To consider

Guidance on the investigation and adjudication of cases involving language concerns

Issue

1. In February 2014, the UK Government announced plans to create a new category of impairment by reason of not having the necessary knowledge of English to practise medicine safely. We will also gain new powers to require doctors under investigation to undergo a language assessment, and also to indefinitely suspend those who repeatedly fail to remediate in relevant cases. This paper sets out the guidance we need to support implementation of these new powers when they commence on 16 June 2014.

Recommendations

2. The Strategy and Policy Board is asked to approve:

   a. An update to Good medical practice on knowledge of English.

   b. Changes to our guidance for case examiners on deciding the outcome of a case at the end of an investigation.

   c. New guidance for MPTS fitness to practise panels and case examiners on when to direct a language assessment.

   d. Changes to our conditions and undertakings banks.

   e. Changes to our interim order and indicative sanctions guidance.

   f. A new factsheet for doctors under investigation due to concerns about their knowledge of English.
Guidance on the investigation and adjudication of cases involving language concerns

Issue

3 At its meeting on 21 November 2013, the Strategy and Policy Board considered our approach to triaging complaints about a doctor’s knowledge of English and approved the use of agreements with doctors (called undertakings) to protect the public in relevant cases. Since then, the Government has agreed to make changes to the Medical Act 1983 (as amended) to create a new category of impairment and strengthen our ability to gather evidence and take action to deal with language concerns. We will soon have new powers to require doctors under investigation to undergo a language assessment and to indefinitely suspend those who fail to remediate. Council authorised the Chair to approve the necessary amendments to our regulations and legislation at its meeting on 24 February 2014, and these are expected to become effective on 16 June 2014.

4 We held a public consultation from 17 September to 10 December 2013 which found widespread support for these changes among doctors, patients and their representative bodies. Many respondents to the consultation identified the need for guidance to help decision makers exercise their new powers fairly and consistently and ensure doctors understand what is expected of them. This paper sets out the changes we propose to make to the guidance used by the Medical Practitioners Tribunal Service (MPTS) and GMC case examiners to support fair and consistent decision making. It also explains the changes we propose to make to Good medical practice (GMP) to reflect the outcome of our public consultation.

Changes to Good medical practice

5 We intend to amend GMP to ensure doctors understand that they must have the necessary knowledge of English to practise medicine in the UK. Under Domain 1: ‘Knowledge, skills and performance’ our guidance will say: ‘You must have the necessary knowledge of English to provide a good standard of practice and care in the UK.’ Where there are concerns a doctor has failed to meet this standard, we may commence an investigation into their fitness to practise. This is consistent with our approach for all other categories of impairment.

6 The planned amendment to GMP will clearly explain the knowledge of English which doctors must have to practise medicine safely in the UK. This principle formed part of the public consultation on how we deal with language cases from 17 September to 10 December 2013 so no separate consultation will be held on this change. We have informally consulted with key interest groups including the medical defence organisations and British Medical Association to check the proposed amendment to GMP will enable them to advise doctors.
Colleagues in Standards, Registrations and Fitness to Practise directorates have been consulted on our approach.

7 The new version of GMP will be announced when the changes to legislation to introduce the new category of impairment take effect. We are working with colleagues in the Strategy and Communication directorate to update the version on our website. A communications plan is being developed to consider how we communicate this change to the wider profession.

Changes to our decision making guidance for case examiners

8 At the end of an investigation into concerns about a doctor, two case examiners decide how we should deal with the case. In making their decisions they are supported by comprehensive guidance. We have drafted amendments to that guidance, at Annex A, to explain the factors which should be taken into account when deciding how to deal with single or multi-factorial cases involving language concerns.

New guidance for case examiners and panels on when to direct a language assessment

9 We have also drafted new guidance for both case examiners and MPTS fitness to practise panels on the factors they should consider when deciding if it is appropriate to direct a language assessment, at Annexes B and C. The key principle underpinning the guidance is that patients must not be put at risk by a doctor’s lack of knowledge of English. Where there are serious concerns that a doctor treating patients does not have sufficient knowledge of English to do so safely, a language assessment will normally be indicated unless the doctor has recently completed the International English Language Testing System (IELTS) to the appropriate standard.

10 Decision makers will take into account any information the doctor is able to provide in relation to their experience working in an English speaking context, any relevant study or qualifications and the timing of events which led to a complaint being made to us. They may also consider any information about a doctor’s knowledge of English which arises during our investigation and adjudication process, for example use of an interpreter during a hearing. In some cases, it is possible that a deterioration of a doctor’s knowledge of English may be symptomatic of a known or undiagnosed health condition. Where there is specific evidence to suggest this, assessment of the doctor’s language may be delayed while a decision is made about whether to direct a health assessment.

11 If a doctor fails to comply with a direction to complete a language assessment within 90 days without good reason, the matter may be referred to an MPTS fitness to practise panel for a hearing. The MPTS fitness to practise panel may adjourn a hearing to direct the doctor to complete a language assessment.
before the hearing reconvenes. The draft guidance sets out a non-exhaustive list of factors to help case examiners exercise their discretion.

Changes to our indicative sanctions guidance

12 Where it has not been possible to resolve concerns about a doctor’s knowledge of English by other means, case examiners are likely to refer the matter to the MPTS for a hearing. This is likely to be the case if a doctor is directed to undergo a language assessment and does not complete this within 90 days, or where a doctor does not perform satisfactorily in a language assessment and declines to make a voluntary agreement to protect the public.

13 In making their decisions, panels are guided by comprehensive guidance on the sanctions appropriate to deal with different types of concerns, called the Indicative Sanctions Guidance (ISG). Under the forthcoming changes to our legislation, the MPTS fitness to practise panel will have a power to indefinitely suspend doctors who repeatedly fail to attain the necessary knowledge of English to practise safely. MPTS fitness to practise panels will not be able to erase doctors from the medical register solely due to language concerns.

14 The power to indefinitely suspend doctors in language cases mirrors our approach in health cases, as set out in the Rules considered by Council at its meeting on 24 February 2014. Before indefinite suspension can be imposed, a doctor must have been suspended for at least two years, and panels must be satisfied that the doctor is incapable or unwilling to remediate. Doctors subject to indefinite suspension must wait at least two years before applying for a review. We have drafted changes to the ISG to reflect this, at Annex D. The ISG has also been updated to guide MPTS fitness to practise panels on use of their power to direct a language assessment and to impose conditions in language cases.

Changes to our conditions and undertakings banks

15 When deciding the appropriate outcome to a case, case examiners and MPTS fitness to practise panels are required to take a proportionate approach in taking action to protect the public. There may be cases involving concerns about a doctor’s knowledge of English where the doctor may safely continue working if directly supervised at all times. Where this is the case, we propose the doctor will usually be required to provide evidence they have completed IELTS to the required standard before returning to unrestricted practice. The draft amendments to our undertakings guidance and undertakings and conditions bank are at Annexes E and F.

Changes to our guidance for interim order panels

16 Where there is an immediate risk to public safety or public confidence, cases may be referred to an interim orders panel (IOP) at any stage of our fitness to practise procedures to decide if it is necessary to take immediate action pending
the outcome of our investigation. We have drafted changes to our guidance on referral to the IOP and guidance on imposing interim orders to reflect the factors which should be taken into account in language cases.

17 If a doctor has not performed satisfactorily in a language assessment and is unwilling to agree undertakings, a referral to the interim orders panel is likely to be indicated. It may also be appropriate to impose an interim order where a doctor refuses or delays completing a language assessment and plans to continue working. Our draft amended guidance on referral to IOPs, and guidance for IOPs is at Annexes G and H.

Factsheet for doctors under investigation in language cases

18 The new category of impairment by reason of not having the necessary knowledge of English is most likely to impact doctors where English is not their first language. In order to promote fairness, transparency and ensure doctors understand what is expected of them, we have produced a plain English factsheet for doctors under investigation due to concerns about their knowledge of English, at Annex I.
Supporting information

How this issue relates to the corporate strategy and business plan

19 Strategic aim two of our 2014 Business Plan is to give all our key interest groups confidence that doctors are fit to practise.

How the issues support the principles of better regulation

20 The changes to our guidance for decision makers will enable cases involving language concerns to be handled in a consistent, proportionate and targeted way. The introduction of a factsheet for doctors subject to investigation into concerns about their knowledge of English supports the better regulation principles of transparency and accountability.

How the action will be evaluated

21 We will monitor the number of complaints about doctors not having the necessary knowledge of English and their outcome. A quality audit will be used to assess decision makers’ compliance with relevant guidance to evaluate the extent to which these cases are handled fairly and consistently.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

22 We ran a public consultation on the way we deal with language cases from 17 September to 10 December 2013. We have worked closely with colleagues in Registration to ensure our guidance on language cases supports a consistent approach across the organisation. Training to raise awareness of the new guidance among panellists, legal assessors, case examiners and staff will take place later this year. Medical defence organisations and doctors currently in our fitness to practise procedures as a result of concerns about their knowledge of English will also be told how the changes will affect them. We will also undertake a review of all internal and external documents to reflect relevant changes to legislation.

Equality and diversity issues

23 An equality analysis for the new category of impairment by reason of not having the necessary knowledge of English to practise medicine safely has been completed and updated to reflect the outcome of the public consultation. The need to provide guidance for decision makers and clear information for doctors to ensure fairness was raised by a range of respondents to the consultation and is set out in our equality action plan.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director - Policy and Planning, Fitness to Practise, arowland@gmc-uk.org, 020 7189 5077.
5 - Guidance on the investigation and adjudication of cases involving language concerns

Annex A

Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners

Introduction

1 This guidance looks at the types of practice or behaviour which may result in a finding of impaired fitness to practise by the GMC or result in a warning.

2 The guidance aims to help case examiners and the Investigation Committee decide the appropriate outcome for a case at the end of an investigation into a doctor’s fitness to practise. While we recognise that individual cases have to be decided on their own merits, the purpose of the guidance is to encourage consistent and criteria-based decision-making.

3 The guidance is a ‘living document’ which will be updated and revised as the need arises.

4 Members of the Investigation Committee and case examiners are obliged to exercise their own judgement in making decisions but within a framework set by the Council. This framework is reflected in this guidance. It refers, where necessary to Good medical practice and other core GMC guidance.

5 Any examples provided in this document are intended to form guidance only, and are not exhaustive, but will provide a benchmark in identifying the kinds of cases which are likely to result in a finding of impaired fitness to practise. In considering an appropriate outcome, the case examiners and members of the Investigation Committee should refer to the guidance in this document, but will also need to take account of the guidance in Good medical practice, other more specific standards guidance and any relevant guidance produced by the royal colleges and other bodies. They should also consult the Indicative Sanctions Guidance which the GMC has prepared for the use of FTP panels.
Equality and Diversity Statement

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

The GMC's Fitness to Practise procedures

The process

7 By far the great majority of doctors deliver good quality healthcare, often in difficult and demanding situations. However, a small proportion do not and concerns about their practice must be investigated under our fitness to practise procedures.

8 Any doctor wanting to practise medicine in the UK must, by law, be both registered and hold a licence to practise. Our fitness to practise powers extend to all registered doctors, whether or not they hold a licence to practise. Following the introduction of licensing, the GMC’s Fitness to Practise sanctions continue to attach to a doctor’s registration. Where a doctor’s name is suspended or erased from the Register by a fitness to practise panel, we will automatically withdraw a doctor’s licence. Where a doctor’s registration is subject to conditions or undertakings which restrict their practice they will still be entitled to hold a licence but must continue to comply with any conditions or undertakings on their registration. If they do not, their registration and licence may be at risk.

9 Information concerning a doctor’s fitness to practise may be received from a complainant or a person acting in a public capacity, or may otherwise come to the attention of the GMC.

10 At any time, the Registrar (on his own motion or where requested by a case examiner or the Investigation Committee) may refer an allegation to an interim orders panel. Guidance on referrals to an interim orders panel is attached at Annex C.

11 Initial investigations will be carried out by the Registrar’s staff (with the assistance of lawyers where required), for example, where there is insufficient information to establish whether the allegation falls within the GMC’s jurisdiction, or where further information is required to see if a pattern of behaviour may be established. These may include making enquiries of the doctor’s employer, colleagues or others, or obtaining medical records or other documentation.

12 Convictions resulting in a custodial sentence are referred direct by the Registrar to a fitness to practise panel. There is a presumption that the same will apply to cautions, non-custodial convictions, and determinations of other regulatory bodies. However, in some cases a warning will be the appropriate response.
There are also a number of minor offences (such as parking offences) where no formal GMC action will be required. Guidance on the handling of convictions and determinations is attached at Annex D.

13 The decision at the end of the investigation stage is to be taken unanimously by a medical and a lay case examiner. Case examiners have been appointed by the Registrar following a rigorous, competency-based, recruitment process designed to assess their decision-making competencies and skills. Where they do not agree, the matter is decided by the Investigation Committee.

14 The case examiners will apply the following test at the conclusion of the investigation stage:

‘The Investigation Committee or case examiner must have in mind the GMC’s duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor’s fitness to practise is impaired to a degree justifying action on registration’

15 At any stage a case may be referred to the police for investigation where the allegations appear to disclose the commission of a criminal offence and where the police appear to have had no previous involvement in the matter.

16 A note on the meaning of fitness to practise, approved by Council, is attached at Annex A. Further legal guidance on the ‘realistic prospect’ test is attached at Annex B by way of an aide memoire.

17 Under section 35C(2) of the Medical Act 1983 (the Act), impairment can only be by reason of any or all of the following:

a misconduct

b deficient professional performance

c a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales)

d adverse physical or mental ill-health

e a determination by a regulatory body either in the British Isles or overseas.

ef not having the necessary knowledge of English.

18 Members of the Investigation Committee and case examiners must not consider the categories set out in paragraph 17 as separate issues. There may be cases that involve concerns about a number of aspects of a doctor’s fitness to practise. In making a decision, it is the cumulative effect of all impairing factors
that must be taken into account. Health-and, performance and language assessments are part of the process of collecting evidence. ‘Passing’ an assessment will not necessarily mean that no action will be taken, as there may be other issues for the case examiner to consider.

19 There will also be cases that demonstrate significant departures from Good medical practice or a significant cause for concern on assessment. These cases may not be so serious as to warrant action on a doctor’s registration but may require a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response in these types of cases will be a warning. A warning should only be considered where the case examiners or the Investigation Committee have already decided that there is no realistic prospect of establishing that the doctor’s fitness to practise is impaired to a degree justifying action on registration.

20 At the end of the investigation there are a number of options open to the case examiners:

a refer the case to a fitness to practise panel

b agree undertakings

c issue a warning (or refer the matter to the Investigation Committee for a hearing regarding whether to issue a warning)

d conclude the case with no further action.

21 Our fitness to practise procedures apply equally to all registered doctors whether or not they hold a licence to practise. All doctors on the register are expected to meet the standards in Good medical practice. The fact that a doctor does not currently hold a licence to practise does not remove the requirement to investigate and respond to concerns about a doctor’s fitness to practise.

22 Where the practitioner chooses not to comment or does not dispute the facts alleged, and where a medical and lay case examiner agree to do so, a warning may be issued. In all other cases in which the case examiners feel a warning may be appropriate, the matter will proceed to an oral hearing before the Investigation Committee to decide whether a warning should be issued. The practitioner has a right to request such an oral hearing to be held. Where new evidence at the hearing casts a fresh light on the case, the Investigation Committee may refer the matter to a fitness to practise panel.

23 Undertakings may only be agreed where the case examiners have decided that the doctor’s fitness to practise is impaired (or is likely to be, on recurrence of a medical condition), where to do so would provide sufficient protection to the public and where there is no possibility of erasure should the matter proceed to
a fitness to practise panel. The restrictions imposed as a result of the undertakings (save for those relating solely to the doctor's health) will be disclosed on enquiry. Guidance in relation to directing assessments and agreeing undertakings is attached at Annex FE.

**Presumption of impaired fitness to practise**

24 There are certain categories of case where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise. These tend to fall within four main headings:

- **a** sexual assault or indecency
- **b** violence
- **c** improper sexual/emotional relationships
- **d** knowingly practising without a licence.

25 In many cases, where the alleged conduct falls within one of these categories, it will result in a criminal conviction. Guidance on handling convictions is attached at Annex D. However, there will be cases which are not prosecuted or which do not result in a conviction, but will nevertheless warrant investigation and action by the GMC.

(The decision in R v Metropolitan Police Commissioner ex parte Redgrave (2003) 1 WLR 1136 indicates that the GMC may take action on a case against a doctor on the same issues as a previous criminal prosecution, notwithstanding that the doctor was acquitted by the criminal process.)

26 Where allegations fall under one of the four headings, there is a presumption of impaired fitness to practise. The case examiners and Investigation Committee will normally refer the case to a fitness to practise panel, unless there are exceptional reasons for not doing so. Where the case examiners do not refer the case to a fitness to practise panel, they will need to be particularly careful to record detailed reasons for having done so.

