



General
Medical
Council

Sanctions guidance

for members of medical practitioners tribunals and
for the General Medical Council's decision makers

This guidance has been approved by the Council of the General Medical Council (GMC). The steering group that developed the amended guidance was chaired by His Honour David Pearl, Chair of the Medical Practitioners Tribunal Service (MPTS), and involved staff from the MPTS and the GMC.

It is for use by medical practitioners tribunals, in cases that have been referred to the MPTS for a hearing, when considering what sanction to impose following a finding that the doctor's fitness to practise is impaired. It also contains guidance on the issue of warnings where a tribunal has concluded that the doctor's fitness to practise is not impaired. It outlines the purpose of sanctions and the factors to be considered.

This guidance is a living document that will be updated and revised as the need arises.

This document will be used by medical practitioners tribunals from 1 March 2016.



This is an important document. Our *Sanctions guidance* is designed to help those in the GMC and MPTS who decide how to respond when a doctor has put patients at risk or undermined confidence in the profession.

This guidance is based on the values and standards contained in the GMC's core guidance *Good medical practice*. It therefore provides a crucial link between that professional guidance and the action that decision makers in our Fitness to Practise directorate and in medical practitioners tribunals take, as well as promoting consistency of decision making.

The development of this new guidance is a testament to the commitment of the Chair of the MPTS, David Pearl, and his staff and the Director of Fitness to Practise, Anthony Omo, and the staff who investigate and present cases. Together, and following an extensive consultation with more than 2,000 responses, they have produced this new guidance, which will help to make sure that cases are dealt with in a fair and proportionate manner.

Professor Terence Stephenson
Chair, General Medical Council
March 2016



I chaired the *Sanctions guidance* project board that oversaw the consultation on, and revisions to, this guidance and I hosted a range of events across the UK.

We received an overwhelming response to the consultation, which has helped to make sure this guidance reflects the views of those we work with. We engaged our tribunal members throughout the consultation process, and following the publication of the document in August 2015. Their feedback has informed the new version.

I am confident that the new guidance will support tribunals in making decisions that are proportionate and fair, and takes account of the complexities of the decision making process.

His Honour David Pearl
Chair, Medical Practitioners
Tribunal Service
March 2016



The original *Sanctions guidance* was published in 2004 and, while we have made small updates over time, this new guidance is the result of the first fundamental review.

As well as being used by MPTS tribunals, it is also essential for our decision makers earlier in the process when deciding whether a case should be referred to the MPTS for a hearing.

Mr Anthony Omo
Director, Fitness to Practise,
General Medical Council
March 2016

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About this guidance

- 1 This document provides guidance to tribunals on imposing sanctions on a doctor's registration, including why a tribunal should impose sanctions and what factors it should consider.¹ It provides a crucial link between two key regulatory roles: setting standards for the medical profession, and taking action when a doctor's fitness to practise is called into question because they have not met the standards.

Who uses this guidance?

- 2 When serious concerns have been raised about a doctor, the case may be referred to the MPTS for a hearing. Medical practitioners tribunals use this guidance to make sure they take a consistent approach when deciding:
 - a whether to issue a warning when a doctor's fitness to practise is not impaired
 - b what sanction to impose, if any, when a doctor's fitness to practise is impaired.
- 3 This guidance makes sure that the parties are aware from the outset of the approach that the tribunal will take to imposing sanctions. The tribunal should use its own judgement to make decisions, but must base its decisions on the standards of good practice established in *Good medical practice*² and on the advice given in this guidance.

¹ Any 'list of factors' referenced in this guidance should be considered as a non-exhaustive list. Tribunals should use their discretion when imposing sanctions, and can consider other factors as they consider necessary and proportionate.

² General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 12 May 2015); previous editions are available at: www.gmc-uk.org/guidance/archive.asp (accessed 12 May 2015).

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- 4 When deciding whether to impose a sanction, tribunals must consider the overarching objective of protecting the public (see paragraph 14).³
 - 5 This guidance is also available to GMC decision makers when they are deciding whether to refer a case to the MPTS for a hearing.

Equality and diversity

- 6 The GMC and the MPTS have statutory obligations to make sure that processes for dealing with concerns about doctors are fair. Anyone who is acting for the GMC or the MPTS is expected to be aware of, and adhere to, equality and human rights legislation. Decision making should be consistent and impartial, and comply with the aims of the public sector equality duty.

Publishing sanctions

- 7 All restrictions or requirements placed on a doctor (except those relating solely to a doctor's health) are published on the online medical register – known as the *List of Registered Medical Practitioners*⁴ – on the GMC website. Copies of tribunal's decisions at hearings held in public are also available on the MPTS website⁵ for approximately 12 months after the end of the hearing.
- 8 Any action taken on a doctor's registration is also sent to relevant organisations, both within and outside the UK, the following month. This is referred to as a 'decisions circular' and enables the GMC to share information with appropriate organisations, such as overseas regulators.

³ This requirement is set out at section 35E(3A) and Schedule 4, paragraph (2G) of the *Medical Act 1983* (inserted by the *General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015*).

⁴ General Medical Council (2015) *List of Registered Medical Practitioners* available at: www.gmc-uk.org/LRMP (accessed 12 May 2015).

⁵ www.mpts-uk.org/decisions/1421.asp (accessed 3 December 2015).

What standards are doctors expected to meet?

- 9** *Good medical practice* and its explanatory guidance define what makes a good doctor by setting out the professional values, knowledge, skills and behaviours required of all doctors working in the UK. A wide range of people, including patients, doctors, employers and educators, are consulted in the development of the standards and guidance.
- 10** *Good medical practice*,⁶ covers the fundamental aspects of a doctor's role, including:
- a** working in partnership with patients and treating them with respect, and establishing and maintaining good relationships with patients and colleagues (including those who are not doctors)
 - b** being competent in all areas of their practice
 - c** keeping knowledge and skills up to date
 - d** being trustworthy and acting with integrity and within the law
 - e** taking part in regular reviews of their own work and that of their team, and taking steps to address any problems.
- 11** Explanatory guidance is provided in the form of detailed guidance⁷ on ethical principles that most doctors will use every day, such as consent and confidentiality, and specific guidance on a range of areas such as raising concerns about patient safety, doctors' child protection responsibilities, and providing care for people who are dying. Case scenarios and tools that help doctors apply the principles in their practice have also been developed.
- 12** Doctors are expected to be familiar with and follow the guidance. They must use their judgement in applying the principles to the various situations they will face as doctors, whether or not they hold a licence to practise, whatever field of medicine they work in, and whether or not they routinely see patients. Doctors must be prepared to explain and justify their decisions and actions. Serious or persistent failure to follow the guidance, which poses a risk to patients and/or the public or undermines confidence in doctors, will put a doctor's registration at risk.

⁶ General Medical Council (2013) *Good medical practice* available at: www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 12 May 2015); previous editions are available at: www.gmc-uk.org/guidance/archive.asp (accessed 12 May 2015).

⁷ General Medical Council *Good medical practice*: Explanatory guidance available at: www.gmc-uk.org/guidance/ethical_guidance/index.asp (12 May 2015).

13 Tribunals should also make sure they are familiar with this guidance when determining a sanction, so they can make fair, proportionate and informed decisions.

The table below, continued on page 10, sets out the explanatory guidance available, for reference.

