**Executive Board meeting – 1 March 2021**

**Agenda item 3 – Fitness to Practise recovery update and changes to our approach to allegations of violence and dishonesty**

<table>
<thead>
<tr>
<th>Action</th>
<th>To note (recovery update) and to approve (changes to guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>This paper has two purposes. It provides an update on recovery work in Fitness to Practise and seeks approval for changes to how we consider allegations of violence and dishonesty. These allegations carry a presumption of impaired fitness to practise and should be investigated and referred to tribunal in most circumstances. However, we have updated our guidance for decision makers to set out that action may not be needed where the doctor’s behaviour does not pose a risk to patients or to public confidence in the profession because it is at the lower end of the spectrum of seriousness.</td>
</tr>
<tr>
<td><strong>Decision trail</strong></td>
<td>Recovery recommendations were agreed by GMC SMT on 2 September 2020. Final drafts of the updated guidance were approved by FPD SMT on 2 February 2021.</td>
</tr>
</tbody>
</table>
| **Recommendations** | a To note the update on the recovery work undertaken in Fitness to Practise (paragraphs 1 to 7)  
 b To note and approve guidance for triage decision makers on considering cases involving low level violence and dishonesty and linked changes to the GMC Thresholds guidance  
 c To note and approve changes to our guidance for case examiners on making decisions at the end of the investigation stage, issuing warnings and considering cases involving health and conduct  
 d To note the proposed approach to consulting on threshold changes in Fitness to Practise. |
| **Annexes** | Annex A: Guidance for decision makers on low level allegations of violence and dishonesty  
 Annex B: GMC Thresholds guidance  
 Annex C: Extract from guidance for decision makers at the end of the investigation stage  
 Annex D: Warnings guidance  
 Annex E: Health and Conduct guidance |
| **Author contacts** | **Anna Rowland**, Assistant Director Policy and Business Transformation, [anna.rowland@gmc-uk.org](mailto:anna.rowland@gmc-uk.org), 020 7189 5077  
 **Helen Hardy**, Policy Manager, [helen.hardy@gmc-uk.org](mailto:helen.hardy@gmc-uk.org), 020 7189 5026 |
| **Sponsoring director** | **Anthony Omo**, Director of Fitness to Practise, [anthony.omo@gmc-uk.org](mailto:anthony.omo@gmc-uk.org), 020 7189 5117 |
Executive Board meeting – 1 March 2021
Agenda item 3 – FTP recovery update and changes to our approach to allegations of violence and dishonesty

Part one – update on Recovery recommendations

1  On 2 September 2020, GMC SMT approved recommendations to assist in clearing backlogs in Fitness to Practise by speeding up live investigations and accelerating progress towards concerns being addressed locally in the first instance. The first part of this paper provides an update on three of these recommendations.

Unless there are exceptional circumstances, all RO referrals to come via Employer Liaison Advisers (ELAs)

2  We have amended the referral form used by Responsible Officers (ROs) to ensure that all RO referrals come via ELAs unless there are exceptional circumstances. We have also implemented a process to identify and act upon urgent enquiries and feedback to the Employer Liaison Service (ELS.) We will monitor this process moving forward.

Work with outreach to make significant efficiency improvements related to the allegations of impairment process, ensuring that all additional allegations of impairment from ROs to be considered through a routine threshold discussion with their ELA

3  After discussing this recommendation with the ELS, it was agreed that requiring the RO to discuss all allegations of impairment with their ELA would frontload the delays rather than creating a solution and run contrary to a local first approach. Instead it would be more effective to retain and reinforce local decision making, offer ELA advice when needed and back this up with discussion at networks.

4  We have therefore done the following to ensure we are providing ROs with sufficient information and tools to decide what new information to send to the GMC.

- All letter templates sent to ROs as part of our employer disclosure process have been updated to include clear reminders of the steps they should take and guidance they should review before submitting any new concerns to us.

- A decision guide has been created which again sets out the clear steps to follow and can be used as a helpful signposting document to all relevant guidance. This guide is sent out with all the letters above.

5  We will evaluate the impact of the changes over the next two months.
Agenda item 3 – FTP recovery update and changes to our approach to allegations of violence and dishonesty

Collect data to understand the number of patient complaints about clinical care that have not been investigated locally that we promote to Provisional Enquiry or full investigation

6 As the 'Local First' project is paused, it was suggested that we could send all patient complaints that might meet our thresholds to the RO for a local investigation (where this hasn’t already taken place) and then consider the matter once the local investigation has concluded. This would however carry risks including the varying quality of local investigations and not acting promptly when informed of a potentially serious concern. It was agreed therefore that data be obtained on the number of cases we currently investigate in this category to enable us to understand the potential benefits of this approach and weigh them against the risks.

7 This data is currently being gathered as part of the scoping work looking at the initial receipt and assessment stage of the fitness to practise process under legislative reform.

Part two - Approach to cases involving allegations of violence and dishonesty

Background

8 In our current guidance, all allegations of violence and dishonesty carry a presumption of impairment, which means they ought to be referred to the medical practitioners tribunal service, unless there are exceptional reasons not to do so. Given the wide range of behaviour that can be defined as violent or dishonest, this has resulted in a number of cases being concluded with no action or a warning at tribunal as the doctor’s fitness to practise was not found to be impaired.

9 We have also reflected on research into promoting and maintaining public confidence in the medical profession. Participants were asked to consider a range of scenarios including where a doctor had punched someone in a nightclub fight and one where a doctor had stolen a low value item from a shop. The detailed findings showed that the vast majority of respondents felt that the GMC should take no action or give doctors a warning for lower level violence and dishonesty issues that occurred outside the workplace.

10 In September, SMT agreed the following recommendations.

---

1 Between September 2018 and June 2020, 33 tribunal hearings involving allegations of violence/dishonesty concluded with a finding of no impairment and either no action or a warning.

2 This was commissioned as part of the gross negligence manslaughter review.
Executive Board meeting – 1 March 2021
Agenda item 3 – FTP recovery update and changes to our approach to allegations of violence and dishonesty

- Enable low level allegations of dishonesty or violence, that are unrelated to the doctor’s practice and have been considered by the Police or other relevant body where no action has been taken, to be closed at triage or following a provisional enquiry.

- In promoted cases where there is an allegation of violence or dishonesty, remove the need for there to be exceptional circumstances for the case not to be referred to tribunal.

Changes to decision making guidance to implement recommendations

Initial investigation stage

11 We are introducing revised guidance for decision makers at triage (including provisional enquiries) to support them in considering the risk posed by doctors in cases involving low level violence and dishonesty outside the doctor’s professional practice. Please see annex A.

12 The guidance sets out that allegations of violence and dishonesty outside a doctor’s professional practice are unlikely to raise a question of impaired fitness to practise, and therefore require a full investigation, where the conduct that gives rise to such allegations:

- is minor in nature; and

- occurred outside the doctor’s professional practice; and

- was investigated by the police or another relevant body, such as the doctor’s employer.

13 Cases that meet the above criteria will be closed with no further action. We will however continue to investigate where the doctor’s behaviour poses a risk to patient safety or to wider public confidence in the medical profession.

Thresholds guidance (annex B)

14 This guidance for responsible officers, medical directors and other employers clarifies the matters where we can, and cannot, take action. To ensure consistency, a sub-section on low level allegations of violence and dishonesty has been introduced which mirrors the changes in the triage guidance.
Executive Board meeting – 1 March 2021
Agenda item 3 – FTP recovery update and changes to our approach to allegations of violence and dishonesty

Case examiner guidance (annex C)

15 We have updated Making decisions at the end of the investigation stage to provide case examiners with discretion to conclude some allegations of violence and dishonesty with a warning or, more rarely, advice or no action.

16 Although violence and dishonesty will continue to carry a presumption of impaired fitness to practise, this presumption will be rebutted where the nature of the conduct is such that the doctor would not pose a risk to public protection, ie it is at the lower end of the spectrum of seriousness. Where this does not apply, allegations of violence and dishonesty will continue to be referred to tribunal unless there are exceptional reasons not to do so.

Warnings guidance (annex D)

17 Limited changes have also been made to our guidance for case examiners, the Investigation Committee and medical practitioners tribunals on warnings. These reflect that some allegations of violence and dishonesty may be suitable for a warning with police cautions for assault and theft given as examples.

Health and conduct (annex E)

18 Changes have also been made to the health and conduct guidance to enable case examiners to conclude more cases with undertakings where there is a clear link between the doctor’s health and the misconduct. For example, a doctor with a dependence on opiates steals drugs from work. Where there is no conviction, we will likely conclude the case with undertakings. However, we consider the presence of a conviction to significantly increase the risk the doctor’s behaviour poses to public confidence and the guidance leads case examiners to refer to tribunal in these circumstances.

Assessing risk in cases involving violence and dishonesty

19 The updated guidance sets out factors which would lower or increase the risk posed by a doctor following an allegation of violence or dishonesty. In assessing risk, decision makers should consider the individual circumstances of the case and carefully consider whether the doctor poses a risk to patients, to public confidence in the profession or to proper professional standards and conduct.

Factors increasing risk

20 In cases involving violence, factors which may increase the risk include the violence being sustained or repeated, directed towards a vulnerable person, or being motivated by hostility on the basis of the doctor’s assumptions about the victim’s protected characteristics eg their race or sexual orientation.
21 In dishonesty cases, factors which may increase the risk include the dishonesty being persistent, involving an attempt to conceal professional misconduct, clinical errors or deficiencies and/or to blame others, or undermining the integrity of a system designed to protect the public.

22 The guidance sets out the risk will be higher in both types of case where:

a the doctor has a history of violent or dishonest behaviour and there is a likelihood of repetition

b the doctor has demonstrated a lack of insight or reflection in relation to their violent or dishonest conduct

c the violence or dishonesty occurred within the context of the doctor’s professional role.

**Key risks and how the changes will support effective regulation**

23 The key risk is a perception we do not take allegations of violence and dishonesty sufficiently seriously which may undermine public confidence in the profession. However this is mitigated by the changes focusing on the actual risk posed by the doctor and applying primarily to behaviour outside professional practice.

24 The changes will support a proportionate approach to regulation and enable us to focus our resources on cases where there is a genuine risk to public protection.

**Stakeholder feedback**

25 We engaged with key stakeholders, including patient organisations, to advise them of the changes and provide them with copies of the draft guidance. The PSA provided detailed feedback expressing serious concerns, particularly in relation to closing violence and dishonesty allegations at triage. The BMA and medical defence organisations were supportive of the new approach, with the latter only raising minor points for consideration.

26 The PSA’s chief concerns arise from their view that allegations of violence and dishonesty should not be closed without a full investigation being carried out, arguing this will lead to a gap in public protection. They consider that “allowing cases to be shut down on the basis of an absence of evidence, before the investigation has been carried out, to be extremely inadvisable, and we question how triage officers could make these types of decisions safely.” They also flag the findings in the public confidence research that “the GMC should take all circumstances into account and investigate thoroughly before deciding
Executive Board meeting – 1 March 2021
Agenda item 3 – FTP recovery update and changes to our approach to allegations of violence and dishonesty

how to act” and respondents’ views that a particular incident might be symptomatic of underlying attitudinal issues that would warrant further investigation.

27 We have considered the PSA’s concerns carefully and, where practicable, made changes to the guidance to address them. For example, we have expanded the definition of vulnerability so it is consistent with our other guidance and referenced that violence can also result in emotional and psychological harm. Where changes have not been taken forward, we have provided a clear explanation and reassurance if appropriate. For example, we have explained that we conduct provisional enquiries at triage to obtain information to support triage decisions. We also monitor the quality of all decision making through regular audits and will, in future, audit decisions on low level violence/dishonesty to ensure they are appropriate and in line with the guidance. We are currently arranging to meet the PSA to discuss our response to their concerns.

Consultation
28 We reflected on the PSA’s feedback that a public consultation should have been held as the proposals would have benefited from more open debate. We have reassured the PSA that we did consult patient organisations and explained our rationale for undertaking a targeted form of consultation, given the changes affect small numbers of cases and are not anticipated to have an adverse impact on any groups, including patients and the wider public. This targeted approach also reflected that the changes were part of COVID recovery work and intended to be implemented swiftly.