27 There may be instances where, following the investigation of the case, the case examiners decide that the case does not meet the investigation stage test because there is no realistic prospect of establishing the case evidentially. If the case examiners decide to close a case on these grounds, detailed reasons should be provided on the decision making form. Case examiners should consider seeking legal advice, in these circumstances, if it has not already been provided. The case examiners should record the reasons for the decision, referring specifically to any legal advice that has been obtained.
Where the allegations fall within one of the categories where there is a presumption of impaired fitness to practise, the case examiners should not normally consider any arguments in mitigation made by the doctor. Mitigation should only be considered following a finding of fact by a fitness to practise panel. The case of Cohen v General Medical Council [2008] EWHC 581 (Admin) (see paragraph 62 for further details) established that evidence that a failing is remediable and has been remedied by a doctor is relevant to consideration of impairment. Cases in which there is a presumption of impaired fitness to practise, however, are unlikely to fall into the category of cases that are easily remediable.

**Sexual assault or indecency**

This encompasses a wide range of conduct from allegations of sexual assault and sexual abuse to allegations in relation to child pornography.

While many allegations relating to sexual assault or indecency will result in a conviction and be referred direct by the Registrar to a fitness to practise panel, there will be cases which are not prosecuted or which do not result in a conviction and which the case examiners will need to consider.

**Violence**

Many allegations of violence will result in a conviction. However, there may be cases which were not prosecuted or which do not result in a conviction. There may be allegations of aggressive or physically threatening behaviour to colleagues or patients or more specific incidents of violence outside of a doctor’s professional environment.

**Improper sexual/emotional relationships**

This encompasses improper sexual and/or emotional relationships with patients or patients’ relatives. Good medical practice states:

‘You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them’.

(GMP paragraph 53)

Maintaining Boundaries provides more detailed guidance on the issue of sexual and improper emotional relationships with current and former patients.

**Presumption that the GMC will take action**

**Dishonesty**

Dishonesty, in any context, is serious as it may undermine trust in the profession. Good medical practice, states that doctors must be honest and
trustworthy and act with integrity, as this is at the heart of medical professionalism. It also states:

‘You must be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals.

(GMP paragraph 77)

35 Paragraphs 78–80 of GMP and the explanatory guidance Financial and commercial arrangements and conflicts of interest provide more detailed guidance. See also the more detailed guidance on conflicts of interest at paragraphs 74–76 of GMP.

36 There will be cases of dishonesty where the allegations, if proven, would amount to such a serious failure to meet the standards required of doctors, that there will be a presumption of an issue of impaired fitness to practise. These types of cases are likely to fall into two categories:

a cases where the doctor’s dishonesty puts patients at risk

b cases where the nature of the dishonesty is such that public confidence in doctors generally might be undermined if the GMC did not take action.

37 Examples in professional practice could include defrauding an employer, improperly amending patient records or submitting or providing false references and information on a CV. Examples outside professional practice might include defrauding the revenue or mishandling charitable funds.

38 Research misconduct is a further example. The term is used to describe a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and the profession have in medicine as a science, regardless of whether this leads to direct harm to patients. Because it has the potential to have far reaching consequences, this type of dishonesty is particularly serious. Allegations in this category may also include false claims as to qualifications/experience and forgery or improper alterations of documents.

39 Good medical practice provides as follows:

‘You must act with honesty and integrity when designing, organising or carrying out research, and follow national research governance guidelines and our guidance’

(GMP paragraph 67)

40 Good Practice in Research provides more detailed guidance on the principles of good research practice which must be followed.
41 However, although the GMC takes all allegations of dishonesty seriously, there will be cases alleging minor dishonesty which are not related to the doctor’s professional practice and which are so minor in nature that taking action on a doctor’s registration is unlikely to be a proportionate response. Examples of dishonesty that are likely to fall into this category might include a failure to pay for a ticket covering all or part of a journey on public transport.

42 In cases of this nature, it is unlikely that these allegations, by themselves, would satisfy the realistic prospect test of establishing that a doctor’s fitness to practise is impaired to a degree justifying action on registration. Nonetheless, the GMC does take all allegations of dishonesty seriously, and allegations of this nature, if admitted or proven, do warrant some action by the GMC. It is likely that the most appropriate response, in cases of this nature, will be a warning.

Knowningly practising without a licence

43 Following the introduction of the licence to practise, it is the licence to practise that confers all the privileges that were previously associated with registration. It will be a criminal offence for a doctor who is registered but who does not hold a licence or for any other person to pretend to have a licence. However, when the allegations relate to a doctor who holds registration but who does not hold a licence we can also take the case forward under our fitness to practise procedures.

44 Each case will need to be considered on its own facts but if a doctor has deliberately misled patients or others about his/her licensing status, there is a presumption the case should be referred forward to a fitness to practise panel hearing.

Other serious or persistent failures to practise in accordance with the principles in Good medical practice

45 Other serious or persistent failures to practise in accordance with the principles in Good medical practice may also raise an issue of impaired fitness to practise. Most concerns about treatment or the standard of a doctor’s clinical practice will fall into this category.

46 In deciding whether a complaint meets the investigation stage test, the case examiners will need to consider both the nature and seriousness of the allegations and whether the issue is easily remediable and has been remediated. The following paragraphs and the examples provided will help the case examiners decide whether a complaint meets the investigation stage test.

Nature of Allegations:

47 Allegations of serious or persistent failures to practise in accordance with the principles set out in Good medical practice can be categorised under the following headings:
a Knowledge, skills and performance

b Safety and quality

c Communication, partnership and teamwork

d Maintaining trust

**Seriousness of Allegations**

48 Where the allegations indicate failures to practise in accordance with the principles set out in *Good medical practice*, the case examiners will need to proceed to consider how serious or persistent the failure or failures are. Whilst doctors are expected to comply with the standards in *Good medical practice*, not all failures to meet standards will amount to an issue of impaired fitness to practise to a degree justifying action on the doctor’s registration. *Good medical practice* is guidance, not a statutory code, so doctors must use their judgement to apply the principles to the various situations they will face. Whether they choose to follow the guidance or not — they must always be prepared to explain and justify their decisions and actions. The guidance in the booklet focuses on a doctor’s professional life. Behaviour that takes place outside a doctor’s professional practice may lead to action on registration where public confidence in doctors generally might be undermined if the GMC did not take action.

49 *Good medical practice* states that ‘serious or persistent failures to follow this guidance will put your registration at risk’. In some cases the concerns may arise from a series of episodes. There will, however, be cases that arise from a single clinical incident. Additional guidance on single clinical incidents is attached at Annex IH. A question of fitness to practise is likely to arise in the following circumstances:

- **A doctor's performance has harmed patients or put patients at risk of harm**

50 A risk of harm will usually be demonstrated by a series of incidents that cause concern locally. These incidents will indicate persistent technical failings or other repeated departures from good practice which are not being, or cannot be, safely managed locally or local management has been tried and failed.

- **A doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients**

51 An isolated lapse from high standards of conduct — such as an atypical rude outburst — would not normally, in itself, suggest that the doctor’s fitness to practise should be in question. The sort of misconduct, whether criminal or not, which may however, indicate a lack of integrity, an unwillingness to practise ethically or responsibly or a serious lack of insight into obvious problems of poor practice will bring a doctor’s registration into question.
A doctor has abused a patient’s trust or violated a patient’s autonomy or other fundamental rights

52 Conduct which shows that a doctor has acted without regard for patients’ rights or feelings, or has abused their professional position as a doctor, will usually give rise to questions about a doctor’s fitness to practise.

53 Examples of acting without regard for patients’ rights or feelings would include failing to obtain appropriate consent or to provide adequate information to the patient. *Good medical practice* provides:

‘You must be polite and considerate.

You must treat patients as individuals and respect their dignity and privacy.

You must treat patients fairly and with respect whatever their life choices and beliefs.

You must work in partnership with patients sharing with them the information they will need to make decisions about their care...

You must treat information about patients as confidential’.  

(GMP paragraphs 46 to 50).

54 *Good medical practice* also explains that doctors must be mindful of the way they express their own personal beliefs to patients.

‘You must not express your personal beliefs, (including political, religious or moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.’

(GMP paragraph 54).

A doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others

55 Cases of dishonesty or fraud on the part of the doctor are likely to fall within the category of Dishonesty where there is a presumption that the doctor’s fitness to practise is impaired. However, there may be cases where the doctor’s actions might not have been strictly dishonest but they may have been designed to mislead others by omission. This might occur in circumstances where a misleading report or reference is provided.

56 *Good medical practice* states that:
‘You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

You must take reasonable steps to check the information is correct.

You must not deliberately leave out relevant information.

(GMP paragraph 71).

More detailed guidance is provided in Writing References.

57 Good medical practice also states:

‘You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.

You must take reasonable steps to check the information.

You must not deliberately leave out relevant information.

(GMP paragraph 72).

‘You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness’.

(GMP paragraph 74).

The doctor’s behaviour was such that public confidence in doctors generally might be undermined if the GMC did not take action.

58 This will include behaviour that takes place outside a doctor’s professional practice. Many cases of this nature will involve a conviction or a police caution. Guidance on dealing with cases of this nature is at Annex D. Paragraph 75 of Good medical practice requires doctors to notify the GMC if, anywhere in the world, they have accepted a caution from the police, been charged with or found guilty of a criminal offence, been criticised by an official enquiry or if another professional body has made a finding against their registration as a result of fitness to practise procedures.

59 Good medical practice also makes it clear that conduct outside a doctor’s professional practice may, nonetheless, affect their fitness to practise.

‘You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.’
A doctor’s health is compromising patient safety

60 The GMC does not necessarily need to be involved merely because a doctor is unwell, even if the illness is serious. However, a doctor’s fitness to practise is brought into question if it appears that the doctor has a serious medical condition (including an addiction to drugs or alcohol) and the doctor does not appear to be following appropriate medical advice about modifying his or her practice as necessary in order to minimise risk to patients.

61 Good medical practice provides:

'If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients.'

(GMP Paragraph 28)

62 This advice is only illustrative of the sort of behaviour which could call registration into question. Good medical practice and the documents it links to including explanatory GMC guidance provide a more complete picture of behaviour of this kind, but even it is not exhaustive.

63 The chart attached at Annex F provides further guidance and illustrative examples of how failures to meet the standards in Good medical practice may give rise to action on a doctor’s registration.

A doctor’s knowledge of English is compromising patient safety

64 Where a doctor lacks the necessary knowledge of English to practise medicine safely in the UK and there is a potential or actual risk to patients it is likely to be appropriate to take action on registration to ensure the public is protected.

65 Good medical practice provides:

‘You must have the necessary knowledge of English to provide a good standard of practice and care in the UK’.

(GMP Paragraph xx)

66 The guidance on directing language assessments at Annex E provides further guidance on relevant issues which may give rise to a serious concern.
Whether the failing is easily remediable and has been remedied

In the case of Cohen v General Medical Council [2008] EWHC 581 (Admin), Mr Justice Silber ruled that at the impairment stage, a panel ought to take account of evidence and/or submissions (in addition to those deployed at the fact-finding stage) from both the doctor and the GMC that the doctor’s failing (as identified at the fact-finding stage):

a is easily remediable

b and that is has already been remedied

c and that it is highly unlikely to be repeated.

Ease of remediation, steps taken to remediate and the likelihood of repetition of the failing are all relevant in considering impairment. All three factors are usually inter-related and normally occur together. It is likely that the more factors that are present, the more weight they will carry. But they may not occur together. For example, there may be evidence that, although the failing is easy to remedy, it has not actually been remedied. The case examiners or the Investigation Committee will need to decide what weight to give to the potentiality for remedy and its actuality: see paragraphs 68–72 below.

Evidence of the factors may include reports and submissions by the doctor concerning courses or training undertaken to remedy the failing and evidence of the doctor’s previous fitness to practise history (which may be relevant to the likelihood of repetition). Mr Justice Silber indicated that evidence of easy remediation tends to favour the doctor, by helping him to negate impairment. Conversely, he indicated that psychiatric or psychological problems making it difficult or impossible for him to remedy the failing would point towards impairment.

In deciding whether a case meets the investigation stage test, the Investigation Committee or the case examiners will need to consider the possible impact on a panel at the impairment stage of material showing that a doctor’s failing is easily remediable and has already been remedied and the level of the risk of repetition. This is likely to be most relevant in cases relating to performance or clinical misconduct.

Examples of appropriate evidence of remediation may include:

a Certificates from completed training modules

b Professional Development documentation

c Competency reports from supervising doctors
Evidence of participation in a College or Faculty run ‘Continuing Professional Development’ scheme or a personal development plan.

Personal statements (‘self certification’) are not considered appropriate evidence of remediation.

Such material may not always be available. Where it is available it may not be clear or determinative. But where it is available, it should be considered. Additionally, where evidence of remediation is available, if a doctor shows a lack of insight, this may be relevant to the third factor highlighted in the Cohen judgment; the likely risk of repetition and will therefore affect the weight attached to such evidence.

If the Investigation Committee or case examiners are satisfied that the failing is easily remediable and has been remedied and there is no likelihood of repetition, they may still decide that impairment could be established before a panel. The weight to be given to that factor, like any other, is a matter for the case examiners’ discretion. The Cohen judgment recognises that there are cases that raise issues of public confidence where, regardless of whether the failing has been remedied, a case should be referred to a panel. These are likely to involve allegations which are very serious in nature and where there is a presumption of impairment.

The cases of Dr C T Yeong and The General Medical Council [2009] EWHC 1923 (Admin) and CHRE v Nursing and Midwifery Council & Paula Grant [2011] EWHC 927 (Admin) have also emphasised the importance of the wider public interest when considering the question of impairment, particularly maintaining public confidence in the profession, where misconduct has taken place over a prolonged period of time and reflects serious attitudinal or behavioural issues rather than of clinical competence. In these circumstances, evidence of remedial action may be far less significant and given considerably less weight.

Undertakings

Undertakings may only be agreed where the case examiners have decided that the doctor’s fitness to practise is impaired (or is likely to be, on recurrence of a medical condition), where to do so would provide sufficient protection to the public and where there is no possibility of erasure should the matter proceed to a fitness to practise panel. Guidance in relation to directing assessments and agreeing undertakings is attached at Annex E.

When the case examiners have decided that a doctor’s fitness to practise is impaired (or is likely to be in the event of the reoccurrence of a medical condition) and that undertakings will be an appropriate way forward, it will be irrelevant whether or not the doctor holds a licence to practise. Fitness to practise sanctions attach to registration and all doctors on the medical register are required to comply with Good medical practice. Even when the issues are
practice related and the doctor has relinquished their licence to practise, practice related undertakings may still be the most appropriate approach, including a commitment to work under medical supervision or undergo retraining.

A registered doctor is entitled to apply for a licence at any time and that doctor’s practice will only be restricted if action has been taken on their registration. If that doctor later obtains a licence, they will need to comply with any undertakings. Case examiners will need to consider in an individual case the most appropriate sanction keeping in mind the possibility of a doctor regaining their licence.

If on review, the doctor’s unlicensed status remains unchanged the case examiners or panel will need to consider the most appropriate action to take. This could include discussing with the doctor the possibility of taking voluntary erasure from the register, a further period of undertakings or conditions or more robust action such as referring the case to a panel or suspending the doctor. Such decisions will need to be made on a case by case basis.

Warnings

There will also be cases that demonstrate significant departures from Good medical practice, not so serious as to warrant action on a doctor’s registration but requiring a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors. The appropriate response in these types of cases will be a warning. A warning may also be appropriate where a performance assessment indicates a significant cause for concern. A warning will not affect a doctor’s registration or right to hold a licence to practise.

Case examiners and the Investigation Committee will first need to apply the investigation stage test as set out in paragraph 14 of this guidance. A warning should only be considered where the case examiners or the Investigation Committee have already decided that there is no realistic prospect of establishing that the doctor’s fitness to practise is impaired to a degree justifying action on registration. The question of whether a warning might be appropriate must be considered in all cases where the case examiners or Investigation Committee decide that the investigation stage test has not been met.

In many cases, determining whether allegations about treatment and clinical practice are serious enough to meet the investigation stage test will be very complex and will depend on a range of factors. These might include the seniority of the doctor, the level of supervision, the effect of external factors such as systems failures and any remediation undertaken by the doctor. Where the case examiners consider that the allegations are on the borderline between
action on registration and a warning, the presumption should be that the case progresses to a fitness to practise panel.

Once it has been established that the investigation stage test has not been met, for whatever reason, the case examiners should consider all the evidence, including arguments in mitigation, when considering whether or not to issue a warning.

Although a warning does not affect a doctor's registration or licence, it will appear on the register during the 5-year period that it remains valid and will be disclosed on enquiry at any time.

**Case Examiner decisions following cancellation of a hearing under rule 28**

Rule 28(3)(c) of the Fitness to Practise Rules allows a member of the Investigation Committee to cancel a hearing and to refer the case back for consideration by the case examiners under Rules 10 and 11. (See separate guidance on the cancellation of hearings under Rule 28.)

When a case is referred back to the case examiners under Rule 28(3)(c), the options open to the case examiners are restricted to considering undertakings under Rule 10 or a warning under Rule 11. It is not open to them to consider other options, such as carrying out further enquiries.

The decision that the case examiners will be asked to make will depend on the grounds for cancelling the hearing. This should be recorded in the referral from the Case Presentation Team.

**Undertakings**

Case examiners may be asked to consider agreeing undertakings where, following referral, while the doctor's fitness to practise appears to be impaired, undertakings appear to be an appropriate way of concluding the case.

The case examiners' decision should take account of the guidance in paragraph 73–76 above and in the guidance on undertakings in Annexes E-F.

When the case examiners decide that it is appropriate to invite the doctor to agree undertakings, the case should progress in accordance with the standard process for agreeing undertakings.

