

# Guidance for medical practitioners tribunals on restoration following disciplinary erasure

## Purpose

- 1 This guidance provides tribunals with advice on the approach to be taken in restoration hearings following disciplinary erasure. It sets out the test to be applied by tribunals and the key factors they should consider when deciding if a doctor should be restored to the register. Its aim is to support consistent decision making in line with our overarching objective. This is to protect the public which includes protecting, promoting and maintaining the health, safety and wellbeing of the public, maintaining and promoting confidence in the medical profession and proper professional standards and conduct among doctors.
- 2 Separate [guidance](#) is available on restoration following voluntary or administrative erasure.

## Contents

- 3 [Part A](#) provides an overview of the legislative framework, the process followed at restoration hearings and the tribunal's powers in respect of restoration.
- 4 [Part B](#) sets out the approach tribunals should take in restoration hearings following disciplinary erasure. It flags the different factors that tribunals should consider and the importance of considering all three elements of the overarching objective when deciding if the doctor is fit to practise.
- 5 [Part C](#) sets out the approach tribunals should take in restoration hearings following disciplinary erasure where there are new allegations of impairment.
- 6 [Part D](#) sets out the tribunal's power to adjourn a restoration hearing to allow for an assessment or further enquiries to be carried out.

- 7 [Part E](#) describes the doctor's right to make further applications for restoration if an earlier application has been refused.
- 8 [Part F](#) sets out the relevant registration and revalidation requirements placed on doctors who return to practice following a lengthy period off the register and [Part G](#) summarises the key points in relation to tribunal decisions.
- 9 Unless otherwise stated, references to Rules are to the [GMC Fitness to Practise Rules 2004 \(as amended\)](#) and references to sections are to the provisions of the [Medical Act 1983 \(as amended\)](#).

## **Part A – Overview of the legislative framework, the process followed at restoration hearings and the tribunal's powers in respect of restoration**

- A1** If a doctor wishes to return to the register after being erased for disciplinary reasons, they must submit an application for restoration<sup>1</sup> to the Registrar of the GMC. A minimum of five years must have elapsed from the date that a doctor was erased before they are able to make an application for restoration. The Registrar will refer completed applications to the MPTS to arrange a medical practitioners tribunal (MPT) restoration hearing. The purpose of a restoration hearing is for the tribunal to decide if the doctor is fit to practise and whether it is consistent with our overarching objective to allow the doctor to regain their registration.
- A2** Restoration hearings are held in public unless the tribunal is considering matters relating to the doctor's physical or mental health or the tribunal decides the particular circumstances of the case outweigh the public interest in holding some or all of the proceedings in public<sup>2</sup>.
- A3** There are three potential scenarios in which a doctor's restoration application may lead to a tribunal hearing:
- ▶ The doctor was erased for disciplinary reasons and applies for restoration after a minimum of five years has elapsed
  - ▶ The doctor was granted voluntary erasure or was administratively erased and the GMC's case examiners decide to refer their restoration application to the MPTS. This is likely to occur where there are unresolved concerns about the doctor's fitness to practise, which were either known about at the

<sup>1</sup> Under section 41

<sup>2</sup> The procedure to be adopted by a MPT is set out at Rule 24

point of erasure or have arisen during the period the doctor has not been registered.

- ▶ The doctor was erased<sup>1</sup> because they did not disclose relevant information about their fitness to practise at the point of registration, and applies for restoration after a minimum of five years has elapsed.

**A4** This guidance only relates to the first scenario where the doctor was erased for disciplinary reasons.

## **Procedure at restoration hearings**

**A5** The GMC's representative will present their submissions first, setting out the background to the case and presenting any relevant evidence regarding the doctor's fitness to practise<sup>2</sup>. The GMC's representative will explain whether the GMC opposes the doctor's application for restoration.

**A6** The doctor or their representative will then present their case in support of their application for restoration. They can submit written documentation and call relevant witnesses to give oral evidence.

**A7** The MPT can grant or refuse a doctor's application for restoration. It can also adjourn the hearing, usually to enable a health, language or performance assessment to be carried out, although the MPT can also direct any other enquiries it feels are necessary. Further detailed guidance on adjournments is at part D. The MPT has no power to restore a doctor to the medical register with restrictions on their registration; therefore it is not possible to grant restoration with conditions or undertakings.

