and dealing with unrepresented doctors or doctors who are unwell. The Case Manager will explain to unrepresented doctors the binding nature of the directions and potential consequences of failure to comply. Parties will be required to give notice of an intention to apply for a costs award and information on costs will be available for unrepresented doctors. The Case Manager will have the power to allow extra time for preparation for the costs assessment, in appropriate circumstances. To ensure certainty and proportionality about costs, costs orders will take account of ability to pay, be based on published guideline rates and be subject to an overall cap. To ensure the process is simple to administer, decisions will be made at the end of proceedings and the amount will be dealt with on the papers by the Case Manager.

8 The making of a costs order will be recorded in hearing minutes unless the hearing is in private. As costs orders do not bite on registration and there is no strong public interest argument for doing so we do not propose to note them separately on the doctor’s register entry on the list of registered medical practitioners (LRMP) however as they are not confidential they would be disclosed to an enquirer on request.

Non-compliance

9 New guidance for decision makers (Annex G) when deciding whether to refer a case for a non-compliance hearing and guidance for the tribunal (Annex H) on making a non-compliance order. Factors include reasonableness of request for compliance, evidence of non-compliance, reasons for non-compliance and whether non-compliance is material to the investigation. Guidance includes guidance on dealing with unrepresented doctors or doctors who are unwell. The process will provide for non-compliance orders to be reviewed/revoked where doctors subsequently comply.

Panel undertakings

10 Amendments to guidance for tribunals (Annex I) when considering panel undertakings to reflect that in future undertakings will be agreed with the GMC rather than the panel.

11 A summary of the key points of the guidance, at Annex J, was circulated to Council by email circular in August 2015.
Equality and diversity issues

12 We believe that the changes to our rules are compliant with the aims of the equality duty. The main equality and diversity considerations related to the changes are:

   a Ensuring that the MPTS and GMC fitness to practise procedures remain fair and robust.

   b Ensuring our selection and recruitment procedures for members of the MPTS statutory committee and panellists is fair and transparent.

   c Ensuring that we continue to monitor the impact of the changes on people with protected characteristics.

   d Assessing whether the reforms will disadvantage or create barriers for people who share protected characteristics.

13 We have carefully considered the aims of the equality duty in developing the guidance and throughout the reforms programme and all are compliant with the overriding objective to be fair. Each of the workstream leads has considered the Equality and Diversity issues arising from the implementation of their new processes. This consideration has been captured and reviewed in drafting the attached guidance. Details of specific considerations related to individual workstreams can be found at Annex L.

14 Furthermore, all our decision makers are to receive unconscious bias training later this year. In addition, as a result of the suicide review we are reviewing our approach to dealing with doctors who are unwell in our fitness to practise procedures and further changes to guidance will be made as result.

Evaluation

15 We are developing a full benefits realisation plan in line with project management best practice for each of the proposals.

Next steps

16 Council will be asked to consider the Amendment Orders at its meeting on 30 September 2015. Subject to Council’s approval, the Orders will pass through Parliament and we expect the changes to come into force at the end of December. We have a developed an implementation plan that was considered by the Performance and Resources Board on 22 September 2015. Subject to the Board’s approval, there will be a phased approach to implementation to cover a short interim period of two weeks between 31 December 2015 and 18 January 2016.

17 The Orders include transitional provisions, for example case management decisions will become binding in all cases where a decision to refer to panel is made on or after
31 December 2015. The power to award costs depends on the binding nature of these decisions and we expect the circumstances in which tribunals may consider costs to arise no earlier than March 2016. The GMC’s right of appeal will apply to any hearing concluded on or after the 31 December 2015.

18 We will publish and inform key interests about the consultation outcome report with our response and recommendations in early October 2015. As referred to above, we have met with representatives from the medical defence organisations to build support for case management and costs proposals and will be meeting again in November 2015 to discuss other key reforms. We are working with colleagues in the Strategy and Communication directorate to develop a detailed communications plan, which will include notifying those doctors already in our processes of the changes.
Appeals by the GMC pursuant to s.40A of the Medical Act 1983 ("s.40A appeals") - Guidance for Decision-makers

Introduction

1. Section 40A of the Medical Act 1983 (as amended by Article 17 of The General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015) empowers the GMC to appeal a “relevant decision” by a Medical Practitioners Tribunal ("MPT") if it considers that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.

2. “Relevant decisions” are defined at s.40A(1) to include:

   Decisions (following the determination of the question of a doctor’s fitness to practice) under s.35D to make:

   a. No direction;

   b. A direction for the imposition, extension or termination of an order of suspension;

   c. A direction for the imposition, extension, variation or revocation of an order for conditional registration.

   Decisions (following the determination of an application by an erased doctor) under s.41 to make:

   d. A direction restoring a doctor’s name to the Register;

   Decisions (where doctor has been found to have failed to comply with an order than he undergo an assessment) under Sch.4 para.5A(3D) or 5C(4) to make:
A direction for the imposition of an order for suspension;

A direction for the imposition of an order for conditional registration

Section 40A gives the GMC a discretionary power to appeal such decisions. Accordingly, the GMC must consider in each case:

whether there are grounds to consider that the decision is not sufficient for the protection of the public; and, if so,

whether it should exercise its right of appeal in respect of that decision.

This document is intended to provide guidance as to how and in what circumstances the GMC's power to appeal such decisions should be exercised.

This Guidance is a living document which will be revised periodically.

The decision whether to appeal

Bringing a s.40A appeal and thereby continuing to question a doctor’s fitness to practise, either without further restriction or at all, notwithstanding the conclusions of an MPT which has already considered the matter, is not a decision which the GMC will take lightly; particularly having regard to the following factors:

The GMC recognises and respects that the MPT is a specialist tribunal with particular experience and expertise. The MPT as an institution is an important part of the statutory scheme in which the GMC operates. It would be improper to bring an appeal simply to invite the court to substitute one reasonable view of the merits for another.

Any decision to exercise the right to appeal under s.40A and thereby reopen the question of the doctor’s fitness to practice and/or the appropriate sanction will undoubtedly place strain upon a doctor, whose case would otherwise be closed. (However, it is important to qualify this consideration with the following point: the GMC may only bring an appeal where it is felt necessary to do so in order to protect the public and considerations of pressure on the doctor must necessarily be a secondary consideration to public protection.)

Whilst considering the above factors, the GMC must also have regard to its overarching objective of protecting the public. The right to appeal pursuant to s.40A is an important mechanism by which the GMC can ensure that it meets this objective.
8 The GMC has a power to bring a s.40A appeal where it considers that the decision of the MPT in the particular case is not sufficient for the protection of the public. The proper purpose of the appeal is not to seek to punish the doctor but rather to pursue the over-arching objective set out in s.1(1A) of the Act (as inserted by Article 21 of the 2015 Rules): the protection of the public.

9 As s.40A(4) of the Medical Act 1983 makes clear, when considering whether a decision is sufficient for the protection of the public, the GMC will need to consider whether the decision is sufficient—

a to protect the health, safety and well-being of the public;

b to maintain public confidence in the medical profession; and/or

c to maintain proper professional standards and conduct for members of that profession.

10 However, as a statutory body, the GMC is required to act reasonably in the exercise of its statutory powers, including the power to bring a s.40A appeal. It would not be acting reasonably if it were routinely to bring appeals which were likely to fail.

11 It will therefore need to consider, as one of the factors in reaching a decision, the likely merits of any appeal (the prospects for success of any such appeal before the court) before making a decision to bring a s.40A appeal even when, in principle, there may be grounds for the GMC to consider that the decision of the MPT in the particular case is not sufficient for the protection of the public.

The questions which the GMC will need to address in deciding whether or not to bring a s.40A appeal

12 When considering whether to bring a s.40A appeal in a particular case, it will be necessary to consider the following questions:

a Based on his assessment of all of the information held, and in the particular circumstances of the case, and having regard to the factors set out in paragraph 9 of this Guidance, does the decision maker consider that the MPT’s decision is not sufficient to protect the public?

Only if the decision maker is of the view, on his assessment of all the information held, in the particular circumstances of the case, in the context of paragraph 9, that there are grounds to consider that the MPT’s decision is not sufficient, does he go on to consider.

b In all of the circumstances, would exercising the power of appeal further, rather than undermine, the achievement of the over-arching objective?
If the answer is yes, then the GMC may exercise its power of appeal

13 In considering (b) above, it may be that the decision maker will be required to consider and weigh a number of competing factors (including his assessment of the prospects of success of the appeal, and the nature and importance of the issues which would be aired).

The assessment of whether the decision is “not sufficient” for the protection of the public

14 Unless the GMC concludes that there are grounds for considering that the decision which has been reached by the MPT is not sufficient for the protection of the public, the power to appeal pursuant to s.40A of the Medical Act will not arise and the GMC will not need to proceed to consider whether it should exercise the power to bring a s.40A appeal.

15 Whilst regard will be had to decisions of the MPT relating to other issues and earlier stages in the hearing, the question as to whether the decision of the MPT is not sufficient for the protection of the public will turn in most cases upon the ultimate outcome (if any) in relation to sanction.

16 Whilst the GMC may conclude that there are grounds for considering that one or more of the other decisions (for example as to fact or impairment) has been wrong, it will be the effect (if any) of such decisions on the ultimate outcome in terms of their finding of impairment and, in particular, the determination as to sanction which will determine whether this threshold for the s.40A appeal is met.

17 If, notwithstanding errors in the MPT’s reasoning and conclusions leading up to their determination on sanction, the sanction is ultimately considered to be an appropriate sanction, then it is unlikely that the GMC will consider that decision which has been reached by the MPT is not sufficient for the protection of the public.

18 When considering whether the decision which has been reached by the MPT is not sufficient for the protection of the public, the GMC will need to have regard to such factors as whether:

a the MPT has made an error of fact; and/or

b the MPT has made an error in its application of the relevant legal principles; and/or

c the MPT has failed adequately to apply the relevant guidance published by the GMC and the MPTS, whether as to Standards or as to Sanctions, when reaching its decision as to impairment and/or sanction in a given case; and/or

d the MPT has failed adequately to set out the reasons for the decision made.
19 When considering the matters referred to at paragraph 18 above, the GMC will be mindful that the MPT:

a is itself a specialist, quasi-judicial tribunal with particular expertise in relation to the determination of such issues in the exercise of its statutory function under the Medical Act 1983, and

b plays a central role in the statutory scheme under which the GMC fulfils its statutory functions and meets its statutory objectives.

20 In line with the decision of the Court of Appeal in the case of Fatnani and Raschid v General Medical Council [2007] EWCA Civ 46 (as to which see further below), the GMC accepts that “particular force [should be] given to the need to accord special respect to the judgment of the professional decision-making body”, here the MPT, in view of its acknowledged expertise in determining “the measures necessary to maintain professional standards and provide adequate protection to the public”.

21 However, this does not mean that the GMC must accept the conclusions of the MPT in this regard in all cases. This is clear from decisions of the High Court in cases subsequent to Fatnani and Rashid. In his judgment in the case of Naheed v GMC [2011] EWHC 702 (Admin) [20], Parker J sets out a helpful summary of the correct approach:

The principal purpose of the panel in relation to sanction is the preservation and maintenance of public confidence in the profession rather than the dispensing of retributive justice. The court must accord, therefore, a certain degree of respect or deference to the judgment of the professional panel when it comes to the imposition of sanctions: see Raschid v GMC [2007] 1 WLR 1470 at paragraph 19 by Laws LJ. The exercise of professional judgment is especially important when it comes to sanction -- see Cheatle v GMC [2009] EWHC 645 (Admin) at paragraph 15 by Cranston J. However, if this court despite paying such respect is satisfied that the sanction is clearly inappropriate, then this court must interfere -- see Salsbury v Law Society [2009] 1 WLR 1286 at paragraph 30 by Jackson LJ.
The assessment of prospects and the legal framework governing the determination of s.40A appeals

22 When considering whether a proposed appeal may have reasonable prospects of success, the GMC will need to have regard to the approach which the court is likely to take in determining the appeal in accordance with the provisions of the Medical Act itself, any relevant case law and the relevant Rules of Court.

23 This is because, when assessing whether a s.40A appeal has reasonable prospects of success, the GMC is assessing whether a judge hearing the appeal, acting in accordance with the law, is more likely than not to allow the appeal.

24 A s.40A appeal is governed by the same court rules which govern other statutory appeals, including appeals brought by doctors pursuant to s.40 of the Medical Act 1983 (“s.40 appeals”) and references to court by the Professional Standards Authority for Health and Social Care (“PSA”) made pursuant to s.29 of the National Health Service Reform and Health Care Professions Act 2002 (“s.29 references”).

25 The legal framework in place will vary depending on which jurisdiction the appeal is to be heard in, whether that be Northern Ireland, Scotland, or England and Wales. For example, where the relevant court before whom the appeal is brought is the Administrative Court of England and Wales, the appeal will be governed by the provisions of Part 52 of the Civil Procedure Rules.

26 CPR 52.11(3) provides as follows:

   The appeal court will allow an appeal where the decision of the lower court was —

   a (a) wrong; or

   b (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court.

27 Judgments of the Court of Appeal will be binding only in England and Wales but nonetheless provide useful guidance in all jurisdictions. Of course, the over-arching objective has now changed and as a result the principles distilled in case law dealing with the old objective will need to be reviewed. However, the case law handed down pertaining to general principles, unrelated to the over-arching objective (such as the nature and status of regulatory bodies and decisions made by them), still stands.

28 In the case of Fatnani and Raschid, the Court of Appeal gave further guidance on the approach which the courts should take in applying the test under CPR Part 52.11(3) when considering appeals against decisions of the MPT. Although this guidance was given in the context of an appeal brought by a doctor pursuant to s.40 of the Medical Act 1983, in view of the points made in paragraph 27 of this Guidance (above), the GMC considers that it should and will apply equally in the case of a s.40A appeal.
These principles were usefully summarised by Mostyn J in his judgment in the recent case of Khan v General Medical Council [2015] EWHC 301 (Admin), when he said the following:

“Taking the reasoning of [the Court of Appeal in Fatnani and Raschid] in combination with CPR 52.11(3), the governing principles are:

i. I can only overturn the decision of the FTPP if I am satisfied that it was either wrong or unjust because of a serious procedural or other irregularity in its proceedings.

ii. In determining whether the decision was wrong, I must pay close regard to the special expertise of the FTPP to make the required judgment.

iii. Equally, I must have in mind that the exercise is centrally concerned with the reputation and standards of the profession and the protection of the public rather than the punishment of the doctor.

iv. The High Court will correct material errors of fact and of law and it will exercise a judgment, although distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case.

v. Where the appeal is against a sanction, my decision must not constitute an exercise in resentencing or the substitution of one view of the merits for another.”

When assessing whether a proposed appeal has reasonable prospects of success, the GMC will therefore need to consider:

a. Whether there is a reasonable prospect that the court will conclude that the decision of the MPT was unjust because of a serious procedural or other irregularity in its conduct of the hearing before it: e.g.

i. that it improperly excluded or otherwise failed to have regard to evidence upon which the GMC sought to rely at the hearing;

ii. that the unreasonable exercise, or failure to exercise, Case Management powers by the MPT, had the effect of rendering the hearing before it unjust;

iii. that it failed to give adequate reasons to explain the decision which it reached;

and/or

b. Whether there is a reasonable prospect that, having paid due regard to both:
i the specialist expertise of the MPT on matters of judgment, and particularly in relation to the application of the Sanctions Guidance, and

ii the MPT's particular advantages in evaluating the evidence as the Tribunal which has heard the live evidence,

the court will be satisfied that the decision of the MPT was wrong.

Errors of Fact

31 Section 40A gives a power to appeal against the “relevant decision”: namely a decision as to sanction.

32 Due to the fact that the MPT is a specialist body with the advantage of relevant experience and expertise, the court is unlikely to interfere with a finding of fact unless it was manifestly wrong. It is now firmly established\(^1\) that findings of primary fact are “virtually unassailable”, particularly where those findings are founded upon an assessment of the credibility of live witnesses. Though the High Court has jurisdiction to reopen questions of fact, it very rarely recalls witnesses and recognises that where a tribunal has had the benefit of live evidence, its decisions on matters relating to that evidence are more likely to be sound than a substitute decision made without the advantage of seeing witnesses.

\(^1\) Southall v GMC [2010] EWCA Civ 407 [47]; Dr Luise Schodlok v GMC [2015] EWCA Civ 769 [71].
ANNEX A

The Professional Standards Authority for Health and Social Care “the PSA”

33 The GMC’s right to appeal exists concurrently with the PSA’s power to appeal. Once one party has brought an appeal/referred the case, the other party is precluded from bringing separate, like proceedings.

34 Where the GMC decides to exercise the power of appeal, the Registrar must notify the PSA without delay. Whilst the PSA will not be able to take separate proceedings once the GMC has commenced an appeal, it can become a party and make representations in a GMC appeal in cases where it considers that there is insufficient protection of the public. If the GMC withdraws an appeal, the PSA can continue the proceedings.

35 If the GMC wishes to withdraw the appeal or agrees terms of a settlement with the respondent, then they must communicate this to the PSA, whether or not the PSA is a party to the appeal. The PSA may then take over conduct of the appeal, which from that time is treated as a s.29 reference.
Guidance for decision makers on Rule 4(5)

Introduction

1. Under s.35CC(5) of the Medical Act, an allegation which is more than five years old will only be investigated by the GMC where it is in the public interest to do so. This is provided for within the General Medical Council (Fitness to Practise) Rules 2004 (as amended) at Rule 4(5):

   No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest for it to proceed.

2. The function of the Registrar at the Rule 4 stage is to act as a preliminary filter, ensuring that cases are referred appropriately. The Registrar has no power to refer a case to the Case Examiners, if at the time the allegation is first made or comes to the GMC's attention, more than five years have elapsed since the most recent events giving rise to the allegation, unless he considers that it is in the public interest for it to proceed.

3. This rule sets a general prohibition against the pursuit of long-delayed complaints, subject to the public interest exception.

4. This document is intended to assist decision makers in applying rule 4(5) by setting out the principles relevant in determining:

   a. Whether at the time the allegation was made, more than five years had elapsed since the most recent events giving rise to the allegation; and if so

   b. Whether it would be in the public interest to investigate the allegation.