29 However, in the light of the PSA’s concerns, there may be scope to set out a consistent approach to how we consult on future changes to our thresholds. This would also reflect our commitment in the new Business plan to “work with diverse groups of patients and the public to embed their experiences into our policy development, as well as into improving our interactions and our work with the profession.\(^3\)”

Approach in Fitness to Practise
30 Our policy guidance is for decision makers to support fair, transparent and consistent decision making across the fitness to practise process.

\(^3\)page 6 of the 2021-23 Business plan which details work to implement the “making every interaction matter” theme of the Corporate Strategy
31 Where we are updating guidance but the amendments are only technical or intended to provide clarification, we engage with the medical defence organisations, BMA and other interested external stakeholders.

32 If we are making changes to our thresholds, we follow the principle that broader consultation is required compared to technical changes and clarifications. However, the extent of this consultation will vary depending on how significant the threshold change is and whether its impact goes beyond specific cohorts of cases. A full public consultation is generally only carried out when a new policy is introduced, a significant policy change is proposed or if there is a clear public interest in obtaining a wide range of views. For example, significant changes to the Sanctions Guidance or publication and disclosure policy changes such as on time limits for publication. However, shorter, and more targeted consultation approaches can be used for narrower changes to our thresholds.

33 While it is unlikely to be proportionate to increase the number of public consultations we undertake, we intend to develop a more consistent approach to how we engage on lower level changes such as the violence and dishonesty thresholds. This would involve more formal consultation than that used for technical changes, ensuring that patient groups and the PSA are always consulted so their perspectives are fed into the policy process. One idea would be to use a consultation template which asks structured questions of key stakeholders who would be given 4-6 weeks to respond. Any responses would be carefully considered before the change is finalised.

Consultation under legislative reform

34 Under the current legislative reform proposals we anticipate greater flexibility and associated accountability for regulators to make changes to rules and processes. This will require a different approach to consultation and engagement for significant policy and process changes. It is too soon to know what changes may need to be considered to our current consultation and engagement processes, but we expect this will be considered as part of the wider legislative reform work.

Equality and diversity

35 We know that male doctors, BME doctors and doctors over 50 are generally over-represented in the FTP process. However, our analysis of the data we hold from the last three years on doctors who are more likely to be impacted by the changes we are introducing (doctors who were investigated for allegations of violence or dishonesty and whose cases were closed by case examiners with no action, and doctors who were referred to tribunal and whose cases were closed
with no formal action or a warning) suggests that this cohort of doctors shares some different characteristics:

i Doctors in the affected cohort were three times as likely to be men;

ii 54% of the doctors in the affected cohort were under 50 years old;

iii 52% of the doctors in the affected cohort identified as BME and 35% as white.

36 As the proposed changes will reduce the number of cases promoted to an investigation or referred to a tribunal hearing and enable us to take a more proportionate approach to cases of low level violence or dishonesty, we anticipate that will have a positive impact on the affected cohort of doctors. It is however not possible for us to determine whether this impact will be evenly spread across the protected groups and we will review the impact of this change after implementation and will consider any new data collected.

Four country perspective

37 There are no specific implications to consider from a four country perspective.

Next steps and evaluation

38 If the changes to our guidance are approved, we will arrange training for operational teams ahead of publication in late March 2021. We will continue to liaise with Registration and Revalidation about any changes that are needed to their guidance on the test of fitness to practise at the point of registration.

39 An evaluation of the impact on the number of cases involving violence and dishonesty that are investigated and referred to tribunal will be carried out by the FTP assurance team in the last quarter of 2021.
Guidance for decision makers on low level allegations of violence and dishonesty

Purpose

1 The purpose of this guidance is to support Triage and Provisional Enquiries decision makers in assessing the risk to public protection posed by a doctor as a result of low level violence and dishonesty allegations.

2 Decision makers should consider this guidance alongside:

- **Triage manual**
- **GMC Thresholds Guidance**
- **Provisional enquiries manual**
- **Guidance on categorising Stream 1**
- **Allocating cases to the National Investigation Team and the Regional Investigation Teams**
- **Guidance for decision makers on when to take a doctor’s fitness to practise history into account**
- **Guidance for decision makers on Provisional enquiries**
  - **Part A – Overarching principles of Provisional Enquiries**
  - **Part B – Assessing suitability for a Provisional Enquiry**
  - **Part C – Allocation to a Provisional Enquiry stream**
Executive Board meeting – 1 March 2021

Agenda item 3, Annex A – FTP recovery update and changes to our approach to allegations of violence and dishonesty

- **Part D – Carrying out a Provisional Enquiry**
- **Part E – Deciding the outcome of a Provisional Enquiry**

**Background**

3 There are certain categories of cases 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 seven main headings:

a sexual assault or indecency

b improper sexual/emotional relationships

c violence

d dishonesty

e unlawfully discriminating in relation to characteristics protected by law

f knowingly practising without a licence

g gross negligence or recklessness about a risk of serious harm to patients.

4 Where allegations fall under one of the seven headings there is a presumption of impaired fitness to practise which means that they will generally meet our threshold for investigation. However, in the case of violence or dishonesty allegations the presumption may be rebutted if the nature of the conduct does not indicate that the doctor poses a risk to public protection.

5 Decision makers will have regard to where on the spectrum the doctor’s alleged failure to meet the standards sits when considering the risk posed by the doctor and deciding whether the violence or dishonesty allegations are likely to raise a question of impaired fitness to practise.

---

1 Rule 4(2) of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) (“the rules”)
2 Our overarching objective to protect the public includes three elements as detailed in the [Approach section](#) of the guidance
3 As set out in [Good Medical Practice](#)
Approach

Whether the doctor poses a risk to public protection and the extent of that risk will be determined on a case by case basis. Decision makers will weigh up the various factors set out in this guidance as they relate to each specific case to determine whether the doctor poses a risk, keeping in mind our overarching objective to protect the public which includes:

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

Decision makers must assess each case on its own merits, ensuring they take the minimum action necessary to protect the public.

Factors to consider

Doctors are among the most trusted professionals and trust is critical to the doctor/patient relationship. In view of this, violence and dishonesty allegations carry a presumption of impaired fitness to practise and therefore should normally be promoted for a full investigation so that the case examiners can consider whether the nature of the allegations are such that the presumption of impairment is rebutted or, if not, require referral for a hearing. However, the range of behaviours which fall into these two broad categories will vary considerably and the nature of some violence and dishonesty allegations are such that they are unlikely to raise a question of impaired fitness to practise and therefore require a full investigation. The conduct that gives rise to such allegations:

a will be minor in nature and less likely to pose a risk to patients, public confidence or proper professional standards and conduct; and

b will have occurred outside the doctor’s professional practice; and

c will have been investigated by the police or another relevant body, such as the doctor’s employer.

Supported by Promoting and maintaining public confidence in the profession, our research into public attitudes towards criminality outside a professional context.
Executive Board meeting – 1 March 2021
Agenda item 3, Annex A – FTP recovery update and changes to our approach to allegations of violence and dishonesty

9 If all these factors are met, the allegations are unlikely to raise a question of impaired fitness to practise and to meet our threshold for investigation.

Considering risk

Violence

10 Allegations of violence are less likely to pose a risk to patients, public confidence or proper professional standards and conduct where the following factors are met:

a the alleged violence was limited in nature rather than sustained or repeated; and

b no weapons were involved; and

c no physical, emotional or psychological harm was caused; and

d the alleged violence was not directed towards a vulnerable person\(^5\); and

e the doctor has no history of violent behaviour\(^6\); and

f there is no evidence on the face of it indicating that the doctor may repeat the alleged violence in the future; and

g there is no evidence on the face of it that the alleged violence was motivated by hostility towards someone’s race, sexual orientation (or perceived sexual orientation), disability, sex, gender (or presumed gender identity), religion or age; and

h the investigation conducted by the police or another relevant body, such as the doctor’s employer, resulted in no formal action or a single warning by the employer.

---

\(^5\) Vulnerability can be permanent or temporary and caused by matters such as age (children and young people younger than 18 years should be considered vulnerable), frailty, disability, illness, or current circumstances such as bereavement or redundancy

\(^6\) Please refer to our Guidance on taking a doctor’s previous history into account
Executive Board meeting – 1 March 2021
Agenda item 3, Annex A – FTP recovery update and changes to our approach to allegations of violence and dishonesty

Dishonesty

11 Allegations of dishonesty are less likely to pose a risk to patients, public confidence or proper professional standards and conduct where the following factors are met:

a the alleged dishonesty was a one off, isolated incident and not persistent or repeated over a period of time; and

b the value of the financial or other material benefit derived by the doctor from the alleged dishonesty was low; and

c the doctor has no history of dishonesty⁷; and

d there is no evidence on the face of it indicating that the doctor may repeat the alleged dishonesty in the future; and

e the alleged dishonesty was not directed towards a vulnerable person⁷; and

f the investigation conducted by the police or another relevant body, such as the doctor’s employer, resulted in no formal action or a single warning by the employer.

Allegations where further information is needed to decide if they are likely to raise a question of impaired fitness to practise

12 If upon receipt of a violence or dishonesty allegation further limited and targeted enquiries are required to help decision makers decide whether the allegation is likely to raise a question of impaired fitness to practise, these will be carried out and the information received will be considered in line with our guidance on provisional enquiries.

13 This will include if:

- on the face of it the allegation is serious enough to pose a risk to public protection but the information we hold suggests aspects may be confused, or based on a misperception, or unlikely to be supported by reliable evidence; and/or

---

⁷ Vulnerability can be permanent or temporary and caused by matters such as age (children and young people younger than 18 years should be considered vulnerable), frailty, disability, illness, or current circumstances such as bereavement or redundancy.
information is required about whether the events that gave rise to the allegation occurred within or outside a doctor's professional practice; and/or

information is required from the police or any other relevant body, such as the doctor's employer, regarding whether the matter has been investigated and/or the outcome of the investigation.
GMC thresholds

Introduction

1 This guidance is for responsible officers (RO), medical directors and other relevant staff who are involved in the employment, contracting or management of doctors. It has been designed to clarify those matters where we can, and cannot, take action. This guidance explains the thresholds for referral to the General Medical Council (GMC). Our overriding obligation is to ensure patient safety – we do not aim to resolve individual complaints or punish doctors for past mistakes, but rather to take action where we need to in order to protect patients or maintain the public’s confidence in the medical profession.

2 A detailed explanation of our fitness to practise procedures, including decision making at the end of a GMC investigation, can be found on our website, www.gmc-uk.org.

23 We can act on any information we receive from any source, which raises a question about a registered doctor’s fitness to practise. Common sources of information include patient complaints, referrals from responsible officers, employers, media reporting and notifications from the police and other bodies acting in a public capacity.

Section 35C(2) of the Medical Act 1983 as amended states that a doctor’s fitness to practise can be impaired by 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 health

e not having the necessary knowledge of English
f  a determination (decision) by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.

34 During an investigation we can consider all aspects of a doctor’s fitness to practise. In many cases we may consider not only the matters raised in the original complaint, but also any other concerns that have come to light during the investigation.

Cases closed at an early stage

Concerns that cannot raise an issue of impaired fitness to practise

45 In some cases, it is clear from the outset that there is no need for us to investigate because the complaint is about matters that cannot raise an issue of impaired fitness to practise. We will normally close these cases without taking any further action.

56 Examples of cases closed without any investigation are:

a  minor motoring offences not involving drugs or alcohol

b  a delay of less than six months in providing a medical report

c  a minor non-clinical matter

d  a complaint about the cost of private medical treatment

Concerns relating to events that took place more than five years ago

7 Where the events that gave rise to the concerns took place more than five years ago, we would only investigate if there is a public interest in progressing the matter despite the difficulties that arise as a result of the delay.