**A8** Tribunals have a broad discretion when considering restoration applications and may direct a doctor's name be restored to the register 'if they think fit.'<sup>3</sup>

**A9** Where there are new allegations of impairment that have not previously been determined, the tribunal must weigh the evidence carefully before they make a decision on restoration, as set out in Part C below.

<sup>1</sup> Under section 44(B)(1)

<sup>2</sup> The order of proceedings at a restoration hearing is set out in rule 24(2)

<sup>3</sup> Section 41(1)

## Part B – Restoration hearings following disciplinary erasure where there are no new allegations of impaired fitness to practise

- B1** The onus is on the doctor applying for restoration to satisfy the MPT that they are fit to return to unrestricted practice<sup>1</sup>. The MPT should not seek to go behind the original tribunal’s findings on facts, impairment and sanction.
- B2** The test to be applied by tribunals when considering if a doctor should be restored is that ‘having considered the circumstances which led to erasure and the extent of remediation and insight, is the doctor now fit to practise having regard to each of the three elements of the overarching objective<sup>2</sup>?’.

### Relevant factors to be considered by the tribunal

- B3** The following factors may be relevant to the tribunal’s decision. They should be carefully balanced in order to make an overall judgment on whether the doctor is fit to practise and that restoration achieves the overarching objective. The relevance of different types of evidence will vary however depending on the circumstances of the individual case.

### The circumstances that led to disciplinary erasure

- B4** Tribunals will be provided with copies of the previous tribunal or panel’s determinations and, in some cases, transcripts of the original hearing. This will enable them to fully consider the background to the restoration application and identify the specific past concerns about the doctor’s fitness to practise.
- B5** The reasons given by the previous MPT to direct erasure will help the tribunal understand why erasure was the only means by which the public could be protected, considering the need to maintain public confidence in the medical profession and/or maintain proper professional standards and conduct for doctors. The previous tribunal’s determinations may also contain helpful information about the doctor’s level of insight and remediation at the time of erasure.

<sup>1</sup> Section 41(6)

<sup>2</sup> GMC v Chandra [2018] EWCA Civ 1898

## Whether the doctor has demonstrated insight into the matters that led to erasure, taken responsibility for their actions, and actively addressed the findings about their behaviour or skills

- B6** It will be important for the MPT to assess whether the doctor has demonstrated insight into the findings that led to their erasure. It is crucial that a doctor has genuine insight into what went wrong and appreciates what could have been done differently. They should also understand how they could act differently in the future to avoid similar concerns occurring again.
- B7** Evidence of the doctor’s current level of insight will be a significant factor for the MPT in assessing the risk the doctor may repeat their previous misconduct or poor performance.
- B8** Oral evidence from the doctor will generally allow the MPT to better assess the doctor’s level of insight than relying on written statements as the tribunal can ask questions to address specific concerns about the doctor’s fitness to practise.
- B9** Tribunals should however be aware that cultural differences and the doctor’s circumstances, for example their ill health, could affect how they express insight or how they frame and communicate an apology or regret. They should be aware of, and sensitive to, these issues when assessing whether a doctor has insight.

### Insight and remorse

- B10** Factors that can be relevant to a doctor demonstrating genuine insight include, but are not limited to, evidence they have:
- a** considered the concern, understood what went wrong and accepted they should have acted differently
  - b** demonstrated that they fully understand the impact or potential impact of their performance or conduct, for example by showing remorse (see below)
  - c** demonstrated empathy for any individual involved, for example by apologising fully (see below)
  - d** taken steps to remediate and to identify how they will act differently in the future to avoid similar issues arising (see below)
- B11** The doctor is unlikely to be able to demonstrate genuine insight if they have failed to demonstrate some or all of the factors above or have only demonstrated them in a limited way.

- B12** Expressing remorse involves the doctor taking responsibility and exhibiting regret for their actions. This could include evidence that the doctor has:
- a** been open and honest about and admitted their wrongdoing
  - b** apologised fully
  - c** undertaken appropriate remediation.