5. Only allegations as defined by s. 35C(2) and rule 2 will fall to be considered under this guidance. Other complaints will be closed under rule 4(3). It may be necessary to conduct rule 4(4) enquiries to establish whether there is such an allegation.
Determined whether rule 4(5) applies is a question of applying the legal framework to the facts. Deciding whether to waive the rule is a matter of judgment for the Registrar (or those to whom he delegates his powers under this rule).

The guidance in this document will apply to the application of Rule 4(5) in cases where the allegation is received or otherwise comes to the attention of the GMC on or after [DATE].

Where an allegation has been received prior to [DATE], but later the decision falls to be reviewed (see paragraphs 31-32 below), the old test will apply and decision makers should refer to the “Aide Memoir” relevant to that test.

This is a living document which will be revised periodically.

Calculating the time which has elapsed

The date the allegation was made or came to the attention of the GMC

The first task for the Registrar under rule 4(5) is to establish with precision the date when the allegation was made to the GMC or otherwise came to the attention of the GMC. In most cases, this will be straightforward. Typically, the allegation is made by a patient, a patient’s representative or some public organisation accompanied by an explicit or implicit request to investigate. Occasionally, an allegation comes to the GMC’s attention indirectly: for example, through media coverage.

The date of the events giving rise to the allegation

The Registrar must then go on to identify the “most recent events giving rise to the allegation” and the date when those events occurred. This involves analysing the nature of the particular allegation in question.

Where the allegation arises from a single incident, identifying the “most recent events” will be straightforward.

However, the exercise is more complex where the allegation raises a series of separate but linked events which straddle the five year deadline. Depending on the circumstances, rule 4(5) may or may not be engaged. For example, an allegation that a practitioner has regularly failed to complete child abuse forms for the last 12 years does not engage rule 4(5) because the “most recent events giving rise to the allegation” are well within the five year deadline. There is a single composite allegation made at the same time by the same person/body, of identical and persistent misconduct, although evidenced by many manifestations in relation to different patients. Where, as in this example, a number of allegations are considered to form a composite whole, and one or more of them has a relevant period (see paragraph 21) of less than five years, the composite whole will be considered as “in time” by reason of the continuing nature of the events. Therefore the matters will not be considered under rule 4(5). In such a case it is important that the GMC has a full and informed
view of the whole course of conduct, even though some of it occurred more than five years before the allegation was made.

14 Conversely, various quite distinct allegations may be made in relation to discrete incidents involving the same practitioner. For example, one allegation of failure to provide an acceptable level of treatment/care and another of dishonesty on a different occasion in relation to a different patient. Each such allegation has to be considered separately for the purposes of rule 4(5). It is possible for one allegation to fall inside and another outside the five year deadline, even if made by the same person at the same time, against the same practitioner.

15 Occasionally, but not often, a single complaint document contains more than one distinct allegation. The Registrar needs to be aware of this possibility and to pinpoint the allegation in question before applying rule 4(5). The same applies to different allegations which rely on distinct grounds within section 35C(2) of the Act.

16 It is impossible to give guidance on all the possible scenarios that may arise. Where there are a number of allegations with a relevant period of more than five years, the Registrar should seek to identify the extent to which the alleged events are linked by common features and ought reasonably to be regarded as a composite whole. The more they are, the more appropriate it will be for them to be considered together under rule 4(5). The less they are, the more it will be appropriate for them to be considered separately under the Rule 4(5) rule. The main factors to be considered are:

   a the similarity of, and/or connections between the matters alleged; and

   b the timing and maker of the allegation.

17 The greater the similarity, the more likely it is to be regarded as a course of conduct giving rise to one composite allegation. It is more likely to be regarded as a single composite allegation if, say, made in one document by one NHS trust than if made by an array of patients over time.

18 If the allegation relates to multiple clinical failings, then the Registrar will need to carefully consider whether we are dealing with several allegations of misconduct or one allegation of deficient professional performance. This decision will affect whether there is one composite allegation (the latest event being within five years) or several separate allegations, some of which might be older than five years. There is case law to assist with this and the legal team can be asked for advice on whether rule 4(5) is engaged.

19 It is not uncommon for more than one allegation of indecency to be raised against a doctor. Sometimes, for example, a further complainant contacts the GMC during the course of an existing investigation because s/he has been prompted or emboldened by
media coverage to come forward to complain of indecency occurring more than five years earlier. Although there may be a close factual similarity between the episodes of alleged misconduct eg they may both be about inappropriate breast examinations, the allegations are made at different times by different patients in respect of different incidents. The later allegation should be considered separately to the existing allegation and assessed immediately to consider if it meets the threshold for an investigation and assessed under Rule 4(5) as to whether the five year rule is engaged and if so should be waived. This is to avoid unfairness because if the later allegation were the only complaint received, the application of rule 4(5) is likely to result in the matter being closed. Whereas if the later allegation were to be considered together with the earlier allegation, the practitioner would be deprived of the protection of rule 4(5) simply because another similar allegation has been made.

20 If, following consideration of whether the allegation meets the threshold for investigation and whether rule 4(5) is engaged, the later allegation proceeds, a decision will need to be taken at that stage about whether it should be joined to the existing allegation. The stage reached by the existing allegation\(^1\) and the presence or otherwise of shared features will both be relevant to that decision\(^2\).

21 Alternatively the Registrar may have to consider an allegation where the principal incident occurred more than five years before the allegation was made but some later incident is said to be an aggravating or relevant factor or manifestation. For example, where, following revision surgery, an allegation is received that an operation carried out more than five years previously fell below expected standards. It is necessary to identify “the most recent events giving rise to the allegation”, (and this means the principal allegation, such as the original substandard surgery in the example above) not the most recent events relevant to the allegation (the later revision surgery in the example above).

**Requirement to identify the actual date**

22 The relevant period is the period which elapsed between the actual date the alleged events took place and the date the allegation was made. The Registrar is therefore required to identify the actual date upon which the events in question occurred, not simply the date upon which the events are alleged to have occurred.

23 In establishing the actual date, the registrar is entitled to take an allegation at face value. The fact that a given date is named in the allegation is prima facie evidence that that was the actual date. Only where there is reasonable room for doubt is the Registrar obliged to carry out further investigations. The Registrar is not required to

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\(^1\) Procedurally, it may be too late for the subsequent allegation to catch up with the existing allegation before any hearing.

\(^2\) See also the guidance at paragraph 54, below.
double check the details given in every allegation and nor is he obliged to seek the doctor’s views.

24 The question for the Registrar is whether there is anything to put him on notice that the date(s) given in the allegation are not correct. The Registrar should not proceed on the basis that the facts are as alleged in the allegation, if the allegation is plainly flawed or there is some other good reason to take a different approach (if for example there has already been an investigation into the allegation, which concluded that the allegation was unfounded).

The Power to carry out investigations

25 Prior to referring a case to the case examiners, the Registrar has a power under Rule 4 (4) to carry out preliminary investigations. A Registrar might require further investigations to be carried out which would help him to determine, for example: whether rule 4(5) is engaged; what occurred at a previous ventilation of the allegation; or what reasons the complainant could give for the delay in making the complaint. The Registrar may also arrange investigations into the length of the relevant period in a given case (Rule 4 (4) (c)).

26 In some cases, the date upon which the alleged incident(s) took place will be clear from the face of the allegation, with no cause for doubt. In those circumstances, it will not be necessary for the Registrar to do more than note the date.

27 However, in other cases, the allegation may lack clarity or even be silent as to the relevant date(s). There may be some inconsistency within the information available to the Registrar which makes it plain that the date(s) given in the allegation cannot be correct. In circumstances such as these the Registrar should make enquiries with the complainant (or an appropriate third party) to confirm the relevant date(s). A failure to carry out such investigations would be unreasonable.

28 In some cases, the dates given are close to the five year limitation period. If the Registrar, having applied his mind to the issue, feels satisfied that it is clear the relevant date falls one side or another of the five year period, he can exercise his discretion not to carry out any further investigations.

29 If it is not clear from the face of the allegation whether (each or any) of the alleged incident(s) occurred before or after the cut-off, the Registrar should seek to clarify the relevant dates with the complainant (or an appropriate third party).

The relevant period

30 Once the Registrar has established both the date of the allegation and the actual date of the most recent events giving rise to the allegation, the period which has elapsed between the two should be calculated. This is the “relevant period”. If the relevant
period is five years or less, no issue arises under rule 4(5) and the remainder of this guidance has no relevance to the case.

31 If the relevant period is more than five years, the Registrar must consider rule 4(5), with reference to the guidance set out below.

Revisiting decisions as to whether Rule 4(5) is engaged

32 The first stage of the test, namely quantifying the relevant period, is a matter of objective fact. Where the Registrar has reached a decision on this which later transpires to have been founded on a mistake as to the underlying facts, he has power to correct the error. This power may arise at any stage of the GMC disciplinary process. It may be, for example, that a doctor’s Rule 7 response or close examination of the evidence by the Case Examiner reveals a discrepancy as to the date. In such circumstances, the Registrar must reconsider whether Rule 4(5) is engaged.

33 This power to revisit the decision relates only to the question of objective fact, as to whether the relevant period is more than five years and whether the Rule is engaged. The process of calculating the relevant period may be reviewed but the power does not extend to revisiting the question of whether to waive the Rule.

Applying Rule 4(5): the substance of the decision

The test

34 Rule 4(5) sets out that where the relevant period is greater than five years, the allegation shall not proceed further unless the Registrar considers that it is in the public interest for it to proceed. Accordingly, the Registrar must assess the extent to which the public interest warrants the investigation of the allegation. It is not in the public interest for every allegation to be investigated regardless of how stale it may be. The relevant question here is “does the public interest warrant this allegation being proceeded with, despite the fact it is late?”

35 Rule 4(5) requires analysis of competing considerations. On the one hand, a reasonable time should be allowed for allegations to emerge (and what is reasonable will vary from case to case). On the other hand, practitioners should not be pursued by moribund allegations. The decision depends on the Registrar’s discretionary judgment, informed by his experience and expertise. Even if some public interest circumstances are present, it is not inevitable that the allegation should proceed\(^3\). For this reason it is necessary for the Registrar to identify and analyse the particular public interest factors which apply in a given case.

\(^3\) Of course, Rule 4(5) does not say that all allegations are entitled to proceed, save late ones: the Registrar must exercise judgment.
The Public Interest

The term “public interest” is not one which can be easily defined. What can be said is that the public interest has two facets: the particular need to protect individuals and a collective need to maintain the confidence of the public in their doctors. It is well established that there is an important distinction between what is in the public interest, and what is interesting to the public.

The principles of the over-arching objective are closely related to the term “public interest”: striving to achieve the objectives set out within the over-arching objective is in “the public interest”. Accordingly to measure whether investigating the allegation would assist in achieving the over-arching objective, is a helpful first step in assessing whether the rule 4(5) test is met.

The general rule is that where the relevant period is more than five years, an allegation will not be investigated. However, the primary focus of the GMC will always be the protection of the public, in keeping with the over-arching objective and it is recognised that there will be some cases, whether by reason of gravity or some other important reason, it will be in the public interest for an allegation to be pursued notwithstanding the passage of time.

The exercise of the decision making powers under rule 4(5) requires a balancing exercise to be carried out between the interests of the public in ensuring that registrants are properly regulated and fit to practise, against the competing public interest that the process of ensuring the same is fair. The public interest requires that appropriately high standards are met not just by doctors themselves, but also by the institution seeking to uphold those standards. The public interest requires not only that allegations are brought into the light, but also that they are resolved justly and fairly. A person facing a stale allegation may be significantly disadvantaged in defending himself: the extent of that disadvantage may mean that it is not in the public interest for the five year rule to be waived.

The Registrar will need to determine whether it will be possible to have a fair and just inquiry in which it will be possible to fairly resolve the issues raised by the allegations. Almost inevitably, an inquiry into the facts of an allegation dating back more than five years will be one which is disadvantaged by the passage of time. The Registrar must weigh up whether the nature of the late allegation is such that it justifies a decision to proceed, notwithstanding the fact that it will almost always be harder for the Case

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4 There is “Public Interest Guidance” which should be referred to. However, the meaning of the term “public interest”, and the relevant factors which fall to be considered, will vary depending on the circumstances and the test which is being applied.

5 Merrison report
Examiner to assess the case and for the MPT to determine accurately whether the allegation is proved on the balance of probabilities.

41 The best way to protect public confidence in the system as a whole is for matters to be investigated as quickly as possible. In an ideal situation, an allegation would be investigated and resolved as close in time to the facts as alleged as possible. This maximises the chances of the Case Examiners or the MPT finding the truth. Public confidence in the process must inevitably be challenged where matters are dealt with a long time after the alleged matters. Accordingly, where the Registrar is making a decision as to whether he might waive the five year rule, he must ask himself whether the nature or seriousness of the allegation justifies this course. Applying this test will allow the Registrar to act in accordance with the true public interest in a given case.

42 In exercising his discretion the Registrar should take into account a range of considerations such as those listed at paragraph 42 below. The weight to be attributed to each of these is to be assessed by the Registrar on a case by case basis. It may be that one or more of the considerations below is not a material factor in a given case. Furthermore this is not an exhaustive list and the Registrar should ensure that he has taken into consideration all the relevant factors in the particular case.

43 As a starting point, the Registrar should take into account the following matters:

i The length of the relevant period (beyond five years)

ii The reason(s) for the lapse in time

iii The extent to which relevant evidence is no longer available due to the lapse of time

iv The gravity of the allegation

v The number of incidents alleged (as distinct from the gravity of the allegation itself): is there a pattern of misconduct or a single episode

vi The extent of any continuing unwarranted risk to the public and/or to public confidence in the medical profession

vii The extent to which the allegation has been ventilated before other public/adjudicatory bodies such as the police, the coroner, the criminal or civil courts, other regulatory bodies and the practitioner’s employer and the outcome of that ventilation

The reasons for the lapse of time

44 In considering the reasons for the lapse of time, the Registrar should take into account the extent to which the maker of the allegation can be criticised for not making it
sooner. Consideration should be given as to whether any reason given explains why there was no complaint made over the whole period, not just at the time of the incident itself: i.e. is there an explanation for the ongoing failure to make a complaint?

45 The Registrar will be required to consider all of the relevant factors, including: the extent of the lapse of time after the complainant knew or should reasonably have known the relevant/essential facts/evidence supporting the allegation; whether there have been problems in clarifying and collecting the relevant/essential facts/evidence; and the extent to which the relevant/essential facts/evidence have been concealed by the practitioner or a third party. The complainant does not need to collect together all the necessary evidence prior to making a complaint, but this may not be known to them. Waiting for the conclusion of a civil claim arising out of the same facts is not a good reason for failing to make a complaint in a timely manner.

46 The Registrar should consider whether the maker of the allegation has protected characteristics which have contributed to the delay. It will be necessary to consider any particular vulnerabilities, language barrier or cultural issues and the impact these may have had on the timing of the making of the allegation. This will sometimes require the Registrar to think about the nature of the allegation itself. It would be wrong for the Registrar to decide that a case should not proceed, solely on the basis of delay caused by a contributory factor of this type.

47 Having made enquiries as to why the complaint was not made sooner, the Registrar must not simply recite the explanation given to him in his decision, but analyse it fully to establish what it means in the context of rule 4 (5) and the public interest test. Does it truly lend support to the waiver of the five year rule?

The extent to which relevant evidence is no longer available due to the lapse of time

48 Often, at the rule 4(5) stage, the Registrar will not know all the details of what evidence will be available and he should not make decisions on the basis of assumptions about what may or may not be available. However, in some cases the Registrar will be made aware of obvious evidential problems. In all cases the Registrar should ensure that he identifies anything already known to be absent before considering whether this might result in real prejudice to the doctor. Plainly the Registrar is not required to carry out a full evidence-gathering process as this will come at a later stage. Some relevant considerations might be whether records or other documents will still exist\(^6\), whether the allegation will now turn solely or largely on oral evidence (because no contemporaneous records were made) and indeed whether witnesses will be available to give oral evidence. If the Registrar knows that significant evidence needed to prove the allegation is absent, then it will rarely be in the public interest for the allegation to proceed.

\(^6\) The Registrar is entitled to take a common sense approach, in considering the NHS Records Retention Policy.
The gravity of the allegation

49 Not all allegations received by the GMC are necessarily grave. A practitioner is vulnerable to disciplinary sanction if his fitness to practise is “impaired” on one of the grounds listed in section 35C(2) of the Act. Before considering rule 4(5), the Registrar is entitled to dismiss an allegation on the ground that it is not an allegation within the meaning of rule 4: that is, an allegation that a practitioner’s fitness to practise is “impaired” on one of the grounds listed in section 35C(2) of the Act or an allegation treated as arising by virtue of section 35CC(3). Similarly, the Registrar is entitled to dismiss an allegation which he considers to be vexatious, without considering rule 4(5): see rule 4(3), which gives these as alternative bases for dismissal.

50 The GMC receives allegations spanning a vast spectrum of gravity: from very trivial to extremely serious. For example, fraud, other dishonesty, sexual misconduct, breach of confidentiality and serious failure to provide an acceptable level of treatment/care are at the graver end of the spectrum. The focus should be on allegations towards that end of the spectrum. Moreover, the Registrar is entitled to have regard not only to the nature of the allegation/s but also to the particular facts and circumstances which underlie them.

51 It is important to consider seriousness in context— not the context of the expected standards, but the context of the types of complaints received and investigated by the GMC. It may also be appropriate to consider the impact on the patient/complainant (guarding against proceeding with the allegation based solely on the individual’s private interests, but bearing in mind that the particular impact on a given individual may increase the public interest in a case being fully investigated).

52 The gravity of the allegation (and consequences) might in the particular circumstances of the case mean that it is in the public interest for the case to be investigated, but the Registrar will always have in mind the question of whether this can be justified in light of the lateness of the complaint. For example, the fact that there has been a tragic outcome does not mean that is necessarily in the public interest for the five year rule to be waived.

7 An allegation is defined in rule 2 to mean “an allegation that the fitness to practise of a practitioner is impaired and includes an allegation treated as arising by virtue of section 35CC(3) of the Act and an allegation relating to a person whose registration is suspended”.