**Warnings**

Case examiners may be asked to consider issuing a warning when, following referral, it appears that, while there is no longer a realistic prospect of establishing that the doctor's fitness to practise is impaired, there are nonetheless concerns which may warrant a warning.
In considering whether a warning is appropriate in these circumstances, the case examiners should apply the guidance in paragraphs 77-81 above and in the separate guidance on issuing warnings.

When a case is referred back to the case examiners in these circumstances on the basis that there is no longer a realistic prospect of establishing that the doctor's fitness to practise is impaired, the case examiners' options will be restricted to considering whether it is appropriate issue a warning; it will not be open to them to consider inviting the doctor to accept undertakings.

When the case examiners decide that it is appropriate to issue a warning, the case should progress in accordance with the standard process for issuing warnings.

**Recording Decisions**

Decisions agreed by case examiners must be recorded on the file. All parties should be able to understand why a decision has been taken, even if they do not agree with the decision. Decisions should be recorded using the Case Examiner Decision Form. It is important that case examiners provide a detailed record of the reasons for their decisions.
Annexes (not attached but available on www.gmc-uk.org)

Annex A: Council’s policy statement on the meaning of Fitness to Practise
Annex B: Aide Memoire on the ‘realistic prospect test’
Annex C: Guidance on referral to an Interim Orders Panel
Annex D: Guidance on dealing with convictions, cautions and determinations
Annex E: Guidance on directing a language assessment
Annex EF: Guidance on agreeing undertakings
Annex GF: Illustrative examples
Annex HG: Case Examiner Decision Form
Annex IH: Guidance on Single Clinical Incidents
Annex JI: Guidance on considering applications for Voluntary Erasure

Policy last updated: April-June 2013
Date for review: June-April 2019
Guidance for case examiners on directing doctors to undertake a language assessment

Introduction

1 A doctor’s fitness to practise may be found to be impaired by reason of not having the necessary knowledge of English to practise medicine safely. Where concerns arise about a doctor’s knowledge of English, the case examiners may direct the doctor to undertake a language assessment to help them decide how to dispose of the matter.

2 The language assessment we use for this purpose is the academic version of the International English Testing System (IELTS). Doctors can access this by making arrangements with test centres authorised by the British Council in the UK or overseas. The cost of language assessments undertaken as a requirement of a fitness to practise process is met by the GMC and doctors are expected to comply within a maximum of 90 days.¹

3 This guidance aims to help case examiners decide whether or not directing a doctor to undertake an English language assessment is an appropriate course of action given the issues that have been raised. It is intended to support consistent and fair decision making in relevant cases.

Factors for consideration

4 This document provides guidance on the factors which may be taken into consideration when determining whether or not to direct a language assessment. When making their decision, case examiners should consider the seriousness of the concerns, the evidence available to them about the doctor’s

¹ Rule 3, Fitness to Practise Rules, Schedule 3 Knowledge of English assessments (as amended 2014), provides that a doctor may be required to comply with a direction to undertake a language assessment within a specified period, up to a maximum of 90 days.
knowledge of English, and any health concerns which may be the underlying cause of communication difficulties.

**Seriousness of concerns**

5 The primary factor which should normally be taken into consideration when deciding if a language assessment is appropriate is the seriousness of concerns and potential or actual risk to patients.

**Low level concerns**

6 Where there are low level concerns which do not pose a significant risk to patient safety, the threshold for directing a language assessment is unlikely to be met. For example, if issues solely relate to minor poor spelling or grammar, sole or occasional instances of minor poor record keeping or difficulty understanding regional slang or English colloquialisms, a language assessment is unlikely to be indicated.

7 We sometimes hold information that a doctor has previously completed an IELTS test and failed to achieve the minimum scores necessary to be eligible for a licence to practise medicine or to join a Medical Performer’s List. In such circumstances, where this is an isolated event and there is nothing to suggest the doctor has practised without the necessary knowledge of English or there are no specific relevant concerns in relation to the doctor’s performance a language assessment is unlikely to be indicated.

**More serious concerns**

8 Where there are serious concerns that a doctor’s lack of knowledge of English may present a risk to patient safety, a language assessment is likely to be indicated. Matters to be considered under this category could legitimately include the following factors:

- a complaint or series of complaints from a patient, health professional or another party re perception that a doctor’s lack of knowledge of English presents a risk to patients.

- Decision or finding by an overseas medical regulatory authority that a doctor does not have sufficient knowledge of English to safely treat patients in an English speaking context.

- Serious performance concerns which appear to be linked to the doctor’s difficulty communicating in English.

- Prescribing error causing harm or risk of harm to patient where underlying cause appears to be poor knowledge of English.
A serious instance or a persistent pattern of poor record keeping linked to a lack of knowledge of English (e.g., patient safety concern as other health professionals unable to understand treatment plans).

9 Case examiners should exercise their judgement to consider the individual features of the case and the actual harm or risk of harm to patients.

### Other evidence of a doctor’s knowledge of English

#### Information provided by the doctor

10 Case examiners should also take into account any other available evidence of a doctor’s knowledge of English. This may include a doctor’s previous IELTS test results, primary medical qualifications, applications to other medical authorities and experience working in an English speaking environment. In evaluating the relevance of any alternative evidence of a doctor’s knowledge of English the case examiners should also consider how recent and how robust the evidence is, and balance this against the seriousness and timing of the index cause for concern.

11 Where a doctor has recently completed an IELTS test, and achieved the minimum scores we require, within the last two years, careful consideration should be given to whether it is necessary to direct the doctor to complete a language assessment. In addition, where a doctor has recently completed a primary medical qualification (PMQ) that has been taught and examined in English, depending on the circumstances, this may be a strong indication that a language assessment is unnecessary. It may be appropriate to seek advice from registration staff in assessing a doctor’s PMQ.

12 Case examiners should also weigh up the relevance of any language assessments the doctor may have undertaken as part of the registration process for another medical regulatory authority in a country where the first and native language is English. Consideration should be given to which language assessment was used and the requirements for satisfactory completion applied by the medical authority. It may also be relevant to consider the doctor’s experience of practising medicine and clinical interactions in an English speaking context and any other concerns raised.

### Issues arising during our investigation or adjudication process

13 There may be situations where concerns about a doctor’s knowledge of English arise during direct interaction with a doctor. Matters which are likely to give cause for concern about a doctor’s knowledge of English include

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2 The British Council advises that proficiency in English deteriorates after two years if it is not used on a regular basis.
requesting or using an interpreter during a meeting or telephone conversation with us, a self-declaration by a doctor that suggests their knowledge may be limited, or where there is other good reason to believe the doctor has serious difficulty in communicating with or understanding others. Case examiners may wish to take these factors into account when deciding if it is necessary to direct a doctor to complete a language assessment.

*Health concerns*

14 When assessing information which relates to concerns about a doctor’s knowledge of English, case examiners should consider whether or not there is any evidence to suggest an underlying health concern. A perceived deterioration in, or lack of knowledge of, English language may be symptomatic of an undiagnosed health condition or the deterioration of a diagnosed health condition. Health concerns which may impact on a doctor’s communication skills include neurodegenerative disorders and acquired brain injuries from either a traumatic or non-traumatic event.

15 Where case examiners have good reason based on specific evidence to indicate that health may be an underlying cause of concern about a doctor’s knowledge of English, they should consider whether a health assessment may be appropriate. If a health assessment is directed in these circumstances the examiners should be asked to comment on whether any medical condition is likely to impact on the doctor’s communication skills. In such cases, careful thought should be given to delaying a decision on whether it is necessary to direct a language assessment until further information is available about the doctor’s health.

*Compliance period*

16 If more than 90 days have elapsed since a doctor was directed to undertake a language assessment during an investigation and they have not provided evidence of having completed the test, they should usually be referred to a fitness to practise panel of the Medical Practitioners Tribunal Service for failure to comply. However, case examiners may exercise their discretion if there is good reason.

17 Factors which may indicate it is appropriate to apply discretion in assessing a doctor’s failure to complete a language assessment are set out below, however this is not an exhaustive list and case examiners should use their own judgment, giving careful consideration to the individual features of the case.

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3 In certain circumstances, the Registrar may wish to refer the case to the MPTS for failure to comply within a shorter timeframe where a shorter compliance period has been specified in the direction.
a The doctor has provided evidence they were unable to access a test within the required period due to a lack of availability at suitable test centres or delay in making necessary reasonable adjustments for disability.

b The doctor is recently bereaved or has caring responsibilities which have made it difficult to study or access test centres.

c The doctor or a close relative is very unwell.

18 When deciding whether or not it is appropriate to extend the time period in which a doctor is required to complete a language assessment case examiners should consider the need to protect the public from risk of harm, the nature of the concerns raised and any extenuating circumstances. Consideration should also be given to the likelihood of a doctor's compliance within a clear alternative timeframe. Any extension to the deadline for a doctor to complete the language assessment will be dependent on the individual circumstances of the case.
Guidance for MPTS fitness to practise panels on dealing with concerns about a doctor's knowledge of English

Introduction

1 A doctor's fitness to practise may be found to be impaired by reason of not having the necessary knowledge of English to practise medicine safely. This guidance aims to help MPTS fitness to practise panels decide how to deal with cases involving concerns about a doctor’s knowledge of English. Firstly, it sets out how MPTS panels should deal with referrals due to concerns about a doctor’s knowledge of English. Secondly, it provides guidance on dealing with referrals due to a doctor's failure to comply with a direction to undertake a language assessment. It also sets out the factors which MPTS panels should take into account when considering whether or not they should direct a doctor to undertake an English language assessment. It is intended to support consistent and fair decision making in relevant cases.

2 The test we use for language assessments is the academic version of the International English Testing System (IELTS). Doctors can access this by making arrangements with test centres authorised by the British Council in the UK or overseas. The cost of language assessments undertaken as a requirement of a fitness to practise process is met by the GMC and doctors are expected to comply within a maximum of 90 days.1

Referrals due to concerns about a doctor’s knowledge of English

3 Where a doctor is referred to a MPTS fitness to practise panel due to concerns about their knowledge of English, a range of evidence may be presented to inform a decision on impairment. The primary factor for consideration in such cases is the outcome of any IELTS assessment which the doctor has recently

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1 Rule 3, Fitness to Practise Rules, Schedule 3 Knowledge of English assessments (as amended 2014), provides that a doctor may be required to comply with a direction to undertake a language assessment within a specified period, up to a maximum of 90 days.
undertaken. IELTS is the test we use for language assessments directed by case examiners or MPTS panels. Doctors may also voluntarily complete the IELTS test to provide evidence of their knowledge of English.

4 The results of the IELTS test is a key factor in deciding if a doctor is impaired due to concerns that they lack the necessary knowledge of English to practise medicines safely. The test has four parts - listening, reading, writing and speaking. Doctors receive individual scores of up to 9 for each of the four parts, and an overall score of up to 9 for all parts.

5 To practise medicine safely, a doctor is expected to achieve a score of at least 7.5 in each of the four parts, and an overall score of at least 7.5 for all parts. If the doctor has completed the IELTS test within the last two years and their results are above the minimum scores, this is likely to be a strong indicator that their fitness to practise is not impaired by reason of their knowledge of English. If the doctor completed the IELTS test within the last two years and their results are below the minimum acceptable scores, this is likely to be a strong indicator that their fitness to practise is impaired by reason of their knowledge of English.

6 In assessing the relevance of an IELTS test in relation to a doctor's fitness to practise the panel should consider how recently it was completed and balance this against the seriousness and timing of the index cause for concern. The panel should also take into account any other available evidence of the doctor's knowledge of English.

7 If the panel makes a finding of impairment due to a doctor's knowledge of English they will need to consider whether it is necessary or desirable to take action on a doctor's registration. Where a doctor is found impaired solely on grounds of their knowledge of English (or combined with health) the doctor cannot be erased from the medical register.

Referrals due to a doctor's failure to comply with a direction to undertake a language assessment

8 Where there are concerns about a doctor's knowledge of English, they may be directed to complete a language assessment during a fitness to practise investigation. If they fail to complete the language assessment within the specified time period without good reason, the doctor will usually be referred to an MPTS fitness to practise panel. Following such a referral, the panel may order the doctor's registration to be suspended, or subject to conditions, on the basis that they have failed to comply.

9 Further, where a doctor refuses to comply with a direction to undertake a language assessment without good reason, this is likely to be a strong indicator that they lack the necessary knowledge of English to practise medicine safely in the UK.
In such cases, the panel may decide to impose an order for non-compliance, or use non-compliance as evidence to support a finding of impairment. Panels should refer to our Indicative Sanctions and Interim Orders guidance to consider any appropriate steps to protect the public.

Directing a language assessment - factors for consideration

MPTS panels have the power to direct a doctor to undergo a language assessment where there are serious concerns about their knowledge of English.

This section provides guidance on the factors which may be taken into consideration when determining whether or not to direct a language assessment. When making their decision, a panel should consider the evidence available to them about the doctor’s knowledge of English, the seriousness of the concerns and any health concerns which may be the underlying cause of communication difficulties.

Evidence of a doctor’s knowledge of English

Where a doctor has recently completed an IELTS test, and achieved the minimum scores we require, within the last two years, careful consideration should be given to whether it is necessary to direct the doctor to complete a language assessment. In addition, where a doctor has recently completed a primary medical qualification (PMQ) that has been taught and examined in English, depending on the circumstances, this may be a strong indication that a language assessment is unnecessary.

The panel should also take into account any other available evidence of a doctor’s knowledge of English. This may include applications to other medical authorities and experience working in an English speaking environment. In evaluating the relevance of any alternative evidence of a doctor’s knowledge of English the panel should also consider how recent and how robust the evidence is, and balance this against the seriousness and timing of the index cause for concern.

When considering the relevance of any language assessments the doctor may have undertaken as part of the registration process for another medical regulatory authority in a country where the first and native language is English, consideration should be given to which language assessment was used and the requirements for satisfactory completion applied by the medical authority.

The British Council advises that proficiency in English deteriorates after two years if it is not used on a regular basis.
Concerns arising during a hearing

16 There may be situations where concerns about a doctor's knowledge of English arise during direct interaction with a doctor, for example, at a fitness to practise hearing. Matters which are likely to give cause for concern about a doctor's knowledge of English include a doctor requesting or using an interpreter during a hearing, meeting or telephone conversation with us, a self-declaration by a doctor that suggests their knowledge may be limited or where there is other good reason to believe the doctor has serious difficulty in communicating with or understanding others. MPTS fitness to practise panels may wish to take these factors into account when deciding if it is necessary to direct a doctor to complete a language assessment.

17 The panel may also find it helpful to refer to the guidance used by case examiners to decide whether it is appropriate to direct a language assessment during an investigation. The guidance for case examiners on directing doctors to undertake a language assessment is published on the GMC website.

Health concerns

18 When assessing information which relates to concerns about a doctor's knowledge of English, the panel should consider whether or not there is any evidence to suggest an underlying health concern. A perceived deterioration in, or lack of knowledge of, English language may be symptomatic of an undiagnosed health condition or the deterioration of a diagnosed health condition. Health concerns which may impact on a doctor's communication skills include neurodegenerative disorders and acquired brain injuries from either a traumatic or non-traumatic event.

19 Where the panel has good reason based on specific evidence to indicate that health may be an underlying cause of concern about a doctor's knowledge of English they should consider whether a health assessment may be appropriate. If a health assessment is directed in these circumstances the examiners should be asked to comment on whether any medical condition is likely to impact on the doctor's communication skills. In such cases, careful thought should be given to delaying a decision on whether it is necessary to direct a language assessment until further information is available about the doctor's health.

Compliance period for doctors directed to complete a language assessment during a hearing

20 Where a hearing has adjourned to allow a doctor to complete a language assessment at the direction of an MPTS panel, we will normally expect the doctor to complete this within 90 days and hearings will be scheduled appropriately. In these circumstances where a doctor fails to provide evidence of completion in time for the hearing to reconvene, without good reason, the panel may exercise its discretion in deciding how to proceed. The panel may
decide to adjourn, impose an order for non-compliance, or use non-compliance as evidence to support a finding of impairment.

21 Factors which may indicate it is appropriate not to take action in relation to a doctor’s failure to complete a language assessment are set out below, however this is not an exhaustive list and decision makers should use their own judgement, giving careful consideration to the individual features of the case.

a The doctor has provided evidence they were unable to access a test within the required period due to a lack of availability at suitable test centres or delay in making necessary reasonable adjustments for disability.

b The doctor is recently bereaved or has caring responsibilities which have made it difficult to study or access test centres.

c The doctor or a close relative is very unwell.

22 When deciding whether or not it is appropriate to extend the time period in which a doctor is required to complete a language assessment decision makers should consider the need to protect the public from risk of harm, the nature of the concerns raised and any extenuating circumstances. Consideration should also be given to the likelihood of a doctor’s compliance within a clear alternative timeframe. Any time extension on completing the language assessment will be dependent on the individual circumstances of the case.
5 - Guidance on the investigation and adjudication of cases involving language concerns

Indicative Sanctions Guidance for the Fitness to Practise Panel
Indicative Sanctions Guidance for the Fitness to Practise Panel
(April 2009, with revisions from August 2009, March 2012, March 2013 and June 2014)

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Introduction

Role and status of the Indicative Sanctions Guidance

1 This guidance has been developed by the General Medical Council (GMC). It is for use by fitness to practise panels in cases that have been referred to the Medical Practitioners Tribunal Service for a hearing when considering what sanction to impose following a finding that the doctor’s fitness to practise is impaired. It also contains guidance on the issue of warnings where a Panel has concluded that the doctor’s fitness to practise is not impaired. It outlines the decision-making process and factors to be considered. The Indicative Sanctions Guidance is an authoritative statement of the GMC’s approach to sanctions issues.