Concerns of low level violence or dishonesty outside a doctor’s professional practice

8 Doctors are among the most trusted professionals and trust is critical to the doctor/patient relationship. In view of this, concerns of violence and dishonesty carry a presumption that can be so serious that, if proven, they will lead to the doctor’s fitness to practise being impaired and therefore are likely to meet the threshold to be referred to us. However, the range of behaviours which fall into these two broad categories can vary considerably and the nature of some violence and dishonesty concerns that occurred outside a doctor’s professional practice can be such that they are unlikely to raise a
Executive Board meeting – 1 March 2021
Agenda item 3, Annex B – FTP recovery update and changes to our approach to allegations of violence and dishonesty

question of impaired fitness to practise. We are likely to close these cases without taking any further action when the concerns relate to conduct that:

a is minor in nature and less likely to pose a risk to patients, public confidence or proper professional standards and conduct; and

b has been investigated by the police or another relevant body, such as the doctor’s employer.

9 We have developed guidance to help our decision makers assess the risk posed by a doctor to public protection\(^1\) as a result of low level violence or dishonesty\(^2\). This is published on the GMC website to aid ROs and employers who are familiar with the GMC’s procedures for dealing with concerns. GMC Employer Liaison Advisers (ELA)\(^3\) can provide further advice based on this guidance to ROs and employers when low level concerns of violence or dishonesty that occurred outside the doctor’s professional practice arise locally.

Concerns that a doctor should reflect on

610 Some concerns would not on their own raise a question about the doctor’s fitness to practise unless they were to be repeated. Although these concerns do not require a GMC investigation, they are matters that a doctor should reflect on as part of their appraisal and revalidation. We usually disclose these concerns to the doctor and their responsible officer, subject to having first notified the complainant of how we use their information and considering any concerns or specific requests they share with us about that use, unless it is impracticable or undesirable to do so for public interest reasons.

711 If a doctor has no responsible officer, we disclose them to the doctor’s employers or contractors to satisfy ourselves that a complaint is not part of a wider pattern of concerns. We would only open an investigation if the information provided by the responsible officer/employer/contractor raised a question about the doctor’s fitness to practise.

\(^1\) Our overarching objective to protect the public includes: protecting and promoting the health, safety and wellbeing of the public; promoting and maintaining public confidence in the medical profession; promoting and maintaining proper professional standards and conduct for the members of the profession

\(^2\) Add a link to the guidance for triage and PE decision makers on low level allegations of violence and dishonesty
Examples of cases disclosed to the doctor and their responsible officer or shared with employers are:

a complaints about the quality of treatment received where there is no indication of any serious risk to the patient or that the doctor acted significantly below appropriate standards.

b complaints about doctors’ poor attitudes to patients, or failing to take their preferences into account.

Provisional enquiries

Some cases that appear to meet the threshold for an investigation are referred for provisional enquiries. These are cases where, although the allegation initially appears to be serious, we need more information to decide whether to investigate further. This may be because it isn’t clear whether there will be sufficient evidence to support the allegation, or because it isn’t clear if the allegation is serious enough to raise a question about the doctor’s fitness to practise and obtaining further information such as expert medical advice might clarify that the allegation is not as serious as it first appeared.

If clarification is likely to be achieved by obtaining one or two pieces of discrete information that can be accessed relatively quickly then that information will be requested. This will help us make a decision about whether an investigation is needed or whether we close the case.

Types of cases that typically lead to provisional enquiries are those where:

a an allegation appears serious but the information we hold suggests aspects may be confused or based on a misperception or there may not be reliable evidence available to support it.

b an allegation relates to a single clinical incident or a single clinical concern and we need information about the seriousness of the allegation and, where there is information to support the allegation, the doctor’s remediation in order to assess the likelihood of repetition.

3 The concerns relate to the care of a single patient and involve one consultation or clinical procedure

4 The concerns relate to the care of a single patient but there was more than one contact between the patient and doctor
Executive Board meeting – 1 March 2021
Agenda item 3, Annex B – FTP recovery update and changes to our approach to allegations of violence and dishonesty

**c** an allegation relates solely to a doctor’s health and we need more information about their condition to assess if there is any risk to patients.

**d** an allegation relates to the doctor’s practice and/or conduct in a clinical setting during the Covid-19 pandemic and the circumstances of the pandemic are likely to be a key factor in explaining the doctor’s actions.

**a** where expert input is needed to confirm the seriousness of the concerns

**b** where an allegation may be based on a misperception or it contains information that suggests it may not raise a question about a doctor’s fitness to practise and this can be checked by swiftly obtaining more information which is readily available.

**Full investigation**

1216 For the remainder of cases, we carry out a full investigation into the doctor’s fitness to practise before we decide what action to take. This may include taking witness statements, obtaining expert reports, or undertaking an assessment of the doctor’s health and/or performance. We must then decide whether we should conclude the case with no further action (with or without advice to the doctor), issue a warning, offer the doctor undertakings or refer the doctor for a hearing by a Medical Practitioners Tribunal.

**Cases where we are likely to take action**

1317 In some cases, the allegations about a doctor are so serious that, if proven, they are likely to result in us taking action on the doctor’s registration. These types of case tend to fall within five-seven main headings:

**a** sexual assault or indecency

**ab** an improper sexual or emotional relationship with a patient or someone close to them

**b** violence

**d** improper sexual or emotional relationship with a patient or someone close to them

**e** dishonesty

**f** unlawfully discriminating in relation to characteristics protected by law
e—

**g.** knowingly practising without a licence

**fh.** gross negligence or recklessness about a risk of serious harm to patients.

1418 Although the majority of concerns can be safely managed at a local level, allegations that fall within any of these five categories are likely to meet the threshold to be referred to us unless they relate to low level allegations of violence or dishonesty outside a doctor’s professional practice which are unlikely to raise a question of impaired fitness to practise as detailed above in the guidance.

1519 Many of the cases we investigate concern the standard of the doctor’s medical practice, including the quality of the care and treatment provided by the doctor. Not all breaches of **Good Medical Practice** will require us to take formal action because many issues can be dealt with adequately by the responsible officer, employer or contractor. GMC action is more likely to be required where the allegations are of serious or persistent failures to meet the standards set out in **Good Medical Practice**.

1620 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 domains:

a. knowledge, skills and performance

b. safety and quality

c. communication, partnership and teamwork

d. maintaining trust.

1721 Our **Employer Liaison Advisers (ELAs)** provide advice to responsible officers on how to handle concerns about doctors and whether the threshold for referral is met on individual cases. They will also advise on the appropriate point at which a referral should be made depending on the seriousness of the concerns and the doctor’s willingness to engage in local remediation. The GMC threshold for referral is likely to be met when any of the following features occur and it is no longer appropriate to manage the concerns locally:

a. a doctor’s conduct or performance falls below the standard set out in **Good Medical Practice** and (including where attempts to improve the doctor’s performance locally have failed) there remains an unacceptable risk to patient safety.
b a doctor about whom the responsible officer, employer or contractor has developed significant concerns disconnects from the responsible officer or leaves the employer or contractor’s employment and the responsible officer, employer or contractor is not confident that alternative safeguards are in place.

c local measures to address the concerns have failed either because the doctor is not complying with them or the concerns are too significant to be remediated at a local level.

d a doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients that is too serious to be dealt with at a local level.

e a doctor has abused a patient’s trust or violated a patient’s fundamental rights for example by performing a procedure or examination without consent or breaching their confidentiality.

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

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

h a doctor’s health condition is compromising patient safety and the risk cannot be safely managed at a local level – see below.

i a doctor’s lack of knowledge of the English language is compromising patient safety and the risk to patients cannot be addressed locally.

Health

1822 A GMC investigation may have a significant impact on the welfare of a doctor and it should be possible, where the doctor is willing to discuss their health with their responsible officer, for the majority of health conditions to be managed at local level without the need for a GMC investigation.

1923 There is no need for our intervention if:

- there are no concerns about the doctor’s conduct, and

- there is no risk relating to the clinical care they provide and the doctor is not working or likely to work or, if working, they are seeking and following treatment
and advice, and taking steps locally to manage any potential risk to patients.

2024 There will however be circumstances in which a doctor’s health poses a clear risk to public protection and we will need to consider the impact of the health condition. This includes where:

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

2125 We have developed Guidance for decision makers on assessing risk in cases involving health concerns to assist GMC decision makers when considering whether we should undertake an investigation into a doctor whose fitness to practise may be impacted by a health problem. This is published on the GMC website to aid ROs and employers who are familiar with the GMC’s procedures for dealing with concerns. ELAs can provide further advice based on this guidance to ROs and employers when concerns about a doctor’s health arise locally.

Convictions, cautions and other methods of police disposal

We investigate all convictions and police cautions received by doctors and our rules contain specific provisions for the management of these cases. If a doctor receives a custodial prison sentence (whether immediate or suspended), their conviction is referred directly for a hearing by a Medical Practitioners Tribunal.

A certificate of conviction is conclusive evidence that the doctor committed the offence and we do not need to re-prove the underlying events.

Under paragraph 75 of Good Medical Practice, doctors are required to notify us if they have accepted a caution or been charged with or found guilty of a criminal offence. Doctors are also required to tell us about the following:

- penalty notices for disorder at the upper tier (England and Wales)
- penalty notices under the Justice Act (Northern Ireland) 2011
- bind overs
- community resolution orders
- discretionary disposals (Northern Ireland)
- fiscal fines (Scotland)
- cannabis warnings (England and Wales)
- anti-social behaviour orders.

These are alternative methods of disposal by the police for low level offences and do not result in a criminal conviction. We currently investigate the above as allegations of misconduct to see whether they raise any issues about the doctor’s fitness to practise which may require action.

We do not currently investigate the following:

- speeding offences unless there are aggravating features

As outlined in our supplementary guidance Reporting criminal and regulatory proceedings within and outside the UK
Executive Board meeting – 1 March 2021
Agenda item 3, Annex B – FTP recovery update and changes to our approach to allegations of violence and dishonesty

- the offence of urinating in public unless there are aggravating features
- minor motoring offences including traffic light offences, talking on a mobile phone while driving, not wearing a seatbelt and careless driving (which is distinct from dangerous driving) unless there are aggravating features.
- penalty notices for disorder at the lower tier penalty level
- fixed penalty notices for road traffic offences
- fixed penalty notices issued by local authorities (for example, for offences such as dog fouling or noise.)

2529 If a doctor has been acquitted of a serious charge such as sexual assault or gross negligence manslaughter, we still investigate to establish if there are any fitness to practise issues arising from the offence that may require action on their registration.

Criticisms by official inquiries

2630 Paragraph 75 of Good Medical Practice also requires doctors to inform us without delay if they have been criticised by an official inquiry.

Doctors may seek advice from you about what we mean by an official inquiry and what we would consider to be criticism possibly requiring investigation by us. This is set out in our guidance Reporting criminal and regulatory proceedings within and outside the UK. Generally speaking, the criticism would have been made by the person leading either a public/formal inquiry or a tribunal in the public domain. Examples include an inquiry conducted under the Inquiries Act 2005, a Coroner’s inquest, a Parliamentary Select Committee or a non-statutory inquiry in the public interest such as the Bichard inquiry (issues arising from the Soham murders). The criticism would relate to serious matters which may call a doctor’s fitness to practise into question.

Determinations by other regulators/professional bodies

2731 We will also investigate if another regulator or professional body has made a finding (determination) against a doctor’s registration as a result of fitness to practise procedures. This could be in the United Kingdom or overseas.

Summary

2832 If a doctor connected to your designated body or working for or contracted by your organisation appears to have reached, or be close to, any of the thresholds (see
paragraphs 1517–2931), you should contact us for advice on how to proceed. You can contact your employer liaison adviser (ELA) on 0845 375 0022 or by email at outreach@gmc-uk.orgliaison@gmc-uk.org.

2933 If you decide to make a referral, you should read the guidance on our website for responsible officers and others making referrals on behalf of an organisation. This can be found at www.gmc-uk.org under the section entitled Concerns about doctors. Referrals should be made by completing the referral form in GMC Connect. If a referral is urgent and GMC Connect cannot be accessed, the referral information should be sent by e-mail to practise@gmc-uk.org in the first instance. Our Fitness to Practise directorate can also be contacted by telephone on 0845 357 0022.

3034 Any employer who is not the doctor’s designated body should consider speaking to the doctor’s responsible officer in the first instance unless the concerns are very serious or urgent. Many concerns can be appropriately dealt with by the responsible officer without the need for referral to the GMC. Where appropriate, the responsible officer will discuss whether the threshold for referral is met with their ELA and provide feedback to the non designated body.