8 It will be rare for a complainant to be deemed “vexatious” and legal advice should be sought on this where necessary.

9 For guidelines on gravity, in the context of sanctions, see the GMC’s Indicative Sanctions Guidance. See also P[15 onwards].
The number of incidents alleged (as distinct from the gravity of the allegation itself): a pattern of misconduct or a single episode.

53 Sometimes, it will also be relevant to consider other allegations made by different people at different times against the same practitioner; but not always. In the case of Gwynn Mr Justice Sullivan noted that when there are similarities between cases it is normally desirable that a single FTP Panel should hear all the available evidence. But he also noted that this is not the rule 4(5) test and that it is the task of the Case Examiners (not the Registrar) to decide which allegations should reach a FTP Panel. So a similarity between two or more allegations does not in itself justify allowing a late allegation to proceed.

54 For example, the late allegation may be linked to existing allegations, all of which are already under investigation by the GMC. Investigating the late allegation may be the only way to give a full picture. However, this is will depend upon the circumstances of the particular case. Not every allegation forming part of a series of linked allegations must, necessarily and regardless of other factors, be allowed to proceed further. If an allegation is inordinately and inexcusably late, or is consequential or peripheral, the Registrar may determine that it should not proceed.

55 Conversely, if the practitioner is already about to face serious allegations before a FTP Panel, or has already been found to be impaired, there may be little public interest in pursuing a very minor (connected or unconnected) additional late allegation. Where an investigation into separate allegation(s) is well progressed, it will be necessary to consider very carefully whether the public interest warrants delay to that investigation in order to incorporate the new matter. This may depend on:

- what (if any) interim order or other restriction is in place.
- the stage which the existing investigation has reached and the extent of any delay caused by considering the late allegation recently received
- an assessment of each allegation independently and a comparison to the allegations already being investigated, to assess whether:
  - The new allegation, although similar, adds significant weight to the case against the doctor (ie. it is likely to make a difference to the outcome of any hearing);
  - The new allegation raises a new issue which adds a different dimension to the case, which might justify a different outcome.

56 It may assist the Registrar to consider the type of allegation which has been made. An allegation of deficient professional performance will comprise of a composite allegation, evidenced by examples of specific failings. Allegations of misconduct are more likely to be separate matters. The Registrar should look at the number of allegations and
consider whether there are common themes. Deficient professional performance is a standard of performance which is unacceptably low, as judged on a fair sample of the doctor’s work. By contrast, a single act or omission will almost always fall to be considered as misconduct rather than deficient professional performance.

*The extent of any continuing unwarranted risk to the public and/or to public confidence in the medical profession*

57 A key consideration here will be whether the practitioner is still practising within the relevant specialty or at all.

58 In some cases the doctor will have previous disciplinary history\(^\text{10}\) with the GMC, either in the form of proven or unproven allegations. Not all will be relevant. The Registrar must guard against relying on unfounded allegations when seeking to quantify any continuing risk. However, in some cases the Registrar may consider previous allegations when determining the question of whether it would be in the public interest to proceed with the allegation. Relevant considerations will include the nature of any such allegations, any similarities or common features, whether they appear to create a pattern of behaviour, whether they were proven or unproven. The Registrar will need to consider what steps were taken in respect of unproven allegations and why. It may be necessary for a decision in respect of those allegations to be revisited under rule 12 which is a matter for separate consideration.

59 When assessing continuing unwarranted risk, the Registrar should take into account any restrictions in place on the doctor’s registration and whether this guards against the risk presented by the new allegation.

*The extent to which the allegation has been ventilated before other public/adjudicatory bodies such as the police, the coroner, the criminal or civil courts, other regulatory bodies and the practitioner’s employer and the outcome of that ventilation.*

60 The question of previous examination of an allegation will be relevant to the public’s confidence in the profession. Normally, the more alternative ventilation there has been, the less compelling is the argument for the GMC to consider the allegation. Of course this will not be the case where another body has made findings critical of the practitioner and/or has recommended that the GMC should become involved and/or there is a perceived need to protect the public from a practitioner who continues to practise. Like other regulators, the GMC should take into account any decisions made by other agencies (such as the police or social services) who have already carried out an investigation into the allegation in question. However the objectives and aims of the GMC are different to those of other bodies. For example it may be the case that a police investigation into a doctor’s behaviour results in the CPS giving

\(^{10}\) There is guidance on Previous History, which should be referred to where necessary.
advice that no further action should be taken. But this does not and should not preclude the GMC from carrying out its own investigation. It is important to bear in mind that the standard of proof in criminal courts is beyond reasonable doubt, whereas the civil standard of proof - the balance of probabilities - applies in GMC proceedings.

61 In summary, having established the reasons for the length of the relevant period, and the facts surrounding it, the Registrar should then assess whether it is proper for the five year rule to be waived. The following are likely to be very important considerations:

\[\text{a} \quad \text{the gravity of the allegation; and} \]

\[\text{b} \quad \text{the extent of any continuing unwarranted risk to the public and/or to public confidence in the medical profession; and} \]

\[\text{c} \quad \text{the potential for a just and fair hearing based on available evidence.} \]

62 Overall though, the considerations above are likely to have a cumulative impact, with no single one emerging as decisive. The Registrar’s reasons should, therefore, be explained by reference to the wording of rule 4(5) (without paraphrase) and by identifying the public interest factors which lead to the conclusion that the five year rule should or should not be waived.

**Seeking the views of the doctor**

63 The Registrar is not under a duty to seek the doctor’s comments before making a decision as to whether or not Rule 4 (5) is engaged. However, in some circumstances it may be appropriate to do so where there are reasonable grounds to believe that the doctor might provide relevant comment and/or information pertaining to the decisions to be made. This might relate either to the duration of the relevant period, or to the question of whether to waive the five year rule. For example, a doctor may be able to provide documentation that is relevant to whether the complainant was in a position to raise the allegation in a more timely way. This is within the discretion of the Registrar, and the fact that the doctor may have been able to provide further information does not mean that the Registrar has acted unreasonably in failing to obtain his comments before making a decision.

**Duty to notify/ give reasons**

64 Pursuant to Rule 4(3)(b) where the Registrar makes a decision under Rule 4(5) that an allegation should proceed, he is required to notify both the doctor and the complainant (if any).
Where the Registrar decides that Rule 4(5) is engaged (that is, decides that the relevant period is more than five years) he is required to give reasons for that decision and for the subsequent decision as to whether or not it is in the public interest for the allegation to be proceeded with. This will require him to note the competing considerations which have arisen.

As a matter of good practice, where the Registrar determines that Rule 4(5) is not engaged (that is, decides that the relevant period is not more than five years), he should make a detailed note of the decision making process, including the circumstances of the case as he has understood them. However, this decision will not be communicated to the doctor, who will, in the usual way, be unaware of the allegation before it has been referred to the Case Examiners. It may be that in the future, the doctor asks for reasons for the decision that Rule 4(5) is not engaged and the GMC should be able to furnish them.

Legal Advice

In circumstances where the decision maker needs advice on whether rule 4(5) applies, or where there is a preliminary view that the 5 year rule should be waived, the GMC’s In-House Legal Team is available to advise.

Checklist

Annex One contains a checklist to assist decision makers in applying the principles governing the proper application of rule 4(5).
3 - New rules implementation - update and guidance

3 - Annex C

Guidance for Medical Practitioners Tribunals/Chairs conducting Reviews on the papers

Introduction

1 This guidance is for Medical Practitioners Tribunals (‘MPT’) and Interim Orders Tribunals (‘IOT’) or Chairs conducting reviews on the papers.

2 The aim of this guidance is to promote consistency and transparency in decision making.

3 The GMC and MPTS Sanctions Guidance\(^1\) sets out principles relevant to the imposition of sanctions in relation to findings of impairment by an MPT. Separate guidance exists on imposing interim orders\(^2\) and Non-compliance hearings\(^3\). This guidance should be used in conjunction with the relevant guidance where a matter is to be heard on the papers.

Powers

The Medical Act 1983

4 When an order made by either an MPT\(^4\) or an IOT\(^5\) is due to be reviewed, the parties agree on the proposed outcome and the Registrar has provided the MPTS with


\(^{3}\) To insert.

\(^{4}\) Section 35D(13) of the Medical Act 1983

\(^{5}\) Section 41A(3A) of the Medical Act 1983
confirmation in writing of the agreement, the MPTS will arrange for a Tribunal or a Chair to consider the proposed outcome on the papers.

5 Because there is no provision for the tribunal or chair to impose an immediate order at a review on the papers, the Registrar will not ask the MPTS to review the case on the papers where an immediate order is part of the sanction submission. If the chair or the tribunal do not agree with the outcome proposed by the parties, or otherwise determine that it is necessary, they can decide that a full review hearing be held with the opportunity for both parties to attend.

The General Medical Council (Fitness to Practise) Rules 2004 (‘the Rules’)

6 The Rules provide that a matter must be considered on the papers where it has been referred to a tribunal for a review hearing and the MPTS receives confirmation in writing that the parties agree the terms of an order which the Tribunal could make under sections 35D(5), (6), (8), (10) or (12) (MPT) or 41A(3) (IOT) of the Act. The confirmation in writing will consist of an agreement signed by both the Registrar and the doctor which is sent to the MPTS by the Registrar.

The purpose of sanctions

7 The purpose of sanctions is to protect the public. This is the statutory overarching objective, which includes:

a protecting the health, safety and wellbeing of the public
b maintaining public confidence in the profession
c promoting and maintaining proper professional standards and conduct for the members of the profession

8 Each subsequent reference to protecting the public in this document should be read as including the three limbs of the overarching objective set out in paragraph 9.

6 Rule 21B of the Fitness to Practise Rules 2004 is in relation to MPT review hearings and Rule 26A is in relation to IOT review hearings

7 The overarching objective set out in section 1(1A) of the Medical Act 1983 (inserted by the General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015).
Equality and diversity

9 The GMC has a statutory obligation to make sure that procedures set out in their rules for dealing with concerns about doctors appearing before a Medical Practitioners Tribunals or Interim Orders Tribunals are fair and just. Anyone who is acting for the GMC or the MPTS is expected to be aware of, and adhere to, the principles of equality and human rights legislation that are relevant to their role. Decision making should be consistent and impartial, and comply with the public sector equality duty.

Tribunal or tribunal chair

10 The Rules provide that consideration on the papers may be carried out by the chair of the tribunal or the tribunal itself.

11 Whether the review on the papers is carried out by a full tribunal, or a tribunal chair, is at the discretion of the MPTS. A tribunal chair is likely to be appropriate in most cases. References in this guidance to the chair should be taken to mean a tribunal chair who is making the decision alone.

Considerations at review

12 When reviewing a matter on the papers, the tribunal or the chair should have due regard to the principles and considerations of the relevant guidance, as listed at paragraph 3. These principles will be integral to any consideration for the tribunal or the chair in deciding whether or not to make the order on the agreed terms.

Material for consideration

13 In order for the review on the papers to take place, the GMC and the doctor will have come to an agreement on a proposed sanction or order and the Registrar will have notified the MPTS of the agreement. The information presented to the tribunal will vary based on the type of hearing but should include:

- a copy of the agreement signed by the Registrar (or Assistant Registrar), on behalf of the GMC, and the doctor
- a bundle of any information relevant to the previous decision along with any information received in the intervening period
- evidence of the doctor’s compliance with any existing conditions (imposed by a previous tribunal)

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8 Rule 21(2) of the Fitness to Practise Rules 2004
14 Where the agreement is to revoke a sanction the information presented will be more limited, containing the outcome of the investigation and details of any action taken.

**Decision**

15 When presented with the record of agreement between the GMC and the doctor and supporting information, the tribunal or chair has only two options:

- Where the tribunal or chair is satisfied that the agreement reached is appropriate for the protection of the public (as outlined at paragraph 9), they can make the order on the agreed terms.

- Where the tribunal or chair cannot make the order on the agreed terms proposed because, for example, they are not satisfied that the agreement adequately protects the public, or they are in any doubt as to the doctor’s capacity to agree to the proposed action, they can direct that a hearing takes place to conduct the review.

16 The tribunal or chair should be satisfied that the information provided to the doctor makes clear the consequences of his or her agreement to the sanction.

17 If, for any other reason the tribunal or chair feels that that the matter should be heard in full, they should make a direction to that effect.

**Decision reasoning**

18 The tribunal or the chair will be expected to detail the reasoning behind their decision. This will be particularly important where the decision is for a hearing to be held. At the subsequent hearing, the tribunal will have sight of this reasoning.

**Power to direct reviews**

19 Under Rule 21B, the decision maker does not have the power to direct a review of the order which is made on a review on the papers.

20 Under section 35D of the Medical Act 1983, the Registrar (or Assistant Registrar acting under delegated authority) has a power to direct a review of the order. An Assistant Registrar will be asked to consider directing a review as required.

21 In accordance with our *Guidance for Assistant Registrars on directing reviews on sanctions imposed by a Medical Practitioners Tribunal*, the Assistant Registrar is likely to direct a review where no review has been directed and the sanction is for 6 months or more.
Publication and disclosure

22 Where the tribunal or the chair make the order on the agreed terms, the outcome of a review on the papers will be recorded on the List of Registered Medical Practitioners (LRMP) in the same way as a full hearing outcome according to the outlines set out in the Publication and disclosure policy⁹.

⁹ http://www.gmc-uk.org/DC4380_Publication_and_disclosure_policy_36609763.pdf
Guidance for decision makers

Guidance for Assistant registrars on directing a review under S35D of the Medical Act or making a referral to a tribunal for an early review under Rule 21 of the GMC (Fitness to Practise Rules) 2004

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<tr>
<th>Author</th>
<th>Rebecca Lucas, FTP Policy and Planning</th>
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Introduction

1 This guidance is for Assistant Registrars exercising powers to direct a review of a sanction under:

   a Section 35D (4B) or (11B) of the Medical Act; or
   b Rule 21 of the GMC (Fitness to Practise) Rules 2004

Circumstances when an Assistant Registrar is likely to direct a review under S35D of the Medical Act

2 The Assistant Registrar (AR) is likely to apply the power to direct a review under S35D of the Medical Act where no review has been directed (including where a Legally Qualified Chair (LQC) has no power to direct a review on making an order at a review on the papers):

   a In all cases where a sanction has been imposed for 6 months or more unless there are exceptional circumstances which indicate that a review is not needed
   b In cases (including cases where a sanction has been imposed for less than 6 months) involving a change of circumstances that indicates that a review is needed.

Cases where a sanction has been imposed by a Medical Practitioners Tribunal (tribunal) for 6 months or more

3 The AR is likely to exercise the power under Section 35D of the Medical Act 1983 to direct a review of conditions or suspension imposed by the Medical Practitioners Tribunal in all cases where the sanction has been imposed for 6 months or more. Our Sanctions Guidance states that a review hearing is likely to be necessary in most cases where a period of suspension has been imposed and in all cases where a period of conditions has been imposed so the Tribunal can obtain assurance that the doctor is fit to return to unrestricted practice.

Cases (including where a sanction has been imposed by a Medical Practitioner Tribunal for less than 6 months) involving a change of circumstances

4 In some cases where no review has been directed (including where a sanction has been imposed for less than 6 months and a review was not considered necessary), the AR may need to consider directing a review under S35D of the Medical Act where there has been a change of circumstances. This is likely to be necessary where:

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1 Section 35D (5 (7)) (4B) of the Medical Act 1983

- The doctor has failed to remediate
- There has been a material change in the doctor's fitness to practise
- The doctor has breached conditions
- We have received supplementary fitness to practise concerns

5 The power to direct a review under Section 35D only applies where the doctor has received a sanction of either conditions or a suspension at a tribunal. It does not apply to undertakings and the AR's power to refer to a panel in undertakings cases comes under Rule 10 or 37A (see paragraphs 25 – 27 for further details).

The circumstances where the Assistant Registrar will need to consider a review under Rule 21 of the GMC’s Fitness to Practise Rules

Breach of restrictions

6 If a doctor has breached their restrictions before a review hearing, the AR may direct an early review under Rule 21 of the GMC’s Fitness to Practise Rules. If this is not necessary because the breach is minor and unlikely to impact on the doctor's fitness to practise, the AR may contact the doctor about the breach by issuing either of the following:

a An ‘AR letter – Rule 10(8) or 37A(3) Breach’ letter for undertakings, or an ‘AR letter – Rule 21 Breach’ for conditions, which highlights to the doctor the importance of compliance with their restrictions.

b A ‘notification of no compliance concerns’ letter which notes that the doctor has breached their restrictions, but that the breach was not the fault of the doctor and therefore we have no compliance concerns regarding their fitness to practise.

Deterioration

7 A doctor’s performance, health or knowledge of English may deteriorate while they are under restriction. If the deterioration renders their current restrictions inadequate to protect the public, the AR may refer the doctor to a tribunal. Alternatively if this is not necessary, the AR may correspond with the doctor about the deterioration by sending a ‘notification of no compliance concerns’ letter. This letter notes the doctor’s deterioration, but explains that because the deterioration was managed appropriately and is therefore unlikely to impact on the doctor’s fitness to practise, no concerns have been raised.

8 The ‘AR letter – Rule 10(8) or 37A(3) breach’ letter should only be sent where a doctor has breached their restrictions. This letter is not appropriate for deterioration cases as the function of the letter is to remind the doctor of the importance of complying with their restrictions and deterioration may not involve a breach of restrictions.
Refer to a hearing

9 If we receive evidence that a doctor has breached a condition, or that their performance or health has deteriorated, referral to a tribunal for an early review may be appropriate. This decision will be made in an effort to protect the public, or to act in the public interest, or in the interest of the doctor. Other circumstances that may lead to the doctor being referred to an early review hearing will be dealt with by the AR on a case by case basis. The referral should be made under Rule 21 of the GMC (Fitness to Practise) Rules 2004.