Role of the guidance	Name of GMC guidance
<p><i>Good medical practice</i> is our core guidance for all registered doctors. As with all our guidance, serious or persistent failure to follow it, which poses a risk to the public or undermines confidence in doctors, will put a doctor's registration at risk.</p> <p><i>Good medical practice</i> is supported by a range of explanatory guidance, which expands on one or more of its high-level principles.</p>	<ul style="list-style-type: none"> • <i>Good medical practice</i>
<p>We have guidance on the fundamental ethical principles that most doctors will use every day, like consent and confidentiality.</p>	<ul style="list-style-type: none"> • <i>Confidentiality</i> • <i>Consent</i>
<p>Guidance that every doctor needs to know about and follow, even though they may not use it regularly in their day-to-day work.</p>	<ul style="list-style-type: none"> • <i>0–18 years</i> • <i>Protecting children and young people</i> • <i>Leadership and management for all doctors</i> • <i>Raising and acting on concerns</i> • <i>Treatment and care towards the end of life</i>

Role of the guidance	Name of GMC guidance
<p>Guidance that may be more relevant to doctors working in certain specialties, or about specific situations some doctors may face during the course of their career.</p> <p>We expect doctors to be familiar with the range of guidance because failure to follow any of it will put their registration at risk.</p>	<ul style="list-style-type: none"> • <i>Accountability</i> • <i>Acting as a witness</i> • <i>Consent to research</i> • <i>Delegation and referral</i> • <i>Doctors' use of social media</i> • <i>Ending your professional relationship with a patient</i> • <i>Financial and commercial arrangements and conflicts of interest</i> • <i>Good practice in research</i> • <i>Maintaining boundaries: Intimate examinations and chaperones</i> • <i>Maintaining boundaries: Maintaining a professional boundary between you and your patient</i> • <i>Maintaining boundaries: Sexual behaviour and your duty to report colleagues</i> • <i>Openness and honesty when things go wrong</i> • <i>Personal beliefs and medical practice</i> • <i>Prescribing and managing medicines and devices</i> • <i>Reporting criminal and regulatory proceedings within and outside the UK</i> • <i>Responsible consultants or clinicians</i> • <i>Use of visual and audio</i> • <i>When a patient seeks advice or information about assistance to die</i> • <i>Writing references</i> <p>Confidentiality</p> <ul style="list-style-type: none"> • <i>Confidentiality: disclosing information for education and training purposes</i> • <i>Confidentiality: disclosing information for insurance, employment and similar purposes</i> • <i>Confidentiality: disclosing records for financial and administrative purposes</i> • <i>Confidentiality: disclosing information about serious communicable diseases</i> • <i>Confidentiality: reporting concerns about patients to the DVLA or the DVA</i> • <i>Confidentiality: reporting gunshot and knife wounds</i> • <i>Confidentiality: responding to criticism in the press</i>

Why do we impose sanctions?

- 14** The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes to:
- a** protect and promote the health, safety and wellbeing of the public
 - b** promote and maintain public confidence in the medical profession
 - c** promote and maintain proper professional standards and conduct for the members of the profession.⁸
- 15** Each reference to protecting the public in this guidance should be read as including the three limbs of the overarching objective set out in paragraph 14.
- 16** Sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect.

Maintaining public confidence in the profession

- 17** Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (see paragraph 65 of *Good medical practice*). Although the tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.

Promoting and maintaining proper professional standards and conduct

- 18** Failure to follow *Good medical practice* does not automatically mean action will be taken. The guidance sets out the principles of good practice, not thresholds at which it is considered a doctor is unsafe to work.
- 19** *Good medical practice* is the benchmark that doctors are expected to meet subject to any mitigating or aggravating factors. Action is taken where a serious or persistent breach of the guidance has put patient safety at risk or undermined public confidence in doctors.

⁸ The overarching objective set out in section 1(1A) of the *Medical Act 1983* (inserted by the *General Medical Council (Fitness to Practise and Overarching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015*).

Taking a proportionate approach to imposing sanctions

- 20** In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive. It should also have regard to the principle of proportionality, weighing the interests of the public against those of the doctor (this will usually be an impact on the doctor's career, eg a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts).
- 21** However, once the tribunal has determined that a certain sanction is necessary to protect the public (and is therefore the minimum action required to do so), that sanction must be imposed, even where this may lead to difficulties for a doctor. This is necessary to fulfil the statutory overarching objective to protect the public.
- 22** The doctor may have had an interim order to restrict or remove their registration while the GMC investigated the concerns. However, the tribunal should not give undue weight to whether a doctor has had an interim order and how long the order was in place. This is because an interim orders tribunal makes no findings of fact, and its test for considering whether to impose an interim order⁹ is entirely different from the criteria that medical practitioners tribunals use when considering an appropriate sanction on a doctor's practice.
- 23** Further guidance on the factors to consider when deciding on specific sanctions is set out in paragraphs 24–156.

⁹ Medical Practitioners Tribunal Service (2013) *Imposing interim orders: guidance for the interim orders tribunal and the medical practitioners tribunal* available at: www.gmc-uk.org/DC4792_Imposing_Interim_Orders___Guidance_for_the_IOT_and_MPT_28443349.pdf (accessed 5 January 2016).

Mitigating and aggravating factors to consider when deciding on a sanction

Considering mitigating factors

- 24** The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 14–16). The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.
- 25** The following are examples of mitigating factors.
- a** Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it. This could include the doctor admitting facts relating to the case, apologising to the patient (see paragraphs 38–40), making efforts to prevent behaviour recurring, or correcting deficiencies in performance or knowledge of English.
 - b** Evidence that the doctor is adhering to important principles of good practice (ie keeping up to date, working within their area of competence), and of the doctor’s character and previous history. This could include evidence that the doctor has not previously been found to have impaired fitness to practise by a tribunal, a previous MPTS panel or by the GMC’s previous panels or committees.
 - c** Circumstances leading up to any incidents that raise concern – eg inexperience (see paragraphs 27–30) or a lack of training and supervision at work.
 - d** Personal and professional matters, such as work-related stress.
 - e** Lapse of time since an incident occurred.

26 If the doctor is presenting evidence that they have attempted to address or remediate the problem, the tribunal should be aware that *Good medical practice* states that doctors should do the following (this list is not exhaustive):

- a** Raise concerns if patients are at risk because of inadequate premises, equipment or other resources, policies or systems, and put matters right where possible (*Good medical practice*, paragraph 25b).
- b** Ask for advice from a colleague, defence body or the GMC if they are concerned that a colleague may not be fit to practise and may be putting patients at risk. If they remain concerned, they must report this in line with GMC guidance and any relevant workplace policy, making a note of steps taken (*Good medical practice*, paragraph 25c).
- c** Be open and honest with patients if things go wrong and respond promptly, fully and honestly to complaints and apologise where appropriate. They must not allow a patient's complaint to adversely affect the care or treatment they provide or arrange (*Good medical practice*, paragraphs 55 and 61).
- d** Cooperate with formal inquiries into the treatment of a patient and complaints procedures, disclosing information relevant to an investigation to anyone entitled to it (*Good medical practice*, paragraphs 72–74).
- e** Keep their knowledge and skills up to date and work with colleagues and patients to improve the quality of their work and promote patient safety (*Good medical practice*, paragraphs 8–13 and 22–23).
- f** Have the necessary knowledge of English to provide a good standard of practice and care (*Good medical practice*, paragraph 14.1).