Further information

3135 This guidance summarises other guidance we have produced for our decision makers.

3236 More detailed guidance for Case Examiners, the Investigation Committee and Medical Practitioners Tribunals is available on our website, as is all our other guidance on the standards expected of doctors including Good Medical Practice.
Annex - Case studies to support Thresholds guidance

The purpose of these case studies is to illustrate the principles in the guidance and help responsible officers, medical directors and others involved in the employment, contracting or management of doctors to apply them in practice.

Case study one – Relationship with patient

Dr Nottingham is a consultant in Rheumatology who has provided medical care to Ms R for several years. He is aware that Ms R has been treated for depression by her general practitioner which was linked to severe pain caused by her condition. In recent months, Dr Nottingham has prescribed increasing amounts of Co-codamol to Ms R to address her pain. Her GP has written to Dr Nottingham to express concern that Ms R has become dependent on Co-codamol which has the potential for addiction. Dr Nottingham discussed the GP’s concerns with Ms R but decided to continue prescribing Co-codamol as she became very distressed saying she simply could not manage without it.

Dr Nottingham has developed feelings for Ms R and broached the subject with her at a recent consultation. Ms R indicated that she feels the same way and, as a result, Dr Nottingham decided to end their long standing doctor-patient relationship. He subsequently entered into a full sexual and emotional relationship with Ms R.

However, Dr Nottingham’s secretary is concerned about the probity of his actions and the appropriateness of his decision to no longer provide medical care to Ms R. The secretary escalates her concerns to the Trust’s Medical Director and Responsible Officer (RO). The RO is unsure whether the threshold for referral to the GMC is met as Dr Nottingham appears to have acted responsibly by ending the doctor-patient relationship to pursue a personal one with Ms R.

GMC guidance

Although most concerns about doctors can be adequately dealt with at a local level, paragraph 15-17 of the Thresholds guidance identifies five-seven categories of case which are likely to meet the threshold for referral. These include an allegation that a doctor had an improper sexual or emotional relationship with a patient or someone close to them.

In Good medical practice we say:

53. You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.
More detailed guidance is provided in our 2013 publication, Maintaining a professional boundary between you and your patient. This contains the following advice to doctors:

You must not pursue a sexual or improper emotional relationship with a current patient [paragraph 4]

You must not end a professional relationship with a patient solely to pursue a personal relationship with them [paragraph 7]

The guidance further states that personal relationships with former patients may also be inappropriate depending on factors such as:

a  the length of time since the professional relationship ended (see paragraphs 9–10)

b  the nature of the previous professional relationship

c  whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable (see paragraphs 11–13)

d  whether you will be caring for other members of the patient’s family

Is the threshold met?

This case is perceived by the RO as a difficult decision on whether referral is merited as Dr Nottingham ended his doctor-patient relationship with Ms R when he developed personal feelings for her. There is no evidence to suggest that an inappropriate relationship was occurring while Dr Nottingham was providing medical care to Ms R.

On balance, our advice would be that this case should be referred to us as Dr Nottingham has breached the guidance in Maintaining a professional boundary between you and your patient. He has ended the doctor-patient relationship solely to pursue a personal relationship and the fact that Ms R was known to be vulnerable having received treatment for depression as a result of the condition for which Dr Nottingham was treating her is an aggravating factor.

However, the key factor supporting a referral is that Ms R had become dependent on increasing amounts of Co-codamol to manage the pain from her arthritis and was increasingly reliant on Dr Nottingham continuing to issue prescriptions for the drug. This illustrates the unequal nature of the previous professional relationship between Dr Nottingham and Ms R. It also highlights the patient’s vulnerability and the potentially exploitative nature of Dr Nottingham’s actions in starting a personal relationship with her.
In these circumstances, the threshold for referral is met as Dr Nottingham has committed a significant breach of our guidance that cannot be adequately dealt with at a local level. The vulnerability of Ms R is an aggravating feature which means that the doctor’s actions would meet the threshold for investigation under our fitness to practise procedures.
Case study two – Bullying/harassment of colleagues to the detriment of patient care

Dr Sheffield has been the subject of allegations of bullying and harassment from three nursing staff. It is alleged that she has intimidated staff by shouting at them in front of patients and copying in the whole department to e-mails complaining about the standard of their work. There have been four reported incidents of Dr Sheffield confronting nursing staff in enclosed spaces about perceived errors in their work using aggressive body language such as jabbing her finger in their faces and advancing towards them. This behaviour has made them feel threatened and victimised and the nurses’ working relationship with Dr Sheffield has almost completely broken down.

Dr Sheffield’s actions have had a direct impact on patient care in the following ways:

- Patients have been present during incidents when Dr Sheffield shouted at nursing staff and questioned their competence by (incorrectly) accusing them of making basic errors e.g. drug dosage, using incorrect equipment. This increased the patients’ anxiety about their health conditions by undermining their confidence in the basic nursing care being provided.

- The dysfunctional relationship between Dr Sheffield and the three nurses means they will no longer communicate directly with her. This absence of teamwork has made patient care much less effective and has the potential for a serious clinical error to occur. There was a recent near miss when a delay was caused in the nursing staff relaying a highly abnormal blood test result to Dr Sheffield as they sent an e-mail rather than bleeping her directly.

- The Clinical Director has been working with the Hospital’s HR department to address the problem and identify a solution which will enable the nurses to work effectively with Dr Sheffield. However, Dr Sheffield refuses to accept that her behaviour has been unacceptable and maintains the nurses are incompetent and placing patients at risk and she has a duty to draw any errors to their attention. Dr Sheffield has refused to attend proposed mediation meetings and courses on interpersonal skills and effective team working.

- Dr Sheffield’s refusal to engage at a local level led the Clinical Director to seek formal advice from the NHSR Practitioner Performance Advice who recommended using their behavioural assessment tools and inviting Dr Sheffield to agree to a behaviour contract. An Occupational health assessment was also carried out which did not identify any health issue that could be affecting Dr Sheffield’s behaviour in the workplace.

- There were several attempts to implement the suggestions from the NHSR, but Dr Sheffield remained unco-operative and refused to sign a behaviour contract. No improvement in her behaviour was observed and the Trust has started formal disciplinary proceedings which have
been significantly delayed by Dr Sheffield’s solicitors raising numerous queries about their fairness and collusion between the three nurses. In the light of the delay and the potential risk to patient care from Dr Sheffield’s behaviour, the Responsible Officer is considering whether to refer her to the GMC.

Is the threshold for GMC referral met?

Paragraph 19-21 of the Thresholds guidance highlights that ELAs can provide advice to responsible officers on whether the threshold for referral is met on individual cases and the appropriate point to refer a case depending on the seriousness of the concerns and the doctor’s willingness to engage in local remediation.

In the first instance, it was appropriate for the concerns about Dr Sheffield’s bullying and harassment of colleagues to be managed locally with input from NCASNHSR. However, given Dr Sheffield’s refusal to admit her behaviour has been inappropriate or engage in any remediation, it is now appropriate to refer the case to the GMC. This is because Dr Sheffield is not complying with local measures and the risk to patient safety has become unacceptable as the nursing staff will no longer communicate directly with her leading to delays in treatment.
Case study three – Doctor with a health condition

Dr Edinburgh (a Specialist Registrar in General Medicine) has requested a meeting with his Responsible Officer to disclose that he was diagnosed with bi-polar disorder two years ago and sectioned under the Mental Health Act. Dr Edinburgh advised that he is seeking advice after a recent crisis when he climbed on to the ledge of a multi-storey car park (believing he could fly) and the Police were called.

Following further discussion, Dr Edinburgh confirmed that his medication has been reviewed and he is compliant with treatment. He is under the care of a consultant psychiatrist attending monthly appointments.

The RO advises Dr Edinburgh to contact the Trust’s Occupational Health department which he does the next day and gives his consent for them to request reports from his GP and treating psychiatrist. The reports confirm that Dr Edinburgh’s condition is now being adequately managed with medication and he is being closely monitored for potential signs of a relapse or non-compliance with his treatment.

Dr Edinburgh agrees to attend monthly meetings with the Occupational Health department and notifies his supervising consultant of his condition. Together, they agree some measures to modify his clinical responsibilities and working practices to minimise the possibility of a relapse occurring in his health condition.

Is the threshold for GMC referral met?

Paragraph 24 of the Thresholds guidance provides advice on the circumstances in which a doctor with a health concern may need to be referred to us. This is only necessary in a small number of cases where:

- there are also concerns about the doctor’s conduct that puts patients or public confidence in the profession at risk and the doctor’s health condition may be a contributory factor – this includes where there are concerns amounting to serious misconduct and criminal offences involving drugs.

- the doctor is working or likely to work and:
  
  - there are, or have been, serious concerns about the clinical care the doctor has provided and the health condition may have been a contributory factor.

  - the nature of the condition may affect the doctor’s conduct or the clinical care they provide and they are not seeking and/or following treatment and advice, and/or are not engaging with local support and steps put in place to manage
any risks to patients. This suggests the doctor may lack insight into any risk, or potential risks, their health condition poses.

- the health condition has only recently been diagnosed, is not well controlled and it is too soon to know if risks to patients can be appropriately managed by the doctor seeking and following treatment and advice and/or engaging with local support and steps to manage risk.

In Dr Edinburgh’s case, the threshold for referral is not met. At present, there is no risk to patients or to public confidence as there are no concerns about Dr Edinburgh’s conduct and he has insight into the extent of his condition. This is evidenced by the fact he is receiving and is compliant with treatment and has sought the advice of the Trust’s Occupational Health department who are monitoring him on a monthly basis.

The situation should be kept under review, however, as the threshold may be met should Dr Edinburgh stop following treatment and advice and/or stop engaging with the Occupational Health department.
Case study four – Criticism by an official inquiry

Dr Exeter, a GP in Devon, has recently been the subject of criticism by the Coroner in their summing up at the inquest into the death of a 28 year old patient. Ms M, a known intravenous drug user, had a telephone consultation with Dr Exeter at which she complained of severe pain, fever and discomfort from an abscess in her groin area. Dr Exeter prescribed Flucloxacillin over the telephone but did not ask Ms M to attend the surgery for a physical examination or refer her to hospital for assessment. The abscess burst two days later, and Ms M suffered severe blood loss which led to a fatal cardiac arrest.

The Coroner was critical of the standard of care provided by Dr Exeter and found that Ms M would have survived if Dr Exeter had examined her in person or asked her to attend Accident and Emergency so that her abscess could be assessed and appropriate treatment instigated.

Dr Exeter has sought her Responsible Officer’s advice on whether she should make a self-referral to the GMC.

Is the threshold for GMC referral met?

Paragraph 28-30 of the Thresholds guidance states that doctors should inform us without delay if they have been criticised by an official inquiry as this is a requirement of Good Medical Practice.

Dr Exeter should be advised by her Responsible Officer to seek advice from her Medical defence organisation about making a self-referral as the following criteria are met:

- a Coroner’s inquest is considered an official inquiry for the purpose of paragraph 75 of Good Medical Practice

- the criticism by the Coroner relates to serious matters with the potential to call Dr Exeter’s fitness to practise into question. In this case, the Coroner found that Ms M would have survived if Dr Exeter had arranged for a physical examination of her abscess to take place.
Case study five – Performance concerns

Dr Bristol was working as a single handed General Practitioner in a busy practice with over 2,800 patients and a large proportion of elderly patients. For several months, Dr Bristol had struggled to keep on top of the general practice administration and paperwork including repeat prescriptions and reviewing the results of his patients’ blood tests and other investigations. He also found it difficult to get to grips with recent changes to the electronic systems for recording test results and other important patient information. Dr Bristol was initially reluctant to ask for help and felt isolated and overwhelmed.

Matters came to a head when Dr Bristol took time off for a minor operation. Upon his return, Dr Bristol belatedly acknowledged the situation had become unacceptable as the locum who covered his absence drew his attention to a significant backlog of pathology results and hospital letters which had not been actioned including changes to medication advised by patients' consultants. As a result, three incidences of potential harm to patients were identified by Dr Bristol.

Dr Bristol arranged a meeting with his Responsible Officer to advise him of the ongoing problems his Practice was experiencing which were now placing patients at risk of serious harm. The Responsible Officer referred the matter to an NHS England Performance Advisory Group where a local investigation was initiated.