### **Remediation and risk of repetition**

- B13** Remediation is where a doctor actively addresses concerns about their behaviour, skills, performance or health. Remediation can take a number of forms and, where successful, will weigh in favour of allowing restoration.
- B14** For remediation to be judged successful it must be focused on activities that reduce the level of risk posed to patients, members of the public and to public confidence in the profession from allowing the doctor to return to practice. Efforts to remediate should be driven by the doctor with support from others as appropriate.
- B15** Remediation can take several forms, including, but not limited to:
- a** participating in training, supervision, coaching and/or mentoring relevant to the concerns raised
  - b** attending courses relevant to the concerns raised, for example anger management, maintaining boundaries, ethics or English language courses
  - c** evidence that shows what a doctor has learnt following the events that led to the concerns being raised, and how they have applied this learning in their practice (where applicable)
  - d** evidence of good practice in a similar environment to where the concerns arose.
- B16** When assessing remediation in restoration cases, the tribunal should consider the following questions:
- ▶ *Are the previous findings/any new concerns about the doctor's behaviour, skills, performance or health remediable?*
  - ▶ *Have the findings about the doctor's behaviour, skills, performance or health been remedied?*
  - ▶ *Are the previous findings about the doctor's behaviour, skills, or performance likely to be repeated?*

**Are the previous findings/any new concerns about the doctor’s behaviour, skills, performance or health remediable?**

- B17** Some concerns, such as clinical errors, are generally more capable of being remedied than others.
- B18** It can be more difficult to demonstrate sufficient remediation in cases involving serious behaviour such as dishonesty, sexual misconduct, violence or abusive behaviour and unlawful discrimination, and cases where the doctor’s behaviour towards patients, colleagues or other individuals in the workplace suggests underlying problems with their attitude or, in very serious cases involving clinical failings, indicates the doctor is reckless as to the safety of patients.

**Have the findings about the doctor’s behaviour, skills, performance or health been remedied?**

- B19** There isn’t a set way to demonstrate remediation; the way in which the doctor can show they have actively addressed the concerns will depend on the specific facts of the case.
- B20** The quality of the steps the doctor has taken to remediate the concerns is key to assessing the impact it has had or is capable of having. The tribunal should consider whether any remediation undertaken by the doctor is:
- a** relevant – in that the steps taken to remediate have directly addressed the concerns identified
  - b** measurable – in that there is objective evidence available that helps the tribunal understand what has been done and what, if anything, is left to be done, and
  - c** effective – in that there is enough information for the tribunal to see how any learning has been assessed and/or applied by the doctor and its impact or success

- B21** Remedial steps that have been completed will usually carry greater weight than actions started by a doctor and not yet concluded, or steps identified by a doctor as action they can take in the future.

**Are the previous findings about the doctor’s behaviour, skills, or performance likely to be repeated?**

- B22** When considering if it is likely that the concerns will be repeated, the tribunal will need to consider the extent of the doctor’s insight and whether the steps that have been taken by the doctor to remediate are sufficient to achieve public protection.

- B23** Tribunals can also consider the following factors in assessing whether the concerns are likely to be repeated:
- a whether there was a pattern of similar concerns
  - b the environment in which a doctor has been working since their erasure
    - i. where a doctor has been working in a similar environment to where the concerns arose and has been exposed to situations when there was a risk of repeating the concerns, the absence of repetition will be relevant
    - ii. where a doctor has not been working in a similar environment to where the concerns arose the absence of repetition will be of little or no relevance
  - c the circumstances giving rise to the concerns – if the concerns arose in unique circumstances which are themselves unlikely to be repeated, then, it may suggest that the risk of repetition in the future is reduced
  - d what steps a doctor has put in place to avoid the circumstances arising again and/or to cope with those circumstances, should they arise again
  - e whether the doctor has an otherwise positive professional record, including an absence of any other concerns from past or current employers or another regulatory body
- B24** A low but nonetheless real risk of repetition may be particularly significant where repetition could have a very serious outcome. A low risk of repetition should therefore be carefully distinguished from identifying no risk of repetition.
- B25** When assessing the weight to be attached to remediation, steps started soon after the relevant events will usually carry more weight than those started just before, or at, the time of the doctor’s application for restoration.