The stage of a doctor's UK medical career

- 27** When a doctor graduates from medical school and begins working in the UK, they may well experience a steep learning curve as they take on new responsibilities. As a doctor's medical career progresses, the tribunal would expect the doctor to gain increased understanding of the social and cultural context of their work, appropriate standards, and national laws and regulations that apply to their area of work.
- 28** Many doctors joining the medical register have previously worked, lived or were educated overseas, where different professional standards and social, ethnic or cultural norms may apply. Doctors are expected to familiarise themselves with the standards and ethical guidance that apply to practising in the UK before taking up employment, although experience of working as a doctor in the UK plays a key role in their development.

29 In some cases, the tribunal may consider the stage of a doctor's UK medical career, and whether they are new to the UK medical register, when making decisions. Evidence that the doctor has gained insight (see paragraphs 41–45), once they have had an opportunity to reflect on how they might have done things differently with the benefit of experience, may be a mitigating factor.

30 In cases involving serious misconduct or serious poor performance – eg predatory behaviour to establish a relationship with a patient (see paragraphs 141–142), or serious dishonesty (see paragraphs 114–122) – the stage of the doctor's UK medical career will have limited influence on the tribunal's decision about what action to take. Serious poor practice or misconduct is not acceptable simply because the doctor is inexperienced.

Remediation of the concerns

31 Remediation is where a doctor addresses concerns about their knowledge, skills, conduct or behaviour. Remediation can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive), and, where fully successful, will make impairment unlikely.

32 However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this.

33 In such serious cases, the tribunal must fully and clearly explain:

- a** the extent to which the issues can be remediated
- b** the steps the doctor has taken
- c** how the seriousness of the findings – including the doctor's failure to take steps earlier – justifies the tribunal taking action, notwithstanding the steps subsequently taken.

References and testimonials to support the doctor

34 Doctors may present references and testimonials to support their good standing in the community or profession. The tribunal should consider what weight, if any, to give to these documents.

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- 35** When considering whether any references or testimonials are relevant to its decision the tribunal should consider:
- a** whether the testimonial is relevant to the specific findings the tribunal has made about the doctor
 - b** the extent to which the views expressed in the testimonial are supported by other available evidence
 - c** how long the author has known the doctor
 - d** how recently the author has had experience of the doctor's behaviour or work
 - e** the relationship between the author and the doctor (eg senior colleague)
 - f** whether there is any evidence that the author has a conflict of interest in providing the testimonial.
- 36** As with other mitigating factors, any references or testimonials will also need to be weighed appropriately against the nature of the facts found proved.

- 37** The tribunal should also take into account that:
- a** variation in the quantity, quality and spread of references and testimonials between cases does not necessarily relate to the good standing of a doctor
 - b** there may be cultural reasons for not requesting references and testimonials (eg some doctors may be less likely to discuss the fact that they are under investigation with colleagues, because of the significant reputational consequences for their family and networks in their communities)
 - c** doctors who qualified outside the UK and have just started working in the UK may find it difficult to get references and testimonials.

Expressions of regret and apology

- 38** When things go wrong and a patient under a doctor's care has suffered harm or distress, doctors should (*Good medical practice*, paragraphs 13, 55 and 61):
- a** take steps to improve by learning from mistakes and preventing similar events recurring
 - b** be open and honest, and apologise.

39 A doctor's apology by itself does not necessarily mean that they are accepting legal liability for what has happened or a breach of statutory duty, which may be admissible as evidence of liability in other legal proceedings. Whether or not it will be treated in this way will be determined by the relevant UK law applying to any other proceedings. In England and Wales, section 2 of the *Compensation Act 2006*¹⁰ provides that an apology, an offer of treatment or other redress shall not by itself amount to an admission of negligence or breach of statutory duty. There is not currently any equivalent legislation in Scotland or Northern Ireland – tribunals should be mindful of this where the issue arose in these countries.. For the purposes of fitness to practise proceedings, an apology by itself will not be treated as an admission of guilt (whether as to facts or impairment).

40 All healthcare organisations have a duty to support doctors and their staff to report adverse incidents and near misses routinely.¹¹ If a doctor does not feel supported to report, and in particular if they are discouraged or prevented from reporting,¹² they should raise a concern in line with the GMC's guidance.¹³ Where it has been established that a doctor has not apologised when a patient has been harmed, because their trust has prevented them from doing so, the tribunal should consider this as a mitigating factor.

The doctor's insight into the concerns

- 41** Expressing insight involves demonstrating reflection and remediation.
- 42** A doctor is likely to have insight if they:
- a** accept they should have behaved differently (showing empathy and understanding)
 - b** take timely steps to remediate (see paragraphs 31–33) and apologise at an early stage¹¹ before the hearing
 - c** demonstrate the timely development of insight during the investigation and hearing.

43 The tribunal should be aware that cultural differences and the doctor's circumstances (eg their ill health) could affect how they express insight. For example, how they frame and communicate an apology or regret.

¹⁰ *Compensation Act 2006* available at: www.legislation.gov.uk/ukpga/2006/29/contents (accessed 5 May 2015).

¹¹ General Medical Council and Nursing & Midwifery Council (2015) *Openness and honesty: the professional duty of candour* available at: www.gmc-uk.org/guidance/ethical_guidance/27233.asp (accessed 30 November 2015).

¹² General Medical Council (2014) *National training survey 2014: bullying and undermining* available at: www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf_58648010.pdf (accessed 15 November 2015).

¹³ General Medical Council (2012) *Raising and acting on concerns about patient safety* available at: www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp (accessed 15 November 2015).

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- 44** Studies of cross-cultural communication show that there are substantial variations in the way that individuals from different cultures and language groups communicate. This is particularly the case when individuals are speaking in their second language – they may use the conventions of their first language to frame and structure sentences, often translating as they speak, which may be reflected in their intonation. As a result, they may not adhere to the conventions or display the subtleties or nuances of their second language. In addition, there may be differences in the way that individuals use non-verbal cues to convey a message, including eye contact, gestures, facial expressions and touch.
- 45** The tribunal should be aware of, and sensitive to, these issues when assessing whether the doctor has insight.

Considering aggravating factors

- 46** The tribunal needs to consider any aggravating factors presented to it against the central aim of sanctions (see paragraphs 14–16).

Lack of insight

- 47** It is important for tribunals to consider insight, or lack of, when determining sanctions. It is particularly important in cases where the doctor and the GMC agree undertakings or the tribunal imposes conditions. The tribunal must be assured that this approach adequately protects patients, in that the doctor has recognised the steps they need to take to limit their practice to remediate.
- 48** A doctor is likely to lack insight if they:
- a** refuse to apologise or accept their mistakes
 - b** promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing
 - c** do not demonstrate the timely development of insight
 - d** fail to tell the truth¹⁴ during the hearing (see paragraph 72 of *Good medical practice*).

¹⁴ This includes being dishonest or misleading.

49 The tribunal should be aware however that cultural differences and the doctor's circumstances (eg their ill health) could affect how they express insight (see paragraphs 41–45).

Previous finding of impairment

50 Where the GMC, or another regulator, has previously made findings of impaired fitness to practise and imposed a sanction on the doctor's registration, the tribunal may wish to consider this as an aggravating factor in relation to the case before it.