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

The GMC’s statutory purpose

3 The statutory purpose of the GMC is to protect, promote and maintain the health and safety of the public. It does this through the four main functions given to it under the Medical Act 1983 as amended (the Act):

- keeping up-to-date registers of qualified doctors
- fostering Good medical practice
- promoting high standards of medical education
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC’s role in setting standards

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

5 The GMC also publishes supplementary ethical guidance, which expands on the principles in Good medical practice, providing more detail on how to comply

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2 http://www.gmc-uk.org/guidance/ethical_guidance/index.asp
with them. This supplementary guidance is published in six additional booklets (on consent, confidentiality, end-of-life care, research, management and children) as well as a range of shorter statements - from writing references to reporting gunshot wounds - all of which can be found on the GMC’s website. When viewing Good medical practice on-line there are direct links through to the supplementary guidance and other information from the relevant paragraphs.

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

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

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

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

"It helps to achieve a consistent approach to the imposition of penalties where serious professional misconduct is established. The panel must have regard to it although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff."
Mr Justice Newman, in *R (on the application of Abrahaem) v GMC [2004]*, described the Indicative Sanctions Guidance as:

"Those are very useful guidelines and they form a framework which enables any tribunal, including this court, to focus its attention on the relevant issues. But one has to come back to the essential exercise which the law now requires in what lies behind the purpose of sanctions, which, as I have already pointed out, is not to be punitive but to protect the public interest; public interest is a label which gives rise to separate areas of consideration."

**Equality and Diversity Statement**

The GMC’s responsibilities

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

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

Doctors’ responsibilities

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

**Publication of outcomes**

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

[^3]: [http://www.gmc-uk.org/about/equality_scheme/index.asp](http://www.gmc-uk.org/about/equality_scheme/index.asp)
Some general principles regarding sanctions

Role of the Panel and the three-stage process

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

a Whether the facts alleged have been found proved;

b Whether, on the basis of the facts found proved, the doctor’s fitness to practise is impaired;

c If so, whether any action should be taken against the doctor’s registration; if the panel has not found the doctor’s fitness to practise impaired, whether a warning should be issued.

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

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

The purpose of sanctions and the public interest

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

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

a Protection of patients

b Maintenance of public confidence in the profession

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

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

⁷ Report of the Committee of Inquiry into the Regulation of the Medical Profession (1975)
c Declaring and upholding proper standards of conduct and behaviour.

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

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

**Proportionality**

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

22 Any sanction and the period for which it is imposed must be necessary to protect the public interest (see paragraphs 18 - 20). In making their decision on the appropriate sanction, panels need to be mindful that they do not give undue weight to whether or not a doctor has previously been subject to an interim order for conditions or suspension imposed by the interim orders panel, or the period for which that order has been effective. Panels need to bear in mind that the interim orders panel makes no findings of fact and that its test for considering whether or not to impose an interim order is entirely different from the criteria used by the fitness to practise panels when considering the appropriate sanction. It is for this reason that an interim order and the length of that order are unlikely to be of much significance for panels. Further detail about the test applied when considering the imposition of interim orders is set out in the GMC’s Guidance for imposing interim orders.

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

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

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

25 In any case before them, the panel will need to have due regard to any evidence presented by way of mitigation by the doctor. Mitigation might be considered in two categories:

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

b Evidence of the doctor’s overall adherence to important principles of good practice (i.e. keeping up to date, working within his/her area of competence etc. - see also paragraph 28 below). Mitigation could also relate to the circumstances leading up to the incidents as well as the character and previous history of the doctor. This could also include evidence that the doctor has not previously had a finding made against him or her by a previous panel or by any of the Council’s previous committees.

26 The panel should also take into account matters of personal and professional mitigation which may be advanced such as testimonials, personal hardship and work related stress. Without purporting in any way to be exhaustive, other factors might include matters such as lapse of time since an incident occurred, inexperience or a lack of training and supervision at work. Features such as these should be considered and balanced carefully against the central aim of sanctions, that is the protection of the public and the maintenance of standards and public confidence in the profession.

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

28 The principles in Good medical practice emphasise that doctors should take a mature and responsible approach to their career; being personally accountable for problems that arise, learning from mistakes, and working as a team. Panellists may wish to see evidence to support a doctor’s contention that he/she has taken steps to mitigate his/her actions or to prevent problems arising. Panellists may wish to note in this respect that Good medical practice states that doctors should:

a raise concerns where he/she has good reason to think that patient safety may be seriously compromised by inadequate premises, equipment or other
resources, and should put matters right where possible (Good medical practice, paragraphs 24 and 25)

b protect patients from risk of harm posed by another colleague's conduct, performance or health (Good medical practice, paragraph 25c)

c be open and honest with patients if things go wrong (Good Medical Practice paragraphs 55 and 61)

d cooperate with any complaints procedure and/or formal inquiry into the treatment of a patient disclosing information relevant to an investigation to anyone entitled to it (Good medical practice paragraphs 72 to 74)

e keep their knowledge and skills up to date and work with colleagues and patients to improve the quality of their work and promote patient safety (Good medical practice paragraphs 8 to 13 and 22 to 23)

You must have the necessary knowledge of English to provide a good standard of practice and care (Good medical practice paragraph x)

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

Guidance on considering references and testimonials

30 The doctor may present references and testimonials as to his/her standing in the community or profession. Panels should consider, where these have been provided in advance of the hearing, whether the authors are aware of the events leading to the hearing and what weight, if any, to give to these documents.

31 As with other mitigating or aggravating factors, any references and testimonials will need to be weighed appropriately against the nature of the facts found proved. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend on the standing of a practitioner. There may be cultural reasons for not requesting them and the panel should also be aware of this. In addition, acquiring references and testimonials may pose a difficulty for doctors who qualified outside the United Kingdom and who are newly arrived in the UK. The panel will need to consider all such factors when looking at references and testimonials.

Expressions of regret and apology

32 Good medical practice provides the following guidance at paragraph 55 and 61 to doctors when things go wrong:
"55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress you should:

a. put matters right (if that is possible)

b. offer an apology

c. explain fully and promptly what has happened and the likely short-term and long-term effects

61 You must respond promptly, fully and honestly to complaints and apologise when appropriate."

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

a patients should be protected from similar events reoccurring, and

b doctors should take positive steps to learn from their mistakes, or when things go wrong.

33 The duty to "offer an apology" where appropriate reflects that, in our society, it is almost always expected that a person will apologise when things go wrong. However, to some individuals (and this may or may not depend on their culture), offering an apology amounts to an acceptance of personal guilt which, depending on the facts, a doctor may regard as inappropriate or excessive. It is also possible that occasionally a doctor may be constrained by issues involving legal liability, for example a criminal investigation, and/or legal advice and therefore does not offer an apology.

34 This ‘insight’ - the expectation that a doctor will be able to stand back and accept that, with hindsight, they should have behaved differently, and that it is expected that he/she will take steps to prevent a reoccurrence - is an important factor in a hearing. When assessing whether a doctor has insight the panel will need to take into account whether he/she has demonstrated insight consistently throughout the hearing, eg has not given any untruthful evidence to the panel or falsified documents. But the panel should be aware that there may be cultural differences in the way that insight is expressed, for example, whether or how an apology or expression of regret is framed and delivered and the process of communication, and that this may be affected by the doctor's circumstances, for example, their ill health.

35 Cross-cultural communication studies show that there are great variations in the way that individuals from different cultures and language groups use language to code and de-code messages. This is particularly the case when using a second language, where speakers may use the conventions of their first language to frame and structure sentences, often translating as they
speak and may also be reflected in the intonation adopted. As a result, the language convention, subtleties or nuances of the second language may not be reflected. In addition, there may be differences in the way that individuals use non-verbal cues to convey a message, including eye contact, gestures, facial expressions and touch.

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

a how a doctor frames his/her ‘insight’

b whether or how a doctor offers an apology

c the doctor’s demeanour and attitude during the hearing.

37 The main consideration for the panel therefore, is to be satisfied about patient protection and the wider public interest and that the doctor has recognised that steps need to be taken, and not the form in which this insight may be expressed.

Where no impairment is found

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

a no action

b issue a warning.

39 In the interests of fairness to both parties, panels should invite submissions from the GMC and the doctor on whether a warning should be issued before considering whether to conclude the case with no action or a warning.

Warnings

40 If the panel finds that the doctor’s fitness to practise is not impaired, it may issue the doctor with a warning as to his/her future conduct or performance, with reference to the facts found proved. A warning may be issued where there has been a significant departure from Good medical practice, or there is a significant cause for concern following an assessment of the doctor’s performance or knowledge of English. Warnings are not appropriate in cases relating solely to a doctor’s health and/or knowledge of English, but may be issued in multi-factorial cases in which health or knowledge of English is raised as one the issues.

41 Further guidance on the purpose of warnings, the factors to take into account when considering whether to impose a warning and the
circumstances in which a warning might be appropriate is set out in the GMC’s Guidance on Warnings.

42 When considering the wording of a warning, panels should have regard to the Guidance on Warnings.

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

44 Warnings are disclosed to any person or body who brought the allegation to the attention of the GMC, the practitioner’s employer, and any other enquirer. They are published via the GMC’s website on the List of Registered Medical Practitioners for a five-year period.

Where impairment is found

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

a no action (see paragraph 48)

b impose conditions on the doctor’s registration for a period up to three years (see paragraphs 56 - 68)

c direct that the doctor’s registration be suspended for up to 12 months (see paragraphs 69 - 76)

d direct erasure of the doctor’s name from the register, except in cases that relate solely to a doctor’s health (see paragraphs 77 - 84).

Panels may agree as an alternative to imposing any sanction any written undertakings (including any limitations on his/her practice) offered by the doctor (see paragraphs 49 – 55).

46 Before moving to a vote the panel should ensure that it fully discusses the case, the submissions made by both parties as to the appropriate sanction and all the options available to it. The submissions made by both parties are just that, submissions; the final decision as to the appropriate sanction is for the panel alone to make operating within the relevant legislation and the framework set out by the Indicative Sanctions Guidance.

47 It is important that the panel’s determination on sanction makes clear that it has considered all the options and provides clear and cogent reasons.

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

11 eg Medical Act 1983 as amended, General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended) and various other Rules
(including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction, especially where it is lower, or higher, than that suggested by this guidance and where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why a particular period of sanction was considered necessary.

No action

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

Undertakings

49 The Rules\footnote{12 Rule 17(2)(m) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)} provide that a panel may agree as an alternative to imposing any sanction \textit{written} undertakings offered by the doctor provided that the doctor agrees that the Registrar may disclose the undertakings (except those relating exclusively to the doctor’s health) to:

\begin{itemize}
  \item a his/her employer or anyone with whom he/she is contracted or has an arrangement to provide medical services
  \item b anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and
  \item c any other person enquiring.
\end{itemize}

50 Undertakings relating to a doctor’s practice are published on the List of Registered Medical Practitioners on the GMC’s website (save those relating exclusively to the doctor’s health).

\footnote{12 Rule 17(2)(m) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)}
51 Undertakings may include restrictions on the doctor’s practice or behaviour, or the commitment to undergo medical supervision or retraining. As with conditions (see paragraphs 56 - 68), they are likely to be appropriate where the concerns about the doctor’s practice are such that a period of retraining, and/or supervision is likely to be the most appropriate way of addressing them, or where the doctor has the insight to limit his/her practice.

52 Undertakings will only be appropriate where the panel is satisfied that the doctor will comply with them, for example, because the doctor has shown genuine insight into his/her problems/deficiencies and potential for remediation. The panel may wish to see evidence that the doctor has taken responsibility for his/her own actions and/or otherwise taken steps to mitigate his/her actions (see also paragraphs 25 - 29 above).

53 The GMC has published separate guidance, Undertakings at FTP hearings, which panels should follow if considering whether to accept undertakings.

54 Panellists should ensure that any undertakings are appropriate, proportionate, are sufficient to protect patients and the public, and are an effective way of addressing the concerns about the doctor. Undertakings should normally follow the format of the standard undertakings in the bank of undertakings. The bank comprises standard sets of undertakings, which allow for effective monitoring by the GMC and disclosure of information to any person requesting information about his/her registration status.

55 Where a panel accepts undertakings, the Registrar will monitor the doctor’s progress and consider any new information received in relation to them, including representations from the doctor or otherwise to suggest that the undertakings are no longer appropriate. The Registrar will consider any breaches of undertakings or information indicating further concerns about the doctor’s fitness to practise and will refer for a review hearing if appropriate. Further detail about the post-hearing procedure is provided in the guidance on Undertakings at FTP hearings and also the separate Guidance on dealing with breaches of undertakings and criteria referral to Fitness to Practise Panels.

**Conditional registration (maximum 3 years)**

56 Conditions may be imposed up to a maximum of three years in the first instance, renewable in periods up to 36 months thereafter. This sanction allows a doctor to practise subject to certain restrictions (eg restriction to NHS posts or no longer carrying out a particular procedure). Conditions are likely to be appropriate where the concerns about the doctor’s practice are

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such that a period of retraining and/or supervision is likely to be the most appropriate way of addressing them.

57 Conditions might be most appropriate in cases involving the doctor’s health, performance, or following a single clinical incident, or where there is evidence of shortcomings in a specific area or areas of the doctor’s practice, or where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision. Panels will need to be satisfied that the doctor has displayed insight into his/her problems, and that there is potential for the doctor to respond positively to remediation/retraining and to supervision of his/her work.

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

59 The GMC has published separate guidance about making referrals to the Postgraduate Dean Responsible Officer or GP Director along with information about the medical career structure of doctors. Panels will need to take this guidance into account bearing in mind that where the issues relate to misconduct or a criminal conviction, knowledge of English or to untreated health problems, referral signposting a doctor to seek support from their Postgraduate Dean Responsible Officer is not an appropriate way forward as they are not able to provide remedial help in such circumstances.

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

61 The objectives of any conditions should be made clear so that the doctor knows what is expected of him or her and so that a panel, at any future review hearing, is able to ascertain the original shortcomings and the exact proposals for their correction. Only with these established will it be able to evaluate whether they have been achieved. Any conditions should be appropriate, proportionate, workable and measurable, and in practical terms should be discussed fully by the panel before voting. Before imposing conditions the panel should satisfy itself that:

17 http://www.gmc-uk.org/Medical_career_structure_doctors_in_training.pdf_25417075.pdf
a the problem is amenable to improvement through conditions or, in cases involving the doctor's health, whether his/her medical condition can be appropriately managed

b the objectives of the conditions are clear

cb a future panel will be readily able to determine whether the objective has been achieved and whether patients will or will not be at risk.

62 When deciding whether conditions might be appropriate the panel will need to satisfy itself that most or all of the following factors (where applicable) are apparent having regard to the type of case (health, language, performance, misconduct etc.) This list is not exhaustive:

a no evidence of harmful deep-seated personality or attitudinal problems

b identifiable areas of the doctor’s practice in need of assessment or retraining

c potential and willingness to respond positively to retraining, in particular evidence of the doctor’s commitment to keeping his/her knowledge and skills up to date throughout his/her working life, improving the quality of his/her work and promoting patient safety (Good medical practice, paragraphs 7 to 13 “Knowledge, Skills and Performance” and 22 to 23 regarding “Safety and Quality”

d willingness to be open and honest with patients if things go wrong (Good Medical Practice, paragraphs 55 and 61)

e in cases involving health issues, evidence that the doctor has genuine insight into any health problems, has been compliant with the GMC’s guidance on health (Good medical practice, paragraphs 28 to 30) and that he/she will abide by conditions relating to his/her medical condition(s), treatment and supervision

f patients will not be put in danger either directly or indirectly as a result of conditional registration itself

g it is possible to formulate appropriate and practical conditions to impose on registration.

63 Where a panel has found a doctor’s fitness to practise impaired by reason of adverse physical or mental health the conditions should include conditions relating to the medical supervision of the doctor as well as conditions relating to supervision at his/her place of employment. Generally, it is inappropriate to impose conditions regarding medical supervision if the doctor’s fitness to practise has not been found impaired by reason of adverse physical or
mental health. An exception would be a case where a doctor has refused to undergo a health assessment.

64 Conditions should normally follow the format of conditions as set out in the FTP Conditions Bank\(^\text{18}\). Panellists may also find it helpful to refer to the definitions of the roles of individuals involved in doctors supervision as provided by the GMC in the Glossary of terms used in FTP actions\(^\text{19}\).

65 The conditions bank has been developed to indicate appropriate wording for restrictions to a doctor's practice (which are published) and for their treatment (which are not published). It is important that panels follow the suggested wording in the bank, where possible, and to maintain a clear distinction between practice and treatment conditions. If practice conditions are imposed that contain a reference to the treatment of a doctor’s health, real practical difficulties are caused by the conflict between the GMC’s duty to publish practice restrictions and the desirability of maintaining medical confidentiality for the doctor.

66 It is, of course, open to panels to impose conditions that are not set out in the conditions bank, as appropriate, in the circumstances of the particular case whilst taking account of the general principles outlined above.