## **What the doctor has done since their name was erased from the register**

- B26** The MPT should also consider any activities the doctor has undertaken since erasure and whether these are relevant to their current fitness to practise. Examples of things which may have a bearing on the tribunal’s decision are:
- ▶ the doctor has obtained employment in a field related to medicine and used it to keep up to date with developments in their speciality
  - ▶ the doctor has undertaken research or teaching in a relevant field

- ▶ the doctor has completed a professional or academic qualification such as a PhD, diploma or MSc in a relevant subject<sup>1</sup>
- ▶ the doctor has written and published articles related to their area of practice in relevant publications.

### **Overseas practice**

**B27** If the doctor has been practising overseas, tribunals should carefully consider whether they are in good standing, have provided a certificate to this effect, and if they are able to provide satisfactory references from current and previous employers.

### **The steps the doctor has taken to keep their medical knowledge and skills up to date**

**B28** The doctor will not have had clinical contact with patients in the UK for a minimum of five years. The onus is on the doctor to demonstrate they have kept their medical knowledge and skills up to date and are safe to resume unrestricted practice.

**B29** Tribunals should evaluate whether the steps the doctor has taken are adequate to allow a return to full practice. Doctors may demonstrate they have maintained their clinical knowledge and skills through:

- ▶ undertaking clinical placements and/or observing clinical consultations
- ▶ attending relevant courses in person
- ▶ overseas practice.

**B30** Less weight should usually be given to online courses as these do not generally provide a proper opportunity for a doctor to witness doctor/patient interaction first hand and this can limit their value. However, tribunals will need to consider if there are good reasons why online learning was the best available way for the doctor to keep their knowledge and skills up to date. For example, if health issues or caring responsibilities meant they found it difficult to attend relevant learning in person.

**B31** Although the MPT has the power to direct the doctor to undergo a performance assessment, this will usually only be appropriate where there are specific concerns about a doctor's competence either dating from the point of erasure or arising from new evidence presented at the hearing. A performance

<sup>1</sup> Copies of certificates should be provided

assessment should not be directed based on a general concern the doctor's skills and knowledge may have deteriorated due to their time off the register.

**B32** Further information about the doctor's registration and revalidation status should they be restored is in part F. This should not be relied on however as assurance of the level of supervision the doctor will have on their return to practice.

### The lapse of time since erasure

**B33** The length of time that has elapsed since the doctor was erased will be relevant although will not necessarily equate to them no longer posing a risk to patients or to public confidence in the profession.

**B34** The longer the doctor has been away from clinical practice, the greater the likelihood that their knowledge and skills will have deteriorated to a degree that may place patients at risk. Tribunals should pay close regard to how the doctor has maintained their knowledge during a lengthy period away from the register.

### Will restoration meet the overarching objective?

**B35** Having considered the different factors above, the tribunal must make findings in relation to whether the doctor is fit to practise. The tribunal should then step back and balance its findings against whether restoration will meet our overarching objective. This balancing exercise will involve careful consideration of each of the elements.



**B36** The overarching objective reflects the purpose of the professional regulation of doctors which is to protect the public. Tribunals must act in a way that:

- a** protects, promotes and maintains the health, safety and well-being of the public
- b** promotes and maintains public confidence in the profession, and

- c promotes and maintains proper professional standards and conduct for members of the profession.

### **Protecting, promoting and maintaining the health, safety and well-being of the public**

- B37** In restoration hearings, it will be important for the MPT to consider any future risk posed by a doctor to patients and members of the public. If the doctor was erased for disciplinary reasons, their conduct or performance was previously judged to be so serious that erasure was the only means by which the public could be protected or that public confidence in the medical profession and proper professional standards and conduct for doctors could be maintained.
- B38** The doctor's response to their erasure and the levels of insight, remorse and remediation they have demonstrated will be important to the tribunal's assessment of future risk.
- B39** Restoration should not be granted if the tribunal considers there to be a risk the behaviour or performance will be repeated which may result in physical or emotional harm being caused to a patient.
- B40** Where the concerns related to the doctor's performance, or in a multi-factorial case, their knowledge of English and/or their health, the tribunal must be satisfied they have fully remediated and there is no longer a risk to patients. If the tribunal is not satisfied the doctor is fit to practise unrestricted, restoration will not be in line with the overarching objective to protect the public.