Dr Bristol has fully engaged with the NHS England investigation and agreed to local Performers List undertakings and an action plan to address the failings at his practice. This includes a four week timetable to clear all the outstanding test results and hospital letters. Dr Bristol has also arranged for himself and his practice staff to attend training sessions on the new software and has recruited an additional member of staff to input data and organise the practice’s administrative systems.

Is the threshold for GMC referral met?

Although the concerns about Dr Bristol are serious, they relate primarily to inadequate administrative systems at his practice which have led to a deteriorating situation where patients were put at risk due to an increasing amount of unactioned test results and hospital letters. There are no specific concerns about Dr Bristol’s professional knowledge and skills.

The Thresholds guidance advises that the majority of concerns can be safely managed at a local level and it is usually only necessary to refer concerns to us where attempts to improve the doctor’s performance locally have failed. Paragraph 19-21 provides examples of scenarios where local management may not be appropriate.
However, in Dr Bristol’s case, immediate referral to the GMC is not indicated as he is engaging with the local investigation and has put in place an effective action plan to address the concerns about his practice.

The case should be kept under discussion with the ELA as referral may become appropriate if Dr Bristol stops co-operating with local measures to improve his Practice’s performance or if it becomes apparent that the concerns are more deep rooted than a failure to maintain adequate administrative systems and procedures which is remediable.
Updates to the case examiner guidance, Making decisions at the end of the investigation stage, in relation to cases involving violence and dishonesty

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 seven main headings:

a sexual assault or indecency

b improper sexual/emotional relationships

c violence

d dishonesty

e unlawful discrimination in relation to characteristics protected by law

f knowingly practising without a licence

g gross negligence or recklessness about a risk of serious harm to patients.

25 violence

26 improper sexual/emotional relationships

27 knowingly practising without a licence

28 unlawfully discriminating in relation to characteristics protected by law

29 dishonesty

30 gross negligence or recklessness about a risk of serious harm to patients.
In many cases, where the alleged conduct falls within one of these categories, it will also 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, as subsequently applied and clarified in cases such as Bhatt v General Medical Council [2011] EWHC 783 (Admin) and Ashraf v General Dental Council [2014] EWHC 2618 (Admin), indicates that the GMC may take action on a case against a doctor on the same issues as a previous criminal prosecution, notwithstanding that the doctor was acquitted by the criminal process.) [note: the above section moved to new paragraph 34]

Where allegations fall under one of the seven headings, there is a presumption of impaired fitness to practise. This means that, where there is evidence to support the allegations, in order to avoid a referral to a medical practitioners tribunal the presumption of impairment must be rebutted.

The presumption of impairment may only be rebutted where:

- in violence and dishonesty cases, the nature of the conduct is such that the doctor would not pose a risk to patients, or to public confidence, or to proper professional standards and conduct, ie it is at the lower end of the spectrum of seriousness.

- in all presumption of impairment cases will normally be referred for a hearing unless there are exceptional reasons for not doing so for concluding that a referral to tribunal is not necessary.

In light of the particular issues that arise in cases involving a doctor who is unwell, issues relating to a doctor’s health may in some circumstances amount to exceptional reasons for concluding that a referral to tribunal of an allegation that carries a presumption of impairment is not necessary but would not always do so. This means the fact an allegation has a presumption of impairment does not preclude the agreement of undertakings where there is cogent evidence the conduct is closely linked to health concerns. A close link between the doctor’s health and an allegation with a presumption of impairment, where any risk to patients and public confidence in the medical profession would be addressed by agreeing undertakings in relation to the doctor’s health, can be a proportionate
way to address a matter as long as the misconduct is at the lower end of the spectrum of seriousness (see guidance on Health and Misconduct).

Where the case examiners do not refer the case to a medical practitioners tribunal, they will need to be particularly careful to record detailed reasons for having not done so.

There may be instances where, following the investigation of the case, the case examiners decide that the case does not meet the realistic prospect test because there is no realistic prospect of establishing the case evidentially. If the case examiners decide to close a case on these grounds, detailed reasons should be provided 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.

Considering arguments in mitigation, as well as evidence of insight and remediation

Arguments in mitigation can include matters which relate to the specific events that are said to have occurred, ‘mitigating circumstances’. Mitigating circumstances may relate to the environment in which a doctor was working and may also include ‘personal factors’ which relate only to the individual doctor but may have impacted directly on the circumstances of the events giving rise to the concern. Personal factors include matters such as a personal emergency, a health condition or other personal issues capable of influencing a doctor’s behaviour and impacting the events in question. When considering whether the realistic prospect test is met, case examiners will take into account any mitigating circumstances which they consider to be relevant along with evidence relating to the doctor’s response to the concern, such as insight and remediation.

Personal factors are distinct from the doctor’s character and good standing, the impact on the doctor’s career and/or on health services. These factors will usually only be relevant when a tribunal is deciding what is a proportionate sanction to impose following a finding of impaired fitness to practise or, in the case of the doctor’s character and good standing in the community, when case
Executive Board meeting – 1 March 2021
Agenda item 3, Annex C – FTP recovery update and changes to our approach to allegations of violence and dishonesty

examiners have decided that the realistic prospect test has not been met and are considering whether a warning would be appropriate.

35. 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 where the allegations fall within one of the categories where there is a presumption of impaired fitness to practise. Personal mitigation should only be considered following a finding of fact by a medical practitioners tribunal or when case examiners are considering a warning, having decided the RPT is not met.

36. Where the allegations fall within one of the categories where there is a presumption of impaired fitness to practise, the case examiners should be mindful that mitigating circumstances will carry less weight.

37. Evidence of insight and remediation will also carry less weight in such cases. With regard to remediation, 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.

38. In some cases, where the alleged conduct falls within a presumption of impairment category, it will also result in a criminal conviction. Guidance on handling convictions is at Annex D. However, there will be cases which are not prosecuted or which do not result in a conviction, but will nevertheless warrant investigation and action by the GMC.

(The decision in R v Metropolitan Police Commissioner ex parte Redgrave (2003) 1 WLR 1136, as subsequently applied and clarified in cases such as Bhatt v General Medical Council [2011] EWHC 783 (Admin) and Ashraf v General Dental Council [2014] EWHC 2618 (Admin), indicates that the GMC may take action on a case against a doctor on the same issues as a previous criminal prosecution, notwithstanding that the doctor was acquitted by the criminal process.)

1 Separate guidance on Warnings can be found here
Executive Board meeting – 1 March 2021
Agenda item 3, Annex C – FTP recovery update and changes to our approach to allegations of violence and dishonesty

Sexual assault or indecency (para 24a)

3639 This encompasses a wide range of conduct from allegations of sexual assault and sexual abuse to allegations in relation to indecent images of children. This encompasses a wide range of behaviour including allegations of sexual assault and abuse, allegations in relation to indecent images of children and allegations of sexual harassment in the workplace. This category also includes misconduct within a clinical setting where there is an allegation the doctor’s behaviour was sexually motivated. For example, performing an intimate examination with no clinical justification or failing to maintain professional boundaries when treating a patient by making a remark of a sexual or inappropriate personal nature.

3740 While many allegations relating to sexual assault or indecency will result in a conviction referred direct by the Registrar to a medical practitioner tribunal, there will be cases where the conviction is referred to the case examiners or which are not prosecuted or which do not result in a conviction and which the case examiners will need to consider.

Improper sexual/emotional relationships (para 24c)

41 A finding of an improper sexual/emotional relationship is a very serious breach of our professional standards. 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)

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

Violence (para 24b)

38 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 which will need to be considered. These may include allegations of aggressive or physically threatening behaviour to colleagues or patients or more specific incidents of violence outside of a doctor’s professional environment.

43 Evidence a doctor has been violent can represent a very serious breach of our professional standards and poses a risk to confidence in the medical profession. Many allegations of violence will result in a conviction. However, there may be
cases which were not prosecuted or which did not result in a conviction which will need to be considered. These may include allegations of aggressive or physically threatening behaviour to colleagues or patients, or more specific incidents of violence outside the workplace. Allegations which arose in the context of a doctor’s professional environment are likely to increase the risk the doctor poses to public protection.

Evidence a doctor has been violent, even when it relates to events in a doctor’s private life and regardless of whether it resulted in physical injury, is a very serious breach of our professional standards and poses a risk to confidence in the medical profession.

Considering risk

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

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

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

a was limited in nature rather than a sustained or repeated assault

b caused no physical injuries or they were very minor in nature. Case examiners should bear in mind that violence can also result in emotional or

---

2 The term “public protection” refers to all three limbs of the overarching objective. These are to protect, promote and maintain the health, safety and wellbeing of the public; to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct.
psychological harm. Where this harm was significant, this may increase the risk to public protection.

c occurred outside the context of the doctor’s professional role.

Case examiners should however be alert to any factors which would increase the overall risk. Although this is not an exhaustive list, the risk posed by the doctor is likely to be higher where one or more of the following factors apply.

The violence:

a was sustained or repeated

b resulted in physical injuries that were more than very minor in nature or caused significant emotional or psychological harm

c occurred in the context of the doctor’s professional role

d was directed towards a vulnerable person

e was motivated by hostility towards someone's race, sexual orientation, disability, sex, gender, religion, age or the doctor’s assumptions about the alleged victim’s protected characteristics.

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

a the doctor having a history of violent behaviour and there being a likelihood of repetition. Case examiners should refer to our guidance on taking a doctor’s previous history into account.

b a lack of insight from the doctor in relation to their violent conduct. This may increase the likelihood of future repetition and the overall risk posed by the doctor.

If, having considered all the circumstances, case examiners are satisfied the RPT is not met, they should consider whether it is appropriate to issue a

---

3 Vulnerability can be permanent or temporary and caused by matters such as age (children and young people younger than 18 years should be considered vulnerable), frailty, disability, illness, or current circumstances such as bereavement or redundancy.
Executive Board meeting – 1 March 2021
Agenda item 3, Annex C – FTP recovery update and changes to our approach to allegations of violence and dishonesty

warning. Warnings allow us to indicate to a doctor that their behaviour represents a significant departure from the standards set out in Good medical practice and should not be repeated.

In some cases, where the violence is at the lower end of the spectrum and/or there are significant mitigating factors, a warning may be disproportionate and the case can be concluded with no action or advice. Case examiners should refer to the Warnings guidance for examples of factors that are relevant to whether a warning is appropriate.

Dishonesty (para 24f)

Evidence a doctor has been dishonest can represent a very serious breach of our professional standards and pose a risk to confidence in the medical profession.

Dishonesty, if proven, will usually amount to such a serious failure to meet the standards required of doctors that there will be a presumption of impaired fitness to practise.

Good medical practice provides that doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients’ trust in them and the public’s trust in the profession.

Examples of dishonesty in professional practice can include:

• defrauding an employer

• improperly amending patient records

• submitting or providing false references and information on a CV or application form or in an exam or appraisal

• Research misconduct which incorporates a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and

Separate guidance on Warnings is here

www.gmc-uk.org
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.

Examples outside professional practice can include:

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

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)

Good Practice in Research provides more detailed guidance on the principles of good research practice which must be followed.

Considering risk

Dishonesty carries a presumption of impaired fitness to practise. However it can encompass a wide range of behaviour, some of which is at the lower end of the spectrum of seriousness and occurs outside a professional context where the link to a doctor’s fitness to practise is less clear.

Case examiners should therefore consider where on the spectrum the doctor’s alleged failure to meet our standards sits. The presumption of impairment is likely to be rebutted in cases at the lower end of the spectrum where the doctor’s behaviour does not therefore pose a risk to public protection. These

---

http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp

www.gmc-uk.org

---

5
cases will often be concluded with a warning but may also sometimes be closed with advice or no action.

58 When considering an allegation of dishonesty, case examiners should weigh all the available evidence together with the individual circumstances of the case. In doing so, they should take into account the three elements of the overarching objective and carefully consider whether the doctor poses a risk to patients, to public confidence in the profession or to proper professional standards and conduct.

59 Depending on the circumstances, the risk posed by the doctor is likely to be lower where all of the following apply:

a the dishonesty was a one off, isolated incident and not persistent or repeated over a period of time and;

b the value of the financial or other material benefit derived by the doctor from the dishonesty was not significant and;

c the dishonesty occurred outside the context of the doctor’s professional role.