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

68 Panels must also consider, as required by Rule 17(2)(o)\(^\text{20}\), whether the conditions imposed should take effect immediately. When doing so panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Panels should explain fully the reasons for any decision reached. Further guidance on when an immediate order might be appropriate is set out at paragraphs 121 - 126 below.

**Suspension (up to 12 months but may be indefinite in certain circumstances in health and/ or knowledge of English only cases)**

69 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner. Suspension from the register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension. Suspension will be an appropriate response to misconduct which is


\(^{19}\) http://www.gmc-uk.org/Glossary_of_Terms_used_in_Fitness_to_Practise_Actions.dot.pdf_25416199.pdf

\(^{20}\) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that the panel considers that the doctor should not practise again either for public safety reasons or in order to protect the reputation of the profession). This may be the case, for example, where there may have been acknowledgement of fault and where the panel is satisfied that the behaviour or incident is unlikely to be repeated. The panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions (see paragraphs 25-29 above).

70 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that he/she has gained insight into the deficiencies and has the potential to be rehabilitated or remediate if prepared to undergo a rehabilitation or retraining programme. In such cases, to protect patients and the public interest, the panel might wish to impose a period of suspension, direct a review hearing and to indicate in broad terms the type of remedial action which, if undertaken during the period of suspension, may help the panel's evaluation at any subsequent review hearing. The panel should, however, bear in mind that during the period of suspension the doctor will not be able to practise. He/she may, however, have contact with patients similar to that of a final year medical student, i.e. under the supervision of a fully registered medical practitioner, and provided that the patients have been informed of the doctor's registration status, the events which resulted in the suspension of the doctor's registration and have given their full consent.

71 The length of the suspension may be up to 12 months and is a matter for the panel's discretion, depending on the gravity of the particular case. Where a doctor is suspended due to concerns about their knowledge of English, a four month period is likely to be appropriate in the first instance to allow the doctor time to acquire evidence of improved language skills. In cases which relate solely to either health or knowledge of English only—cases, there are provisions to suspend a doctor's registration indefinitely – see paragraph 73 below.

72 As far as doctors with serious health problems and insufficient knowledge of English are concerned, the option of erasure does not exist unless there are also other factors (such as a conviction, misconduct or deficient performance), which have resulted in the finding of impaired fitness to practise. In those cases, suspension is appropriate where the doctor's health or knowledge of English is such that he/she cannot practise safely even under conditions. In such cases, the Panel may direct a review hearing to obtain further information as to whether the doctor is then fit to resume practice either under conditions or unrestricted.
In cases which relate solely to a doctor’s health or language, it is open to the panel, if the doctor’s registration has been suspended for at least two years because of two or more successive periods of suspension, to suspend the doctor’s registration indefinitely. If the panel decides to direct indefinite suspension there is no automatic further hearing of the case, although it is open to the doctor to request a review after a period of two years has elapsed from the date when the indefinite suspension took effect.

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

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

- a serious breach of Good medical practice where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public interest
- in cases involving deficient performance where there is a risk to patient safety if the doctor’s registration were not suspended and where the doctor demonstrates potential for remediation or retraining
- in cases which relate to the doctor’s health, where the doctor’s judgement may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions
- in cases which relate to knowledge of English, where the doctor’s language skills impact on his/her ability to practise and there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions
- no evidence of harmful, deep-seated personality or attitudinal problems
- no evidence of repetition of similar behaviour since incident
- panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour.

Panels must also consider, as required by Rule 17(2)(o)21, whether to direct that the doctor’s registration be suspended with immediate effect. When doing so panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Further

21 General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
guidance on when an immediate order might be appropriate is set out at paragraphs 121 - 126 below.

Erasure

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

78 Lord Bingham, Master of the Rolls, in the case of Bolton v The Law Society\textsuperscript{22}, stated that:

“All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness. Thus it can never be an objection to an order of suspension in an appropriate case that the solicitor may be unable to re-establish his practice when the period of suspension is past. If that proves, or appears likely to be, so the consequence for the individual and his family may be deeply unfortunate and unintended. But it does not make suspension the wrong order if it is otherwise right. The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.” [our emphasis]

79 The Gupta\textsuperscript{23} judgment, which adopted the approach set out in Bolton v The Law Society, emphasised the GMC’s role in maintaining justified confidence in


\textsuperscript{23} Dr Prabha Gupta v GMC (Privy Council Appeal No. 44 of 2001)
the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk:

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

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

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

[emphasis added]

and drew attention to the statement that:

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

[emphasis added]

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

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

particularly serious departure from the principles set out in Good medical practice i.e. behaviour fundamentally incompatible with being a doctor

a a reckless disregard for the principles set out in Good medical practice and/or patient safety.

b doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 112 - 113 regarding failure to provide an acceptable level of treatment/care)

c abuse of position/trust (see Good medical practice paragraph 65 “you must make sure that your conduct at all times justifies your patients’ trust in you and the public’s trust in the profession”)

d violation of a patient’s rights/exploiting vulnerable persons (see for example Good medical practice paragraph 27 regarding children and young people,

\(^{24}\) Dr Willem Bijl v GMC (Privy Council appeal No. 78 of 2000)
paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services)

e. Offences of a sexual nature, including involvement in child pornography (see further guidance below at paragraphs 92 - 104)

f. Offences involving violence

g. Dishonesty, especially where persistent and/or covered up (see further guidance at paragraphs 105 - 111 below)²⁵

h. Putting own interests before those of patients (see Good medical practice – “Make the care of your patient your first concern” on the inside cover and paragraphs 78 to 80 regarding conflicts of interest)

i. Persistent lack of insight into seriousness of actions or consequences.

Erasure is not available in cases where the only issue relates to the doctor’s health or knowledge of English.

83 When directing erasure, panels must also consider, as required by Rule 17(2)(o)²⁶, whether to make an order suspending the doctor’s registration with immediate effect. When doing so panels must consider any evidence received and any submissions made by the parties before making and announcing their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 121 - 126 below.

84 A doctor who has been erased cannot apply to be restored to the register until five years have elapsed²⁷. At that stage the panel will have to decide whether the doctor is fit to resume unrestricted practice. Further guidance on doctors’ restoration to the register is provided in the Guidance for doctors on registration following erasure by a Fitness to Practise Panel²⁸.

Other issues relevant to sanction

Considering conviction, caution or determination allegations

85 Convictions refer to a decision by a criminal court in the British Isles, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence.

²⁶ General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
²⁷ Section 41(2)(a) Medical Act 1983 as amended
²⁸ http://www.gmc-uk.org/Guidance_for_doctors_on_restoration_following_erasure_by_a_Fitness_to_Practise_Panel.pdf_25416789.pdf
Cautions refer to offences committed in the British Isles or elsewhere but where no court proceedings took place because the doctor has admitted the offence and criminal proceedings were considered unnecessary.

Determinations refer to decisions by another health or social care regulatory body, in the United Kingdom or elsewhere, which has made a determination that the fitness to practise of the doctor as a member of that profession is impaired or an equivalent finding.

Where the panel receives in evidence a signed certificate of the conviction or determination, unless it also receives evidence to the effect that the doctor is not the person referred to in the conviction or determination, then the panel is bound to accept the certificate as conclusive evidence of the offence having been committed or the facts found by the determination. In accepting a caution, the doctor will have admitted committing the offence.

The purpose of the hearing is not to punish the doctor a second time for the offences for which he/she was found guilty. The purpose is to consider whether the doctor’s fitness to practise is impaired as a result and, if so, whether there is a need to restrict his/her registration in order to protect the public who might come to the doctor as patients and to maintain the high standards and good reputation of the profession. Panels will be aware of the paragraphs in Good medical practice regarding the need to be honest and trustworthy, and to act with integrity (paragraphs 56 to 57).

The Panel should, however, bear in mind that the sentence or sanction previously imposed is not necessarily a definitive guide to the seriousness of the offence. There may have been personal circumstances that led the court or regulatory body to be lenient. For example, the court may have expressed an expectation that the regulatory body would erase the doctor. Similarly, the range of sanctions and how they are applied may vary significantly amongst other regulatory bodies.

Panels may wish to note that Good medical practice imposes a duty on doctors to “tell us without delay if, anywhere in the world, (a) they have accepted a caution from the police or been criticised by an official inquiry or (b) been charged with or found guilty of a criminal offence, or (c) another professional body has made a finding against their registration as a result of fitness to practise procedures.” (Good medical practice paragraph 75).

Sexual misconduct

This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual

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29 Rule 34(3) and (4) General Medical Council (Fitness to Practise) Rules Order of Council 2004
30 Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001)
31 CHRP v (1) GDC and (2) Mr Fleischmann [2005] EWHC 87 (Admin)
misconduct with patients, colleagues or patients’ relatives. See further guidance on sex offenders and child pornography at paragraphs 95 - 104 below.

93 Panels should note the principle set out in paragraph 53 of Good medical practice "You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them" and the separate guidance issued on Maintaining Boundaries.

94 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust which a doctor occupies, or where a doctor has been required to register as a sex offender. The risk to patients is important. In such cases erasure has therefore been judged the appropriate sanction:

“The public, and in particular female patients, must have confidence in the medical profession whatever their state of health might be. The conduct as found proved against Dr Haikel undoubtedly undermines such confidence and a severe sanction was inevitable. Their Lordships are satisfied that erasure was neither unreasonable, excessive nor disproportionate but necessary in the public interest.”

Sex offenders and child pornography

95 Any doctor who has been convicted of, or has received a caution for a sexual offence listed in Schedule 3 of the Sexual Offences Act 2003 is required to notify the police ("register") under S80 of the Sexual Offences Act 2003 and may be required to undertake a programme of rehabilitation or treatment. Sexual offences include accessing and viewing or other involvement in child pornography, which involves the exploitation or abuse of a child. Such offences seriously undermine patients’ and the public’s trust and confidence in the medical profession and breach a number of principles set out in Good medical practice (paragraph 65 regarding honest and integrity, paragraphs 46 to 49 regarding establishing and maintaining partnerships with patients, particularly paragraph 47 regarding respecting their dignity, and paragraph 27 regarding children and young people).

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

97 Taking, making, distributing or showing with a view to being distributed, to publish, or possession of an indecent photograph or pseudo-photograph of a child is illegal and regarded in UK society as morally unacceptable. For these reasons any involvement in child pornography by a registered medical practitioner raises the question whether the public interest demands that his/her registration be affected.

32 http://www.gmc-uk.org/guidance/current/library/maintaining_boundaries.asp
33 Dr Mohamed Shaker Haikel v General Medical Council (Privy Council Appeal No. 69 of 2001). See also Dr Ali Abdul Razak v General Medical Council [2004] EWHC205 (Admin). 96. In the case of CHRP v (1) GDC and (2) Mr Fleischmann [2005] EWHC 87 27
Whilst the courts properly distinguish between degrees of seriousness, the Council considers any conviction for child pornography against a registered medical practitioner to be a matter of grave concern because it involves such a fundamental breach of patients’ trust in doctors and inevitably brings the profession into disrepute. It is therefore highly likely that in such a case, the only proportionate sanction will be erasure but the panel should bear in mind paragraphs 15-4 and 45-113 of this guidance, which deal with the options available to the panel, and the issue of proportionality. If the panel decides to impose a sanction other than erasure, it is important that particular care is taken to explain fully the reasons and the thinking that has led it to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.

The panel should be aware that any conviction relating to child pornography will lead to registration as a sex offender and possibly to court ordered disqualification from working with children. The Council has made it clear that no doctor registered as a sex offender should have unrestricted registration. The panel will therefore need to ensure that, in cases where it imposes a period of suspension, the case should be reviewed before the end of the period of suspension to consider whether a further period of suspension is appropriate or whether the doctor should be permitted to resume practice subject to conditions.

The Council has also expressed the view that, in order to protect the public interest, the panel should consider whether any such conditions ought to include no direct contact with any patients during the period the doctor is registered as a sex offender. (Doctors may of course be registered as sex offenders following other sexual offences not related to child pornography.)

The panel should also consider whether doctors registered as sex offenders should be required to undergo assessment, for example by a clinical psychologist, to assess the potential risk to patients before they may be permitted to resume any form of practice.

When panels are reviewing cases where the doctor has completed the prescribed period of registration as a sex offender (which is dependent on the nature and gravity of the offence) and is no longer required to register as a sex offender panels should take into account the following factors:

- the seriousness of the original offence
- evidence about the doctor’s response to any treatment programme he/she has undertaken
- any insight shown by the doctor
- the likelihood of the doctor re-offending
- the possible risk to patients and the wider public if the doctor was allowed to resume unrestricted practice
the possible damage to the public’s trust in the profession if the doctor was allowed to resume unrestricted practice.

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

104 Where panels have doubt about whether a doctor no longer required to register as a sex offender should resume unrestricted practice, the doctor should not be granted unrestricted registration.

**Dishonesty**

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

“You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.” (*Good medical practice* paragraph 65)

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

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

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

107 In relation to providing and publishing information about their services *Good medical practice* advises doctors that:

“When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients’ vulnerability or lack of medical knowledge” (paragraph 70)

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

“...Health Authorities must be able to place complete reliance on the integrity of practitioners; and the Committee is entitled to regard conduct which undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole.”

Examples of dishonesty in professional practice could include defrauding an employer, falsifying or improperly amending patient records or submitting or providing false references, inaccurate or misleading information on a CV and failing to take reasonable steps to ensure that statements made in formal documents are accurate. (see Good medical practice paragraphs 19 to 21 regarding the duty to keep clear, accurate and legible records, and paragraphs 71 to 74 regarding writing reports and CVs, giving evidence and signing documents; see also our separate guidance on writing references).

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

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

(see also our separate guidance on Research: The Role and Responsibilities of Doctors).

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

Failing to provide an acceptable level of treatment/care

Cases in this category are ones where a practitioner has not acted in a patient’s best interests and has failed to provide an adequate level of care, falling well below expected professional standards (please refer to the guidance set out at paragraphs 14 to 21, 24 to 26, 51 and 56 to 59 of Good medical practice, particularly where a reckless disregard for patient safety or a breach of the fundamental duty of doctors to “Make the care of your patient your first concern” have been demonstrated.

A particularly important consideration in such cases is whether or not a doctor has, or has the potential to develop, insight into these failures. Where this is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

36 http://www.gmc-uk.org/guidance/current/library/writing_references.asp
39 See judgment in the case of Dr Purabi Ghosh v General Medical Council (Privy Council Appeal No.)
Review hearings

114 Rule 22 sets out the procedure a panel must follow at a review hearing. The panel will need to consider and make a finding as to whether the doctor’s fitness to practise is impaired or he/she has failed to comply with any conditions imposed at the previous hearing (giving reasons for its decision) before determining whether to impose a further order. The panel’s powers to impose orders at a review hearing are set out in section 35D of the Act. The guidance provided in this section applies in relation to orders at review hearings as well as regarding a panel’s initial decision as to sanction.

115 Where the panel decides that a period of conditional registration or suspension would be appropriate, it must decide whether or not to direct a review hearing, to be held shortly before the expiry of the period. The panel should give reasons for its decision whether to direct a review hearing or not so that it is clear that the matter has been considered and the basis on which the decision has been reached. Where the panel does not direct a review hearing, the reasons should include an explanation of the factors that led it to decide that the doctor would be fit to resume unrestricted practice following expiry of the period of conditions or suspension. Where the panel directs a review hearing, it may wish to make clear what it expects the doctor to do during the period of conditions/suspension and the information he/she should submit in advance of the review hearing. This information will be helpful both to the doctor and to the panel considering the matter at the review hearing.

116 It is important that no doctor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the panel considers that he/she is safe to do so. In some misconduct cases it may be self-evident that following a short period of suspension, there will be no value in a review hearing. In most cases, however, where a period of suspension is imposed and in all cases where conditions have been imposed, the panel will need to be reassured that the doctor is fit to resume practice either unrestricted or with conditions or further conditions. The panel will also need to satisfy itself that the doctor has fully appreciated the gravity of the offence, has not reoffended, and has maintained his/her skills and knowledge and that patients will not be placed at risk by resumption of practice or by the imposition of conditional registration. The panel should consider whether the doctor has produced any information/objective evidence regarding these matters.

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

69 of 2000). Also Dr John Adrian Garfoot v General Medical Council (Privy Council Appeal No. 81 of 2001).
40 Rule 22(f) General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
41 Section 35D (9) and (10) Medical Act 1983 as amended
conditions for a period of up to three years, revoke or vary any of the previous conditions.42

118 Where a doctor's registration is suspended, the panel may direct that the current period of suspension be extended (up to 12 months), that the doctor's name be erased from the register (except in a health only case) or impose a period of conditions (up to three years)43. In cases involving solely the doctor's health or language, it is also open to the panel to suspend the doctor's registration indefinitely44 (see also paragraph 73 of this guidance).

119 Where a review hearing cannot be concluded before the expiry of the period of conditional registration or suspension, the panel may extend that period for a further short period45 to allow for re-listing of the review hearing as soon as practicable, with the objective of preserving the status quo pending the outcome of the review hearing. It is advisable for panels to invite submissions from both parties as to the length of time they might require and determine the period of extension accordingly.

120 The panel may as an alternative to imposing any sanction take into account any written undertakings offered by the doctor, which it considers sufficient to protect patients and the public interest and provided that the doctor agrees that the Registrar may disclose the undertakings (except those relating exclusively to the doctor's health) to:

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

b Anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and

c Any other person enquiring.