Circumstances surrounding the event

51 Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:

- a** a failure to raise concerns (see paragraphs 127–129)
- b** a failure to work collaboratively with colleagues (see paragraphs 130–132)
- c** discrimination against patients, colleagues and other people (see paragraphs 133–135)

d abuse of professional position (see paragraphs 136–142), particularly where this involves:

i predatory behaviour (see paragraphs 141–142)

ii vulnerable patients (see paragraphs 139–140)

e sexual misconduct (see paragraphs 143–144)

f sexual offences and/or child pornography (see paragraphs 145–153)

g drug or alcohol misuse linked to misconduct or criminal offences (see paragraphs 154–156).

Conduct in a doctor's personal life

- 52** Tribunals are also likely to take more serious action where certain conduct arises in a doctor's personal life, such as (this list is not exhaustive):
- a** misconduct involving violence or offences of a sexual nature (see paragraphs 143–144)
 - b** inappropriate behaviour towards children or vulnerable adults (see paragraphs 139–140 and 145–153)
 - c** issues relating to probity – ie being honest and trustworthy and acting with integrity (see paragraphs 114–122)
 - d** misuse of alcohol or drugs leading to a criminal conviction or caution (see paragraphs 154–156)
 - e** discriminating in relation to characteristics protected by law: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, sex and sexual orientation (see paragraphs 133–135).

Considering statements from Responsible Officers

- 53** The tribunal may be presented with a statement from the doctor's Responsible Officer during a hearing, setting out the extent to which the doctor has reflected on the matter before the tribunal and how far any issues about their performance or behaviour have been addressed. The information contained within this statement should be weighed appropriately against the nature of the facts found proved.
- 54** In some cases it may not be possible to obtain a statement, either because the doctor does not have a Responsible Officer (because they have given up their licence or are using alternative routes for revalidation) or simply because the Responsible Officer hasn't provided this information. Tribunals should not draw any adverse inference in cases where a statement from a Responsible Officer is not present.

Deciding whether to issue a warning when a doctor's fitness to practise is not impaired

55 Where a tribunal finds a doctor's fitness to practise is not impaired, it cannot impose a sanction. However, it must consider, under rule 17(2)(m) whether to:

- a** take no action
- b** issue a warning if the doctor's conduct, behaviour or performance has significantly departed from the guidance in *Good medical practice*.

56 The tribunal may issue the doctor with a warning about their future conduct or performance, with reference to the facts found proved. Where the departure from *Good medical practice* that requires a response relates to a doctor's health or knowledge of English, a warning would not be appropriate. Warnings may be issued in multifactorial cases in which health or knowledge of English is raised as one of a number of issues, but not where they are the only area the tribunal wishes to address.

57 Further guidance on the purpose of warnings, the factors to take into account when considering whether to impose a warning and the circumstances in which a warning might be appropriate is set out in the *Guidance on warnings*.¹⁵

58 When deciding the wording of a warning, the tribunal should refer to the *Guidance on warnings*.

59 It is important that the tribunal gives clear reasons for issuing, or for not issuing, a warning.

¹⁵ General Medical Council (2015) *Guidance on warnings* available at: www.gmc-uk.org/Guidance_on_Warnings.pdf_25416870.pdf (accessed 12 May 2015).

Deciding what sanction to impose when a doctor's fitness to practise is impaired

- 60** Where a tribunal finds a doctor's fitness to practise is impaired, it can:
- a** take no action (see paragraphs 62–64)
 - b** agree to accept undertakings that have been agreed between the doctor and the GMC (including any limitations on the doctor's practice) as an alternative to imposing a sanction (see paragraphs 65–72)
 - c** impose conditions on the doctor's registration for up to three years (see paragraphs 73–84)
 - d** suspend the doctor's registration for up to 12 months (see paragraphs 85–100)
 - e** erase the doctor's name from the medical register, except in cases relating solely to a doctor's health and/or knowledge of English language (see paragraphs 101–105).
- 61** The tribunal's written decision is known as the determination. It must give clear and cogent reasons (including mitigating and aggravating factors that influenced its decision) for imposing a particular sanction. It must show that it started by considering the least restrictive option, working upwards to the most appropriate and proportionate sanction. This is particularly important where the sanction is lower, or higher, than that suggested by this guidance and/or where it differs from those submitted by the parties. In addition, the determination should include a separate explanation as to why the sanction should last for a particular period.
- Take no action**
- 62** Where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 14–16). But there may be exceptional circumstances to justify a tribunal taking no action.
- 63** To find that a doctor's fitness to practise is impaired, the tribunal will have taken account of the doctor's level of insight and any remediation, and therefore these mitigating factors are unlikely on their own to justify a tribunal taking no action.

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- 64** Exceptional circumstances are unusual, special or uncommon, so such cases are likely to be very rare. The tribunal's determination must fully and clearly explain:
- a** what the exceptional circumstances are
 - b** why the circumstances are exceptional
 - c** how the exceptional circumstances justify taking no further action.

Agree undertakings offered by the doctor

What are undertakings?

- 65** Undertakings are restrictions on a doctor's practice or behaviour agreed between the doctor and the GMC. They may include, for example, a restriction to NHS posts or no longer carrying out a particular procedure, or commit the doctor to undergo medical supervision or retraining.
- 66** Undertakings can be agreed at two stages in the fitness to practise process: by the case examiners before a matter is referred to a hearing; and at a hearing, after the tribunal has made a finding of impairment. In the latter, the doctor and the GMC may agree undertakings which the tribunal, if it considers the undertakings sufficient to protect the public, can then take into account when considering the appropriate sanction.¹⁶

In which cases can undertakings be agreed?

- 67** Undertakings are likely to be appropriate in cases:
- a** involving the doctor's health
 - b** involving issues around the doctor's performance
 - c** where there is evidence of shortcomings in a specific area or areas of the doctor's practice
 - d** where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.
- 68** Undertakings are likely to be workable where:
- a** the doctor has insight that they need to restrict their practice
 - b** a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
 - c** the tribunal is satisfied that the doctor will comply with them
 - d** the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.
- 69** The tribunal may wish to see evidence that the doctor has taken responsibility for, or has taken steps to mitigate, their actions (see paragraphs 24–45).

¹⁶ The tribunal is given the power to take undertakings into account by the *General Medical Council (Fitness to Practise) Rules Order of Council 2004* (as amended).

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- 70** The tribunal should consider the guidance *Undertakings at medical practitioner tribunal hearings*¹⁷ when deciding whether to accept undertakings.

Deciding what the undertakings should be

- 71** The tribunal must be satisfied that the undertakings are sufficient to protect patients and the public interest (see paragraphs 14–16), and the doctor must agree that the GMC or MPTS may disclose the undertakings (except those relating only to the doctor’s health) to:
- a** anyone the doctor is employed by, contracts with, or provides medical services for
 - b** anyone the doctor is seeking to be employed by, contract with or provide medical services for
 - c** anyone else who asks for them.
- 72** Undertakings should normally follow the wording in *Agreeing a doctor’s undertakings*.¹⁸

Impose conditions on the doctor’s registration (for up to three years)

What are conditions?

- 73** Similar to undertakings, conditions restrict a doctor’s practice or require them to do something. But conditions are imposed on, rather than agreed with, the doctor for up to three years. The conditions can be renewed for a further three-year period each time they are reviewed.
- 74** In many cases, the purpose of conditions is to help the doctor to deal with their health issues and/or remedy any deficiencies in their practice or knowledge of English, while protecting the public. In such circumstances, conditions might include requirements to work under supervision.