### **Promote and maintain public confidence in the profession**

- B41** Patients and members of the public must be able to trust doctors with their health, safety and wellbeing. Doctors are expected to act with honesty and integrity to ensure their behaviour justifies that trust.
- B42** Where a doctor's past behaviour is so serious that it remains capable of undermining the trust that the public places in doctors, it is unlikely that restoration will be in line with the overarching objective. This applies to behaviour both inside and outside of a doctor's professional practice. There will be some cases where, even if insight and remediation have been fully demonstrated and there has been a significant lapse of time since erasure, public confidence in the profession would be undermined by allowing the doctor to practise again.
- B43** Tribunals should ask themselves whether an ordinary, well informed member of the public who is aware of all the relevant facts would be concerned to learn the doctor had been allowed to return to practice. They should also have

regard to the fact that maintaining public confidence in the profession as a whole is more important than the interests of an individual doctor.

**B44** Although public confidence will be a stronger factor in cases involving behavioural misconduct, in certain cases, a clinical failing or error by a doctor will be so serious that, even if it is unlikely to recur, it is capable of undermining the public's trust in the profession. Restoration is unlikely to meet the overarching objective in these circumstances.

### **Promote and maintain professional standards and conduct**

**B45** We promote the professional values, knowledge, skills and behaviours expected of all doctors working in the UK by setting standards.

**B46** To ensure that doctors work to a consistent set of standards, and patients understand what to expect from the care they receive, action is taken by tribunals where serious or persistent failures to follow the standards set pose a risk to patients or to public confidence in doctors. Erasing a doctor sends a clear message to the profession about what constitutes unacceptable behaviour and practice and corresponds with our duty to promote and maintain professional standards and conduct.

**B47** Where there has been a very serious and/or persistent departure from the published standards resulting in erasure, it may not be consistent with the third element of the overarching objective to allow the doctor to practise again.

### **Types of case where restoration is generally unlikely to meet the overarching objective**

**B48** There will be cases where restoration is generally unlikely to be in line with the overarching objective. This would be irrespective of the length of time that has elapsed and whether there is strong evidence the doctor has demonstrated insight and maintained their clinical knowledge and skills.

**B49** Restoration is unlikely to meet the overarching objective if the doctor was erased for conduct that was of an exceptionally serious nature such as being convicted of the following types of criminal offence:

- ▶ murder
  
- ▶ rape or sexual assault by penetration

- ▶ sexual offences involving children or adults with a mental disorder impeding choice. This could include the creation, possession or distribution of child sex abuse materials.
- ▶ offences involving human trafficking, slavery, servitude and forced or compulsory labour
- ▶ extortion and blackmail.

**B50** This is not an exhaustive list and there may be other cases where restoration would be likely to undermine public confidence in the profession irrespective of other factors such as remediation.

**B51** Tribunals should also exercise caution and consider carefully whether the doctor is fit to practise unrestricted in the following circumstances:

- ▶ the doctor has a criminal conviction resulting in a suspended sentence which remains in force
- ▶ the doctor is on the Sex Offenders register.

**B52** It will usually be inappropriate for a doctor to hold unrestricted registration in these circumstances and restoration cannot be granted subject to conditions.

## Part C – Restoration hearings following disciplinary erasure where there are new allegations of impaired fitness to practise

- C1** In a small number of restoration hearings, tribunals may need to consider new information about the doctor's fitness to practise that has arisen since their erasure. For example, this may include criminal cautions/convictions or determinations by another regulatory body if the doctor has been working in another country or the doctor may have been working in a field related to medicine that does not require registration.
- C2** The approach which should be taken by tribunals is to consider all the factors detailed in part B in relation to the original matters which led to erasure. In addition, where there are previously untested allegations which call into question the doctor's fitness to practise, tribunals must weigh the evidence carefully to reach a judgment:
- a** firstly on whether the new allegations are proved on the balance of probabilities
  - b** secondly on whether the doctor's fitness to practise is impaired by reason of those new allegations.

The tribunal should invite the parties to make submissions and present evidence on both questions.