10 If we receive evidence that a doctor has breached a Case Examiner or tribunal undertaking, or that their performance, health or knowledge of English has deteriorated, referral to the tribunal for a fitness to practise hearing (in a Case Examiner undertakings case) or a review hearing (in a tribunal undertakings case) may be appropriate. This decision will be made in an effort to protect the public, or to act in the public interest, or in the interest of the doctor. The rules that apply are as follows:

   a Rule 10(8) of the GMC (Fitness to Practise) Rules 2004, for undertakings that have been agreed under Rule 10(4), i.e. following a case examiner decision to invite the doctor to agree undertakings

   Or

   b Rule 37A(3) of the GMC (Fitness to Practise) Rules 2004, for undertakings taken into account by a tribunal under Rule 17(4) or 22(3), i.e. undertakings agreed by the GMC and taken into account by the Medical Practitioners Tribunal.

11 There is a key difference in the operation of these two sets of rules. Rules 10(8) and 37A(3) allow for referral to a tribunal in respect of specific issues arising in relation to doctors subject to undertakings, for example a breach of a doctors undertakings, whereas Rule 21 provides a broader power that allows a referral back to a Tribunal for an early review where information is received that makes it desirable for the Registrar to do so. This broader power to refer under Rule 21 is designed to encompass referrals where conditional registration is not working, as well as cases where the doctor is in breach. An example would be failure to remediate despite complying with the letter of conditions.

12 The AR needs to consider the purpose of a proposed referral to a Tribunal, and what action we will be asking the Tribunal to take. The purpose of a referral to a Tribunal is not punitive, and would normally be based on a concern about potential risk to patients. However a referral might also sometimes be appropriate where a breach does not pose a risk to patients but it is necessary in order to uphold confidence in the profession in cases where a doctor disregards a restriction on their registration. For this reason it will sometimes be appropriate to refer a doctor for breach of a condition or undertaking even though a Tribunal may not increase the severity of the restrictions.
**Referral to tribunal where a doctor has breached their restrictions**

13 Any decisions on whether to refer a doctor found to have breached their restrictions needs to take account of the following factors:

   a  whether the breach is isolated, a one off or repeated
   b  whether patient safety has been significantly compromised as a result of the breach
   c  whether compliance was within or outside the doctor’s control
   d  whether the breach is indicative of a disregard of the instructions issued by the GMC and/or MPTS
   e  whether the AR believes that the breach was a mistake on the doctor’s part and that reoccurrence is unlikely
   f  the doctor has breached their undertakings or conditions within one year of them being imposed

Examples of breaches of undertakings or conditions that are likely to merit referral are:

   a  repeated or persistent failure to engage with the GMC and/or supervision
   b  evidence of failure to comply with restrictions to abstain from alcohol or drugs
   c  evidence of deterioration of professional performance following attempts at remediation
   d  evidence of deterioration of medical condition, where the doctor demonstrates a lack of insight and fails to engage in treatment or follow the advice of the medical supervisor and/or treating doctors
   e  evidence of deterioration of English language where the doctor’s knowledge and use of English has worsened or the doctor has not sufficiently improved upon their English language skills despite conditions to that effect.

14 The two most common breaches of restriction are failure to comply with medical supervision requirements and failure to abstain from alcohol. The circumstances of every such failure will need to be taken into account when deciding whether to refer a doctor who appears to be in breach of a restriction.

**Missed appointments**

15 We accept that supervision appointments may be missed for very good reasons, and would not normally refer a doctor to a Tribunal in respect of a single missed appointment where they have provided adequate reasons and rescheduled the appointment. If multiple appointments have been missed the reasons will need to be significantly more compelling in order to avoid referral to a Tribunal.
Failure to abstain from alcohol

16 We accept that relapse is a feature of addiction and dependency, and that therefore from time to time doctors required to abstain from alcohol will fail to do so. It will not be appropriate to refer every such failure to a Tribunal. However, in order for us to require a doctor to be abstinent, we will have previously developed significant patient safety and/or public confidence concerns in respect of their alcohol use, so we must take every failure to comply very seriously.

17 Where a doctor required to abstain has relapsed, but subsequently re-commences abstinence and treatment, has an appropriate support network in place and is complying with supervision and all other requirements, we will not usually refer them to a Tribunal. If relapse occurs again the AR has discretion to refer the doctor to a Tribunal.

Referral to tribunal where the doctor’s health, performance or English language has deteriorated

18 Decision makers should consider the significance of any deterioration in the doctor’s performance, health or English language and the evidence that supports that assessment when deciding whether to refer a doctor to a tribunal. However, if deterioration occurs in conjunction with a breach of restrictions, the breach should be dealt with as a priority.

Health

19 Information may be received that suggests a doctor’s health has deteriorated where for example, a doctor with bipolar affective disorder has had a serious relapse and has been admitted to hospital. Usually such deterioration is well managed by the doctor and there is no patient safety or confidence issue. However, in instances where the deterioration is not managed or where the doctor has failed to engage with the GMC, it may be appropriate for the AR to refer the doctor to a tribunal to ensure that patient safety is protected and confidence is maintained.

Performance

20 Information may be received that suggests a doctor’s performance has deteriorated where for example, a doctor has not maintained their knowledge of medicine in a particular area and over time their ability to perform in this area diminishes. If we receive information that suggests a significant deterioration it may be appropriate to obtain Case Examiner advice on whether a performance assessment is required and, depending on the outcome of any performance assessment, refer the matter to a tribunal.

English language

21 Information may be received that suggests that a doctor’s knowledge of English language has deteriorated or otherwise gives rise to further fitness to practise concerns. This information is likely to come from a doctor’s employer in response to local concerns about the doctor’s language skills. If the deterioration appears to be significant, it may be appropriate to refer the doctor to a tribunal to ensure that the public is protected.
Refer to a hearing

22 A doctor can be said to have agreed undertakings, having either:

a been invited to do so by the Case Examiners under Rule 10, or

b had undertakings agreed with the GMC and approved by a Medical Practitioners Tribunal under Rule 37A.

23 In either scenario, as a result of information received by the GMC, the Case Examiner may wish to vary the undertakings. The Registrar can then write to the doctor inviting them to comply with the varied undertakings.

24 If the doctor has not, within 28 days of the invitation, agreed to comply with the varied undertakings, it may be appropriate for the AR to refer the doctor to a tribunal under Rule 10 or 37A. Our powers to direct a review under Section 35D only apply to conditions and suspensions so do not apply to undertakings cases.

25 If the doctor has breached undertakings, the breach may be serious enough to required referral to a Medical Practitioners Tribunal. ‘In the event of a referral, the AR should consider whether to also make a referral to the Case Examiners. The Case Examiners will decide whether the doctor is referred to the Interim Orders Tribunal as the undertakings will cease to apply and interim restrictions may be required to protect the public.’ (See ‘Imposing interim orders: Guidance for the interim orders tribunal and the medical practitioners tribunal’)

Not to Refer to a hearing

26 If based on the guidance above, the AR determines that the doctor should not be referred to a tribunal, the AR may notify the doctor that no referral has been made under:

a Rule 10(8) for CE undertakings

b Rule 37A(3) for tribunal undertakings

c Rule 21 for tribunal conditions.

Breach in undertakings where the AR decides the breach is not serious enough to warrant a referral to tribunal

3 Footnote to updated guidance to be inserted before go live
27 An ‘AR letter – Rule 10(8) or 37A(3) breach’ may be sent if the doctor has breached their undertakings, but the breach is not serious enough to require referral to a Tribunal. This notification will:
   a  highlight the undertakings breach
   b  reaffirm to the doctor the importance of compliance with their restrictions
   c  remind the doctor they may be referred to Tribunal if any subsequent breaches occur.

28 This notification does not act as a sanction and does not appear on the public record.

29 The fact we have sent this notification may be disclosed to the doctor’s RO (and additional employers where the RO isn’t the doctor’s employer) who will have previously been notified of the breach and other relevant parties involved in monitoring the doctor’s compliance with the restrictions (these the doctor’s notes section of the restrictions bank).

30 The fact we have sent this letter to the doctor will be disclosed to the case examiners as part of the review of the doctor’s case to ensure that any wider pattern of behaviour can be taken into account. If the case is referred to a Tribunal, a copy of the letter will form part of the bundle of papers presented when the doctor’s case is considered.

31 The letter itself may be disclosed to the doctor’s medical supervisor if one is in place, and if know, the doctors treating psychiatrist and GP.

32 If further concerns arise, the AR will consider this information and may decide to refer the case to a Tribunal, based on a pattern of behaviour/repeated failures to comply with restrictions.

33 If the doctor’s revalidation was put on hold while we made a decision, the doctor will be given a new submission date.

Breach in conditions where the AR decides it is not serious enough to warrant a referral to tribunal

34 A ‘Notification of the AR’s decision under Rule 21’ may be sent if the doctor has breached their conditions, but the breach is not serious enough to require referral to an early review hearing. This notification will:
   a  highlight the conditions breach
   b  reaffirm to the doctor the importance of compliance with their restrictions
   c  remind the doctor they may be referred to tribunal for early review if any subsequent breaches occur.

35 This notification does not act as a sanction and does not appear on the public record.

36 The fact we have sent this notification may be disclosed to the doctor’s RO (and additional employers where the RO isn’t the doctor’s employer) who will have previously been notified of the breach and other relevant parties involved in monitoring the
doctor’s compliance with the restrictions (see the doctor’s notes section of the restrictions bank)

37 A copy of the letter will form part of the bundle of papers presented to the Tribunal when it meets to review the doctor’s case to ensure that any wider pattern of behaviour can be taken into account.

38 The letter itself may be disclosed to the doctor’s medical supervisor if one is in place and if known, the doctors treating psychiatrist and GP.

39 If further concerns arise, the AR will consider this information and may decide to refer the case to a Tribunal for early review, based on a pattern of behaviour/repeated failures to comply with restrictions. This information will also be considered by the Tribunal at the next scheduled review hearing.

40 If the doctor’s revalidation was put on hold while we made a decision, the doctor will be given a new submission date.

Breach of restrictions that were beyond the doctor’s control or where the deterioration did not raise compliance concerns

41 If the doctor was unable to comply with their restrictions due to factors entirely beyond their control or where the doctor’s deterioration was managed appropriately, a ‘Notification of no compliance concerns’ may be issued under Rule 10(8), Rule 37A(3) or Rule 21 to confirm the AR’s decision that a referral to Tribunal is not necessary.

42 The fact we have sent this notification may be disclosed to the doctor’s RO (and additional employers where the RO isn’t the doctor’s employer) who will have previously been notified of the breach and other relevant parties involved in monitoring the doctor’s compliance with the restrictions (see the doctor’s notes section of the restrictions bank)

43 In undertakings cases, the fact we have sent this letter to the doctor will be disclosed to the Case Examiners as part of the annual review of the doctor’s case. In conditions cases, a copy of the letter will form part of the bundle of papers presented to the Tribunal when it meets to review the doctor’s case. This will ensure that any wider pattern of behaviour can be taken into account.

44 The letter itself may be disclosed to the doctor’s medical supervisor if one is in place and if known, the doctors treating psychiatrist and GP.

45 Examples where this form of notification may be appropriate include:

   a  where a doctor may have been required to attend a training course but no such course exists, but not where there is a fee and the doctor has declined to pay it.

   b  where a doctor may have been required to attend medical supervision according to a specified pattern, but that pattern has been altered by the supervisor and the GMC is of the view that the supervision is sufficient.

   c  where a doctor has had a deterioration in their mental health, however they have put safeguards in place to ensure that the public are protected.
If the doctor's revalidation was put on hold while we made a decision, the doctor will be given a new submission date.
3 - New rules implementation - update and guidance

3 - Annex E

Guidance for Medical Practitioners Tribunals on Case Management and Exercising Powers Under Rule 16(8) (Adverse inferences, refusal to admit evidence and awarding costs)

Introduction
1. This guidance will apply to cases where

   - A pre-hearing meeting takes place; or
   - A first or second listings teleconference takes place; or
   - A letter imposing rules or directions upon parties is sent out;

   after [DATE]. This is a living document and will be subject to periodic review.

2. The overriding objective of the GMC in making procedural rules is to ensure that Medical Practitioners Tribunals (MPT’s) deal with cases fairly and justly. One key way in which the GMC meets this overriding objective is through the inclusion within the GMC (Fitness to Practise) Rules 2004 (as amended) (“the Rules”) of provisions for the making of case management directions to enable and facilitate the fair and just determination of cases.

3. Under Rule 16(7A), a case management direction is binding on the parties and on any subsequent MPT considering the case, unless the MPT considers that:

   a. there has been a material change in circumstances; or
   b. it is not in the interests of justice for the direction to be binding.

4. Pre-hearing compliance with the Rules and case management directions allows both parties the opportunity to prepare and then present their case efficiently and
effectively to the MPT, on the basis of mutual and timely prior disclosure of their respective evidence. This allows all parties to appreciate, in advance of the hearing, what the real issues in the case are and allows for a good understanding of the extent to which they are disputed. Parties in the context of fitness to practise proceedings are the GMC and the doctor facing allegations, together with their representatives.

5 The Medical Act 1983 (as amended by the General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015) empowers the GMC when making procedural rules to provide for the consequences of non-compliance and the Rules include such provisions.

6 Where a party has failed to comply with a rule or case management direction, the MPT has the discretion to:

   a draw adverse inferences; and/or
   
   b refuse to admit the evidence (where the failure relates to the admissibility of evidence); and/or
   
   c award costs.

7 These powers can be exercised following an application from a party or on the MPT’s own initiative.

8 This guidance sets out the circumstances and factors relevant in exercising these powers. In practice, the exercise of these powers will occur relatively rarely due to the specific nature of the criteria to be met before each of the powers is available.

9 In exercising these powers, the MPT must have regard to the over-arching objective: the protection of the public. Pursuant to s.1B(1) of the Medical Act, this will entail pursuing the following objectives

   a protecting the health, safety and well-being of patients and the public;
   
   b maintaining public confidence in the profession; and
   
   c Promoting and maintaining proper professional standards and conduct for members of that profession.

Determining whether a case management direction should be binding

10 The powers under Rule 16(8) are available to the MPT following a failure to comply with a Case Management direction or a rule. The default position is that a Case Management decision is binding. However the rules provide a set of narrow
circumstances where the MPT may find that a decision should not be binding where there has been a change of circumstances or another reason why it would not be in the interests of justice for the direction to be binding. In the vast majority of cases it will be immediately obvious that the directions should be binding but in some cases careful consideration will be required.

Failure to comply

Before considering whether to exercise any of these powers, the MPT should first decide whether there is a rule or direction which has not been complied with. This will first of all require the MPT to look at whether, as a matter of fact, there was a case direction made or a rule which required the party to carry out a particular action, by a particular date. The MPT will then consider whether the action was carried out and whether this was done on time. In some cases both parties will agree the facts, but in others it will be necessary to hear evidence and/or submissions before reaching a conclusion. The MPT should have regard to the record of directions (made at a pre-hearing meeting, listing teleconference or by way of correspondence). Whilst the MPT may be assisted by reference to any observations made by the Case Manager regarding compliance, this is a question for the MPT to decide on its own judgment.

In cases where the MPT finds that a party has not complied with a rule or direction, it will assist the MPT to consider all of the circumstances of the non-compliance to establish whether this amounts to a culpable failure. This will include but is not limited to:

a What was the nature and extent of the failure to comply?

b Who was responsible for the failure to comply?

c What impact did the failure have on the other party, the MPT and/or the progress of the case?

d What obstacles were faced by the party who failed to comply with the rule or direction?

e What steps did that party take to overcome the obstacles?

f Was there anything else that might reasonably have been done to avoid the non-compliance?

g Did the party seek to minimise disruption by notifying the opposing party and/or the Case Manager of the problem?

h What reasonable steps could the party have taken to avoid non-compliance with the rule or direction?
In considering the factors set out at (a)-(h) above, together with any other factors, the MPT will have regard to whether there were barriers to his or her compliance outside his or her control.

These factors will be of relevance when turning to consider whether it would be appropriate to exercise the powers referred to in the remainder of this guidance.

**Drawing Adverse Inferences**

14 This part of the guidance refers to powers which are available to the MPT following a failure to comply with a rule or case management direction. It does not interfere with the MPT’s ability to draw an inference in relation to evidence heard during the course of the hearing. An adverse inference can be drawn against either the GMC or a doctor facing allegations.

15 The purpose of the power to draw an adverse inference is to ensure that a party cannot secure an unfair advantage by hindering the MPT’s full and unfettered examination of the relevant evidence and issues in the case. The power to draw an adverse inference will be considered where a party has failed to provide evidence leaving the MPT unable to assess its quality and/or determine what it means in the context of the case as a whole.

16 Where a party has failed to comply with a rule or a Case Manager direction, the MPT may draw an adverse inference but only if this is appropriate in all of the circumstances of the case.

17 The MPT should first decide whether there has there been a failure to comply. If it concludes that a party has failed to comply with a rule or direction, then it should turn to the circumstances in which that failure arose and consider the factors in paragraph 12 above.

18 Having considered all of the circumstances, the MPT should go on to determine its view on the motivation of the failing party: whether the failure was ill-motivated or made in bad faith. If the MPT concludes that the failure occurred because the failing party had an ulterior motive in seeking to keep unfavourable material away from the MPT, or otherwise conceal the truth from it, then it could be appropriate to draw an adverse inference.

19 Given the nature of the issue, it will almost always be the case that there will be no direct evidence as to the motivation of the failing party. The MPT will need to assess all of the circumstances of the failure in the context of the case as a whole, in determining whether there was improper motivation.
Before drawing an adverse inference, as a matter of fairness, the MPT should first consider whether there may be another explanation for the failure. It should be noted that a denial of the failure is not the same as an explanation for the failure. An inference against a party should only be drawn where it is the only reasonable inference to be drawn from the failure and there can be no other reasonable explanation.

The MPT, having drawn an adverse inference, should apply this inference to the relevant issue(s) in the case. It will then take this into account when considering the case as a whole. An adverse inference should be considered in the context of all of the evidence available in the case. The MPT should not find an allegation is proved or not proved, or base a decision on impairment, on the basis of an adverse inference alone. The MPT’s power to draw an adverse inference does not reverse the burden of proof.

In determining whether to draw an adverse inference, it may assist the MPT to work through the following questions (with reference to the more detailed guidance set out above):

a. Has a party failed to comply with a rule or case management direction? (The MPT should then consider the factors in paragraph 12 above)

b. What reason has been given for the failure? In all of the circumstances, what conclusion is to be drawn about the motivation behind the failure?

c. What was the nature and impact of the failure? Has the MPT been able to make a full assessment of the relevant issue(s) in the case or has the failure denied them access to some material evidence?

d. Is an adverse inference the only inference to be drawn?