60 However, even where all the above principles apply, case examiners should bear in mind that the realistic prospect test may still be met depending on the particular circumstances and seriousness of the alleged dishonesty.

61 Case examiners should be alert to factors which would increase the overall risk. These may include one or more of the following, although this is not an exhaustive list.

a The dishonesty was persistent.

b The value of the benefit was significant.

c The dishonesty occurred in the doctor’s professional role.

d The dishonesty involved an attempt to conceal professional misconduct, clinical errors or deficiencies and/or to blame others.

ea The dishonesty undermined the integrity of a system designed to protect the public.
f The dishonesty was directed towards a vulnerable person.

g The doctor has a history of dishonest behaviour and there is a likelihood of repetition. Case examiners should refer to our guidance on taking a doctor’s previous history into account.

h The doctor has demonstrated a lack of insight in relation to their dishonest behaviour. This may increase the likelihood of future repetition and the overall risk posed by the doctor.

If, having considered all the circumstances, case examiners are satisfied the RPT is not met, they should consider whether it is appropriate to issue a warning to signify to the doctor that their behaviour was unacceptable and should not be repeated.

Although the GMC takes all allegations of dishonesty seriously, there will be some cases alleging minor dishonesty which are not related to the doctor’s professional practice and which are so minor in nature where taking action on a doctor’s registration issuing a warning is unlikely to be a proportionate response. And closure with advice or no action is appropriate. Case examiners should refer to the Warnings guidance for examples of factors that are relevant to whether a warning is indicated.

Vulnerability can be permanent or temporary and caused by matters such as age (children and young people younger than 18 years should be considered vulnerable), frailty, disability, illness, or current circumstances such as bereavement or redundancy.

Separate guidance on Warnings is here.

www.gmc-uk.org
Guidance on warnings

Introduction

1 This guidance aims to help GMC case examiners, the Investigation Committee and the medical practitioners tribunal determine when it is appropriate to issue a warning. While we recognise that individual cases must be decided on their own facts, the purpose of the guidance is to encourage consistent and appropriate decision making. This guidance focuses on thresholds and criteria; for warnings at the investigation stage there is separate operational guidance covering the process for issuing a warning.

2 This document should be considered in the context of the main decision-making guidance for case examiners and the Investigation Committee and the Sanctions Guidance for medical practitioners tribunal members.

3 Warnings are available at both the investigation stage and the adjudication stage of the fitness to practise procedures.

4 At the investigation stage, the case examiners or the Investigation Committee must first apply the investigation stage test and satisfy themselves that there is no realistic prospect of establishing that the doctor’s fitness to practise is impaired to a degree requiring action on his or her registration. When a case is referred to the MPTS for a hearing, the tribunal should only consider whether a warning is appropriate, once it has found that the doctor’s fitness to practise is not impaired.

5 This guidance does not cover the factors that should be considered in determining whether a doctor’s fitness to practise is or is not impaired. Decision makers should refer to the main guidance in this respect.

6 The same thresholds apply to issuing warnings at both the investigation stage and when the case has been referred to a medical practitioners tribunal. There should be no distinction between the significance attached to warnings issued at the investigation stage and warnings issued by the tribunal.
Given their purpose, warnings are not appropriate if the allegations against a doctor relate solely to his or her health. They are, however, available in all other cases, including multifactorial cases in which health is raised as an issue.

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 medical register for a two-year period. After two years, warnings cease to be published on the medical register and are no longer disclosed to general enquirers. However they are kept on record and disclosed to employers indefinitely on request.

A warning does not prevent a doctor from holding a licence to practise and does not place any restrictions on their registration.

**The purpose of warnings**

The power to issue warnings, together with other powers available to the GMC and to MPTS tribunals, is central to their role of protecting the public which includes protecting patients, maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

Warnings allow the GMC and MPTS tribunals to indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. They are a formal response from the GMC and MPTS tribunals in the interests of maintaining good professional standards and public confidence in doctors. The recording of warnings allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a warning may be taken into account by a tribunal in relation to a future case against a doctor, or may itself comprise misconduct serious enough to lead to a finding of impaired fitness to practise.

If any individual allegation is serious enough to amount to a finding of impairment, if proved, then more serious measures are likely to be required at the outset. These more serious measures include undertakings and conditions which restrict the doctor’s practice. A warning will not be appropriate where there is a requirement to restrict the doctor’s future practice in any way, following a finding of impaired fitness to practise. Warnings are not available in cases which have resulted in, or in which there is a realistic prospect of a finding of impairment, and the GMC is not able to actively monitor how the doctor responds to a warning.
13 Although warnings do not restrict a doctor’s practice, they should nonetheless be viewed as a serious response, appropriate for those concerns that fall just below the threshold for a finding of impaired fitness to practise.

14 Warnings should be viewed as a deterrent. They are intended to remind the doctor that their conduct or behaviour fell significantly below the standard expected and that a repetition is likely to result in a finding of impaired fitness to practise. Warnings may also have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable.

15 It is also important to differentiate between warnings and letters of advice which may be given at the investigation stage. The latter is simply a mechanism to provide helpful advice to a doctor on any given issue. A warning is a formal response drawing the doctor’s attention to specific concerns and highlighting that any repetition is likely to result in a finding of impaired fitness to practise.

The test for issuing a warning

16 A warning will be appropriate if there is evidence to suggest that the practitioner’s behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the GMC or by a MPTS tribunal. A warning will therefore be appropriate in the following circumstances:

- 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.

17 There is no definition of ‘significant’ in the Medical Act or in the Fitness to Practise Rules. The paragraphs below are therefore intended to help decision makers, at both the investigation and hearing stages, consider whether a warning is appropriate.

18 The guidance has been drafted in the light of our operational experience of warnings issued since the reformed procedures were introduced in 2004. The guidance aims to identify some of the factors that decision makers will need to take into account when determining whether a warning is appropriate. Although a number of the warnings that have been given were in response to criminal offences, this guidance focuses on the overriding principles rather than specific offences. The examples quoted in this guidance are intended to assist decision makers but are not intended to serve as precedents. Each case must be considered on its own merits.
Factors to consider

19 Once the decision makers are satisfied that the doctor’s fitness to practise is not impaired, they will need to consider whether the concerns raised are sufficiently serious to require a formal response from the GMC or MPTS tribunals, by way of a warning. When doing so the decision makers must have regard to the public interest (See paragraph 10 above.)

20 The decision makers should take account of the following factors to determine whether it is appropriate to issue a warning.

a There has been a clear and specific breach of *Good medical practice* or our supplementary guidance.

b The particular conduct, behaviour or performance approaches, but falls short of, the threshold for the realistic prospect test or in a case before a tribunal, that the doctor’s fitness to practise has not been found to be impaired.

c A warning will be appropriate when the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise. Warnings may be an appropriate response to any type of allegation (subject to the comments in paragraph 7 regarding cases solely relating to a doctor’s health); the decision makers will need to consider the degree to which the conduct, behaviour or performance could affect patient care, public confidence in the profession or the reputation of the profession. If the decision makers consider that a warning is appropriate, the warning should make clear the potential impact of the conduct, behaviour or performance in question, accordingly.

d There is a need to record formally the particular concerns (because additional action may be required in the event of any repetition).

Treatment cases

21 Given the terms and function of a warning, it will normally be appropriate to issue a warning following a specific breach of *Good medical practice* or allegation of misconduct rather than more generalised concerns about the standard of a doctor’s practice.

Convictions and cautions

22 There is a presumption that cases involving a conviction or caution should proceed to a medical practitioners tribunal. There will, however, be cases involving minor...
convictions or cautions that do not require referral to a medical practitioners tribunal or that, having been referred to a tribunal, are not considered serious enough to warrant a finding of impaired fitness to practise.

23 Examples of convictions and cautions that have resulted may result in a warning include one-off drink driving offences where we are satisfied that there are no underlying health concerns, disorderly behaviour (without violence) while drunk, and minor criminal damage. As stated earlier, each case must be considered on its own merits and the response will depend on the particular circumstances of the case. The decision maker will need to consider, in addition to the illegality of the conduct, if there are any other reasons why repetition may cause concern, having in mind any issues of patient protection, the public’s confidence in the profession or the reputation of the profession. Maintenance of proper professional standards and conduct.

23 (for example, whether in relation to a conviction or caution for affray, this reveals a tendency towards violence in confrontational situations).

Cases involving dishonesty and violence

24 There is a presumption that the GMC should take some action when of impaired fitness to practise where the allegations concern dishonesty or violence. This presumption can be rebutted however where the doctor’s behaviour is not a risk to public protection which includes maintaining public confidence in the medical profession.

25 There will be some cases alleging involving dishonesty or violence that are not related to the doctor’s professional practice and/or which are sufficiently minor in nature that taking action on the doctor’s registration would be disproportionate. A warning is likely to be appropriate in these cases. Examples might include, in the absence of any other concerns, police cautions for theft or common assault.

Proportionality

2426 In deciding whether to issue a warning the decision maker should apply the principle of proportionality, weighing the interests of the public with those of the
practitioner.* It is important to bear in mind, of course, that warnings do not restrict the practitioner’s practice and should only be considered once the decision maker is satisfied that the doctor’s fitness to practise is not impaired.

**Evidence**

**Investigation stage**

**Case Examiners**

2527 Warnings are only relevant at the case examiner stage if there are no disputed facts once the doctor has made representations, and if the doctor has not exercised his or her right to a hearing before the Investigation Committee.

2628 The case examiners should not issue a warning if the allegations are so serious as to give rise to a finding of impairment, but the evidential test is not met (namely the allegations are not provable before a tribunal).

**Investigation Committee**

2729 The Investigation Committee has a role in considering afresh whether to refer the doctor to a medical practitioners tribunal hearing or whether to issue a warning or conclude the case with no action. The Investigation Committee will have sight of all the evidence available to the case examiners, any further submissions, and, if the committee considers it necessary in order to discharge its functions, any oral evidence. It will only refer a case to a tribunal where information arises during the hearing that was not available to the case examiners, and that suggests that to do so would be appropriate.

2830 The Investigation Committee, when considering a case previously considered by case examiners, is likely to have additional information available. The fact that the Investigation Committee subsequently decides not to issue a warning does not mean therefore that the Committee concluded that the case examiner’s decision was ‘wrong’.

* Further guidance on the issue of proportionality can be found in the case of Bolton v The Law Society [1994] 1 WLR 512, [1993] EWCA Civ 32.

---

www.gmc-uk.org D6
Executive Board meeting – 1 March 2021
Agenda item 3, Annex D – FTP recovery update and changes to our approach to allegations of violence and dishonesty

**Hearing stage**

2931 At the hearing stage the tribunal will only consider the question of whether a warning is appropriate once it has made findings of fact and concluded that the doctor’s fitness to practise is not impaired. The tribunal should seek representations from both parties on whether a warning is appropriate before reaching a decision.

**Factors to consider when deciding if a warning is appropriate**

Mitigation

30 A distinction can be made between circumstantial mitigation (relating to the specific events that are said to have occurred) and personal mitigation (relating to the doctor’s character, career or personal circumstances).

31 If the decision makers have concluded that the doctor’s fitness to practise is impaired or that the realistic prospect test is met, they cannot then take account of personal mitigation to decide that a warning is appropriate. As explained above, warnings may only be issued where the decision makers have concluded that the doctor’s fitness to practise is not impaired or that the realistic prospect test is not met.

32 However, if the decision makers are satisfied that the doctor’s fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:

- the level of insight into the failings.
- a genuine expression of regret/apology.
- previous good history.
- Whether the incident was isolated or whether there has been any repetition.
- Any indicators as to the likelihood of the concerns being repeated.
- Any rehabilitative/corrective steps taken.
- Relevant and appropriate references and testimonials.
Executive Board meeting – 1 March 2021
Agenda item 3, Annex D – FTP recovery update and changes to our approach to allegations of violence and dishonesty

**Reasons for decisions**

33 The decision makers should record their reasons for issuing or for not issuing a warning.

**Drafting warnings**

34 Bearing in mind their purpose, warnings must be relevant to the doctor’s practice, highlight the conduct/behaviour that led to the warning and place the doctor on notice about his or her future conduct, behaviour or performance.