¹⁷ General Medical Council (2015) *Undertakings at medical practitioners tribunal hearings* available at: www.mpts-uk.org/DC4253_Undertakings_at_Medical_Practitioners_Tribunal_hearings.pdf_3799534.pdf (accessed 5 January 2016).

¹⁸ General Medical Council (2015) *Agreeing a doctor’s undertakings* available at: www.gmc-uk.org/DC4351_Undertakings_Bank_25416205.pdf (accessed 12 May 2015).

In which cases can conditions be imposed?

75 Conditions might be most appropriate in cases:

- a** involving the doctor's health
- b** involving issues around the doctor's performance
- c** where there is evidence of shortcomings in a specific area or areas of the doctor's practice
- d** where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.

76 Conditions are likely to be workable where:

- a** the doctor has insight
- b** a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
- c** the tribunal is satisfied the doctor will comply with them
- d** the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

77 When deciding whether remedial training is possible, the tribunal needs to consider any objective evidence that has been submitted. For example, assessments of the doctor's performance, health or knowledge of English, or evidence about the doctor's practice, health or knowledge of English.

78 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

- a** no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage
- b** identifiable areas of their practice are in need of assessment or retraining
- c** willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety (*Good medical practice*, paragraphs 7–13 on knowledge, skills and performance and paragraphs 22–23 on safety and quality)

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- d** willing to be open and honest with patients if things go wrong (*Good medical practice*, paragraphs 55 and 61)
 - e** has insight into any health problems, complies with the guidance on health (*Good medical practice*, paragraphs 28–30) and will abide by conditions relating to their medical condition, treatment and supervision and will not put patients in danger, either directly or indirectly, as a result of conditional registration.

Deciding what the conditions should be

- 79** Conditions should be appropriate, proportionate, workable and measurable.
- 80** Conditions should normally follow the wording in *Imposing conditions on a doctor's registration*¹⁹ to maintain a clear distinction between conditions on a doctor's practice (which are published) and conditions for their treatment (which are not published). Tribunal members may also find it helpful to refer to the definitions of the roles of individuals involved in doctors' supervision in the *Glossary for undertakings and conditions*.²⁰
- 81** Practice-related conditions may be imposed that contain a reference to a doctor's health. While practice-related conditions must be published, the tribunal can, where appropriate, impose conditions that are not set out in *Imposing conditions on a doctor's registration*, to minimise any impact on the doctor.
- 82** The tribunal should consider whether the conditions imposed should take effect immediately,²¹ taking into account any evidence received and any submissions made by the parties. The tribunal should explain fully the reasons for its decision. Further guidance on when an immediate order might be appropriate is set out in paragraphs 166–172.
- 83** The tribunal should clearly set out the objectives of the conditions so the doctor knows what is expected of them. This is also important to help tribunals at future review hearings understand the original findings and the exact proposals to respond to them, and to evaluate whether the issues have been resolved.

¹⁹ *Imposing conditions on a doctor's registration* available at: www.gmc-uk.org/DC4326_MPT_Conditions_Bank_25415696.pdf (accessed 6 January 2016).

²⁰ *Glossary for undertakings and conditions* available at: www.gmc-uk.org/DC4327_Glossary_of_Terms_used_in_Fitness_to_Practise_Actions_25416199.pdf (accessed 12 May 2015).

²¹ This requirement is set out in rule 17(2)(o) of the *General Medical Council (Fitness to Practise) Rules Order of Council 2004* (as amended).

84 Where a tribunal has found a doctor's fitness to practise impaired because of adverse physical or mental health, the conditions should include that the doctor needs medical supervision as well as supervision at their place of employment. Generally, it is not appropriate to impose medical supervision as a condition if the doctor's fitness to practise has not been found impaired by adverse physical or mental health. An exception may be a case where a doctor has refused to undergo a health assessment.

Suspend the doctor's registration (for up to 12 months, but may be indefinite in cases relating solely to a doctor's health and/or knowledge of English)

85 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbecoming a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

86 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

87 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–45).

88 Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.

89 In such cases, to protect the public, the tribunal might wish to impose a period of suspension. The suspension will need to be reviewed and therefore a review hearing should be directed. Such a direction should indicate in broad terms the type of action and evidence of remediation (such as complying with any invitations from the GMC to undergo a performance assessment or English language assessment) which, if carried out during the period of suspension, may help the tribunal's evaluation at any subsequent review hearing. However, the tribunal should bear in mind that during the period of suspension the doctor will not be able to practise.

90 The doctor may, however, have contact with patients if supervised by a registered doctor, provided that the patients have been informed of the doctor's registration status and the events that resulted in the doctor's registration being suspended, and have given their full consent.

Determining the length of suspension

91 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of *Good medical practice*, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the

breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

- b** In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.
- c** In cases that relate to the doctor's health, where the doctor's judgement may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions, or the doctor has failed to comply with restrictions or requirements.
- d** In cases that relate to knowledge of English, where the doctor's language skills affect their ability to practise and there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions.
- e** No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.
- f** No evidence of repetition of similar behaviour since incident.
- g** The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

Area	Factor
Seriousness of the findings	<ul style="list-style-type: none"> • The extent to which the doctor departed from the principles of <i>Good medical practice</i> • The extent to which the doctor failed to take prompt action when patient safety, dignity or comfort was seriously compromised • Whether the doctor showed a lack of responsibility toward clinical duties/patient care • The extent to which the doctor's actions risked patient safety or public confidence • The extent of the doctor's significant or sustained acts of dishonesty or misconduct • The seriousness of the doctor's inappropriate behaviour • The extent of the doctor's predatory behaviour • The impact that the doctor's actions had on vulnerable people and the risk of harm
Subsequent steps taken	<ul style="list-style-type: none"> • Whether the doctor is reluctant to take remedial action • Whether the doctor is reluctant to apologise • The extent to which the doctor failed to address serious concerns over a period of time
Extent to which the doctor has complied	<ul style="list-style-type: none"> • The extent to which the doctor failed to comply with restrictions/requirements • Whether the doctor showed a deliberate or reckless disregard for restrictions/requirements • Whether the doctor failed to be open and honest with GMC and local investigations

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- 92** The tribunal must also consider, as required by rule 17(2)(o),²² whether to suspend the doctor's registration with immediate effect. The tribunal must consider any evidence received and any submissions made by the parties before making and announcing its decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 166–172.
- 93** The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.
- 94** The following factors will be relevant when determining the length of suspension:
- a** the risk to patient safety/public protection
 - b** the seriousness of the findings and any mitigating or aggravating factors (as set out in paragraphs 24–54)
 - c** ensuring the doctor has adequate time to remediate.
- 95** The tribunal's primary consideration should be public protection and the seriousness of the findings. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.
- 96** The table on the next page gives examples of aggravating factors that will also be relevant to the length of suspension, under broad categories, depending on the nature of the case.
- 97** Where a doctor is suspended because of findings in relation to insufficient knowledge of English, a six-month suspension is likely to be needed in the first instance. This is to give the doctor sufficient time to improve their language skills, and take an International English Language Testing System assessment. In cases that relate solely to either health or knowledge of English (where erasure is not available as a sanction) the tribunal can suspend a doctor's registration indefinitely where necessary (see paragraph 99).

²² *General Medical Council (Fitness to Practise) Rules Order of Council 2004* (as amended).