Refusing to Admit Evidence

The purpose of the power to refuse to admit evidence is to protect the fairness of the proceedings and to ensure that a party cannot gain an unfair advantage by manipulating the hearing process.

Justice demands that determinations are made on the basis of evidence, and in general terms the MPT will be best able to deliver justice where they have access to all of the available evidence. Excluding evidence is a draconian step which should only be taken where absolutely necessary. An order to exclude evidence can be made against either the GMC or a doctor facing allegations.

Where a party has failed to comply with a rule or a case management direction relating to the admissibility of evidence, including deadlines for submitting it, the MPT may
refuse to admit the evidence, either by way of a preliminary ruling on a legal argument, or during the course of the hearing.

26 In deciding whether to exclude evidence, the MPT should consider the following questions:

a Has a party failed to comply with a rule or direction pertaining to the evidence in question? (The MPT should then consider the factors in paragraph 12 above);

b Does the party have a reasonable excuse for that failing?

c Has the party deliberately sought to disrupt the proceedings by the manner or timing of the production of the evidence?

d What issue in the case does the evidence go to?

e Will the other party be prevented from (or be significantly disadvantaged in) addressing the material issues raised by the evidence in question?

27 The MPT must always ensure that the hearing is fair, but fairness involves fairness to both parties. Ensuring fairness may require the MPT to balance the interests of one party against another. For example, allowing one party to present its case fully (by the admission of evidence served late in the proceedings) may conflict with the ability of the other party to answer that case.

28 The MPT should always consider whether there is any other mechanism which would allow the hearing to proceed fairly, before refusing to admit evidence. This could include adjourning the case to allow the other party time to prepare, notwithstanding the fact that adjournments are generally undesirable.

**Awards for Costs**

29 Usually, each party will bear their own costs. The MPT’s decision as to the merits of an application for costs is separate from its findings in relation to facts, impairment and sanction. The purpose of the power to award costs is to encourage parties to comply with the rules and Case Manager directions, to improve efficiency and thus to ensure that the over-arching objective is met.

30 Where a party has failed to comply with a rule or a case management direction, and they have behaved unreasonably in the conduct of the proceedings, the MPT may make an award of wasted costs against the party. An award of costs can be made against either the GMC or a doctor facing allegations.

31 Although the MPT will hear and decide applications in relation to costs only at the end of a hearing, the behaviour which gives rise to an application should be highlighted
immediately. Where a party has failed to comply with a rule or direction, the other party should bring this to the attention of the MPTS or the Case Manager (or the MPT, if the hearing has commenced) without delay. If the other party intends to make an application for costs, this should be communicated to the MPTS, the Case Manager or the MPT immediately. An application for costs will only be appropriate where the other party has failed to comply with a rule or direction and has engaged in unreasonable behaviour and as a result time or money has been wasted.

32 Upon being put on notice that a party intends to make an application for costs, the MPT should inform the other party of the steps that should be taken in order to prepare for a potential costs application, including gathering information relating to the sums wasted and ability to pay (even though this will only be relevant if the MPT makes an order for costs).

33 The MPT will consider any relevant evidence and submissions from both parties on:

a. the alleged failure to comply with rules or a Case Manager direction; and

b. the allegedly unreasonable behaviour in the conduct of the proceedings.

34 In determining whether to make a costs award, the MPT will need to consider the following questions:

a. Has there been a failure to comply with a rule or direction? (The MPT should then consider the factors in paragraph 12 above);

b. Has the party who failed to comply acted unreasonably (see paragraph 36-41 below) in the conduct of the proceedings?

c. If the answers to (a), (b) are “yes”, should the MPT exercise its discretion to make a costs award against the party who failed to comply?

35 The additional question, as to whether the other party incurred any costs/wasted any time, which but for the non-compliance would not have been incurred/wasted, will be determined by the Case Manager if the MPT makes an order for costs.

36 Unreasonable behaviour may be either procedural (relating to the process) or substantive (relating to the issues in the case). For the purposes of an application for costs, “unreasonable behaviour” relates to behaviour in the course of the hearing itself, or in preparation for the hearing. The failure to comply may itself amount to “unreasonable behaviour”.

37 In Ridehalgh v Horsfield and others [1994] Ch. 205 CA (Civ. Div.), Sir Thomas Bingham MR defined “unreasonable” behaviour as
“...describing conduct which is vexatious, designed to harass the other side rather than advance the resolution of the case, and it makes no difference that the conduct is the product of excessive zeal and not improper motive. But conduct cannot be described as unreasonable simply because it leads in the event to an unsuccessful result or because other more cautious representatives would have acted differently. The acid test is whether the conduct permits of a reasonable explanation. If so, the course adopted may be regarded as optimistic and as reflecting on a practitioner’s judgment, but it is not unreasonable.”

38 The MPT should consider all of the circumstances surrounding the behaviour in question. The MPT may wish to consider the following non-exhaustive list of questions, which are independent of one another (although of course more than one may feature in a single case). Has the party engaged in:

a conduct that is designed to frustrate the process?;

b uncooperative and obstructive conduct that goes beyond the limits of acceptability or fairness and for which there is no reasonable excuse?;

c behaviour that jeopardises the fairness of the proceedings?;

d the pursuit of a case which is known to be dishonest?;

e the evasion of rules or directions intended to safeguard the interests of justice (e.g. deliberately conniving at incomplete disclosure)?

39 The question of what is reasonable is related to and proportionate to the purpose and objectives of the party. It is important that parties are not unduly fettered in the pursuit of appropriate objectives, for example the presentation of a proper defence or the protection of the public.

40 The fact that a particular course of action undertaken by a party did not result in an outcome that was favourable to the party will not of itself render that action “unreasonable”. Delay, absent other features, is not enough to amount to unreasonable behaviour but it may be an outward sign of such behaviour.

41 The MPT will consider the relevant behaviour in the context of the circumstances of the case as a whole, and will guard against labelling behaviour born out of language barriers, cultural differences, or illness as “unreasonable”.

42 In considering whether to make a costs award, the MPT should not take into account the paying party’s ability to pay. If a costs award is made, this important factor will be taken into account at the assessment of costs stage, when the Case Manager will review any evidence on ability to pay, as provided by the paying party (see paragraphs 41-42 below).
Costs awards Against Legal Representatives

43 An MPT faced with making a decision as to whether to make a costs award against a legal representative should make full allowance for the fact that it may be difficult for the representative to freely present his position, given the principles of legal professional privilege and client confidentiality. In these circumstances a costs award against the representative should only be made where – proceeding very carefully - it is plain to see that there is nothing that could be said by the representative even if he were unrestrained, which would allow him to resist the application. Assessment of Costs

44 If the MPT makes a costs award, an assessment of the amount of costs to be paid will be made by a Case Manager. The receiving party has a period of 28 days from the conclusion of the proceedings to serve a schedule of wasted costs on the paying party and the Case Manager. Upon receipt of the schedule of wasted costs provided by the receiving party, the paying party must within 28 days serve a written response to the schedule, together with details and evidence of their ability to pay. The Case Manager has a discretion to vary this time limit in individual circumstances if it is just and fair to do so.

45 Costs will be assessed on the basis of the amount of the receiving party's time that was wasted. The Case Manager will assess whether there are any wasted costs and use the Guidance on Assessing Costs in determining the appropriate sum and will have regard to the paying party’s ability to pay.
Annex 1: Guideline Figures

Introduction

1 As is made plain in the guidance to which this document is annexed, it is intended that the costs scheme as a whole will benefit all parties by encouraging compliance with case directions and rules. The costs scheme is not a costs recovery scheme: for this reason, in many cases, there may not be a full recovery of the wasted costs incurred.

2 The Case Manager must balance the interests of the paying party and the receiving party, so as to achieve the fairest outcome. This means looking at whether a cost is reasonable in the context of market rates, and also whether it was reasonable for a cost to be paid, taking into account the circumstances of the party who incurred the costs. The purpose of this document is to assist the Case Manager in that task.

Reasonable advocacy costs

Background

3 The purpose of this document is to assist the Case Manager in assessing whether a sum claimed is reasonable. These figures take into consideration the rates charged by chambers in Manchester, to appear in Fitness to Practice hearings at the GMC, for a single case. Rates charged by chambers in Manchester were used in the production of this guideline because hearings are heard in Manchester.

4 Where the services of an advocate are secured by way of a fixed term contract, for example under the GMC’s set rates or under rates agreed between defence organisations and a set of chambers it is anticipated that the rates will be lower than those set out below, because advocates will accept a reduced fee in order to secure a regular flow of work into chambers.

5 In all cases, the indemnity principle applies and the Case Manager will not allow a claim for more than the costs actually incurred. Accordingly, the Case Manager will have regard to the actual agreement in place as to the advocate’s fee, even if this is less than the lower end of the relevant bracket. The figures below are intended to act as a guideline only.

Guideline Figures

6 In all cases, the Case Manager will have regard to the figures below. The Case Manager will exercise his or her judgment as to whether there are any features of the
case which justify a departure from these guidelines. In so considering the guidelines, the Case Manager will always seek to ensure that the outcome is fair and just.

<table>
<thead>
<tr>
<th>Duration of Listing</th>
<th>Brief Fee</th>
<th>“Refresher” (Daily Rate for second and subsequent days of the hearing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 days</td>
<td>£1000-£2000</td>
<td>£750-£1,250</td>
</tr>
<tr>
<td>2-5</td>
<td>£2,000-£4,000</td>
<td>£750-£1,250</td>
</tr>
<tr>
<td>5-7</td>
<td>£4,000-£5,000</td>
<td>£750-£1,250</td>
</tr>
<tr>
<td>7-10</td>
<td>£5,000-£7,000</td>
<td>£750-£1,250</td>
</tr>
<tr>
<td>10 days+</td>
<td>£7,000-£10,000</td>
<td>£750-£1,250</td>
</tr>
</tbody>
</table>

Where an otherwise unnecessary conference or written advice has been necessary, the appropriate guideline for reasonable costs would be £150/hour. In a particularly complex case this figure could be raised to something in the region of £250.

Using the Guideline Figures

7 The brackets above only provide a guideline, which must be considered in the context of the facts of the particular case. The Case Manager will consider features such as: the volume of papers, the number and nature of the expert reports, any particular complexities of the case and whether the parties were required to deal with novel points of law. Where the application includes a claim for wasted costs arising out of an adjourned hearing, the proximity of the hearing date and the notice of an adjournment is a relevant factor. It may be appropriate to apply a sliding scale with a higher proportion of the sum being awarded in cases where there is shorter notice.

8 In very rare circumstances, there may be a genuine reason as to why a party felt it necessary to secure the services of an advocate from out of the area, whose fees are higher than those set out in the guideline brackets above. The Case Manager will assess each case on its merits but it will be for the claiming party to provide evidence as to why the costs claimed are in fact reasonable in the circumstances.

9 Guidance is given above as to what will, in the vast majority of cases, be deemed to be a reasonable “brief fee”. This fee usually remunerates the advocate for reading the papers, preparing the case, attending one case conference (i.e. a meeting between the client and the advocate) and the first day of the main hearing. However, the brief fee
will rarely (if ever) be recoverable, as usually the work done in return for the brief fee will be necessary regardless of the failure to comply/unreasonable behaviour and so will not fall to be considered as “wasted” costs. In cases where an additional brief fee has been paid, the Case Manager will consider what proportion, if any, of the sums claimed should be allowed.

**The overall Cap**

10 In order to ensure certainty for the parties and to ensure that no party is required to pay a disproportionate amount, an overall cap will apply to sums which can be awarded against a party. This cap does not include costs arising out of the instruction of an expert witness but it does include all other costs and disbursements.

<table>
<thead>
<tr>
<th>Duration of hearing</th>
<th>Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 days</td>
<td>£2,550</td>
</tr>
<tr>
<td>3-5 days</td>
<td>£9,600</td>
</tr>
<tr>
<td>5-7 days</td>
<td>£13,250</td>
</tr>
<tr>
<td>7-10 days</td>
<td>£15,800</td>
</tr>
<tr>
<td>10 days +</td>
<td>£17,750</td>
</tr>
</tbody>
</table>

N.B. All sums in this guidance are exclusive of VAT.
3 - New rules implementation - update and guidance

3 - Annex F

Guidance for Case Managers on the Assessment of Costs

The timetable

Preparation by the parties

1. Where an MPT has made an order for costs, it will follow that the receiving party has a period of 28 days to submit a schedule of their wasted costs together with written submissions supported by evidence. The paying party will have a period of 28 days from the receipt of the receiving party's schedule to prepare and serve their written submissions together with evidence relating to their ability to pay.

2. There may be circumstances in which one or both parties may need longer than 28 days. In such circumstances, the party should write to the Case Manager and to the other party without delay. It is within the Case Manager's discretion, if he or she feels it would be just and fair, to allow a party further time to prepare for the costs hearing.

3. The Case Manager will consider what efforts have been made by the party seeking more time to comply with the 28 day time frame and will take into account whether the request for more time was itself made in a timely fashion.

4. Once it was known that an application for costs was to be made, the MPT will have put parties on notice of the preparation which would need to be carried out in respect of the costs application and the Case Manager will have regard to the whole period of time which has been available to the parties in determining whether or not it would be just and fair to allow further time.

5. If the paying party does not respond to the receiving party's schedule, the receiving party may ask the Case Manager to proceed to a determination.

6. Where it has been necessary for a party to instruct a new legal team following the MPT's decision on costs, that party may wish to ask for more time. The Case Manager
will review whether that legal team has had sufficient time to prepare. The doctor will be expected to have acted with due expedition in instructing a new team and should not delay in instructing new representatives. In all of the circumstances of the case, the Case Manager will allow further time if it is just and fair to do so.

Where a party seeks to appeal a decision of the MPT

7  Where a party seeks to appeal a decision of the MPT, the Case Manager will usually go on to assess the sum of costs to be paid in accordance with the usual timetable. However, in exceptional circumstances, it may be that the Case Manager takes the view that it would be inappropriate to determine the sum of costs to be payable before the appeal is heard. In those circumstances, it would be within the Case Manager’s discretion to postpone the costs decision until the outcome of the appeal is known. The Case Manager may postpone the costs decision in this way of his or her own volition, or on application from either party. If the Case Manager is considering a postponement he or she must invite written submissions from both parties. Having made a decision on postponement, he or she will provide both parties with written reasons within 7 days of the decision having been made.

Agreement between the parties

8  If the parties are able to reach an agreement as to the sum of costs to be paid to the receiving party, they should write to the Case Manager setting out the terms agreed. The Case Manager has discretion whether or not to endorse that agreement and order the agreed sum to be paid. If the Case Manager believes the agreement to be unfair he or she will assess costs in the usual way.

The Assessment of Costs

9  The Case Manager will assess costs following the determination by the MPT that a paying party has failed to comply with a case management direction or rule, and has behaved unreasonably, resulting in the MPT making a costs order against the paying party. This assessment will be made on the papers.

10  The Case Manager should only allow claims in respect of costs which have been incurred as a result of the failure to comply. If a cost would have been incurred in any event, the claim for that particular cost should not be allowed.

11  In determining what has been reasonable in a given case, the Case Manager may be assisted by having sight of a copy of the paying party’s own costs schedule, if the paying party wishes to provide a copy of the same.
12 In assessing costs, the Case Manager will make summary assessments relating to various heads of costs. It would not be appropriate or proportionate for the Case Manager to carry out a detailed assessment of costs.

13 The Case Manager will first need to assess whether each item claimed represents work or time which was wasted by reason of the paying party's failure to comply. If the item does not represent wasted time or work it will not be recoverable.

14 Having done so, the Case Manager will then assess whether each item was reasonably incurred and whether the sum claimed is reasonable based on the guideline rates (see Annex X).

The cap

15 The Case Manager’s assessment of the costs to be paid will be subject to an overall cap. The period for which the case was listed (not the actual length of the hearing) will determine the level of the cap (see Annex X).

Preparation Costs

16 Only preparation which has actually been undertaken may be claimed, not preparation which may have been done at some future time.

17 In assessing the costs which are reasonably to be claimed in respect of work carried out by solicitors, trainee solicitors, legal executives, fee earners & paralegals, the Case Manager will have regard to the Guideline Hourly Rates (GHR).

18 The GHR will provide guidance for the Case Manager on what is reasonable, but any amount to be awarded remains a matter for the Case Manager’s discretion.

19 The length of the period for which the case is listed is not always a reliable indicator of how much preparation has been required.

Disbursements including Advocacy Costs

20 With all costs, including disbursements, a party has a responsibility to ensure that costs are not unreasonably incurred. The Case Manager will consider all the circumstances in the case when reviewing the costs which have been incurred. Spending should be proportionate. Where, for example, a party has chosen to instruct Queen’s Counsel in a straightforward case which could have been presented by suitably experienced junior counsel, the Case Manager may determine that this was not reasonable and may decide that only a proportion of the cost claimed should be met by the paying party.

21 Advocacy costs may be claimed either in respect of hearing days which have occurred unnecessarily (i.e. where the advocate has actually appeared) or in respect of
ineffective hearing days where the receiving party has instructed an advocate (i.e. where the advocate has not appeared). When considering whether a sum claimed in respect of advocacy costs is reasonable, the Case Manager will first consider the period for which the case was listed (not the actual duration of the case) and the level of experience of the advocate.

22 In the case of ineffective hearings where the advocate has not appeared, it will be for the receiving party to show that they were still required to pay the instructed advocate and have actually incurred costs in paying the advocate. The Case Manager must then assess what proportion of those costs should be awarded. The Case Manager may need to consider the proximity of the date the receiving party was notified that the listed hearing date would not be effective to the hearing date as in some cases, the fee payable to counsel will depend on how much notice was given of the vacated hearing.

23 Assessing the appropriate fee for the advocate in a specific case will be a matter for the discretion of the Case Manager, applying the appropriate guideline (see Annex X), taking into account the features of the case. The Case Manager will consider what fee would be paid to a hypothetical Counsel, with the relevant experience, capable of conducting the case effectively but unwilling or unable to demand the fees charged by Counsel of pre-eminent reputation (Simpsons Motor Sales (London) Ltd v Hendon Borough Council [1965] 1 WLR 112).