Immediate orders (suspension or conditions)

121 The doctor is entitled to appeal against any substantive direction affecting his/her registration. The direction does not take effect during the appeal period (28 days) or, if an appeal is lodged, until that appeal has been disposed of. During this time, the doctor’s registration remains fully effective unless the panel also imposes an immediate order.

122 The panel may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is in the public interest, or is in the best interests of the practitioner.46 The interests of the practitioner include avoiding putting him or her in a position where he/she may come under

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42 Section 35D (11) and (12) Medical Act 1983 as amended
43 Section 35D (5) Medical Act 1983 as amended
44 Section 35D (6) Medical Act 1983 as amended
45 Under the provisions of Section 35D Medical Act 1983 as amended
46 Section 38 of the Medical Act 1983 as amended
pressure from patients, and/or may repeat the misconduct, particularly where this may also put him/her at risk of committing a criminal offence (eg irresponsible prescribing when the doctor is in prison, particularly of drugs of addiction; *Good medical practice*, paragraphs 16(a) and 19 to 21 and ‘Good practice in prescribing medicines’). These factors should be balanced against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require the imposition of an immediate order.

123 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety, for example, where he/she has provided poor clinical care (ie breached paragraphs 14 to 21, 24 to 26, 51 and 56 to 59, *Good medical practice*) or abused a doctor’s special position of trust (*Good medical practice* paragraphs 53, 65 and 75), or where immediate action is required to protect public confidence in the medical profession.

124 It is sometimes argued by doctors, or their representatives, that no immediate order should be made as the doctor needs time to make arrangements for the care of his/her patients before the substantive order for suspension or erasure takes effect. In considering such arguments, panels will need to bear in mind that any doctor whose case is considered by a fitness to practise panel will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients prior to the hearing should the need arise. In any event, the GMC also notifies the doctor’s employers, or in the case of general practitioners, the Primary Care Trust, of the date of the hearing and they have a duty to ensure that appropriate arrangements are in place for the care of the doctor’s patients should an immediate order be imposed.

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

126 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the panel based on the facts of each case. The panel should, however, have regard to the seriousness of the matter which led to the substantive direction and consider carefully whether it is appropriate for the doctor to continue in unrestricted practice pending the substantive order taking effect. The panel should consider the matter in camera and when announcing its decision whether or not to impose an immediate order, give reasons for the decision taken.

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Annex A

List of other documents and guidance available to Panels

Medical Act 1983 (as amended):  
http://www.gmc-uk.org/about/legislation/medical_act.asp

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

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

General Medical Council (Fitness to Practise) Rules 2004 (as amended):  

Good medical practice - Current edition  
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp  

Supplementary ethical guidance  

Guidance to the Fitness to Practise Rules:  
http://www.gmc-uk.org/Guidance_to_the_FtP_Rules_2_.pdf_35398575.pdf

Meaning of Fitness to Practise:  

Guidance on agreeing undertakings at the investigation stage (Consensual Disposal)  
http://www.gmc-uk.org/Guidance_for_decision_makers_on_assessing_insight_when_considering_whether_undertakings_are_appropriate.pdf_32423692.pdf

Pre-Adjudication Case Management Procedure Guidance Manual  

Guidance for Specialist Advisers  
Guidance on warnings

Undertakings at FTP Panel hearings – Procedure and guidance

Undertakings bank

FTP Conditions Bank

Guidance for making referrals to the Postgraduate Dean or GP Director
http://www.mpts-uk.org/static/documents/content/Guidance_for_making_referrals_to_the_Postgraduate_Dean.pdf_25416687.pdf

Medical career structure – Doctors in training
http://www.mpts-uk.org/static/documents/content/Medical_career_structure_doctors_in_training.pdf_25417075.pdf

Glossary of terms used in FTP actions

Guidance on the use of clinical attachments

International Classification of Diseases (ICD10):
http://www.who.int/classifications/apps/icd/icd10online/

Imposing Interim Orders – Guidance for IOP and FTP Panels

IOP Conditions Bank

Voluntary Erasure – Guidance for decision-makers:
Guidance for doctors on restoration following erasure by a Fitness to Practise Panel:
http://www.gmc-uk.org/Guidance_for_doctors_on_restoration_following_erasure_by_a_Fitness_to_Practise_Panel.pdf_25416789.pdf

Managing Fitness to Practise Panel hearings – guidance for panel chairmen:
http://www.mpts-uk.org/decisions/1655.asp
Guidance on Undertakings

Introduction and overview

1 The purpose of this guidance is to demonstrate the way in which Rule 10 of the Fitness to Practise Rules 2004 (revised) is to be put into effect by the General Medical Council (GMC).

2 This guidance should be considered together with other guidance for decision makers, including the main decision making guidance for case examiners (CEs) and guidance on single clinical incidents.

3 Rule 10 provides for the agreement of undertakings between a doctor and the GMC, when it appears that the doctor’s fitness to practise is impaired and the doctor is prepared to comply with the undertakings.

4 Undertakings may be appropriate in cases involving doctors who are registered both with and without a licence to practise.

5 A doctor who is subject to undertakings is entitled to hold a licence to practise, however will need to comply with the terms of the undertakings.

6 When the CEs have decided that there is a realistic prospect of a Fitness to Practise Panel (panel) finding a doctor’s fitness to practise impaired (including in the event of the reoccurrence of a medical condition) and that undertakings will be sufficient to protect the patients and maintain public confidence, it will be irrelevant whether or not the doctor holds a licence to practise. Fitness to practise sanctions attach to registration and all doctors on the medical register are required to comply with Good Medical Practice. Even when the issues are practice related and the doctor has relinquished their licence to practise, practice related undertakings may still be the most appropriate approach, including a commitment to work under medical supervision or undergo retraining in the event they return to practice.

7 A registered doctor may apply for a licence at any time and that doctor’s practice will only be restricted if action has been taken on their registration. If
that doctor later obtains a licence, they will need to comply with any undertakings. Case examiners will need to consider in an individual case the most appropriate sanction keeping in mind the possibility of a doctor regaining their licence.

8 Undertakings may include restrictions on the doctor’s practice or activity, or the commitment to undergo/remain under medical supervision or undertake retraining. The undertakings will be disclosed to the doctor’s employer and to any other enquirer, unless they contain confidential information about the doctor’s health. Undertakings relating to a doctor’s practice are published on the List of Registered Medical Practitioners (LRMP) on the GMC’s website.

9 The GMC’s Case Review Team (CRT) will monitor the doctor’s compliance with undertakings. Following a period of undertakings, and taking into account any new information received, the case examiners may decide to maintain, vary or revoke the undertakings agreed. CEs will have regard both to compliance and insight when considering whether to vary or retain undertakings.

The process for agreeing undertakings

10 Following the completion of our preliminary enquiries, the CEs will consider all the available evidence, including, where relevant, any performance, language and/or health assessment reports, and apply the investigation stage test:

‘The Investigation Committee or case examiner must have in mind the GMC’s duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor’s fitness to practise is impaired to a degree justifying action on registration’

11 When the Investigation Committee (IC) or CEs are satisfied that there is no realistic prospect of establishing that the doctor’s fitness to practise is impaired, they should consider whether it is appropriate to issue a warning. If they conclude that a warning is not appropriate, the case should be concluded.

12 Rule 10 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) provides that where it appears to the CEs that:

(a) the practitioner’s fitness to practise is impaired; or

(b) the practitioner suffers from a continuing or episodic physical or mental condition which, although in remission at the time of the assessment, may be expected to cause a recurrence of impairment of the practitioner’s fitness to practise,

they may recommend that the practitioner be invited to comply with such undertakings as they think fit (including any restrictions on practice).
13 Rule 10(5) provides:

(5) The Registrar shall not invite the practitioner to comply with any such undertakings where there is a realistic prospect that, if the allegation were referred to a FTP Panel, his name would be erased from the register.

14 If, during the course of our enquiries and investigation, it appears likely that undertakings may be an appropriate outcome, the Registrar will contact the complainant or referring body to seek their views on the possibility of concluding the case by agreeing undertakings with the doctor.

15 Undertakings may only be proposed when, to do so, would be sufficient to protect patients and maintain public confidence. Undertakings may not be proposed where there is a realistic prospect that, if the allegations were referred to a panel, the doctor would be erased from the Register.

16 If there has been an assessment of the doctor’s health or performance, the assessments will include an opinion on whether the doctor is fit to practise, either generally or on a limited basis. Assessment reports will also include recommendations on the management of the case. CEs should take account of the recommendations and any additional evidence to decide whether the case reaches the investigation stage test threshold.

17 If there has been an assessment of the doctor’s language, CEs should refer to the GMC policy on the level of knowledge required to practise medicine safely which is published on our website here. Where a doctor has failed to achieve the minimum criteria to satisfy us they have the necessary knowledge of English this is likely to indicate the case reaches the investigation stage threshold. CEs should also take account of any additional evidence available.

18 In situations in which the allegations relate solely to a doctor’s health and or language, the Medical Act specifically precludes the possibility of erasure. CEs must, however, consider all relevant evidence relating to the doctor’s fitness to practise, and there will be situations in which issues of conduct or performance, outside the scope of the health or language assessment, raise the possibility of erasure. In considering whether there is a realistic prospect of erasure, the CEs should refer to the guidance on the investigation stage test and to the Indicative Sanctions Guidance (ISG).

19 If the CEs are satisfied that there is no realistic prospect of the doctor being erased, they may consider whether undertakings are sufficient to protect patients. The CEs must also have in mind the GMC’s duty to act in the public interest, which includes the protection of patients and maintaining the public confidence in the profession.
When a medical and a lay CE recommend that the doctor should be offered undertakings, the Registrar will write to the doctor inviting him to state, within 28 days, whether he is prepared to comply with the undertakings.

If undertakings have been offered or accepted, the case can still be referred to a panel, if:

a. The practitioner declines to accept the proposed undertakings, or fails to reply to an invitation to do so.

b. The practitioner subsequently breaches the undertakings.

c. The GMC receives new information suggesting deterioration in the practitioner’s health or performance, or otherwise casting a fresh light on the case.

Under rule 10(6), where undertakings have been agreed, the Registrar may carry out any additional enquiries that are considered necessary. These might take the form of an assessment of the doctor’s health or performance or some other form of enquiry. Further enquiries may be required, for example, to assess whether undertakings should be varied or lifted.

Criteria for agreeing undertakings

If properly managed, undertakings provide an effective tool for responding effectively and proportionately to serious fitness to practise concerns. Undertakings mean that we can intervene at an early stage and agree measures to protect patients, by restricting the doctor’s practice or by setting out measures for remediation and development.

In considering whether undertakings may be appropriate, the CEs shall have regard to the guidance for decision-makers on the application of the investigation stage test.

When considering whether to offer the doctor to accept undertakings, CEs should consider:

a. Whether undertakings are workable, measurable, attainable, proportionate and offer sufficient safeguards to protect the public.

b. Whether there is reason to believe the doctor will comply with the undertakings.

In particular, in performance cases, emphasis on retraining and development is likely to be more effective in addressing the cause of the problem than imposing a period of suspension. In cases where the allegations relate solely to conduct issues such as dishonesty undertakings are not likely to be appropriate.
although undertakings may be appropriate in multi-factorial cases involving misconduct (where the underlying cause may be linked to a health or performance issue).

2627 Under Rule 10(5) the CEs cannot consider undertakings when there is a realistic prospect of the doctor being erased if referred to a panel hearing. Indicators that there is a realistic prospect of the doctor being erased if the case were referred to a panel include:

a The allegations involve dishonesty (especially where persistent or covered up), violence or indecency and abuse of position of trust.

b A particularly serious departure from or reckless disregard for the principles set out in Good Medical Practice.

c Violation of a patient’s rights or exploiting a vulnerable adult or child for example in relation to expressing personal beliefs.

d Putting the doctor’s own interests before those of patient, for example in relation to conflicts of interest.

2728 Undertakings are also not likely to be appropriate where there is any significant disagreement as to the facts.

2829 CEs should consider any comments provided by the complainant or referring body together with other relevant considerations. The CEs are not obliged to comply with any preferences expressed by the complainant or referring body but should have regard to them.

Reasons for decision

2930 The CEs shall record the reasons for their decision. In particular, they shall record their reasons for agreeing undertakings when the complainant or referring body has made representations that the case should be referred to a panel hearing.

Categories of undertaking

3031 There are three broad categories of undertaking:

a Those which relate to the treatment of a doctor’s underlying health condition.

b Those which relate to the need to address deficiencies in clinical performance or knowledge of English.

c Those which relate to multi-factorial cases involving misconduct (where the underlying cause may relate to a health or performance issue).
CEs may use their discretion in drawing up the undertakings, but they should be based on the balance of opinion within any available reports. CEs should ensure that any undertakings are workable, measurable, attainable and proportionate, and are sufficient to protect patients and the public, and are an effective way of addressing the concerns about the doctor.

Undertakings should normally follow the format of the standard undertakings in the bank of conditions and undertakings. Bespoke undertakings should normally only be drafted if there is not an appropriate standard undertaking available.

Unless there are exceptional circumstances, an undertaking which requires a doctor to refrain from all forms of medical practice should only be used in health cases. Any exception to be agreed with Head of Case Review.

Link to undertakings bank

Amending undertakings

The Rules allow for undertakings to be amended if, as a result of information received, including any report or further assessment, it appears to the CEs that the undertakings should be varied or cease to apply.

If it seems that an amendment to the undertakings would be appropriate, the CEs should invite the doctor to indicate whether he or she agrees with the proposed amendment to the original undertakings. If the doctor agrees, there is no problem. However, if the doctor does not agree with the proposed change, the CEs must decide whether, in the light of comments made by the doctor, to continue with the original undertakings or to refer the case to a panel.

1 For further information, see separate guidance on varying undertakings.
Changes to our undertakings and conditions banks

1. The following requirements may be placed on a doctor’s registration where there are serious concerns about a doctor’s knowledge of English:

<table>
<thead>
<tr>
<th>Siebel number</th>
<th>Undertaking</th>
<th>Confidential (C)/Non-confidential (NC)</th>
<th>Area</th>
<th>Sub-area</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>tbc</td>
<td><strong>a</strong> To provide evidence that I have completed the International English Language Testing System (IELTS) test and achieved a score of 7.5 or above overall and in each of the four parts.</td>
<td>NC</td>
<td>Practice</td>
<td>Restriction/Information Sharing</td>
<td>Supervision requirements will also usually be imposed.</td>
</tr>
<tr>
<td>Siebel number</td>
<td>Condition</td>
<td>Confidential (C)/ Non-confidential (NC)</td>
<td>Area</td>
<td>Sub-area</td>
<td>Notes</td>
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<td>---------------</td>
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<td>tbc</td>
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<td>NC</td>
<td>Practice</td>
<td>Restriction/ Information Sharing</td>
<td>Supervision requirements will also usually be imposed.</td>
</tr>
</tbody>
</table>

2 The above restrictions will be added to Part One of the banks under the sub-heading ‘Knowledge of English.’
Guidance on referral to an Interim Orders Panel

1. Section 41A of the Medical Act 1983, as amended, provides for an Interim Orders Panel or a Fitness to Practise panel to make an order suspending a doctor’s registration, or imposing conditions upon a doctor’s registration for a period of up to 18 months. Any such orders must be reviewed by the panel within six months of the order being made, and thereafter every six months. An order may also be reviewed where new evidence relevant to the order becomes available. If the panel wishes to extend an order beyond the period initially set, it must direct the Registrar to apply to the High Court for permission to do so.

2. The panel may make such an order at any stage of any of the GMC’s fitness to practise procedures. Cases may be referred to the Interim Orders Panel by the Registrar or by a case examiner.

3. An Interim Orders Panel may make an order when it determines that it is necessary for the protection of members of the public or is otherwise in the public interest or the interests of the doctor. As well as protection of the public, the public interest includes:

   a. Preserving public confidence in the profession.
   b. Maintaining good standards of conduct and performance.

4. The panel may make an order only if the respondent doctor has been given an opportunity to attend and to make representations on whether an order should be made. However, the panel may proceed in the absence of the doctor, if it is satisfied that the doctor has been served with notice of the proceedings. The procedure rules specify that a doctor must receive a reasonable period of notice before their case is considered by the Interim Orders Panel. In practice, we should aim to give doctors at least 7 days notice of the hearing, but in cases of exceptional urgency the period of notice may be shorter.

5.
Cases should be referred to an Interim Orders Panel where the doctor faces allegations of such a nature that it may be necessary for the protection of members of the public, or otherwise be in the public interest or in the interests of the doctor, for the doctor’s registration to be restricted whilst those allegations are investigated.

The panel may make an order suspending a doctor’s registration or imposing conditions upon a doctor’s registration for a maximum period of 18 months. The panel must review the order within six months of the order being imposed and thereafter, at intervals of no more than six months. If the panel wishes to extend an order beyond the period initially set, it will direct the Registrar to apply to the High Court for permission to do so.

The following factors should be taken into account when considering whether to refer a case to an Interim Orders Panel:

- The seriousness of risk to members of the public if the practitioner was to continue to hold unrestricted registration. In assessing this risk, the panel will consider the seriousness of the allegations, the weight of the evidence, including evidence about the likelihood of further offences occurring whilst the allegations are investigated.