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- 98** For doctors with serious health problems or insufficient knowledge of English, erasure is only an available sanction if there are also other factors (such as a conviction, misconduct or deficient performance), which have resulted in the finding of impaired fitness to practise. Suspension is appropriate where the doctor's health or knowledge of English is such that they cannot practise safely even under conditions. In these cases, the tribunal may direct a review hearing to obtain further information as to whether the doctor is then fit to resume practice either under conditions or unrestricted.
- 99** In cases that relate solely to a doctor's health or language where the doctor's registration has been suspended for at least two years because of two or more successive periods of suspension, the tribunal can suspend the doctor's registration indefinitely. If the tribunal decides to direct indefinite suspension, there is no automatic further hearing of the case. But two years after the indefinite suspension takes effect, the doctor can ask for it to be reviewed.
- 100** The tribunal must provide reasons for the period of suspension chosen, including the factors that led it to conclude that the particular period of suspension, whether the maximum available or a shorter period, was appropriate.

Erase the doctor's name from the medical register

- 101** The tribunal may erase a doctor from the medical register in any case – except one that relates solely to the doctor's health and/or knowledge of English – where this is the only means of protecting the public.
- 102** Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.
- 103** Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).
- a** A particularly serious departure from the principles set out in *Good medical practice* where the behaviour is fundamentally incompatible with being a doctor.
 - b** A deliberate or reckless disregard for the principles set out in *Good medical practice* and/or patient safety.
 - c** Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 123–126 regarding failure to provide an acceptable level of treatment or care).
 - d** Abuse of position/trust (see *Good medical practice*, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').
 - e** Violation of a patient's rights/exploiting vulnerable people (see *Good medical practice*, paragraph 27 on children and young people, paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services).
 - f** Offences of a sexual nature, including involvement in child pornography (see further guidance below at paragraphs 145–153).

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- g** Offences involving violence.
 - h** Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 114–122).
 - i** Putting their own interests before those of their patients (see *Good medical practice* paragraph 1: – ‘*Make the care of [your] patients [your] first concern*’ and paragraphs 77–80 regarding conflicts of interest).
 - j** Persistent lack of insight into the seriousness of their actions or the consequences.

104 If the tribunal decides that a doctor should be erased from the medical register, it must also consider whether to make an order to immediately suspend the doctor’s registration, as required by rule 17(2)(o).²³ The tribunal must take into account any evidence it has received and any submissions made by the parties before making and announcing its decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 166–172.

105 A doctor who has been erased cannot apply to be restored to the medical register until five years have elapsed.²⁴ At that stage the tribunal will have to decide whether the doctor is fit to resume unrestricted practice. Further guidance on doctors’ restoration to the medical register is provided in the *Guidance for doctors on restoration following erasure by a medical practitioners tribunal*.²⁵

²³ *General Medical Council (Fitness to Practise) Rules Order of Council 2004* (as amended).

²⁴ Section 41(2)(a) of the *Medical Act 1983* (as amended).

²⁵ *General Medical Council Guidance for doctors on restoration following erasure by a medical practitioners tribunal* available at: www.mpts-uk.org/DC4432_Guidance_for_doctors_on_restoration_following_erasure_by_an_MPT_25416789.pdf (accessed 6 January 2016).

Other issues relevant to sanctions

Considering conviction, caution or determination allegations

- 106** Convictions refer to a decision by a criminal court in the British Islands, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence.
- 107** Cautions refer to offences committed in the British Islands or elsewhere but where no court proceedings took place because the doctor admitted the offence and criminal proceedings were considered unnecessary.
- 108** Determinations refer to decisions by another health or social care regulatory body, in the UK or elsewhere, which has made a determination that the fitness to practise of the doctor as a member of that profession is impaired (or an equivalent finding).
- 109** If the tribunal receives a signed certificate of a conviction or determination, unless it also receives evidence to the effect that the doctor is not the person referred to in the conviction or determination, then it must accept the certificate as conclusive evidence that the offence was committed, or that the facts are as found by the determination. A tribunal can make an exception to this if it receives evidence to the effect that the doctor is not the person referred to in the conviction or determination. In accepting a caution, the doctor will have admitted committing the offence.
- 110** The purpose of the hearing is not to punish the doctor a second time for the offences they were found guilty of. The purpose is to consider whether the doctor's fitness to practise is impaired as a result. If so, the tribunal then needs to consider whether to restrict the doctor's registration to protect the public (who might come to the doctor as patients) and to maintain the high standards and good reputation of the profession. The tribunal should take account of paragraphs 65–67 of *Good medical practice* regarding the need to be honest and trustworthy, and to act with integrity.

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

112 The tribunal may wish to note that *Good medical practice* (paragraph 75) imposes a duty on doctors to 'tell us without delay if, anywhere in the world, [they]

a have accepted a caution from the police or been criticised by an official inquiry

b been charged with or found guilty of a criminal offence

c another professional body has made a finding against [their] registration as a result of fitness to practise procedures'.

113 As a general principle, where a doctor has been convicted of a serious criminal offence or offences, they should not be permitted to resume unrestricted practice until they have completed their sentence.

Considering dishonesty

114 *Good medical practice* states that registered 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.

115 In relation to financial and commercial dealings, paragraph 77 of *Good medical practice* also sets out that:

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

116 Paragraphs 78–80 of *Good medical practice* and the separate guidance on *Financial and commercial arrangements and conflicts of interest*,²⁶ further emphasise the duty to avoid conflicts of interest.

117 In relation to providing and publishing information about their services paragraph 70 of *Good medical practice* advises doctors that:

'When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.'

²⁶ General Medical Council (2013) *Financial and commercial arrangements and conflicts of interest* available at: www.gmc-uk.org/guidance/ethical_guidance/21161.asp (accessed 12 May 2015).

118 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor's clinical responsibility (eg providing false statements or fraudulent claims for monies) is particularly serious. This is because it can undermine the trust the public place in the medical profession. Health authorities should be able to trust the integrity of doctors, and where a doctor undermines that trust there is a risk to public confidence in the profession. Evidence of clinical competence cannot mitigate serious and/or persistent dishonesty.

119 Examples of dishonesty in professional practice could include:

- a** defrauding an employer
- b** falsifying or improperly amending patient records
- c** submitting or providing false references
- d** inaccurate or misleading information on a CV
- e** failing to take reasonable steps to make sure that statements made in formal documents are accurate.

120 For further detail on a doctor's obligations see *Good medical practice* paragraphs 19–21 on the duty to keep clear, accurate and legible records, and paragraphs 71–74 regarding writing reports and CVs, giving evidence and signing documents. See also separate guidance on writing references and *Acting as a witness in legal proceedings*.²⁷

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

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

(See also separate guidance on *Research: Good practice in research and Consent to research*.²⁸)

122 Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 114–122).

²⁷ General Medical Council (2013) *Acting as a witness in legal proceedings* available at: www.gmc-uk.org/guidance/ethical_guidance/21188.asp (accessed 12 May 2015).

²⁸ General Medical Council (2013) *Good practice in research and Consent to research* available at: www.gmc-uk.org/static/documents/content/Good_practice_in_research_and_consent_to_research.pdf (accessed 27 November 2015).

Failing to provide an acceptable level of treatment or care

- 123** Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards (set out in domains one and four of *Good medical practice* on knowledge, skills and performance, and maintaining trust). Particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to '*Make the care of [your] patients [your] first concern*' (*Good medical practice*, paragraph 1).
- 124** A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

- 125** Remediation (where a doctor addresses concerns about their knowledge, skills, conduct or behaviour) can take a number of forms, including coaching, mentoring, training, and rehabilitation (this list is not exhaustive), and, where fully successful, will make impairment unlikely.
- 126** However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.