24 Remuneration for solicitor advocates will be assessed in accordance with the normal principles for remuneration of solicitors. It is not appropriate to seek a brief fee and refreshers as if the advocate were a member of the Bar. If the cost of using a solicitor advocate is more than the cost of instructing Counsel, the higher cost is unlikely to be deemed recoverable.

25 There is no guideline for experts’ fees, as the level of expertise required and the nature of the speciality opined upon will vary dramatically from case to case. In assessing whether or not an expert’s fee should be allowed, the Case Manager will consider whether the sum charged is reasonable. Like in all other aspects of the assessment, the Case Manager will also have careful regard as to what proportion, if any, of the cost was wasted by reason of the paying party’s failure to comply.

26 With all disbursements, the Case Manager will have careful regard as to whether the costs could have been avoided if the receiving party had acted with reasonable care in seeking to mitigate their losses (for example by notifying an expert witness that the hearing would be ineffective, as soon as possible, rather than delaying unnecessarily).

**Self-represented doctors**

27 There is an absolute cap on the amount recoverable by a self-represented doctor, namely two-thirds of what would be payable to a hypothetical legal team carrying out
the same work, plus the reasonable costs of disbursements. Where a doctor acts as his own advocate, he may claim a maximum of two-thirds of what would have been payable to a professional advocate.

28 The Case Manager will use the guidelines above to determine the figure which would have been paid to the hypothetical legal representative.

29 In respect of preparation costs, the GHR will not apply to work done by a self-representing doctor, as this is a rate for legal professionals. The rate awarded to the self-represented doctor may be either:

a an hourly rate to reflect actual financial loss; or

b A fixed hourly charge (presently £18/hr) to represent the lost time.

30 For actual financial loss, it is for the self-represented doctor to establish by evidence and on balance of probabilities that a financial loss has been suffered. He must go on to show what the loss actually is, following a three stage test:

a he must show that he was liable to be working

b he must then show that he would have been employed and

c he must show how much he would have earned.

31 Each of the above must be supported by evidence. If he cannot meet the three stages of the test, the hourly rate will be awarded.

32 When making an award of costs in favour of a self-represented doctor, the Case Manager will:

a Identify a rate, being either the actual financial loss or the fixed hourly rate;

b Assess the time reasonably spent (perhaps with an additional uplift for research and taking into account the fact that a doctor may need longer than a professional lawyer for some aspects of the case preparation, but less for others). When assessing what was reasonable in a given case, the Case Manager will not regard as unreasonable decisions made because of language barriers, cultural differences, or illness;

c Assess the figure a hypothetical legal representative of the appropriate grade would have charged for the same work (as set out in paragraph 29);
d  Allow the self-represented doctor’s claim in full, or if necessary, discount the figure to two-thirds of the amount that would have been charged by the hypothetical legal representative;

e  Assess & add any disbursements to reach a final figure.

Claims relating to a Mackenzie friend

33 Where a self-represented doctor is assisted by a Mackenzie friend, the doctor can make a claim for wasted costs arising out of work he has done himself, but no claim can be made for respect of work done by the Mackenzie friend.

Claims relating to a “suitable person”

34 Where a doctor is formally represented by a “suitable person”¹, rather than by a solicitor or barrister, a claim may be made in respect of wasted costs arising out of work which was done by them after they were given permission to act for the doctor and not before. As with all costs, a party may only claim back that which he was actually liable to pay out, and so where a claim is made for work done by a “suitable person”, it is for the doctor to show that there is a genuine written agreement between them that the doctor will pay (or has already paid) the sum claimed.

Costs arising out of the application for costs

35 The receiving party is entitled to claim reasonable costs relating to the preparation of the application for costs and the schedule of costs itself.

Ability to pay

36 Having assessed the sum of costs which has been properly claimed, the Case Manager will turn to the question of the paying party’s ability to pay. The presumption is that the paying party is able to pay, unless they can show otherwise. In considering the evidence provided by the paying party, the Case Manager will have regard to what would be just and fair in all the circumstances of the case.

¹ This means where the doctor is represented by a person who has been permitted under Rule 33(1)(c) to act on his behalf.
Notification & Payment

37 The Case Manager will provide to both parties a copy of her decision as to the sum to be paid, within 7 days of the decision having been made².

38 The costs awarded will usually be payable within 14 days of the notification of the Case Manager’s decision, unless the Case Manager specifies a different period.

² Challenge of a decision of a Case Manager would be by way of Judicial Review
3 - New rules implementation - update and guidance

3 - Annex G

Guidance for decision makers on referring a case for a non-compliance hearing
Introduction

1. Under the GMC (Fitness to Practise) Rules, 2004 (as amended) (‘the Rules’), at Rule [17ZA], the GMC may refer a doctor to a Medical Practitioners Tribunal (MPT) where the doctor has failed to comply with a requirement to provide information or a direction to undergo an assessment (referred to in this guidance as a “direction”) from the GMC and whether, by doing so, the doctor has impaired the GMC’s ability to investigate concerns.

2. This guidance sets out the factors to be considered when deciding whether to refer a case for a non-compliance hearing.

Non-compliance process

3. The power to refer to a non-compliance hearing is discretionary and is intended to be used where a doctor’s failure or refusal to comply with a request or assessment significantly impairs our ability to proceed with an investigation or take action in response to concerns.

4. We can take action where:
   - a doctor has failed to submit to or comply with a request for an assessment of their health, performance or knowledge of English;
   - having agreed to undergo/submitted to an assessment, the doctor has failed to comply with the requirements imposed in respect of that assessment;
   - the doctor has failed to provide information required from them that is key to the progress of an investigation.

5. Although non-compliance hearings will be heard before a Medical Practitioners Tribunal, a non-compliance hearing is distinct from both a Medical Practitioners Tribunal hearing, which considers matters of impaired fitness to practise, and an Interim Orders Tribunal.

6. At a non-compliance hearing an MPT will be asked to consider:
   - whether or not the direction was reasonable given the circumstances of the case
   - whether or not the doctor has failed to comply with the direction, and
   - whether or not there was good reason for a doctor’s refusal or failure to comply (i.e. it was unavoidable or otherwise excusable).

7. Where a doctor has refused to comply with a direction to undergo an assessment or with a requirement to provide information that is key to the progress of an investigation, they may be referred to a non-compliance hearing, where a tribunal can
impose conditions of up to three years on a doctor’s registration, or suspend a doctor for a period of up to 12 months.

8 In most cases, the restrictions imposed will be subject to review by a tribunal, before the period of conditions or suspension has expired, that will consider whether or not the doctor has complied in order to determine whether the restrictions should be maintained, varied or revoked.

9 After being suspended for two years, and where there is evidence of continued non-compliance, the tribunal, on review, will be able to suspend the doctor indefinitely. A doctor cannot be erased for non-compliance.

10 If a doctor has interim orders at the point of referral to a non-compliance hearing, the non-compliance tribunal is empowered to revoke the interim orders and impose a non-compliance sanction which it considers sufficient to protect the public in respect of all relevant matters.

Referrals for non-compliance

11 When referring a case for a non-compliance hearing, the decision maker should look to answer the following questions:

- Was the requirement to provide information or direction to undergo an assessment reasonable given the allegations under investigation?
- Has the doctor explicitly refused to comply with the above direction or, by lack of response, failed to reply over a period of at least xxxx weeks to three reminders?
- Has the doctor submitted to a direction, but subsequently failed to comply with directions made in line with that assessment?
- Is the information or assessment directed material to the investigation and does the doctor’s failure to comply therefore materially impair our ability to proceed with the investigation?

Other routes of investigation

12 Before referring a doctor to a non-compliance hearing, the decision maker should consider whether or not the information requested, or the outcome of the assessment, is material to the investigation, and whether or not the doctors failure to comply will materially impair our ability to investigate.

13 If there are other means by which information can be acquired, or the allegations can otherwise be scrutinised, these avenues should be pursued before a referral to a non-compliance tribunal is made.
14 A non-compliance referral should usually be made where a doctor’s failure or refusal to comply leaves the GMC with no reasonable avenues of investigation and therefore hampers its ability to fulfil its statutory objective of protecting the public.

15 Examples of cases appropriate for referral to a non-compliance hearing can be found at Annex A.

**Reasonable directions**

16 A reasonable direction is one proportionate to the allegations under investigation and considered necessary to further our investigations. In order for a direction to be considered reasonable, the letters sent to the doctor must outline the potential consequences of non-compliance.

17 Where a doctor is known not to have sought representation from a medical defence organisation or other body, the decision maker should ensure consequences of non-compliance have been clearly communicated. The doctor should also be advised to seek representation.

**Health, Performance and English Language Assessments**

18 In pure health, performance or English language cases, a reasonable direction might be a direction to undergo an assessment, the results of which will enable us to progress an investigation and take action necessary to protect the public.

19 If the decision maker is in any doubt as to the thresholds for directing an assessment, they should refer to the relevant guidance on directing health\(^1\), performance\(^2\) and English language\(^3\) assessments.

**Failure to provide information**

20 A reasonable direction for information must be information required to progress an investigation and should be considered appropriate in relation to the allegations under investigations.

21 This may include, but is not limited to:

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\(^1\) [Guidance for decision makers on directing a health assessment](http://www.gmc-uk.org/DC6339_Guidance_for_decision_makers_on_directing_a_health_assessment_60761806.pdf)

\(^2\) [Guidance for decision makers on directing a performance assessment](http://www.gmc-uk.org/DC6343_Guidance_for_decision_makers_on_directing_a_performance_assessment_60761601.pdf)

\(^3\) [Guidance for decision makers on directing doctors to undertake a language assessment](http://www.gmc-uk.org/DC5933_CE_Decision_Guidance___Annex_E___Directing_a_language_assessment.pdf_58270963.pdf)
a work details form
- details of a specific employer or placement
- details of specific times or dates relevant to an investigation
- details of a pharmacy where we are investigating self-prescribing
- private patient medical records where they are held only by the doctor under investigation.

22 Where a referral is made to a non-compliance hearing, the decision maker must have sufficient reason to believe that the doctor is in possession of the document or information and must outline this reasoning in their decision.

**Failure to comply**

23 A doctor may have failed to comply where either:

a a doctor has *explicitly* refused to comply with a direction to provide information or a direction to undergo an assessment

b a doctor has failed to respond to three directions to provide information or undergo an assessment over a period of at least xxxx weeks.

24 In scenario (a), the doctor’s refusal must be demonstrable in writing in the form of either a letter or an email and should be unambiguous. Furthermore, the doctor should be made aware of the potential consequences of non-compliance prior to a referral.

25 In scenario (b), where a doctor does not respond to a request or invitation, each subsequent request should make clear the potential consequences of continued non-compliance. Where a doctor has failed to respond to our normal process for directing an assessment, or with a direction to provide information, three reminders should be sent to the doctor over a period of xxxx weeks, warning of the potential consequences of the doctor’s failure to respond. The letters should, where possible, be sent both to the doctor’s registered address and email address to give the doctor a number of opportunities to comply.

26 Where a doctor has failed to comply with a direction to undergo an assessment, the subsequent letters must not be considered new invitations, but should be reminders for the doctor to submit to the original invitation.

27 It will be necessary to provide proof of service of the direction to provide information or assessment sent to the doctor, either through recorded delivery post to the doctor’s registered address, or an email ‘read receipt’.
Good reason for non-compliance

28 Before making a referral to a non-compliance hearing, the decision maker should consider whether or not a doctor’s physical or mental health might have some impact on their ability to comply with a direction, or their ability to appreciate the potential consequences of non-compliance. This may be of particular pertinence where a doctor is an inpatient.

29 There may be situations in which a doctor is unable to comply with a direction to undergo an assessment because they are out of the country and are unable to return. Where this is out of the doctor’s control, it may be a good reason for non-compliance. Efforts should therefore be made to understand the doctor’s status before making a referral.

Multi-factorial cases

30 Where an investigation is concerned with more than one head of impairment, and the doctor’s failure to comply relates to only one (e.g. the doctor is under investigation for health and misconduct, but refuses to undergo a health assessment), the case should still be referred to non-compliance hearing where the outcome of the health assessment is considered to be material to the investigation.

31 Where a doctor is referred to a non-compliance hearing as a result of a failure to comply with one aspect of an investigation, any ongoing investigations into other heads of impairment may continue.

Referrals for early review

32 Where a doctor complies with a direction before a non-compliance order is due to expire, and the decision maker is satisfied that the doctor has complied with the direction, the case should be referred for an early review hearing under Rule 21.

33 In assessment cases, a doctor must not only have submitted to undergo the assessment, but must also have complied with all requests requirements of him/her for the assessment. A referral for an early review will not be appropriate until an assessment has been completed.
Annex A

Case study 1 – health
We receive a referral from a Medical Director about a doctor who she suspects is suffering from depression and has begun engaging in substance abuse in order to manage his depression. The doctor has been off work for extended periods in the past due to mental health and new concerns from the doctor’s colleagues and patients have led the referrer to write to us about the doctor’s presentation while on duty.

Having opened an investigation, a Case Examiner decides that we should direct a health assessment.

Having received a written direction to undergo an assessment, the doctor replies indicating that he does not feel an assessment is necessary and does not intend to submit to the assessment. We send a second letter to the doctor, advising of the potential consequences of refusing to comply with the direction. The doctor replies, arguing that he has already dealt with his health concerns in the past and therefore refuses to undergo an assessment.

The doctor having explicitly refused to undergo an assessment despite having been advised of the consequences of non-compliance, the case should be referred to a non-compliance hearing.

Case study 2 – misconduct
We receive a complaint from a patient about a GP who failed to diagnose her with cancer despite three visits to the surgery with red flag symptoms. Upon receiving the complaint, an Assistant Registrar decides that the case passes the threshold for investigation and advises that we contact the doctor’s employers for further information.

We send a copy of the complaint to the doctor along with a Work Details Form (WDF), requiring details of the doctor’s employment. Despite responding to the letter, the doctor does not send in the completed WDF. A reminder is sent but no response is received. The IO then sends a second reminder by recorded delivery to the doctor’s registered address warning of the consequences of non-compliance.

After a third reminder has been sent within a period of xxxx weeks, and the doctor has not responded (or, having responded, has failed to supply a completed WDF) the case should be referred to a non-compliance hearing.
Non-compliance hearings guidance for medical practitioners tribunals

Introduction

1. The aim of this guidance is to promote consistency and transparency in decision making relating to non-compliance hearings.

2. This guidance is for use by Tribunals in cases that have been referred to the MPTS for a non-compliance hearing when considering what sanction to impose following a finding that the doctor has failed to comply with a reasonable requirement to provide information or a direction to undergo an assessment without good reason (referred to in this guidance as a “direction”). It outlines the decision-making process and factors to be considered.

3. The GMC and MPTS Sanctions guidance\(^1\) sets out principles relevant to the imposition of sanctions in relation to findings of impairment by a Medical Practitioners Tribunal. Non-compliance sanctions differ from those outlined in the sanctions guidance, in that a non-compliance tribunal will not make a finding of impairment. Wherever principles from the sanctions guidance are relevant to non-compliance, they will be referenced appropriately.

The function of non-compliance hearings

4. Under the GMC (Fitness to Practise) Rules, 2004 (as amended) (the FTP Rules), at Rule [17ZA], the GMC may present evidence to a Medical Practitioners Tribunal (MPT) in relation to the question of whether-

the practitioner has failed to submit to, or comply with, an assessment under Schedule 1 [performance assessments] or 2 [health assessments];

having submitted to an assessment under Schedule 1, the practitioner has failed to comply with requirements imposed in respect of that assessment;

the practitioner has failed to undertake an assessment of knowledge of English in accordance with Schedule 3 or has undertaken such an assessment but has failed to provide the information requested in accordance with that Schedule;

the practitioner has failed to provide information required from him/her under section 35A(1A) of the Medical Act 1983 (as amended).

5 As part of an investigation, the GMC may direct that a doctor undergo an assessment of their health, performance, or knowledge of English Language. Furthermore, the GMC may require information from a doctor.

6 Where a doctor is found to be consistently or explicitly refusing to comply with a direction to undergo an assessment or to provide information that is key to the progress of an investigation, they may be referred to a non-compliance hearing, where a tribunal can impose conditions of up to three years on a doctor’s registration, suspend a doctor for a period of up to 12 months, or take no action.

7 The restrictions imposed may be subject to review by a tribunal which will consider whether or not the doctor has complied in order to determine whether the restrictions should remain in place or be varied.

8 If, on review, a doctor continues to refuse to comply with the direction to provide information or undergo an assessment or fails to engage with an assessment, after being suspended for two years, the tribunal will be able to suspend the doctor indefinitely. A doctor cannot be erased for non-compliance.

9 A non-compliance hearing differs from an end stage MPT hearing in that there is no finding of impairment. A non-compliance hearing differs from an IOT in that a non-compliance tribunal will make findings of fact in relation to compliance.

General principles regarding non-compliance

Hearing process

10 In accordance with Rule [17ZA (2)] of the FTP Rules,, a hearing will include the following main elements:
- presentation of the GMC case, ie evidence of failure to provide information required or failure to submit to an assessment or comply with requirements of an assessment
- presentation of the doctor’s case
- the MPT’s findings on the issue of non-compliance
- further submissions from both parties
- the MPT’s decision on whether to make an order for conditions or suspension following a finding of non-compliance
- Consideration of an immediate order
- Consideration, as appropriate, of any interim order already in place, whether it needs to be revoked and whether, based on assessment of risk, any additional order needs to be made to protect the public and/or upholding confidence in the profession during the term of the non-compliance order while the GMC continues its investigation.

**The purpose of sanctions**

11 The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes:

a. protecting the health, safety and wellbeing of the public

b. maintaining public confidence in the profession

c. promoting and maintaining proper professional standards and conduct for the members of the profession

12 Each subsequent reference to protecting the public in this document should be read as including the three limbs of the overarching objective set out in paragraph 11.