- Whether public confidence in the medical profession is likely to be seriously damaged if the practitioner were to continue to hold unrestricted registration whilst the allegations are resolved.

- 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 himself/herself.

The following factors may also be relevant:

- Whether the practitioner has complied with any undertaking given or conditions previously imposed in relation to this matter.

- The practitioner’s history with the GMC (if any).

The following examples are illustrative of cases which, depending on all the circumstances, may suggest that referral to an Interim Orders Panel is appropriate. The list is not exhaustive and there may be others where referral would be appropriate.

Risk to patients: clinical issues

This category concerns cases where, if the allegations are substantiated, there is an ongoing risk to patients from the doctor’s clinical practice. Such cases will normally involve either a series of failures to provide a proper standard of care,
or one particularly serious failure. Allegations indicating a serious lack of basic medical knowledge or skills, may well require referral to an Interim Orders Panel.

12 If concerns have been raised about a doctor’s knowledge of English language, it may be appropriate to consider referral to IOP where a doctor has been asked to undergo a language assessment, has refused to undergo a language assessment, or there is an unexpected delay in completing this. However, it is the seriousness of the index concern which is the primary factor for consideration in making a referral.

13 A referral is likely to be indicated if the GMC becomes aware that a doctor has not achieved a satisfactory level of attainment in an English language assessment. This includes where the doctor has indicated they plan to retake the assessment in the near future. However, it is the seriousness of the index concern which is the primary factor for consideration in making a referral.

14 This category also includes cases of doctors who have appeared before a Fitness to Practise panel and had their registration either suspended or erased but without immediate suspension being imposed, but where we receive new information which was not available at the time of the original determination that the doctor poses an immediate risk to patients.

Risk to patients/public confidence: non-clinical issues

15 These are cases not directly related to clinical practice but where, if the allegations are substantiated, the doctor poses a risk to patients if allowed to continue in unrestricted practice.

16 This category includes cases where the doctor faces allegations of a nature so serious that it would not be in the public interest for the doctor to hold unrestricted registration whilst the allegations are resolved even though there may be no evidence of a direct risk to patients. The question would be whether public confidence in the profession may be seriously damaged by the doctor concerned holding unrestricted registration whilst the allegations are resolved.

17 Matters of this kind, which would normally already be under investigation by the police, would include very serious alleged offences including murder, attempted murder, human trafficking, blackmail, manslaughter, rape, attempted rape, sexual assault and sexual abuse of children. Relevant offences may include abuse of children through grooming, prostitution or pornography and any offence by an adult relating to a child under 13 or person with a mental disorder impeding choice under the Sexual Offences Act 2003, Sexual Offences Act (Scotland 2010) and Sexual Offences (Northern Ireland) Order 2008. Police investigations into other matters may also suggest that a referral to an Interim Orders Panel is appropriate, depending on the individual circumstances of the case.
18 Where there is a question of doubt regarding a complaint that relates to the appropriateness of an examination of a patient a Medical Case examiner, because of their experience, would be best placed to review the case. In these instances cases should be referred to a Medical Case Examiner to make the IOP decision.

19 It may also be in the interests of public safety and public confidence to refer matters to the IOP where a doctor is alleged to have breached the guidance on relationships with patients in Good Medical Practice. Where there is evidence to suggest a doctor has used their professional position to establish or pursue a sexual or improper relationship with a patient or someone close to them (paragraph 32, GMP) this is a strong indicator that a referral is appropriate.

20 There are also circumstances in which failure to comply with the GMC’s Guidance for Doctors on Maintaining Boundaries (2006) may suggest that it is necessary to refer the doctor to the IOP, depending on the individual circumstances of the case. A referral is very likely to be indicated if the initial allegations feature one or more of the following factors:

a Failure to obtain informed consent before undertaking an intimate examination, particularly where the examination is not clinically indicated.

b Failure to offer a chaperone for an intimate examination or failure to make arrangements to ensure a chaperone is present throughout, where this has been requested by the patient.

c Failure to maintain professional boundaries when undertaking an examination which the patient may perceive to be intimate particularly where this involves examination of breasts, genitalia or rectum but depending on the circumstances may also include any examination where it is necessary to touch or even be close to the patient.

d Failure to treat the patient with dignity or allow them privacy when getting dressed or undressed, including unnecessary personal comments, particularly where this has been perceived to be sexually motivated.

e Sexualised behaviour towards the patient including any acts, words or behaviour designed to arouse or gratify sexual impulses and desires.

f Pursuing a sexual relationship with a former patient, where at the time of the professional relationship the patient was vulnerable, for example because of their mental health problems or lack of maturity.
21 The point at which doctors who are the subject of criminal investigations should be referred to an Interim Orders Panel is flexible and will depend on all the circumstances of the case.

*Cases involving a breach of conditional registration or of undertakings to limit practice*

22 These are cases where the doctor has breached restrictions imposed on his or her registration or has broken undertakings to the GMC to limit his or her practice. Examples would include:

a The doctor breaches conditions imposed by the Fitness to Practise panel or the IOP.

b The doctor breaches agreed undertakings.

c The doctor refuses to co-operate with a performance or health assessment, or prevaricates or falls ill temporarily so that completion of the assessment or medical examination is delayed.

23 The Interim Orders Panel has a duty to act to protect members of the public and the wider public interest. It is therefore important that cases are referred as soon as information becomes available suggesting that the doctor’s registration needs to be restricted on an interim basis. It will not always be possible to gather all the evidence that might potentially be available before referring the matter to a panel.

24 The Interim Orders Panel will make no finding of fact but the complaint must be credible and backed up where possible by corroborative evidence although the lack of corroborative evidence should not be a bar in itself to a referral to an Interim Orders Panel. The complainant may not be in a position to provide such evidence at this early stage.

*Recording decisions*

25 Decisions agreed by case examiners must be recorded on file. All parties should be able to understand why a decision has been taken, even if they do not agree with the decision (i.e. it should be clear that the facts have been properly considered on their merits and the appropriate test has been applied).

26 The case examiner’s written decision should contain:

a A summary of the essential facts. It is not sufficient to rely upon the Investigation Officer’s referral summary.
b The precise basis of referral: that is to say, public protection, public interest or interests of the doctor (or a combination of those reasons).

c The evidence that supports the referral.

d Standard phrases such as ‘referral to panel is indicated in this case’ are not sufficient and should not be used.
Guidance on the investigation and adjudication of cases involving language concerns

Guidance for the interim orders panel and the fitness to practise panel
Imposing interim orders

Guidance for the interim orders panel and the fitness to practise panel
Introduction

1 This guidance is for use by interim orders panels (IOP). It will also be of assistance to:
   - doctors whose cases are referred to an IOP
   - barristers or solicitors who represent doctors or the GMC before an IOP
   - a fitness to practise panel (FTP Panel), when considering whether to impose an interim order on a doctor’s registration
   - legal assessors advising IOPs and FTP panels.

2 The aim of the guidance is to promote consistency and transparency in decision making relating to interim orders. The guidance is a ‘living document’ and will be revised as the need arises.

The role and functions of the IOP

3 The role of the IOP is to consider whether a doctor’s registration should be restricted on an interim basis, either by suspension or by imposing conditions on their registration. Cases considered by an IOP are heard in private although they may be heard in public in certain circumstances e.g. the doctor requests a public hearing or the IOP considers it appropriate.\(^1\)

4 Section 41A of the Medical Act 1983, as amended, provides for an IOP, or a FTP Panel, to make an order, either suspending or imposing conditions upon a doctor’s registration, for a period of up to 18 months. In practice, the vast majority of interim orders will be imposed by an IOP. A FTP Panel may however impose such orders and is likely to do so if, for example, it adjourns a case and considers that it is necessary to do so pending its resumed consideration of the matter. Further guidance on when it may be necessary for a FTP Panel to consider the imposition of an interim order is set out in paragraphs 41 - 44 below.

Referral process

5 The Registrar may refer a case to the IOP at any stage if he or she is of the opinion that the IOP should consider making an interim order.\(^2\) The case examiners and Investigation Committee also have powers to direct the Registrar

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1 Rules 41(3), (4) and (6) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 as amended by The General Medical Council (Fitness to Practise) (Amendment in Relation to Standard of Proof) Rules Order of Council 2008 and The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009 (also referred to as the “Rules”)

2 Rule 6 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
to refer a case to the IOP. ³ Cases should be referred to an IOP where the
doctor faces allegations of such a nature that it may be necessary for the
protection of members of the public, or otherwise be in the public interest or in
the interests of the doctor, for the doctor’s registration to be restricted whilst
those allegations are investigated. This category also includes cases of doctors
who have appeared before a Fitness to Practise Panel, had their registration
either made subject to conditions, but without immediate conditions being
imposed, or suspended or erased but without immediate suspension being
imposed and we receive new information which was not available at the time of
the original determination, which suggests that the doctor poses an immediate
risk to patients, or that the wider public interest or the interests of the doctor
(for example his/her health) may be adversely affected. Further guidance on
the circumstances in which cases should be referred is provided at Annex A. ⁴

**Powers of the IOP**

6 An IOP may make an order when it considers it necessary to do so for the
protection of members of the public or it is otherwise desirable in the public
interest to maintain public confidence and uphold proper standards of conduct
and behaviour. The IOP may also make orders where it is in the interests of the
doctor.

7 An IOP does not make findings of fact or determine the allegations against the
doctor.

**Review of interim orders**

8 Except in the circumstances referred to in paragraph 9 below, any order
imposed must be reviewed by an IOP within six months of the order being
made, and thereafter every six months. However, following a first or
subsequent review of an order, the doctor may request an early review. If three
months have elapsed since the date of the immediately preceding review, then
the order shall be reviewed as soon as practicable after receipt of a request for
an early review. An order may also be reviewed at any time when new evidence
relevant to the order becomes available, which may affect the order in place. ⁵ If
the GMC wishes to extend an order beyond the period initially set, then it must
apply to the relevant Court ⁶ to extend the order. Each extension will be for a

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³ Rule 8(6) of The General Medical Council (Fitnese to Practise) Rules Order of Council 2004 (as
amended and section 35C(8) of the Medical Act 1983, as amended
⁴ The guidance set out in the Annex was developed, and agreed by the Fitness to Practise Committee,
to assist Case Examiners in deciding whether a case should be referred to the IOP.
⁵ S41(2) Medical Act 1983 as amended
⁶ The relevant Court means the Court of Session where a doctor’s registered address is in Scotland,
the High Court in Northern Ireland where a doctor’s registered address is in Northern Ireland and the
High Court in England and Wales for all others Where reference is made to the High Court in this
document it includes the Court of Session and the High Court in Northern Ireland.
maximum period of 12 months, however there is no limit on the number of extensions which may be granted.

9 There are, however, three instances where a review must take place within three months of the first or any subsequent order having taken place:

a where an order for interim conditions has been replaced with an order for interim suspension

b where an order for interim suspension has been replaced with an order for interim conditions

c where the High Court has extended an order beyond the period initially set.

Absence of the doctor

10 The absence of the doctor does not preclude the proceedings from taking place. An IOP may, however, only make an order if the doctor has been given an opportunity to attend and be heard on the question of whether such an order should be made. 7

11 If the doctor does not appear and is not represented before it, the Panel should proceed if it is satisfied that all reasonable efforts have been made to serve the doctor with notice of the proceedings. The Rules 8 require that notice of the hearing be served “in such time before the hearing as is reasonable in the circumstances of the case” [emphasis added]. In practice, doctors will normally receive at least seven days’ notice of the hearing, but in cases of exceptional urgency the period of notice may be shorter. Notice of the hearing must be sent to the doctor at his/her registered address or last known address and if the doctor is represented by a solicitor or trade union or defence organisation, the Notice can also be served on the representative provided they have ‘gone on record’ as acting for the doctor. 9 Service of any notice may be proved by:

a Confirmation of posting

b A signed statement from any person serving the Notice confirming that the Notice was delivered to, sent to or left at:

i the doctor’s registered address or last known address

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7 Section 41A(4) of the Medical Act 1983 as amended
8 Rule 26(1) of the The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
9 Rule 40 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended) and Paragraph 8 of Schedule 4 to the Medical Act 1983, as amended
the business or electronic email address of the doctor’s solicitor, trade union or defence organisation. 10

12 An IOP does not have to be satisfied that the doctor is aware of the proceedings only that all reasonable efforts have been made to serve the doctor with notice of the proceedings. 11 It is the doctor’s responsibility to maintain an effective registered address.

Applications for adjournment

13 Rule 29(2) provides that an IOP may, at any stage in its proceedings adjourn the hearing, whether of its own motion or upon the application of either party.

14 Postponement (as opposed to adjournment) does not fall within the IOP’s remit. Under the provisions of rule 29(1), applications for postponements can only be made to the case manager before the opening of a hearing. 12 Where a doctor’s application for a postponement has been rejected by the case manager, the doctor may make an application for adjournment at the hearing. While the grounds of such an application may be similar, it is for the IOP to consider the matter afresh.

15 In the event that an application for adjournment is made, an IOP should, having formally opened the hearing, carefully consider the submissions made and invite the other party also to make submissions on whether the case should be adjourned. It is vital that in accordance with Rule 29(3) both parties should be given reasonable opportunity to make their representations; but, where necessary, parties should be reminded of the importance of keeping submissions brief, addressing the reasons why an adjournment is considered necessary (or the reasons why it is opposed) and that they should not enter into presentation of the issues of the case.

16 Having heard the submissions made by each party and where appropriate sought advice from the legal assessor the IOP should consider the matter in the absence of the parties. It is for the IOP to decide whether, in the circumstances of the case, it is appropriate to grant the application. In doing so the panel will need to balance fairness to the applicant with the potential risk, resulting from any adjournment, to the public, the wider public interest or the doctor.

10 Rule 40 of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
11 Rule 31 of The General Medical Council (Fitness to Practise Rules Order of Council 2004 (as amended). Subsequent reviews normally take place every six months. The Panel may, however, impose a shorter period of time within which a review must be heard, if it considers it appropriate in all the circumstances of the case.
12 Guidance on postponement can be found in ‘The postponement of the Interim Orders Panel or Fitness to Practise panel hearing under rule 29’.
Information available to the IOP

17 Prior to the hearing, papers and supporting documents are sent to the IOP, the doctor and the parties’ legal representatives, and the legal assessor. Due to the nature of the IOP’s work, documents may be received at the last moment; those documents are tabled on the day of the meeting and must, where possible, be read by panellists before they hear any submissions on the case. However, every effort should be made by all parties to ensure that documents are submitted in advance of the hearing to enable panels to consider them. Where documents are to be tabled by either party on the day of the hearing, the IOP may request of the relevant party that the bundle is indexed and paginated. Where the size of the bundle is substantial, parties should highlight key documents for consideration by the panel.

18 Both the GMC Presenting Officer and the doctor or their representative may make submissions and adduce documentary evidence. Those submissions are limited to the question whether, given the circumstances of the case, it is necessary to impose/maintain an order either imposing interim conditions or interim suspension on the doctor’s registration. It is important to keep in mind that the IOP does not make findings of fact or to resolve disputes of fact. For this reason, the Rules provide that no person may give oral evidence before an IOP unless the Panel is satisfied that ‘such evidence is desirable to enable it to discharge its functions’. In the past the IOP have rarely found it necessary to hear oral evidence from witnesses, but each case must be considered on its own merits. However, the IOP will always hear from the doctor, if s/he wishes to give evidence.

Test applied

19 The IOP must consider, in accordance with section 41A, whether to impose an interim order. If the IOP is satisfied that:

a in all the circumstances that there may be impairment of the doctor’s fitness to practise which poses a real risk to members of the public, or may adversely affect the public interest or the interests of the practitioner; and

b after balancing the interests of the doctor and the interests of the public, that an interim order is necessary to guard against such risk, the appropriate order should be made.

20 In reaching a decision whether to impose an interim order an IOP should consider the following issues:

13 Rule 27(2) of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)
a The seriousness of risk to members of the public if the doctor continues to hold unrestricted registration. In assessing this risk the IOP should consider the seriousness of the allegations, the weight of the information, including information about the likelihood of a further incident or incidents occurring during the relevant period.

b Whether public confidence in the medical profession is likely to be seriously damaged if the doctor continues to hold unrestricted registration during the relevant period.

c 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.

21 In weighing up these factors, the IOP must carefully consider the proportionality of their response in dealing with the risk to the public interest (including patient safety and public confidence) and the adverse consequences of any action on the doctor's own interests.

22 In assessing whether or not it is appropriate to take action, the IOP should consider the seriousness of any police charges and the acceptability of their decision on interim action should the doctor later be convicted or acquitted (including public confidence issues as above).

23 When considering whether or not to make an interim order, the IOP cannot accept any undertakings given by the doctor as it has no power to accept them and they are, in any event, unenforceable.

Allegations of sexual misconduct

24 In general, where allegations involve sexually inappropriate behaviour towards patients or the doctor is under police investigation for a sexual criminal offence, particular consideration should be given to the impact on public confidence if the doctor were to continue working unrestricted in the meantime.

25 The following factors are likely to indicate, balanced alongside other considerations, that a case is likely to raise significant public confidence issues if no interim action is taken:

a information that a doctor is under investigation by police in connection to serious offences such as rape or attempted rape, sexual assault or attempted sexual assault or sexual abuse of children

b allegations that a doctor exhibited predatory behaviour in seeking or establishing an inappropriate sexual or emotional relationship with a vulnerable patient
serious concerns about a doctor’s sexualised behaviour towards a patient in a single episode

d allegiations of a pattern of sexually motivated behaviour towards patients.