Cases that indicate more serious action is likely to be required

Failure to raise concerns

127 All doctors have a responsibility to promote and encourage a culture that allows all staff to raise concerns openly and safely. Doctors' duties to raise concerns are set out in paragraphs 24–25 of *Good medical practice* and in the explanatory guidance *Raising and acting on concerns about patient safety*.²⁹ These duties apply to all doctors and not just those with specific management or leadership responsibilities.

128 More serious outcomes are likely to be appropriate if a doctor has concerns that they failed to raise, where:

- a** there is reason to believe a colleague's fitness to practise is impaired and may present a risk of harm to patients (*Good medical practice*, paragraph 25(c))
- b** a patient is not receiving basic care to meet their needs (*Good medical practice*, paragraph 25(a))

c patients are at risk because of inadequate premises, equipment or other resources, policies or systems (*Good medical practice*, paragraph 25(b))

d they have a legal duty to report.

129 Where the doctor has repeatedly failed to raise concerns over an extended period, and/or has failed to raise concerns that present a serious risk to patient safety, the tribunal should consider whether it is appropriate to remove or suspend the doctor to maintain public confidence.

²⁹ General Medical Council (2012) *Raising and acting on concerns about patient safety* available at: www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp (accessed 12 May 2015).

Failure to work collaboratively with colleagues

- 130** Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in paragraphs 35–37 of *Good medical practice*.
- 131** Colleagues include anyone a doctor works with, whether or not they are also doctors.
- 132** More serious outcomes are likely to be appropriate if there are serious findings that involve:
- a** bullying
 - b** sexual harassment
 - c** physical violence towards colleagues
 - d** unlawful discrimination (see paragraphs 133–135).

Discrimination against patients, colleagues and other people

- 133** Doctors must treat their colleagues and patients fairly, whatever their life choices and beliefs. The guidance is set out in paragraphs 48, 54 and 57 of *Good medical practice*.
- 134** Discrimination undermines public confidence in doctors and has the potential to pose a serious risk to patient safety. This includes views about a patient's or colleague's lifestyle, culture, or their social or economic status, as well as the characteristics covered by equality legislation³⁰ (*Good medical practice*, paragraph 59).
- 135** More serious outcomes are likely to be appropriate where a case involves discrimination (as defined by equality legislation) against patients, colleagues or other people who share protected characteristics, either within or outside their professional life. This does not affect a doctor's right to opt out of providing a particular procedure because of their personal beliefs or values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients (see the explanatory guidance *Personal beliefs and medical practice*³¹).

³⁰ The *Equality Act 2010* specifies nine groups of individuals who have 'protected characteristics' which are covered by this legislation: age, disability, race, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief, and sexual orientation.

³¹ General Medical Council (2013) *Personal beliefs and medical practice* available at: www.gmc-uk.org/guidance/ethical_guidance/21171.asp (accessed 12 May 2015).

Abuse of professional position

- 136** Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in paragraph 53 of *Good medical practice* and in the explanatory guidance documents *Maintaining a professional boundary between you and your patient*³² and *Ending your professional relationship with a patient*.³³
- 137** Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.³⁴
- 138** Personal relationships with former patients may also be inappropriate depending on:
- a** the nature of the previous professional relationship
 - b** the length of time since it ended (doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them – see *Maintaining a professional boundary between you and your patient*³³)
 - c** the vulnerability of the patient (see paragraphs 139–140)
 - d** whether the doctor is caring for other members of the family.

Vulnerable patients

- 139** Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:
- a** presence of mental health issues
 - b** being a child or young person aged under 18 years
 - c** disability or frailty
 - d** bereavement
 - e** history of abuse or neglect.
- 140** Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor.

³² General Medical Council (2013) *Maintaining a professional boundary between you and your patient* available at: www.gmc-uk.org/guidance/ethical_guidance/21170.asp (accessed 12 May 2015).

³³ General Medical Council (2013) *Ending your professional relationship with a patient* available at: www.gmc-uk.org/guidance/ethical_guidance/21160.asp (accessed 12 May 2015).

³⁴ A definition of 'someone close to them' is provided in the explanatory guidance, *Maintaining a professional boundary between you and your patient* (paragraph 6).

Predatory behaviour

141 If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety, and to public confidence and/or trust in doctors. More serious action is likely to be appropriate where there is evidence of (this list is not exhaustive):

- a** inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship
- b** use of personal contact details from medical records to approach a patient outside their doctor-patient relationship
- c** visiting a patient's home without an appointment or valid medical reason.

142 More serious action, such as erasure, is likely to be appropriate where a doctor has abused their professional position and their conduct involves predatory behaviour or a vulnerable patient, or constitutes a criminal offence.

Sexual misconduct

143 This encompasses a wide range of conduct from criminal convictions for sexual assault and sexual abuse of children (including child pornography) to sexual misconduct with patients, colleagues, patients' relatives or others. See further guidance on sex offenders and child pornography at paragraphs 145–153.

144 Sexual misconduct seriously undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies, or where a doctor has been required to register as a sex offender. More serious action, such as erasure, is likely to be appropriate in such cases.

Sex offenders and child pornography

145 Any doctor who has been convicted of, or has received a caution for, a sexual offence listed in Schedule 3 to the *Sexual Offences Act 2003* must notify the police (register) under section 80 of the *Sexual Offences Act 2003* and may need to undertake a programme of rehabilitation or treatment. Sexual offences include accessing and viewing or other involvement in child pornography, which involves the exploitation or abuse of a child. These offences seriously undermine patients' and the public's trust and confidence in the medical profession and breach a number of principles set out in *Good medical practice* (paragraph 65 regarding honesty and integrity, particularly paragraph 47 regarding respecting patients' dignity, and paragraph 27 regarding children and young people).

146 Taking, making, distributing or showing with a view to being distributed to publish, or possession of, an indecent photograph or pseudo-photograph of a child is illegal and regarded in UK society as morally unacceptable. For these reasons, where there is any involvement in child pornography by a registered doctor the tribunal should consider whether the public interest demands that their registration be affected.

147 While the courts distinguish between degrees of seriousness, any conviction for child pornography against a registered doctor is a matter of grave concern because it involves such a fundamental breach of the public's trust in doctors and inevitably brings the profession into disrepute. It is therefore highly likely that, in these cases, the only proportionate sanction will be erasure. However, the tribunal should bear in mind paragraphs 20–23 and 55–105 of this guidance, which deal with the options available to it, and the issue of proportionality. If the tribunal decides to impose a sanction other than erasure, it is important that it fully explains the reasons and the thinking that has led it to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.