13 As explained at paragraph 15 of the Sanctions Guidance, sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect.

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2 The overarching objective set out in section 1(1A) of the Medical Act 1983 (inserted by the General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015).
Equality and Diversity

14 The GMC has a statutory obligation to make sure that procedures set out in their rules for dealing with concerns about doctors before a Medical Practitioners Tribunals are fair and just. Anyone who is acting for the GMC or the MPTS is expected to be aware of, and adhere to, the principles of equality and human rights legislation that are relevant to their role. Decision making should be consistent and impartial, and comply with the public sector equality duty.

Considerations for the tribunal

15 The considerations for a tribunal assessing non-compliance can be broken into three broad categories, all of which should be satisfied before the tribunal proceed to impose a sanction.

- Was the GMC’s direction to provide information or to undergo an assessment reasonable given the circumstances of the case and the evidence available to decision maker(s)?

- Is there sufficient evidence to show that the doctor has failed to comply with the direction?

- Is there evidence to suggest that there was good reason for the doctor’s failure to comply (i.e. was it unavoidable or otherwise excusable)?

16 In relation to each of the above considerations, the representative for the GMC must direct the attention of the Medical Practitioners Tribunal to any relevant evidence and call witnesses. The practitioner in question may, in response, adduce evidence and call witnesses in relation to any question addressed by the representative of the GMC.

Reasonable directions

17 The tribunal must consider whether or not a direction to undergo an assessment or to provide information is reasonable given the particular circumstances of the case.

18 In most cases, a reasonable direction:

- will relate either to a direction to provide information or to undergo an assessment (as outlined at paragraph 5)

- must have been made in line with the GMC’s powers as laid out in the Medical Act 1983 (as amended) and the GMC (Fitness to Practise) Rules 2004.

- is one proportionate to the allegations under investigation (e.g. concerns were sufficiently serious that that the GMC was justified in directing a health or performance assessment).
is one where a doctor’s failure or refusal to comply would significantly impair the GMCs ability to investigate concerns and therefore fulfil its statutory objective.

19 The tribunal should not exercise hindsight at this stage of consideration and should only look to decide whether or not the direction was reasonable at the time the decision was made and based on the evidence available to decision maker(s) at the time of the request.

**Failure to provide information**

20 A reasonable direction to provide information may include, but is not limited to, a request for:

- a work details form
- details of a specific employer or placement
- details of specific times or dates relevant to an investigation
- details of a pharmacy where we are investigating self-prescribing
- patient medical records where they are held only by the doctor under investigation.
- non-documented information in possession of a doctor.

21 The tribunal should be satisfied that, whatever form the information takes, the doctor’s failure to provide the information would significantly impair the GMCs ability to investigate concerns.

22 Information as defined here excludes information or documents which a civil court could not compel to be produced in civil proceedings or that would be prohibited by or under any enactment.

**Failure to comply**

23 Before taking action, the tribunal should be satisfied that the doctor has failed to comply. In considering a doctor’s failure to comply, the tribunal may wish to address the following points:

- has the doctor explicitly refused to comply with a direction to provide information or direction to undergo an assessment?
- has the doctor failed to respond to direction to provide information or to undergo an assessment despite three reminders over at least a xx week period?
Has the doctor submitted to a direction, but subsequently failed to comply with directions made in line with that assessment?

is there any evidence before the tribunal to suggest that the doctor has complied with the request or direction?

**Reason for non-compliance**

24 Before proceeding to impose a sanction, if the tribunal is satisfied that the doctor has failed to comply, they should consider whether or not there was good reason for the doctor’s failure to comply, i.e. it was unavoidable or otherwise excusable because:

- for reasons of adverse physical or mental health, a doctor was unable to respond to or comply with a request, even where the request is seen to be reasonable
- a doctor has demonstrated that he/she has not received an invitation to undergo an assessment or request for information
- a doctor can demonstrate that he/she is not in possession of the information or documentation requested by the GMC
- a doctor can demonstrate that, for reasons beyond his/her control, he/she was unable to comply with the direction.

25 Where a doctor is known not to have sought representation from a medical defence organisation or other body, the tribunal should consider whether or not the doctor appears to have understood the consequences of non-compliance.

**Finding of non-compliance**

26 Having considered any evidence presented in respect of the questions referred to in paragraph 4, the Medical Practitioners Tribunal must announce its finding on non-compliance and provide reasons.

27 Where the tribunal finds that either:

- the GMC’s direction was not reasonable
- the doctor did comply, or there is insufficient evidence to show that he failed to comply, or
- the doctor had good reason for not complying,

no order should be made.
28 Where a tribunal finds that a doctor has refused or failed to comply with a reasonable request, it may receive further evidence and hear any further submissions from the relevant parties as to its decision whether to impose sanctions.

29 In considering whether or not to impose a sanction, the tribunal must consider not only whether or not the doctor has failed to comply, but also whether, on the basis of the findings, conditions or suspension are required in order to protect the public.

30 Where a tribunal finds a doctor has failed to comply with a reasonable direction and had no good reason for non-compliance, some action against the doctor’s registration is likely to be necessary in order to protect the public interest.

**Conditional registration (maximum 3 years)**

31 A tribunal may direct that a doctor’s registration is to be conditional on his or her compliance with a specific direction or invitation and can impose a condition to this effect. This condition will specify the direction with which the doctor must comply and will stipulate a period of time within which the doctor should comply. This will be the only condition relating to a finding of non-compliance. Further conditions can be imposed in order to protect the public (see below).

32 Conditions might be appropriate where the doctor has provided some mitigation for non-compliance that, while not sufficient to provide good reason for non-compliance, satisfies the tribunal that conditions are sufficient.

33 Conditions are unlikely to be appropriate where a doctor has refused to comply or failed to respond to three reminders over at least a xxxx week period and there is no mitigating information to suggest that conditions are likely to be sufficient.

34 Conditions may be imposed up to a maximum of three years, reviewable in periods as seem appropriate to the tribunal, or at the request of either party. Further guidance about review hearings is set out at paragraphs 65 - 73 below.

35 The objectives of any conditions should be made clear so that the doctor knows what is expected of him or her. Any conditions should be appropriate, proportionate, workable and measurable.

36 The condition relating to non-compliance should follow the format of the non-compliance condition in Annex A where possible. Any further conditions put in place for
the protection of the public should match the format of conditions found in the interim orders bank\(^3\).

**Suspension (up to twelve months and potentially indefinite after a period of two years)**

37 As outlined at paragraph 72 of the sanctions guidance\(^4\), ‘suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner. Suspension from the register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension, although this is not its intention’.

38 When considering a period of suspension, the tribunal might consider the following factors:

- the previous opportunities for the doctor to comply
- whether the doctor has refused to comply or failed to respond to three reminders over at least a xx week period and there is no mitigating information to suggest that conditions are likely to be sufficient.

**Indefinite suspension**

39 If a doctor continues to refuse to comply with the direction after being suspended for two years, the tribunal can suspend the doctor indefinitely. If the tribunal decides to direct indefinite suspension, there is no automatic further hearing of the case, although it is open to the doctor to request a review after a period of two years has elapsed from the date when the indefinite suspension took effect.

40 Tribunals must also consider, as required by Rule [17ZA (h)], whether the suspension imposed should take effect immediately. When doing so tribunals must consider any evidence received and any submissions made by the parties before making and announcing their decision. Tribunals should explain fully the reasons for any decision reached. Further guidance on when an immediate order might be appropriate is set out at paragraphs 47 - 53 below.

**Determining the length of sanction**

\(^3\) [http://www.gmc-uk.org/DC4344_IOP_Conditions_Bank_25416202.pdf]

The tribunal have the power to suspend a doctor for up to 12 months or to impose conditions for up to 36 months. The following factors will be relevant when determining the length of sanction:

- the nature of the original direction (i.e. what is it the doctor has failed to comply with?)
- the amount of time the doctor is likely to require in order to evidence full compliance
- the risk to members of the public or confidence in the profession.

Whilst each case should be considered on its own circumstances, the GMC expect that a Performance Assessment will take at least 6 months to complete, and a Health Assessment or English Language Assessment will take at least 3 months to complete. Any scheduled review should allow sufficient time for these assessments to be completed.

Where a non-compliance sanction is put in place as a result of a failure to provide information, consideration should be given to the length of time it might take a doctor to provide the information. If the information is already in the doctor’s possession (e.g. employment details), a period of one month should allow the doctor sufficient time to demonstrate compliance. If the doctor needs to acquire the information from a third party, a period of three months might be more appropriate.

Given that a matter will only be referred to a non-compliance tribunal when a doctor has been persistently non-compliant with a request that is material to a GMC investigation, compliance should be demonstrated and reviewed by the tribunal before a sanction is revoked. The review period should be long enough for a doctor to comply with all requirements of any assessment or request for information. The tribunal may wish to make clear what it expects the doctor to do during the period of conditions/suspension and the information he/she should submit in advance of the review hearing. This information will be helpful both to the doctor and to the tribunal considering the matter at the review hearing.

Tribunals must provide reasons for the period of sanction chosen, including the factors that led them to conclude that the particular period, whether the maximum available or a shorter period, was appropriate.

Tribunals must also consider, as required by Rule [17ZA (h)], whether the conditions imposed should take effect immediately (rather than taking effect after the 28 day appeal period). When doing so, tribunals must consider any evidence received and any submissions made by the parties before making and announcing their decision. Tribunals should explain fully the reasons for any decision reached. Further guidance
on when an immediate order might be appropriate is set out at paragraphs 47 - 53 below.

**Immediate orders**

47 A doctor is entitled to appeal against any direction affecting his/her registration. This includes conditions or suspension imposed in respect of non-compliance. A sanction does not take effect during the appeal period (28 days) or, if an appeal is lodged, until that appeal has been disposed of. During this time, the doctor’s registration remains fully effective unless the tribunal also imposes an immediate order.

48 The tribunal may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is in the public interest, or is in the best interests of the practitioner.

49 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety, or where immediate action is required to protect public confidence in the medical profession.

50 It is sometimes argued by doctors, or their representatives, that no immediate order should be made as the doctor needs time to make arrangements for the care of his/her patients before the substantive order for suspension takes effect.

51 In considering such arguments, tribunals will need to bear in mind that any doctor whose case is considered by a non-compliance tribunal will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients prior to the hearing should the need arise. In any event, the GMC also notifies the doctor’s employers, or in the case of general practitioners, NHS England, of the date of the hearing and they have a responsibility to ensure that appropriate arrangements are in place for the care of the doctor’s patients should an immediate order be imposed.

52 Where the tribunal has directed a period of conditional registration as the outcome of the hearing, it may impose an immediate order of conditional registration. Where the tribunal has directed suspension or indefinite suspension as the substantive outcome of the case, it may impose an immediate order to suspend registration. Before making a decision the tribunal must consider any submission or evidence and will need to invite these from both parties in advance of making a decision.

53 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should, however, have regard to the seriousness of the matter which led to the substantive direction and consider carefully whether it is appropriate for the doctor to continue in unrestricted practice pending the substantive order taking effect.
Existing interim orders

54 A doctor may have interim restrictions in place at the point of referral to a non-compliance hearing. Whilst these may relate to the same allegations that led to the non-compliance referral, they may also arise from concerns relating to other heads of impairment.

55 Where the tribunal decides that the doctor has, without good reason, failed to comply with a reasonable direction, and they go on to put a sanction in place, they may, at the sanction stage, also consider the existing interim order.

56 Where a non-compliance sanction is imposed, the tribunal should revoke any interim order before the non-compliance sanction takes effect.

Power of the tribunal to impose an order to protect the public during the term of a non-compliance order

57 Where a doctor’s registration is made conditional by a non-compliance tribunal, the tribunal should ensure that any restrictions necessary for the protection of members of the public or in the doctor’s interests are put in place to protect against the same risks identified by the IOT where the tribunal consider these risks still to be present or any new risks identified by the tribunal. The tribunal will have sight of all documents relating to the ongoing investigation, including a full copy of the documents viewed by the preceding interim orders tribunal and any further documents received by the GMC in the intervening period. This will form part of the original bundle presented to the panel for their consideration in relation to non-compliance.

58 In multi-factorial cases, where the doctor has failed to comply with a direction made in respect to one head of impairment, but other heads of impairment are under investigation, the tribunal will need to consider any risks that arise from all allegations when imposing a sanction.

59 In order to assess the nature and seriousness of the risk, the tribunal will carry out a risk assessment. The tribunal will **not** make any findings of fact in order to assess the nature or seriousness of the risk but will decide what action, if any, is needed to protect the public based on the information that is available to the tribunal. As the role of the tribunal in this respect is akin to the role of an interim orders panel, the tribunal should consider the factors contained in the *Imposing interim orders* guidance:

- The seriousness of risk to members of the public if the doctor continues to hold unrestricted registration (during the term of the non-compliance order).
- Whether public confidence in the medical profession is likely to be seriously damaged if the doctor continues to hold unrestricted registration (during the term of the non-compliance order).

- Whether it is in the doctor’s interests to hold unrestricted registration. For example, the doctor may clearly lack insight and need to be protected from him or herself.

60 The order will remain in force until the tribunal, on review, is satisfied that an order is no longer required because the risk has been mitigated or the doctor has fully complied with the original request and the non-compliance order can be revoked.

**Power of the tribunal to impose an interim order to protect the public following revocation of a non-compliance order**

61 Upon review of a doctor’s compliance at a review directed by the tribunal, or at an early review prompted by evidence of compliance from the doctor, the tribunal must decide whether or not a sanction is still required.

62 Where a non-compliance sanction (conditions or suspension) is revoked, the tribunal must consider whether or not they feel an interim order is required in order to protect members of the public or in the doctor’s interests during the GMC’s ongoing investigation. The tribunal will have sight of all documentation as would be required by an interim orders tribunal and should apply the same test as would such a tribunal. Any interim order imposed would be subject to the usual requirement for interim orders to be reviewed every six months, up to a maximum of 18 months.

63 The non-compliance tribunal will need to consider the doctor’s compliance and any information presented as evidence of that compliance when considering an interim order. In a health case, for example, the tribunal would likely need to see health reports as evidence that the doctor has complied with the GMC’s request to undergo an assessment. As such, their considerations on interim orders should take these reports into account.

64 Tribunal members should refer to the *Imposing interim orders* guidance and/or relevant section of the *MPTS: Tribunal Procedural Guidance* in making these considerations.

**Review Hearings**

65 Rule [22A] sets out the procedure a tribunal must follow at a review hearing. The tribunal will need to consider and make a finding as to whether the doctor has complied with the direction that led to the non-compliance sanction or whether he/she has failed to comply with any conditions imposed at the previous hearing (giving reasons for its decision) before determining whether to impose a further sanction.
66 The tribunal should make clear in their initial determination that the onus is on the doctor to demonstrate compliance at a review hearing and that the doctor can, if they feel they have fully complied, request an early review of their non-compliance sanction.

67 A review of conditions must take place within 36 months of the original determination. A review of suspension must take place within 12 months.

68 When reviewing the non-compliance sanction, the tribunal may wish to consider the following factors:

- Whether or not the doctor has complied with the original direction that led to the imposition of the sanction or any requirements contained in a non-compliance condition.
- Whether there is any new information before the tribunal that might affect the tribunal’s decision on a sanction.
- Whether or not the doctor has complied with any further conditions put in place by the previous tribunal for the protection of the public during the term of the non-compliance order.

69 In making its decision, the tribunal can decide to:

- revoke the sanction
- maintain the existing sanction (where the sanction has not yet expired)
- vary the sanction
- extend the sanction.

70 Where a tribunal has found that the doctor has not complied with a non-compliance condition, a further order of conditions is unlikely to be sufficient. An order to direct a suspension (up to 12 months) is likely.

71 Where a doctor’s registration is suspended, the tribunal may direct that the current period of suspension be extended (up to 12 months). Where a doctor has been suspended for a period of two years, it is also open to the tribunal on review to suspend the doctor’s registration indefinitely.

72 A case can be referred for an early review if evidence of compliance is available before the scheduled review. An early review may be directed by the Registrar, where such evidence becomes available.

73 Where the tribunal decides to revoke a non-compliance order it should consider, where appropriate, whether an interim order is required to protect the public.
3 - New rules implementation - update and guidance

3 - Annex I

Undertakings at Medical Practitioners Tribunals

1 Under Rules [17(4)] and [22(3)] of the General Medical Council (Fitness to Practise (FTP) Rules Order of Council 2004, the Medical Practitioners Tribunal (MPT) may, where they find a practitioner’s fitness to practise impaired, take into account any written undertakings agreed between the GMC and the doctor (including any limitations on his or her practice) which the GMC considers appropriate.

2 Where the GMC and the practitioner agree undertakings, the MPT may close the case with no action. The MPT should take undertakings into account only where:

   a the MPT considers the undertakings to be sufficient to protect, promote and maintain the health and safety of the public and maintain public confidence in the profession, and

   b the practitioner has expressly agreed to the Registrar disclosing details of those undertakings (save those relating exclusively to the health of the practitioner) to:

      i any person by whom the practitioner is employed to provide medical services or with whom he has an arrangement to do so;

      ii any person from whom the practitioner is seeking such employment or such an arrangement; and

      iii any other enquirer.

3 In circumstances in which an MPT makes a finding that the practitioner's fitness to practise is impaired, the Sanctions Guidance (August 2015) sets out at paragraph xx the only circumstances where an MPT should accept undertakings and not make an order on a doctor’s registration. These are in circumstances where:

   a All the requirements set out at paragraphs 1 and 2 are met, and
b The MPT is satisfied that the undertakings cover any conditions that it would otherwise impose, and

c The MPT is satisfied that the doctor has sufficient insight to abide by the written undertakings given before the tribunal.

4 If the MPT is not satisfied that undertakings are appropriate, it should proceed to consider a sanction. If an MPT agrees to make no order following agreement of undertakings between the practitioner and the GMC, the undertakings will be reviewed by the Registrar rather than a tribunal.

5 The MPT can only consider undertakings where the doctor and the GMC agree on the terms of the undertakings.

Procedure before a fitness to practise tribunal

6 The procedure outlined in paragraphs 6 to 12 below relates to all cases which are heard by MPTs.

7 When an MPT has found a practitioner’s fitness to practise to be impaired, it is open to the doctor or the GMC to propose undertakings that they will invite the other party to agree.

8 Where either party proposes undertakings, there will be a short break (around one hour in length) in the hearing to allow for the parties to consider undertakings. All undertakings should be drawn from the existing undertakings bank1, where possible.