- C3** A doctor's fitness to practise may be regarded as 'impaired' if the concern falls within one of six categories<sup>1</sup>:
- ▶ misconduct
  - ▶ deficient professional performance
  - ▶ a conviction or caution in the British Islands for a criminal offence (or if it's a conviction elsewhere then there is an equivalent criminal offence in England and Wales)
  - ▶ adverse physical or mental health
  - ▶ not having the necessary knowledge of English
  - ▶ a determination by another health regulatory body (in the United Kingdom or elsewhere) that a person's fitness to practise is impaired

<sup>1</sup> Section 35C of the Medical Act

- C4** There is no complete statutory definition of impaired fitness to practise and when considering whether a doctor's fitness to practise is impaired there is no required standard of proof. The decision is a matter for the tribunal's judgment alone.
- C5** As part of their submissions, the GMC will present any evidence about new allegations that have not previously been determined by a tribunal. The doctor will have been given notice of any new allegations in advance of the hearing and provided with copies of any information or evidence that underpins them. It is for the GMC to prove new allegations on the balance of probabilities.
- C6** Where the new concerns relate to the doctor's performance, health or knowledge of English, the onus will be on the doctor to undergo the relevant assessment if directed to do so by the GMC. Any assessments will usually have taken place prior to the restoration hearing. The assessment outcome will provide the tribunal with objective evidence of whether the doctor's fitness to practise is impaired.
- C7** Tribunals can rely<sup>1</sup> on certificates of conviction, determinations by overseas regulators and determinations by health and social care regulatory bodies as conclusive proof and the matters underpinning them do not need to be proved again at a restoration hearing.
- C8** Having considered all the factors relevant to the original erasure and any new information, the tribunal should then take a step back and consider if the doctor is fit to practise and whether restoration is in line with the overarching objective, considering each of the three elements. These are set out in part B.

## **Determinations by overseas regulatory bodies**

- C9** Tribunals should be cautious about allowing restoration where the doctor is the subject of a determination by a regulatory body overseas and has current restrictions on their ability to practise in another country. This may be a strong indication they are not fit to practise without restriction in the UK.

<sup>1</sup> Under Rule 34(3) and 34(4)

## Part D – Adjourning for a performance, language or health assessment

- D1** The tribunal has the power to adjourn the hearing and direct that the doctor undergoes an assessment of their health, performance or language<sup>1</sup>. A performance or language assessment will be at the doctor’s own cost.
- D2** Assessments may be appropriate in order to obtain objective evidence of whether any previously identified deficiencies in the doctor’s performance or language skills have been remedied. Any assessments considered necessary by the GMC will usually have been carried out prior to the restoration hearing.
- D3** Tribunals can also adjourn the restoration hearing to enable any other information that is relevant to whether the doctor is fit to practise unrestricted to be obtained. They should however refer to the relevant guidance<sup>2</sup> before doing so.
- D4** Generally, an adjournment is only likely to be appropriate where the tribunal is satisfied that the adjournment is necessary for the tribunal to fairly carry out its function and that the information cannot reasonably be obtained by other means. When the hearing resumes, both parties should have an opportunity to make submissions on any assessment report or other new evidence before a decision is made on restoration.

## Part E – The doctor’s right to make further applications for restoration

- E1** If restoration is refused, the doctor must automatically wait at least 12 months<sup>3</sup> before applying again. The tribunal has no discretion to make this period longer or shorter unless the doctor has made two or more previous applications.
- E2** If it is the doctor’s second unsuccessful application, tribunals should consider whether to indefinitely suspend the doctor’s right to apply for restoration<sup>4</sup>.
- E3** The doctor has the right to make representations on the question of whether the tribunal should use their power to indefinitely suspend further restoration applications.

<sup>1</sup> Under Rule 24(g)

<sup>2</sup> [Guidance for Medical Practitioners Tribunals on adjourning to direct an assessment or for further information or reports to be obtained](#)

<sup>3</sup> Section 41(2)(b)

<sup>4</sup> Under section 41(9)

## **Review of a decision to suspend indefinitely the doctor's right to re-apply**

- E4** The doctor may apply<sup>1</sup> to the Registrar for the decision to indefinitely suspend their right to re-apply for restoration to be reviewed by a tribunal after three years from the date of the decision.
- E5** The tribunal may grant the application to allow the doctor to make a further application for restoration or refuse it. If the doctor's application is not successful, they cannot make a further application for review within three years of the date of the tribunal's decision. The tribunal has no discretion to make this period shorter or longer. If the doctor is unsuccessful, there is no statutory right of appeal, although the doctor has a right to challenge the decision by way of judicial review.