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- 148** The tribunal should be aware that any conviction relating to child pornography will lead to registration as a sex offender and possible inclusion on the Children’s Barred List by the Disclosure and Barring Service under the *Safeguarding Vulnerable Groups Act 2006* (as amended).³⁵ The Council of the GMC has made it clear that no doctor registered as a sex offender should have unrestricted registration. The tribunal will therefore need to make sure that, in cases where it imposes a period of suspension or conditions, the case is reviewed before the end of this period to consider whether a further period is appropriate.
- 149** To protect the public, the tribunal should consider whether any conditions it imposes should stipulate no contact with any patients while the doctor is registered as a sex offender. (Doctors may of course be registered as sex offenders following other sexual offences not related to child pornography.)
- 150** The tribunal should also consider whether doctors registered as sex offenders should be required to undergo assessment (eg by a clinical psychologist) to evaluate the potential risk they pose to patients before they may be permitted to resume any form of practice.
- 151** When a tribunal is reviewing cases where the doctor has completed the prescribed period of registration as a sex offender (which is dependent on the nature and gravity of the offence) and is no longer required to register as a sex offender, the tribunal should take into account:
- a** the seriousness of the original offence
 - b** evidence about the doctor’s response to any treatment programme they have undertaken
 - c** any insight shown by the doctor
 - d** the likelihood of the doctor reoffending
 - e** the possible risk to patients and the wider public if the doctor were allowed to resume unrestricted practice
 - f** the possible damage to the public’s trust in the profession if the doctor were allowed to resume unrestricted practice.
- 152** Each case should be considered on its merits and decisions should be taken in the light of the particular circumstances relating to the case.

³⁵ www.legislation.gov.uk/ukpga/2006/47/contents (accessed 12 May 2015).

153 If the tribunal has doubts about whether a doctor who no longer needs to register as a sex offender should resume unrestricted practice, it should not grant the doctor unrestricted registration.

Drug or alcohol misuse linked to misconduct or criminal offences

154 Doctors are expected to act with honesty and integrity and uphold the law – this includes their use of drugs and alcohol. Any serious or persistent failure in this regard that puts patients at risk or undermines public confidence in doctors will put their registration at risk.

155 When a doctor is unwell, including because of drug or alcohol addiction, they must take appropriate steps to make sure this does not affect patient safety. This includes regularly reflecting on their standard of practice and the care they provide (*Good medical practice* paragraph 28).

156 While misuse of drugs or alcohol is serious, and not solely where linked to criminal conduct, there are certain factors that aggravate these issues. The aggravating factors that are likely to lead the tribunal to consider taking more serious action (this list is not exhaustive) are:

- a** intoxication in the workplace or while on duty
- b** misuse of alcohol or drugs that has impacted on the doctor's clinical performance and caused serious harm to patients or put public safety at serious risk
- c** misuse of alcohol or drugs that has resulted in violence, bullying or misconduct of a sexual nature
- d** misuse of alcohol or drugs that led to a criminal conviction, particularly where a custodial sentence was imposed (see paragraphs 154–156).

Review hearings

- 157** It is important that no doctor is allowed to resume unrestricted practice following a period of conditional registration or suspension unless the tribunal considers that they are safe to do so.
- 158** In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):
- a** they fully appreciate the gravity of the offence
 - b** they have not reoffended
 - c** they have maintained their skills and knowledge
 - d** patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.
- 159** Should there be a change of circumstances in the future and a review hasn't been directed, under section 35D (4B and 11B) of the *Medical Act 1983*, the registrar may, at any time before the expiry of the sanction, refer the case back to the MPTS for a review hearing. The reasons given for not directing a review might help inform any decision under this section.
- 160** It is therefore important that tribunals fully explain any instance where they decide not to direct a review hearing.
- 161** Where a tribunal has found that the doctor has not complied with the conditions on their registration³⁶ it will need to consider carefully whether the breach was wilful, ie the doctor is culpable. If it finds that the breach was wilful, a more serious outcome is likely to be appropriate.³⁷
- 162** Where a doctor's registration is suspended, the tribunal may direct that:
- a** the current period of suspension is extended (up to 12 months)
 - b** the doctor's name is erased from the medical register (except in cases that relate solely to the doctor's health and/or knowledge of English)
 - c** impose a period of conditions (up to three years).³⁸

³⁶ Section 35D (9) and (10) of the *Medical Act 1983* as amended.

³⁷ Section 35D (11) and (12) of the *Medical Act 1983* as amended.

³⁸ Section 35D (5) of the *Medical Act 1983* as amended.

163 In cases that solely involve the doctor's health or language, the tribunal can choose to suspend the doctor's registration indefinitely³⁹ (see paragraph 99).

164 Where a review hearing cannot be concluded before the conditional registration or suspension expires, the tribunal can extend it for a short period.⁴⁰ This would allow for re-listing of the review hearing as soon as practicable and to maintain the status quo before the outcome of the review hearing.

165 When considering a sanction, the tribunal may take into account any written undertakings offered by the doctor, which it considers sufficient to protect members of the public and the public interest. This is provided that the doctor agrees that the GMC may disclose the undertakings (except those relating exclusively to the doctor's health) to:

- a** their employer or anyone with whom they are contracted, or have an arrangement, to provide medical services
- b** anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so
- c** any other person enquiring.

Immediate orders (suspension or conditions)

166 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor⁴¹ include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.

167 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.

³⁹ Section 35D (6) *Medical Act 1983* as amended.

⁴⁰ Section 35D (5) and (12) *Medical Act 1983* as amended.

⁴¹ Section 38 of the *Medical Act 1983* as amended.

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- 168** Doctors and their representatives sometimes argue that no immediate order should be made as the doctor needs time to make arrangements for the care of their patients before the substantive order for suspension or erasure takes effect.
- 169** In considering this argument, the tribunal will need to bear in mind that any doctor whose case is considered by a medical practitioners tribunal will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients before the hearing, should the need arise.
- 170** In any event, the GMC also notifies the doctor's employers or, in the case of general practitioners, the relevant body, of the date of the hearing. They have a duty to make sure that appropriate arrangements are in place for the care of the doctor's patients should an immediate order be imposed.
- 171** Where the tribunal has directed conditional registration as the substantive outcome of the case, it may impose an immediate order of conditional registration. Where the tribunal has directed suspension or erasure as the substantive outcome of the case, it may impose an immediate order to suspend registration.
- 172** Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.

Annex

List of other documents and guidance available to tribunals

Medical Act 1983 (as amended)

General Medical Council (Constitution of Panels and Investigation Committee) Rules 2004

General Medical Council (Legal Assessors) Rules 2004

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

Good medical practice – Current edition (You can download previous and no longer current versions of *Good medical practice*, published in 2001, 1998 and 1995 respectively, from our archive section at www.gmc-uk.org/guidance/archive.asp)

Supplementary ethical guidance

Guidance to the GMC's Fitness to Practise Rules 2004 (as amended)

Meaning of fitness to practise

Guidance on undertakings

Case management procedure: Guidance for parties and representatives

Guidance for specialist advisers

Guidance on warnings

Undertakings at medical practitioners tribunal hearings

Undertakings bank

Medical practitioners tribunal conditions bank

Medical career structure: Doctors in training

Glossary for undertakings and conditions

Guidance on clinical attachments

International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)

Imposing interim orders: Guidance for the interim orders tribunal and the medical practitioners tribunal

Interim conditions bank

Guidance for making decisions on voluntary erasure applications

Guidance for doctors on restoration following erasure by a medical practitioners tribunal

Managing medical practitioners tribunal hearings: Guidance for tribunal chairs

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: **0161 923 6602**

Fitness to Practise Policy team,
General Medical Council,
350 Euston Road, London NW1 3JN

Email: enquiries@mpts-uk.org
Website: www.mpts-uk.org
Telephone: **0161 923 6263**

Medical Practitioners Tribunal Service
7th Floor, St James's Buildings,
79 Oxford Street, Manchester M1 6FQ

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service.

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