9 If the GMC informs the doctor that undertakings have not been accepted, the tribunal will reconvene to consider a sanction. This will be the only opportunity for a doctor to agree undertakings at tribunal stage.

10 If the GMC and doctor agree a set of undertakings, (including notifying the doctor that the undertakings will be disclosed to any enquirer, save those relating exclusively to the doctor’s health, and that they will be made available through the List of Registered Medical Practitioners), the hearing will reconvene. The undertakings will be presented to the MPT for consideration. A template for recording the undertakings is attached at Annex B.

11 When considering the undertakings, the MPT should give thought to the following questions in order to assess whether the conditions outlined at paragraph 2 and 3 above are met.

1 http://www.gmc-uk.org/DC4351_Undertakings_Bank_25416205.pdf
a  Is the doctor’s fitness to practise impaired?

b  Have undertakings been agreed between the doctor and the GMC?

c  Have the undertakings been made in writing?

d  Are the undertakings sufficient to protect, promote and maintain the health and safety of the public and maintain public confidence in the profession?

e  Is the tribunal satisfied that the undertakings cover any conditions that it would otherwise impose?

f  Does the practitioner expressly agree that the Registrar shall disclose details of the undertakings (save those relating exclusively to the doctor’s health) to:

   i  any person by whom the practitioner is employed to provide medical services or with whom he has an arrangement to do so;

   ii any person from whom the practitioner is seeking such employment or such an arrangement; and

   iii any enquirer.

g  Are the undertakings specific, measurable, attainable and realistic?

h  Is the tribunal satisfied that the doctor has sufficient insight to abide by the written undertakings given before it and that there is no other reason to suggest that the doctor will not comply with them?

12 If the answer to all of the questions above is yes, the tribunal may decide that undertakings are sufficient as an alternative to imposing any sanction.
Post-hearing procedure

13 At the end of the hearing, if an MPT decides to take into account written undertakings agreed between the GMC and the doctor, MPTS staff will add the undertakings to the doctor's registration record.

14 The GMC will monitor and review all undertakings (e.g., by actively seeking reports from employers and GMC advisers), and consider any new information received in relation to them, including representations from the doctor or information otherwise to suggest that the undertakings are no longer appropriate. The Case Examiners can make decisions on variation or revocation, where information is received which would suggest this is appropriate. The GMC Registrar will consider any breaches of undertakings to determine what action is appropriate or proportionate and whether a referral to the MPTS to arrange for the matter to be considered by a MPT at a review hearing should be made.

(See separate guidance on breaches of undertakings)
Annex A - Template undertakings form

[CASE NAME]

[DATE OF HEARING]

I, [Name], General Medical Council reference number [xxxxxxxx], hereby undertake the following:

[Public undertakings]
1. 
2. 
3. 

[Confidential undertakings]
4. 
5. 

The above undertakings reflect the evidence I provided on oath to the medical practitioners tribunal of the Medical Practitioners Tribunal Service on [date].

I am aware that the General Medical Council will monitor my compliance with the above undertakings by [seeking regular reports from my employer/details of any other steps which seem appropriate].

I am aware that [the above undertakings] [undertakings number 1-3] will be disclosed to third parties should the General Medical Council receive enquiries about my registration status and be made available on the List of Registered Medical Practitioners in line with the GMC’s publication and disclosure policy.

Signed ………………………………….……….  Dated…………………………..
Summary of changes that require new or significant amendment to existing guidance

Change to the Medical Act

Right of appeal

1 Following changes to the Medical Act approved by Parliament in March, the GMC has a right of appeal where a “relevant decision” (a fitness to practise sanction, a decision to restore a doctor to the register or an order in response to a doctor’s non-compliance with a fitness to practise investigation) is not sufficient to protect the public.

Five year rule

2 Changes made to the Medical Act, approved by Parliament in March, have been reflected in a change to Rule 4(5), that provides that no investigation may proceed if the events that give rise to the concerns occurred more than five years ago (the five year rule) unless it is in the public interest to proceed in the exceptional circumstances of the case. The “exceptional circumstances” element of the test has been deleted. In considering all the factors in the case, the Registrar will take into account any protected characteristics which may have contributed.

Reviews on the papers

3 Changes made to the Medical Act have also been reflected at Rule 21B of the Fitness to Practise Rules, stipulating that matters must be considered on the papers where they have been referred to an MPT or Non-Compliance Tribunal and the MPTS receives confirmation that the GMC and the practitioner have come to an agreement on the direction, revocation or variation to be made by the Tribunal. Changes at Rule 26A allow similar changes for Interim Orders Tribunals.

4 In both of the above cases, the considerations may be carried out by either the tribunal or the tribunal chair. The tribunal/chair considering the matters is empowered either to approve the agreement, thereby cancelling the scheduled hearing, or order
that the matter be heard by a tribunal. As a safeguard, the tribunal/tribunal chair will be asked to consider issues of adverse health and the doctor’s representation before making a final decision.

**Registrars directing reviews**

5 Changes to Rule 35D of the Fitness to Practise Rules give the Registrar the authority to direct a review of a sanction of conditions or suspension prior to the expiry of the sanction where one has not been directed by the Tribunal that imposed the sanction or subsequent Tribunal review hearing.

6 All cases with conditions and a suspension where the Tribunal that imposed the sanction has not directed a review has not already been directed will be reviewed and consideration will be given to whether a review should be directed before the expiry of the sanction. This may be to provide assurance that the doctor is fit to practise before the sanction expires or because we have received new information that suggests that although a review may have been considered unnecessary at the time the sanction was imposed, a review should now be imposed.

**Change to the Medical Act and Fitness to Practise Rules**

**Case management and costs**

7 Changes made to the Medical Act have been reflected in changes to Rule 16 and the creation of a new Rule 16A. Under the new rules, Case Management directions are binding (subject to narrow exceptions at the discretion of the MPT). Where a party has breached a Rule or direction, the MPT has powers to draw an adverse inference, exclude evidence and/or (where there is also unreasonable conduct) award costs.

8 An MPT may draw an adverse inference where an ill-motivated party has failed to supply evidence, in an effort to stop the MPT from getting to the truth of the relevant issue. An MPT may exclude evidence where it would be unfair to admit it, because the other party would be significantly disadvantaged in addressing the material issue, by reason of the improper timing of the production of the evidence (having first considered other options, such as adjourning the case). An MPT may make an order for costs where there has been unreasonable behaviour as well as a failure to comply with a direction. The assessment of the sum of costs to be paid will be made by a legally qualified Case Manager.

9 The question of the amount of costs to be awarded will be dealt with on the papers by a legally qualified case manager, using guidelines). Parties will be required to give notice of an intention to seek an order for costs. Due regard will be given to issues that arise when dealing with unrepresented doctors or doctors who may be unwell. The Case Manager will bear in mind ability to pay when assessing costs.
Non-compliance hearings

10 Rules 17ZA and 22A are being changed to reflect a new form of non-compliance hearing on the basis that a doctor has a duty to comply with their regulator to protect patients. The new rules outline the power to refer a doctor for a non-compliance hearing where he/she fails to comply either with a direction to undergo an assessment or a request for information without which the GMC would be unable to fulfil its statutory function. Due regards will be given to issues that arise when dealing with unrepresented doctors or doctors who may be unwell.

Panel undertakings

11 Changes to Rule 17 of the Fitness to Practise Rules mean that panel undertakings are now to be agreed between a doctor and the GMC, rather than between a doctor and a panel. At a hearing the panel will take into account any undertakings agreed between the doctor and GMC during the hearing when considering a sanction and, if they consider them sufficient, will make no order.

12 Further to this, we consulted on a change to Rule 37(A) whereby a doctor who has previously agreed undertakings at a hearing may be referred for a review hearing where we want to change the undertakings and the doctor does not agree with the proposed changes. This brings our powers to change panel undertakings in line with our powers to change undertakings agreed at the investigation stage.

Undertakings relating to English Language

13 We have a new power to refer a doctor to a hearing where a doctor has undertakings relating to his English Language skills and those skills have deteriorated or otherwise give rise to further fitness to practise concerns.

Provisional enquiries

14 Changes to Rule 13 mean that we do not have to tell a doctor’s employers about a provisional enquiry unless we need information from the employer. The doctor will be able to notify his/her employer if he/she chooses to do so for example to seek support. If we open an investigation we will notify the employer at that stage.
Summary of the guidance

Costs and case management

Costs

The tribunal will have a new power to make a costs order, introduced by the S60 Order following a DH consultation. The circumstances in which a costs order may be appropriate are deliberately narrow - comprising a two stage test:

- where there is a failure to comply with a rule or direction AND
- unreasonable conduct in the proceedings.

The rules provide that following a costs order made by a tribunal, the sum to be paid will be decided by a legally qualified Case Manager who will take into account the paying party’s ability to pay.

We are keen that the costs model that we operate:

- is effective in incentivising compliance such that the need to make an order will be rare
- is proportionate, in that it provides a clear incentive but does not have a disproportionate impact on a paying party
- is simple to administer but fair, avoiding where possible any satellite litigation about costs
- is easy for doctors to understand

To achieve these aims we have drafted guidance for tribunals and the Case Manager that provides:

- Guidance on the types of breach which might justify an order for costs
- Guidance on what amounts to unreasonable conduct
- That costs applications will be heard at the end of the fitness to practise proceedings
- However, any party intending to make an application for a costs order should signal their intention to do so immediately
The tribunal will then advise the party whose conduct is giving rise to a risk of a costs order at the time the conduct is being carried out of the steps that should be taken to prepare for the costs application.

The amount to be awarded will be based on actual costs incurred specifically as a result of time wasted as a result of the other party’s breach of directions. Only reasonable costs will be allowed. The Case Manager will be guided by published guideline rates and any order will be subject to an overall cap.

A discretion for the Case Manager to provide additional time to comply with requests for information in relation to a costs order where the circumstances require.

Comprehensive information for unrepresented doctors will be produced alongside the guidance.

**Adverse inferences and exclusion of evidence**

We have also drafted new guidance to assist the tribunal in the exercise of new and enhanced powers upon breach of a rule or direction. The tribunal may draw an adverse inference where an ill-motivated party has failed to supply evidence, in an effort to stop the MPT from getting to the truth of the relevant issue. The tribunal may exclude evidence where it would be unfair to admit it, because the other party would be significantly disadvantaged in addressing the material issue, by reason of the improper timing of the production of the evidence (having first considered other options, such as adjourning the case).

**New right of appeal**

The GMC Right of Appeal was introduced by the Section 60 Order following consultation by the Department of Health. The changes to the Medical Act provide that the right of appeal arises where the GMC considers an order made by a tribunal to be insufficient to protect the public or uphold confidence in doctors or maintain professional standards.

We have drafted guidance for decision makers on when to exercise the right of appeal. The guidance clarifies the following:

- The right of appeal will not affect certain principles established in existing case law – that a certain amount of deference is due to a professional panel that has heard all the evidence in the case and that an appeal must not constitute an exercise in substitution of one view of the merits for another.
- The tribunal itself plays an important role in the statutory scheme that delivers the overarching objective.
- The factors to be taken into account when deciding whether to exercise the right of appeal are that a) the decision maker considers, on his assessment of all the information held, in the particular circumstances of the case, that the MPT’s decision is not sufficient AND b) in all the circumstances, exercising the power of appeal would further rather than undermine the achievement of the GMC’s statutory overarching objective. The decision maker will consider the merits of the appeal and the importance of the issues which would be aired.

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www.gmc-uk.org
Changes to the five year rule

Changes to the Medical Act will remove the ‘exceptional circumstances’ test from the five year rule. We have drafted new guidance (replacing the existing ‘Aide Memoire’) for the approach to be taken to the remaining public interest test when considering allegations that relate to events more than five years before the allegation. The guidance sets out the factors to be taken into account in considering the public interest to include:

- The date of the events giving rise to the allegation
- The period between the events arising and the allegation being made
- The reasons for the lapse of time
- The extent to which evidence is still available
- The gravity of the allegations
- The number of incidents alleged
- The extent of any continuing risk to the public or to public confidence in doctors
- The extent to which the allegation has been ventilated before other public/adjudicatory bodies

New non-compliance hearings

The changes to the Medical Act will introduce a new type of hearing for dealing with non-compliance with an investigation. New guidance for decision makers on referring a case for a non-compliance hearing provides guidance on the factors to be taken into account including whether:

- the request for compliance was reasonable
- the doctor refused to comply or failed to respond to a request for compliance
- reasonable efforts have been made to achieve compliance by voluntary means and the doctor has been notified of the consequences of non-compliance
- the non-compliance is material to the investigation
- any response from the doctor to indicate any reasons for non-compliance

New guidance for the tribunal provides that tribunals will determine:

- whether the request for compliance was reasonable
- whether the doctor has failed to comply with the request
- whether there was good reason for the failure to comply.

The guidance provides that where a non-compliance order is made any interim order will be revoked by the non-compliance tribunal. This is to avoid a doctor being subject to two different review regimes, which could have a disproportionate impact (for example a non-compliance review hearing in Manchester followed by an interim order review hearing in Manchester a few days later or the following week).
The non-compliance tribunal will be able to impose an order that provides the same protection as the interim order that has been revoked to ensure any risk to patients and public confidence is managed during the term of the non-compliance order. If the doctor complies and the non-compliance order is revoked, the guidance provides for the tribunal to impose an interim order to address any ongoing risks.

The guidance clarifies that once a doctor has complied with the relevant request the order will be reviewed and, where appropriate, revoked.

**New power to conduct reviews on the papers when reviewing sanctions**

Currently any review of sanctions imposed by a panel including interim sanctions must be reviewed at a hearing in front of a full panel even where the doctor agrees with the GMC’s proposed sanction. New powers in the Medical Act introduced by Section 60 Order will enable reviews of sanctions where the doctor agrees with the GMC’s proposed approach to be reviewed on the papers by either a tribunal chair or by a full tribunal.

New guidance for decision makers on conducting reviews on the papers provides guidance on the factors for chairs or tribunals to take into account when deciding whether to approve the terms of the proposed agreement between the doctor and the GMC or refer the case for a hearing as follows:

- Where the tribunal/chair is satisfied that the agreement reached is appropriate for the protection of the public, they can approve the terms of the direction, revocation or variation submitted.
- Where the tribunal/chair is, for any reason, not satisfied that the agreement adequately protects the public, or is in any doubt as to the doctor’s capacity to agree to the proposed action, they can direct that a hearing takes place to conduct the review.

The guidance further provides that where a doctor is known to be unrepresented, the tribunal/chair should be satisfied that he/she understands the consequences of his/her agreement to the sanction, particularly where the sanction submission is indefinite suspension. If, for any other reason the tribunal/chair feels that the doctor is not in a position to agree to the proposed direction, variation or revocation, the tribunal should direct that the matter be heard in full.

**New power to direct a review under S35D Medical Act**

Our guidance on making a referral to a tribunal under S21 Fitness to Practise Rules 2004 has been updated (paragraphs 1-7) to include guidance on the new power for the Registrar to direct a review under S35D of the Medical Act.

The power will be exercised in cases where no review has previously been directed and a sanction has been imposed for six months or more or in cases (including those where the sanction has been imposed for less than six months) where there has been a change of circumstances such as:

- a failure to remediate
- a material change in the doctor’s ability to practise
- a breach of conditions or
- receipt of supplementary fitness to practise concerns.

**Changes to undertakings at Medical Practitioner Tribunals**

Changes to the Medical Act will introduce changes to the way that panel undertakings are agreed. Currently panel undertakings are agreed between the doctor and the panel. Following the change undertakings agreed at a hearing will be agreed between the doctor and the GMC and the tribunal will make no order, if it considers the undertakings to be sufficient to protect the public and uphold confidence in doctors.

We have amended the guidance on undertakings agreed at a hearing. The amended guidance provides for the circumstances in which a tribunal, following a finding of impairment, can make no order on the basis of undertakings agreed between the doctor and the GMC where:

- Where the MPT consider the undertakings are sufficient to protect the public, and the practitioner has agreed to the Registrar disclosing details of the non-health related undertakings to any enquirer)
- The tribunal is satisfied that the undertakings cover any conditions that it would otherwise impose, and
- The tribunal is satisfied that the doctor has sufficient insight to abide by the written undertakings given before the tribunal.
Equality and Diversity considerations

Five year rule

1. In considering a case during a five year rule decision, the decision maker will take into account any protected characteristics that may have contributed to the case having not been brought to our attention previously.

Reviews on the papers

2. The tribunal guidance annexed here directs the attention of the tribunal to the potential issues for unrepresented doctors, and doctors suffering from adverse physical or mental health. The tribunal guidance includes advice around the tribunal/tribunal chair’s ability to direct that a review take place where they are not satisfied that a doctor is in the position to commit to an agreement on the papers. As a safeguard, the tribunal/tribunal chair will be asked to consider issues of adverse health and the doctor’s representation before making a final decision.

Registrars directing reviews

3. E&D issues will be reflected in the guidance by reminding the decision maker of stress that could be incurred by directing an early review in a pure health case. Furthermore, the decision maker will be reminded of the need to apply the criteria for early review fairly to prevent a disproportionate number of registrar directed referrals against doctors who are already over-represented in our processes and those with protected characteristics as identified in our consultation.

Case management and costs

4. This guidance reminds the MPT that special care must be taken when considering the exercise of these powers against unrepresented doctors, especially where there may be E&D issues. A respondent to the consultation noted that an award for costs could place extra pressure on an unwell doctor: we are considering our approach to health cases as part of our work in response to the suicide review.
Furthermore, the Guidance reminds panels to guard against labelling behaviours influenced by language barriers, cultural differences, or illness as “unreasonable”. The Case Manager will bear in mind ability to pay when assessing costs, and this will be made plain, which should help to limit the pressure on vulnerable doctors.

**Non-compliance hearings**

Based on our Equality analysis, the guidance also highlights the importance of addressing factors of adverse physical or mental health when considering a doctor’s reason for failing to comply and when determining whether or not the doctor is in a position to fully appreciate the potential consequences of non-compliance. Special considerations are also suggested in the guidance where a doctor is known to be unrepresented, and therefore potentially unable to fully understand the non-compliance process.