35 A warning will normally need to do the following.

a Highlight the particular concerns that have led to the warning;

b Make clear why the concerns impact on patient safety and/or on public confidence in the profession and/or the reputation of the profession and/or on proper professional standards and conduct;

c Make clear what the conduct, behaviour or performance is, that it should not be repeated, and why;

d Refer to any relevant guidance in *Good medical practice* or other GMC supplementary guidance.

36 Warnings should follow the format adopted in the warnings template at Annex A. The template provides for warnings to be specific to the identified failings in conduct, performance or behaviour, relevant to the case in question.
Executive Board meeting – 1 March 2021
Agenda item 3, Annex D – FTP recovery update and changes to our approach to allegations of violence and dishonesty

Guidance on warnings – Annex A

Dr X

INSERT the facts – as agreed with the doctor or as established by the Investigation Committee. Eg: On 18 October 2007, you accepted a Police caution for....

[NOTE: This should be kept as simple as practically possible – and where there is a caution or conviction for a criminal offence, the exact offence should be stated. However, there is an opportunity to include, in exceptional circumstances and as briefly as possible, the background and context to these facts, where this is appropriate in light of the individual case. Where contextual information is included this should not under any circumstances attempt to ‘go behind’ the facts, especially where there is a conviction or caution.

NOTE: In cases primarily about treatment or clinical judgement, it is important not to name particular patients. In these cases, warnings should include a short generalised summary of the facts. Rather than list each particular incident (of which there may be many), a warning should usually describe, in general terms, the shortcomings or omissions evidenced in the case(s) in hand.]

This conduct / behaviour / performance [delete as appropriate] does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice and associated guidance. [Include, if appropriate – In this case, paragraph X of {title of guidance} is particularly relevant NB: in caution / conviction cases, paragraph 65 of Good medical practice should usually be quoted] - please also quote the relevant paragraphs of the guidance so that it is clear to those viewing the warning the precise terms of that guidance. Whilst this failing in itself is not so serious as to require any restriction on your registration, it is necessary in response to issue this formal warning.

This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.

Annex A - Last published: XXX
Guidance for decision makers on assessing the impact of health in misconduct, conviction, caution and performance cases

Cover note

In September 2015 we asked Professor Louis Appleby, a leading mental health expert, to advise us as we carried out a fundamental review of cases relating to a doctor’s health and the way we communicate with doctors who may be vulnerable. Following this review, we are exploring and putting in place measures to reduce the impact of a GMC investigation on doctors – particularly those with health concerns. A key measure relating to cases where health is a concern is a move to resolve more of these cases consensually (via undertakings), where this is appropriate.

In light of this review, we have revisited our guidance on cases where both health and misconduct or performance allegations are present. These cases present a particular challenge because, while we wish to reduce the impact of GMC investigation on unwell doctors as far as possible, we will continue to need to address allegations of misconduct or poor performance where there is a risk to patients or confidence in the medical profession.

Due to this, it is critical that our guidance on responding to cases where both health and misconduct or performance allegations are present is clear and robust, but also proportionate. How we respond will depend on the severity of the conviction or alleged misconduct and/or the nature of the risk presented by any alleged poor performance. In cases where the conviction or caution or alleged misconduct/poor performance are at the lower end of the spectrum of issues that would normally require action and there is cogent evidence that these are linked to health allegations, they may be resolved by taking action solely to address the health allegations. However, in light of our role to protect patients and uphold confidence in doctors, we must address the conviction or caution, or address the alleged misconduct or poor performance in addition to any action we take to address health allegations in cases where the alleged misconduct or poor performance:

Working with doctors Working for patients
Executive Board meeting – 1 March 2021
Agenda item 3, Annex E – FTP recovery update and changes to our approach to allegations of violence and dishonesty

a—is not linked to a doctor’s health, or

b—is linked but is a serious allegation or a serious conviction/caution/conviction or caution, including where a doctor has received a conviction or caution for misconduct.

This guidance aims to minimise the impact on unwell doctors with health concerns as far as possible while ensuring that we protect patients and public confidence in doctors. For further information, please contact: FTPPolEnq@gmc-uk.org.

The purpose of any action taken by the GMC is not to be punitive but to protect the public and the wider public interest, although it may have a punitive effect. See the judgement of Newman J in the case of the Council for the Regulation of Healthcare Professionals v General Dental Council (Fleischmann) [2005].
Introduction

1. This guidance aims to help decision makers make fair and consistent decisions in misconduct, conviction or caution, and performance cases that would otherwise meet the realistic prospect test (RPT), where a health condition is a contributory factor. It sets out the factors to consider when deciding how a misconduct, conviction, caution or performance case, which also involves a doctor’s health, should be treated.

2. A health condition problem may explain, or provide a reason for, poor performance, misconduct or behaviour leading to a conviction or caution. In some cases it may be possible to address the allegation of misconduct or poor performance that would otherwise meet the RPT by dealing solely with the health condition problem and without taking specific action in relation to the misconduct or performance issue.

3. To do so, three factors must be present:
   a. Cogent evidence that a doctor’s health condition is linked to the allegation of misconduct or poor performance and;
   b. Where the doctor has a pre-existing health condition that puts patients or public confidence in the profession at risk poses a risk to their medical practice, there must be evidence that a doctor has taken steps to minimise reoccurrence of any risks posed by their health condition, e.g. seeking and following compliance with treatment. Where the events giving rise to the conduct or performance concern incident happened at the onset of a health condition or despite the doctor seeking and following compliance with treatment, this will be regarded as a mitigating factor, and;
   c. Evidence that the allegations of misconduct or poor performance are at the lower end of the spectrum of matters that would otherwise meet the RPT and would usually require action to protect patients or public confidence in the medical profession.

4. As a result of the above there may be no realistic prospect of establishing that a doctor’s fitness to practise is impaired by reason of the alleged misconduct and/or poor performance. Where there is no realistic prospect of finding impairment by reason of misconduct and/or poor performance, this may mean that a case can be

* In this overview, we are also using the term “misconduct” to refer to cautions/convictions and determinations.
treated as a pure health case, rather than as a multifactorial case involving health and misconduct and/or poor performance.

5. In most cases where the alleged misconduct that meets the realistic prospect test (RPT) and carries a presumption of impairment and which is by its very nature more serious, the alleged misconduct will normally need to be addressed, even if it is linked to a doctor’s health condition. This is because of the public confidence issues these allegations raise. However, given the broad range of misconduct that carries a presumption of impairment, there are some circumstances (and these are discussed later in this guidance) in which an allegation of misconduct or performance carrying a presumption of impairment is linked to a health condition and it may be possible to address it by dealing solely with the health allegation problem and without taking specific action in relation to the misconduct or performance issue.

56. A criminal conviction for misconduct that would otherwise meet the realistic prospect test would usually require action to specifically to address the conviction even where the misconduct is closely linked to a doctor’s health condition. In these cases, action that solely addresses the allegation about the doctor’s health condition is unlikely to be sufficient to address the risk to public confidence issues raised by the conviction.

67. Where there is evidence to support a serious allegation of misconduct or a serious performance allegation or there is no cogent evidence of a link between a health condition and a misconduct/performance allegation, then the allegations should be treated separately.

78. If a doctor has received a conviction for a serious offence, or a conviction resulting in a custodial sentence, these cases must be referred directly to a Medical Practitioners Tribunal (MPT).

89. This document should be read in conjunction with the following pieces of guidance:
   a. Guidance for the Investigation Committee and Case Examiners on making decisions at the end of the investigation stage
   b. Guidance for decision makers on assessing risk in health cases

* Including suspended sentences
c  Guidance for decision makers on assessing insight when considering whether undertakings are appropriate

c  Guidance for decision makers on agreeing, varying and revoking undertakings

d  Sanctions guidance, for members of medical practitioners tribunals and the General Medical Council’s decision makers.

Factors to consider

910  The seriousness of the alleged misconduct/performance issue raised about a doctor, the behaviour leading to a conviction/caution, and the potential risk to future patient safety, are the primary factors that should be taken into account when considering whether an allegation of misconduct or poor performance can be managed solely by addressing the health allegation.

1011  Decision makers should also take into account other factors relating to a case, such as:

a  a doctor’s insight into the (alleged) misconduct and/or alleged poor performance;

b  a doctor’s insight into their health condition and its impact on their practice;

c  whether the doctor is seeking and following treatment;

cd whether the doctor is engaging with local support and steps put in place to manage risk;

de the likelihood that the alleged misconduct/alleged poor performance might be repeated.

1112  Further details of factors to be considered are set out in the Sanctions guidance and Guidance for the Investigation Committee and Case Examiners on making decisions at the end of the investigations stage.

Misconduct

Lower-level misconduct

13  There will be less serious allegations of misconduct that are at the lower end of the spectrum of misconduct issues that would otherwise meet our threshold, for
example, a doctor with an opiate dependence who steals drugs from work (but is not convicted of theft) or who fraudulently self prescribes. Where, where there is no patient safety risk and there is cogent evidence that the doctor’s health condition is linked to the alleged misconduct, case examiners may address the allegations solely by taking action to address the health allegation issue. This will only be appropriate where there is cogent evidence that the doctor’s health condition explains the doctor’s conduct, meaning that the allegation of misconduct will not meet the realistic prospect test. Case examiners should however balance any aggravating or mitigating factors in deciding if the RPT is met in relation to the alleged misconduct.

14 This will also apply (in limited circumstances) to cases that fall within one of the categories of presumed impairment (see paragraph referred to in paragraph 523 above), where the alleged misconduct lies at the lower end of the spectrum of allegations which carry a presumption of impairment, as follows:

a. In violence and dishonesty allegations, where exceptional circumstances are not required to rebut the presumption of impairment, as the nature of the conduct does not indicate that the doctor poses a risk to patients or to public confidence in the profession.* Where there is evidence that the allegations are linked to the doctor’s health condition, the RPT is unlikely to be met and undertakings can be agreed to address the health concern health allegations.

b. In other presumption of impairment cases, a doctor’s health condition may in some circumstances (but would not always) constitute an exceptional circumstance that could justify solely addressing the allegations about the doctor’s health. Given the seriousness of these cases, this approach can only be taken in cases where there is cogent evidence of a link to a doctor’s health condition ie, there are specific circumstances relating to the doctor’s health condition such as the sudden onset of a condition or where the doctor has sought and is following treatment that treatment fully complied with has been ineffective, and the alleged misconduct is at the lower end of the spectrum.

* Please refer to the sections on violence and dishonesty in Making decisions at the end of the investigation stage
Executive Board meeting – 1 March 2021
Agenda item 3, Annex E – FTP recovery update and changes to our approach to allegations of violence and dishonesty

1215 Where a doctor’s health condition has some connection to the misconduct allegations, but it does not explain the doctor’s behaviour, if the alleged misconduct (even where less serious) would still meet the realistic prospect test, the case should be treated as a health and misconduct case.

Deciding whether undertakings are appropriate in health and misconduct cases

1316 Health related undertakings are unlikely to be appropriate where the case examiners have determined there is a realistic prospect of an MPT finding a doctor’s fitness to practise to be impaired and where undertakings will not be sufficient to protect patients and maintain public confidence in the profession.

1417 Some cases will not be appropriate for undertakings, e.g. where evidence is disputed or a doctor does not agree to undertakings.

1518 When deciding to resolve cases involving concerns about a doctor’s health condition through undertakings, case examiners should also take into account any mitigating or aggravating factors as specified in the Sanctions guidance and refer to the Guidance for decision makers on agreeing, varying and revoking undertakings, and Guidance for decision makers on assessing insight when considering whether undertakings are appropriate.

1619 Examples of the types of cases which might be suitable for undertakings can be found in Annex A.

Serious misconduct and convictions/cautions

1720 Some health and misconduct or conviction/caution allegations will still need to be referred to a MPT. This is may be the case even where health provides an explanation for the misconduct.