## **Part F – Post restoration matters**

- F1** Doctors can apply for restoration either with or without a licence to practise. Once the tribunal has granted restoration, even if it is for registration only, the doctor will subsequently have the right to apply for a licence to practise.
- F2** If the doctor held provisional registration prior to being erased, they will be restored with provisional registration only.

## **Approved practice settings and revalidation**

- F3** Where doctors are restored after five years or more away from practice they will only be permitted to work in an Approved Practice Setting (APS) until their first revalidation. If a doctor has the APS restriction on their registration, they can only practise in the UK if they have a connection to a designated body<sup>2</sup>. A designated body is an organisation that has established clinical governance processes including appraisal systems that support doctors with their revalidation and promote and protect the interests of patients. Connection to a designated body means the doctor:
- ▶ is supported with appraisal and revalidation
  - ▶ is supported with training and continuing professional development (CPD)

<sup>1</sup> The application will be governed by rule 24 of the General Medical Council (Fitness to Practise) Rules 2004 and sections 41(9) and 41(11) of the Medical Act

<sup>2</sup> Unless the doctor is based in Jersey, Guernsey, Isle of Man or Gibraltar and maintains a connection to a Suitable Person there. In these jurisdictions, the Suitable Person has a statutory responsibility to report fitness to practise concerns to the GMC.

- ▶ is monitored and supported in delivering quality care
- ▶ either has a Responsible Officer or a Suitable Person with both being responsible for making revalidation recommendations to the GMC. While only Responsible Officers have a statutory responsibility to report any fitness to practise concerns to the GMC, a Suitable Person will monitor any concerns which might arise about the doctor's practice. The Suitable Person will also keep records of evaluations of the doctor's fitness to practise, including annual appraisals and any other investigations or assessments.

- F4** Doctors with the APS restriction can work in any organisation and undertake locum or private work if they maintain a connection to a designated body and adhere to any reporting requirements set by their Responsible Officer, Suitable Person and/or training body. They must cease work in the UK if they no longer have a connection to a designated body and cannot practise again until a connection to a new one has been established.
- F5** It is important that tribunals do not place undue weight on the APS restriction when deciding whether to restore a doctor. It is not intended as a regulatory mechanism to monitor doctors with a history of disciplinary erasure. It should not therefore be viewed as a method of assurance for the GMC that a doctor, once restored, will be subject to any additional monitoring or performance reviews in comparison with a doctor who has no fitness to practise history.
- F6** When a doctor has been restored, it is the responsibility of their employer(s) and Responsible Officer or Suitable Person to support their return to practice. And for Responsible Officers to report any concerns about the doctor's fitness to practise to the GMC where there is a risk to patients or public confidence in the profession.
- F7** If a doctor is returning to General Practice, they will also be supported through formal induction and refresher/returner schemes available in each of the four devolved countries of the United Kingdom.
- F8** The Academy of Medical Royal Colleges has also published guidance on return to practice and the actions that should be taken by different parties including Responsible Officers or Suitable Persons and employers if a doctor has not worked for a significant period of time.

## Revalidation

- F9** Doctors who were erased after 3 December 2012 and have missed a revalidation date due to being unregistered are usually required to undergo revalidation within 12 months of their restoration. However, this date may be moved to allow the doctor enough time to gather their evidence to meet the

requirements. Doctors who were erased prior to 3 December 2012 will undergo revalidation within five years.

## **Part G – Tribunal decisions**

- G1** It is important that tribunals give clear reasons for their decision to either refuse or grant restoration which address all the factors relevant to the doctor's fitness to practise.
  
- G2** Decisions must clearly demonstrate that all three elements of the overarching objective were considered and that, if restoration was granted, this was judged to be consistent with our duty to protect the public. This includes to protect and maintain the health, safety and wellbeing of the public, to maintain and promote public confidence in the profession and proper professional standards and conduct.