26 Where a doctor is under investigation for any other serious criminal offence, particular consideration should be given to the impact on public confidence if the doctor were to continue working unrestricted in the meantime.

27 Where allegations involve sexual misconduct, there may be a significant risk to patient safety and public confidence in the profession if decisions at the interim stage are not seen to reflect the seriousness of the individual case.

Doctor’s health

28 Where there are issues about the doctor’s health, the IOP should bear in mind that its primary duty is to protect members of the public and the wider public interest, and not to assume responsibility for, or give priority to, the treatment or rehabilitation of the doctor. However, where the IOP considers it appropriate to make an order for interim conditions, these may include conditions relating to the ongoing treatment and supervision of the doctor.

Interim conditions or interim suspension?

29 The IOP shall first consider whether it is necessary to impose an interim order to protect patients and or desirable to maintain public confidence and uphold proper standards of behaviour. If it decides that an order is appropriate, it must consider whether to impose interim conditions on the doctor’s registration. If it considers an interim order for conditions inappropriate, it must consider whether to suspend the doctor’s registration.

30 Where the concerns raised are particularly serious and conditions are unlikely to mitigate the potential risk posed to patient safety, suspension may be the proportionate response. For example, if a doctor’s alleged lack of knowledge of English language mean they are unable to communicate safely with patients, colleagues and/or supervisors, conditions are unlikely to be workable or effective in protecting the public.

2931 In deciding the appropriate action, the Panel must very carefully consider the issue of proportionality in weighing the significance of any risk to patient safety or public confidence, for example in not suspending the doctor against the damage to him by preventing him from practising. [Sandler 2010]

3032 Under s41A(1) Medical Act 1983 the suspension of a doctor on ‘public protection’ grounds can only be done if it is necessary but there is no such qualification on suspension where it is desirable in the ‘public interest’ to maintain public confidence. [Sandler 2010].
When considering the imposition of conditions, the IOP must ensure that any conditions imposed are workable, enforceable, and will protect the public, the wider public interest, or the doctor’s own interests. Conditions should normally follow the format of conditions set out in the IOP conditions bank.

The following factors may also be relevant:

a. Whether the practitioner has complied with any undertaking given to the GMC or conditions previously imposed under GMC fitness to practise procedures.

b. The practitioner’s history with the GMC (if any).

**Workability and effectiveness of conditions**

In cases involving allegations of sexual misconduct, one or more of the following factors are a strong indicator that conditions requiring the use of a chaperone may not be workable or effective:

a. Any serious concerns that the doctor has not complied with existing chaperoning arrangements at their place of work.

b. Allegations that a doctor asked a chaperone to leave the room during an intimate examination.

c. Allegations that a doctor exhibited sexually indicated behaviour towards patients in the presence of a chaperone.

**Public confidence**

The public has a right to know about a doctor’s fitness to practise history to enable them to make an informed choice about where to seek treatment. To balance this with fairness to the doctor, allegations leading to the imposition of interim conditions are not published or disclosed to general enquirers. It is therefore the responsibility of the IOP to consider whether, if allegations are later proved, it will damage public confidence to learn the doctor continued working with patients while the matter was investigated.

With this in mind, the presence of one or more of the following factors are a strong indicator that conditions may not be adequate to maintain public confidence in the profession or the medical regulator:

a. Information that a doctor has been charged by police in connection to serious offences such as rape or attempted rape, sexual assault or attempted sexual assault or sexual abuse of children.

b. Allegations of a pattern of sexually inappropriate conduct towards patients.
In exercising their discretion in relation to the particular facts of each case the IOP should also consider any immediate risk to patient safety [Yeong 2009]. However, there are circumstances in which it is necessary to take action to protect public confidence even where there is no immediate risk to patients.

**Criminal Charges**

Where the allegations involve serious criminal charges the panel should consider recent case law in relation to the proportionality of their response. The statutory test is there, and that is the one to be applied. One would like, all the same, to think that in all these kinds of cases of potential interim suspension an interim orders panel would at least be asking itself, as part of its thought process, the following: will it be acceptable for us not to suspend in a case of this kind if at the end of the day the charges are proved and the guilt of the applicant is established? That is one aspect. Another part of the thought process should be: will it be acceptable for us to suspend an applicant in a case of this kind if, at the end of the day, the applicant may be acquitted of all charges? Those considerations should form at least part of the thinking of an interim orders panel...’ [Sosanya 2009]

It is incumbent on the panel to consider the individual features of each case and the particular facts of the criminal charges. In evaluating the acceptability of intervening or declining to do so, the IOP should have in mind the ultimate possibilities of both the practitioner's acquittal and his/her conviction of the particular charges.

**Period of order**

Where it imposes an interim order an IOP must specify the length of the order. The maximum period for which an initial order may be imposed is 18 months. It is important to bear in mind that if the IOP wishes to extend an order beyond the period initially set, the GMC will need to apply to the relevant Court to do so.

In considering the period for which an order should be imposed an IOP should bear in mind the time that is likely to be needed before the matter is resolved (for example, the time needed to complete any investigation into allegations regarding the doctor’s fitness to practise, including obtaining assessments of the doctor’s health and/or performance, and for the case to be listed for hearing by a FTP Panel). The IOP should also bear in mind that there is provision enabling it, or a FTP Panel, to revoke, vary or replace an interim order on review (see paragraphs 37 and 38 below).

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14 Section 41A(3) of the Medical Act 1983, as amended.
Review of interim orders

4143 With the exception of the circumstances mentioned in paragraph 9 above, the IOP must review an interim order within six months of the order being imposed, and thereafter, at intervals of no more than six months during the lifetime of the order. A review of an order may also be held at any time when new evidence relevant to the order becomes available. Further, following a first or subsequent review of the order, the doctor may also request an earlier review, which shall be heard as soon as practicable after three months from the date of the immediately preceding order (see also paragraph 9 above).

4244 When reviewing interim orders an IOP must fully consider all the circumstances relating to the case, including any new information. It must decide whether the order should be maintained, varied, replaced or revoked. In doing so the IOP should apply the same test and take account of the same factors as set out in paragraphs 18-23 above.

Reasons for decisions

4345 Rule 27(4)(g) of the Rules makes clear that when announcing its decision the IOP “shall give its reasons for that decision” [emphasis added]. An IOP must therefore ensure that reasons are given for any decisions taken, including decisions not to impose an order. The courts do not expect an IOP to give long detailed reasons but the reasons given must be clear and explain how the order is considered necessary.

4446 Although IOP decisions should be fairly concise, they must include the following information with specific reference to the distinct features and particular facts of each individual case.

a The risk to patients should be clearly identified to support the proportionality of any action it was necessary to take.

b The risk to public confidence in the profession if the doctor continued working without restriction on their registration and the allegations are later proved, to support the proportionality of any interim action taken.

c Where an order is made primarily because it is desirable in the public interest to uphold public confidence and there are no concerns about clinical practice specific reasons should be given for why this is appropriate.

d Reasons for the initial period of time for which an interim order is imposed.

e Where no order is imposed, clear reasons must be given.

Cases where a FTP Panel considers imposing an interim order
The imposition of interim orders will normally be considered by the IOP. A FTP Panel may also impose an interim order (section 41A of the Medical Act) but this is only likely to occur in a relatively small number of cases where, for example, a case has been referred to a FTP Panel but adjourned and the FTP Panel considers that the imposition of such an order may be necessary in the interim, pending its further consideration of the matter.

FTP Panels will need to bear in mind that the notice of hearing sent to doctors who are not already subject to an interim order, does not only notify them of the details of their hearing into allegations against them by a FTP Panel but also includes a reference to the Panel’s powers under section 41A of the Medical Act to place an interim order of conditions or suspension on their registration under the circumstances described at paragraph 30 above. It also informs them that any such order would be reviewed after six months, and at regular intervals thereafter, as set out in Section 41A(2).

If the doctor is present and/or legally represented the FTP Panel should proceed to hear submissions by both parties (the doctor and/or his representative and Counsel for the GMC) on whether an interim order should be imposed following the procedure set out in paragraph 44 below. In fairness both to the doctor and the GMC, the FTP Panel should notify them that they wish to consider whether an interim order should be imposed and allow them a short period to obtain instructions and prepare their submissions. If, however, the doctor is not present or not represented he or she will not be able to make submissions on this question. However, as outlined in paragraph 42 above, the doctor will have had notice of the Panel’s powers in this regard. Therefore the requirement that no interim order “shall be made …unless he has been afforded an opportunity of appearing before the Panel and being heard on the question of whether such an order should be made in his case;” will have been met.

When considering whether to impose an interim order, a FTP Panel should:

a consider the matter in private, unless the doctor requests that the matter be considered in public

b follow the procedure set out in Rule 27 of the General Medical Council (Fitness to Practise) Rules 2004, and

c apply the same test and follow the same advice set out above for the IOP.
Annex A

Guidance on referral to an Interim Orders Panel

The following examples are illustrative of cases which, depending on all the circumstances, may suggest that referral to an Interim Orders Panel is appropriate. The list is not exhaustive and there may be others where referral would be appropriate.

Risk to patients: clinical issues

1 This category concerns cases where, if the allegations are substantiated, there is an ongoing risk to patients from the doctor’s clinical practice. Such cases will normally involve either a series of failures to provide a proper standard of care, or one particularly serious failure. Allegations indicating a serious lack of basic medical knowledge or skills, may well require referral to an Interim Orders Panel.

2 This category also includes cases of doctors who have appeared before a Fitness to Practise panel and had their registration either suspended or erased but without immediate suspension being imposed, but where we receive new information which was not available at the time of the original determination that the doctor poses an immediate risk to patients.

Risk to patients/public confidence: non-clinical issues

3 These are cases not directly related to clinical practice but where, if the allegations are substantiated, the doctor poses a risk to patients or public confidence in the profession if allowed to continue in unrestricted practice.

4 This category includes cases where the doctor faces allegations of a nature so serious that it would not be in the public interest for the doctor to hold unrestricted registration whilst the allegations are resolved even though there may be no evidence of a direct risk to patients. The question would be whether public confidence in the profession may be seriously damaged by the doctor concerned holding unrestricted registration whilst the allegations are resolved.

5 Matters of this kind, which would normally already be under investigation by the police, would include very serious alleged offences including murder, attempted murder, human trafficking, blackmail, manslaughter, rape, attempted rape, sexual assault and sexual abuse of children. Relevant offences may include abuse of children through grooming, prostitution or pornography and any offence by an adult relating to a child under 13 or person with a mental disorder impeding choice under the Sexual Offences Act 2003, Sexual Offences Act (Scotland 2010) and Sexual Offences (Northern Ireland) Order 2008. Police investigations into other matters may also suggest that a referral to an Interim Orders Panel is appropriate, depending on the individual circumstances of the case.
6 It may also be in the interests of public safety and public confidence to refer matters to the IOP where a doctor is alleged to have breached the guidance on relationships with patients in Good Medical Practice. Where there is evidence to suggest a doctor has used their professional position to establish or pursue a sexual or improper relationship with a patient or someone close to them (paragraph 32, GMP) this is a strong indicator that a referral is appropriate.

7 There are also circumstances in which failure to comply with the GMC's Guidance for Doctors on Maintaining Boundaries (2006) may suggest that it is necessary to refer the doctor to the IOP, depending on the individual circumstances of the case. A referral is very likely to be indicated if the initial allegations feature one or more of the following factors:

a failure to obtain informed consent before undertaking an intimate examination, particularly where the examination is not clinically indicated

b failure to offer a chaperone for an intimate examination or failure to make arrangements to ensure a chaperone is present throughout, where this has been requested by the patient

c failure to maintain professional boundaries when undertaking an examination which the patient may perceive to be intimate particularly where this involves examination of breasts, genitalia and rectum but depending on the circumstances may also include any examination where it is necessary to touch or even be close to the patient

d failure to treat the patient with dignity or allow them privacy when getting dressed or undressed, including unnecessary personal comments, particularly where this has been perceived to be sexually motivated

e sexualised behaviour towards the patient including any acts, words or behaviour designed to arouse or gratify sexual impulses and desires.

f pursuing a sexual relationship with a former patient, where at the time of the professional relationship the patient was vulnerable, for example because of their mental health problems or lack of maturity.

8 The point at which doctors who are the subject of criminal investigations should be referred to an Interim Orders Panel is flexible and will depend on all the circumstances of the case.
Cases involving a breach of conditional registration or of undertakings to limit practice

9 These are cases where the doctor has breached restrictions imposed on his or her registration or has broken undertakings to the GMC to limit his or her practice. Examples would include:

   a the doctor breaches conditions imposed by the Fitness to Practise panel or the IOP

   b the doctor breaches agreed undertakings

   c the doctor refuses to co-operate with a performance or health assessment, or prevaricates or falls ill temporarily so that completion of the assessment or medical examination is delayed.

10 The Interim Orders Panel has a duty to act to protect members of the public and the wider public interest. It is therefore important that cases are referred as soon as information becomes available suggesting that the doctor's registration needs to be restricted on an interim basis. It will not always be possible to gather all the evidence that might potentially be available before referring the matter to a panel.

11 The Interim Orders Panel will make no finding of fact but the complaint must be credible and backed up where possible by corroborative evidence although the lack of corroborative evidence should not be a bar in itself to a referral to an Interim Orders Panel. The complainant may not be in a position to provide such evidence at this early stage.
How we deal with complaints about your knowledge of English: information for doctors

All doctors working in the UK must have the necessary knowledge of English to provide a good standard of practice and care in the UK, according to our guidance Good medical practice.

If we receive a complaint about your knowledge of English, we may investigate and we may need to assess your English language skills. This factsheet explains how we assess your English language skills and decide if we need to restrict your registration to work as a doctor in the UK. Doctors should also seek independent legal advice.

How we investigate complaints about a doctor’s language skills

If we are investigating concerns about your knowledge of English, we’ll ask if there is any evidence you think may help us to assess your language skills. For example, you could provide details of other examinations you have taken, such as a recent primary medical qualification that has been taught and examined in English.

We may ask you to complete a language assessment. We will decide whether to do so based on guidance for decision makers on directing doctors to undertake a language assessment [insert web address]. The language assessment we use is the academic version of the International English Language Testing System (IELTS) test.

How do I take the IELTS test?

You can take the test at test centres authorised by the British Council in the UK or overseas. Reasonable adjustments can be made for IELTS candidates with special requirements including hearing, visual or learning difficulties. You should contact the test centre in advance to discuss your specific needs. For more information about the test, please see the British Council website www.ielts.org/trf.

What is the pass mark?

There is no pass or fail mark for IELTS. The test has four parts – listening, reading, writing and speaking. You will receive individual scores of up to 9 for each of the four parts, and an overall score of up to 9 for all parts. We accept a score of at least 7.5 in each of the four parts, and an overall score of at least 7.5.
What if I have done the test before?

You may have done the test before – for example, when you applied for a place at medical school or when you joined the medical register. If so, you should let us know and give us a copy of your results. Depending on how recently you last did the test, we may still ask you to do it again. This is because your knowledge of English may have deteriorated over time. We must also take into account any concerns that have been raised.

Do I have to pay for the test?

No – we will cover the cost of a language assessment as part of a fitness to practise process. If we decide that you must do the IELTS test, we will send you a letter to let you know. To book the test free of charge please contact the British Council via email [insert email address].

How many times can I take the test?

If you do not achieve the minimum scores we require for a satisfactory language assessment, you may wish to re-sit the test. You can take the IELTS test as many times as you wish, but we will only pay the cost once if we formally direct you to complete a language assessment. You may wish to undertake additional study before taking the test again.

If you decide to take the test again, please send us a copy of the results at the earliest opportunity. We may take this information into account as evidence of improved knowledge of English.

What if I do not take the test?

Once you are asked to complete a language assessment, you have 90 days to do so and send us the results. If you have not provided the test results by this deadline, you will usually be referred to a fitness to practise panel of the Medical Practitioners Tribunal Service (MPTS).

What if I’m unwell on the day of the test?

You can book another time to complete the test free of charge. You should provide a medical certificate to the IELTS organisation within five days.

If you know or suspect that you have a health condition that may be the underlying cause of a deterioration in your communication skills or knowledge of English, please let us know. In some circumstances where there are concerns about your health, we may need to handle your case differently. For more information about support for doctors with health concerns, please visit our Your health matters webpages.

What happens at the end of our investigation?

When you have completed the IELTS test, you should send us a copy of the results. Two senior members of GMC staff called case examiners (one medical and one non-medical) will consider all the available evidence and decide how to deal with your
case. They may decide to conclude the case with no further action, agree undertakings, or refer the case to an MPTS fitness to practise panel.

What happens if a panel finds me impaired due to language concerns?

The panel may place conditions on your registration or suspend your name from the medical register for a fixed period. Your name cannot be permanently removed from the medical register where concerns relate solely to your knowledge of English and/or your health. However, if you repeatedly fail to remediate over time, the panel can indefinitely suspend your registration.

Indefinite suspension

If your registration has been suspended without break for at least two years due to concerns about your knowledge of English and/or health and the panel is satisfied you are unlikely or unwilling to remediate, they may decide to suspend your registration indefinitely. If this happens, you must wait two years before you can request a review hearing. If a review hearing takes place, you may find it helpful to provide evidence of your improved knowledge of English.