1821 These types of cases fall into three categories:

a Allegations of serious misconduct that raise public confidence issues.
Executive Board meeting – 1 March 2021
Agenda item 3, Annex E – FTP recovery update and changes to our approach to allegations of violence and dishonesty

b Where a doctor has a conviction that results in a custodial sentence* (where the Registrar is required to refer directly to an MPT).

c Where a doctor has a non-custodial conviction that has been referred to the case examiners for a decision, and the conviction would, in itself, meet the RPT. A response specifically to address the conviction is usually required because of the public confidence issues raised by this type of case.

1922 Allegations of serious misconduct that pose a risk to the public’s confidence in the medical profession may relate to a doctor’s actions during their professional practice or an incident which has taken place in their personal life.

2023 Where the alleged misconduct is so serious that public confidence would only be maintained by referring the case to a MPT, the case should not be resolved through undertakings, even where a doctor’s health may explain or provide a motive for the alleged misconduct.

2124 The more serious the allegations of misconduct, the more likely there will be a public interest in the matter being referred to a hearing. The sorts of allegations that are likely to result in a referral, if they do not fall within the exceptions identified at paragraph 143, include (but are not limited to):

a Sexual assault or indecency

b Improper sexual or emotional relationship(s)

c Violence

d Dishonesty

e Unlawfully discriminating in relation to characteristics protected by law

f Violence

g Improper sexual or emotional relationship(s)

h Knowingly practising without a license

* Including suspended sentences
Executive Board meeting – 1 March 2021
Agenda item 3, Annex E – FTP recovery update and changes to our approach to allegations of violence and dishonesty

1. Unlawfully discriminating in relation to characteristics protected by law

2. Dishonesty

3. Gross negligence or recklessness about a risk of serious harm to patients.

2225. Criminal convictions also raise specific public confidence issues. Where a doctor has a conviction for misconduct that results in a custodial sentence,* the case must be referred to a MPT. A criminal conviction for misconduct that would otherwise meet the realistic prospect test would usually require action to specifically to address the conviction even where the misconduct is closely linked to a doctor’s health condition. In these cases, action that solely addresses the allegation about the doctor’s health condition is unlikely to be sufficient to address the public confidence issues raised by the conviction.

2326. The Guidance on convictions, cautions, and determinations and other methods of disposal has further information on the types of cases that should be directly referred to an MPT.

2427. See Annex B for a list of example cases.

Performance

2528. An allegation of poor performance may be the result of, or may be amplified by, a health condition, or a doctor may have unrelated health and performance allegations. Because of the risks to patients raised by poor performance, it will usually be necessary to respond to the performance allegations as well as the health allegations where both are present. There may be limited circumstances in which the performance allegations are at the lower end of the spectrum and the link with the doctor’s health condition is so clear that it may be appropriate to address the performance allegations solely by addressing the doctor’s health allegations. However, any risk to patients will need to be carefully assessed and addressed.

26. In some cases there is cogent evidence of a link between allegations about a doctor’s performance and a health condition, in other cases a link is suggested but is not clearly evidenced, or there may be no link between health and performance.

* Including suspended sentences
Health and performance allegations may be addressed by health and performance undertakings to manage any risks and can be varied as appropriate as a doctor’s health and/or performance improves.

In cases where there are misconduct allegations in addition to those about health and performance, these should also be addressed. In line with the guidance above, these may be treated as health cases addressed by taking action solely in relation to health in some circumstances.

Undertakings may be appropriate to address both health and performance allegations where case examiners have determined that there is a realistic prospect of an MPT finding the doctor’s fitness to practise to be impaired, and where undertakings will be sufficient to protect patients and maintain public confidence.

Some health and/or performance cases will not be appropriate for undertakings. This will be where evidence is disputed, a doctor does not agree to undertakings, undertakings would be insufficient to protect the public or there are additional allegations of misconduct which must be ventilated before a Medical Practitioners Tribunal.
Annex A – Examples of health and misconduct/performance cases where undertakings may be suitable

This annex outlines a number of case studies where both health and misconduct/performance allegations are present and there is no patient harm. While these case studies can be used to give an indication of the types of cases where undertakings might be considered, each case will be different and there may be other mitigating or aggravating factors present which affect the outcome.

Example 1

**Substance use disorder** Misuse of drugs and criminal caution

A doctor was arrested and given a caution for possession of a Class C drug. A health assessment finds that the doctor has self-prescribed the drug (a sedative) which they take on a regular basis to control an anxiety disorder. The health assessor recommends supervision. There is clear evidence of a cogent link between the misconduct and the doctor’s health condition and the doctor has insight into their health problems and is in appropriate treatment. A caution was given but there were no concerns about the doctor’s clinical performance or risk to patients.

Suitable for undertakings - In this case the misconduct is closely linked to the doctor’s health condition and, while serious, it is not so serious as to require us to refer it to a hearing. Undertakings would be suitable in this case if the doctor has insight and is engaged in treatment.

Example 2

**Alcohol use disorder** Misuse of alcohol

A doctor is suspended from work after drinking excessively the night before a shift and not turning up for work on two occasions. When the doctor’s employer contacted them to follow up, it became clear that the doctor was not able to work due to excessive alcohol intake. The doctor’s employer suspended the doctor and referred the doctor to the GMC. A health assessment diagnosed harmful use of alcohol and an alcohol dependency disorder.

Suitable for undertakings – While missing a shift is a serious matter, this case is likely to be suitable for undertakings because there is cogent evidence of a link between the alcohol consumption and the doctor’s health condition, and because the doctor did not exacerbate the situation by attending work while under the influence of alcohol.
Example 3

Performance

A doctor is referred for concerns that have arisen recently, including being late for clinic and arriving in a dishevelled state, and for making a series of mistakes involving correspondence and record keeping. The doctor has also shouted at a colleague on two occasions. A health assessment diagnoses a mental health condition and the health examiner’s opinion is that concerns at work relate to the doctor’s health condition. The doctor accepts the GMC’s findings and acknowledges the impact that their health has had on their work.

Suitable for undertakings – Likely to be suitable for health undertakings as the performance allegations are clearly linked to the doctor’s health, there is no patient harm, and the doctor has insight into their health condition. If there is likely to be an ongoing risk to patients that is not addressed by health supervision, performance undertakings are likely to be necessary.

Example 4

Presumption of impairment - violence

A doctor was refused access to a nightclub. As the security guard tried to remove the doctor from the area, the doctor became verbally abusive and in resisting attempts to move him from the area pushed the security guard away. The push was not forceful but nevertheless results in a caution for common assault. A health assessment diagnoses alcohol dependency, and the health examiner’s viewpoint is that the misconduct is linked to the doctor’s health condition.

Suitable for undertakings – Likely to be suitable for undertakings where there is cogent evidence that the incident is linked to the doctor’s health, it is the doctor’s first offence, the doctor has insight, and is engaged in treatment. While all violence has a presumption of impairment, this can be rebutted in some circumstances including where the incident was at the lower end of the scale of violent conduct, did not involve a patient. As there is also cogent evidence that the police caution is linked to the doctor’s health condition, the case can be concluded with undertakings.
Example 5

**Presumption of impairment - dishonesty**

A doctor receives a caution conviction for shop-lifting stealing a number of small items (laptop, charger). This is the doctor’s first offence. A health assessment diagnoses a mental health condition and discussion with the doctor reveals that they were away from home during a training placement and were isolated when they became unwell. The assessment found a clear link between the doctor’s health and the theft. The doctor has insight into their condition and is receiving treatment for it, and it is judged that the risk to patients is low.

**Suitable for undertakings** – Likely to be suitable for undertakings as there is cogent evidence that the misconduct is linked to the doctor’s health, the incident was at the lower end of the scale of conduct involving theft, there is no patient harm, and the doctor has insight and is engaged in treatment.

Example 6

**Substance use disorder, Misuse of drugs, presumption of impairment – dishonesty**

A doctor steals drugs and syringes for their personal use from work and is referred to us by their employer. A health assessment diagnoses opiate dependence syndrome. The doctor has insight into their condition and is currently complying with treatment.

**Suitable for undertakings** – The allegation of theft has a presumption of impairment (dishonesty), although this can be rebutted if the doctor’s dishonest behaviour does not pose a risk to patients or to public confidence. This case is suitable for undertakings as there is a clear link with the doctor’s health, the misconduct is not at the most serious end of the scale, and no harm was caused to patients.

Example 7

**Substance use disorder, Misuse of drugs, presumption of impairment – dishonesty**

A GP is referred to the GMC for fraudulently issuing prescriptions for their own personal use in the names of fictional patients. The prescriptions were for anti-depressants and benzodiazepines (sleeping tablets.) The doctor has undergone a health assessment which diagnosed them with a severe depressive disorder. They are now seeking treatment under their own name, have engaged with their Occupational Health department and expressed remorse for their actions.

**Suitable for undertakings** – Although the doctor’s actions were dishonest, and therefore carry a presumption of impairment, this presumption can be rebutted where the doctor’s dishonest behaviour does not pose a risk to patients or to public confidence in the
profession. This case is suitable for undertakings as there is a clear link between the misconduct and the doctor’s health, the misconduct is not at the most serious end of the spectrum, and no direct harm was caused to patients.
Annex B – Examples of health and misconduct or conviction/caution cases where undertakings are not appropriate

Example 1

Substance use disorder Misuse of drugs, presumption of impairment – dishonesty, criminal conviction

A doctor is convicted of theft after stealing controlled drugs for their own use from hospital stock over a three month period. A health assessment diagnoses opiate dependence syndrome.

Referral to a hearing – Given the criminal conviction for misconduct that requires action meets the realistic prospect test in its own right, undertakings would not be suitable. If the matter had not resulted in a criminal conviction, health undertakings may be sufficient if the doctor had not put patients at risk as a result of his their misconduct (for example by removing for their own use medication that had been prescribed to a patient to support their care), had insight and was complying with treatment. See example 6 in annex A.

Example 2

Presumption of impairment – violence and dishonesty and criminal conviction

A doctor is convicted of three counts of aggravated burglary and possession of crack cocaine. A health assessment diagnoses opiate dependence syndrome.

Referral to hearing - In this case, the misconduct is very serious, carries a presumption of impairment (which has not been rebutted) and resulted in a criminal conviction so undertakings would not be suitable. If it attracted a custodial sentence the case would have to be referred directly to a hearing under our rules.

Example 3

Presumption of impairment – sexual assault
Executive Board meeting – 1 March 2021
Agenda item 3, Annex E – FTP recovery update and changes to our approach to allegations of violence and dishonesty

A doctor is convicted of sexual assault against two junior nurses and a receptionist. The doctor was found to have kissed and touched their breasts without consent. A health assessment diagnoses a depressive disorder and harmful use of alcohol.

**Referral to hearing** - This misconduct is extremely serious, carries a presumption of impairment and would not be suitable for undertakings given the public confidence issues it raises. This includes cases where the doctor has not been convicted of the alleged actions but findings have been provided-proved in fitness to practise proceedings. If the conviction attracted a custodial sentence the case would have to be referred directly to a hearing under our rules.

**Example 34**
*Presumption of impairment – images of sexual abuse of children, criminal conviction*

A doctor is convicted of viewing 250 indecent images of children. A health assessment diagnoses a depressive disorder and harmful use of alcohol.

**Referral to hearing** - This misconduct is extremely serious and carrying a presumption of impairment and therefore health would not constitute an exceptional circumstance. It raises significant public confidence issues and would not be suitable for undertakings. This type of case is also likely to carry a custodial sentence where we are required to refer direct to a hearing under the rules.

**Example 45**
*Presumption of impairment – dishonesty, criminal conviction*

A doctor receives a conviction for forging and stealing multiple prescriptions which they presented at a number of local pharmacies over a period of 12 months. The doctor had previously received a warning from the GMC for self-prescribing. A health assessment finds that the doctor is suffering from a mental health condition which the doctor attempted to control through self-medication. The case was referred to a hearing as the doctor lacked insight, dismissed their actions as negligible, and the actions were prolonged and serious.

**Referral to a hearing** – The misconduct is serious and protracted. It carries a presumption of impairment (which has not been rebutted), resulted in a criminal conviction and the doctor lacks insight. Health would not therefore constitute an exceptional circumstance not to refer, despite cogent evidence of a link to a doctor’s health condition.
Executive Board meeting – 1 March 2021
Agenda item 3, Annex E – FTP recovery update and changes to our approach to allegations of violence and dishonesty