



General
Medical
Council

Sanctions guidance

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

Forewords

This is an important document. The Sanctions Guidance is designed to help those who decide how to respond when a doctor has put patients at risk or undermined confidence in the profession. The guidance for these decision makers is in turn based on the values and standards contained in our core guidance *Good medical practice*. It therefore provides a crucial link between that professional guidance and the action that the decision makers in the Fitness to Practise Directorate and Medical Practitioners Tribunal (MPTS) tribunals take, as well as promoting consistency of decision making.

The development of the 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 2000 responses, they have produced a new document which will help to make sure that cases are dealt with in a fair and proportionate manner.



Professor Terence Stephenson
Chair, General Medical Council

I chaired the Sanctions Guidance project board which oversaw the consultation on, and revisions to, this guidance and I hosted a range of events with key stakeholders across the UK.

We received an overwhelming response to the consultation which ensures that the guidance reflects the views of our key stakeholders.

I am confident that the new guidance will support tribunals in making decisions that are proportionate and fair.



His Honour, David Pearl
Chair, Medical Practitioners Tribunal Service

The original Sanctions Guidance was published in 2004 and, while we have made small updates over time, this 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

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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.

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

This document will be used by MPTS medical practitioners tribunals from 31st December 2015

About this guidance

- 1 This document provides guidance to tribunals on imposing sanctions on a doctor's registration, including why the tribunal should impose sanctions and what factors they should consider. 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 the guidance?

- 2 When serious concerns have been raised about a doctor, the case may be referred to the MPTS for a hearing. Fitness to practise tribunals use the 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 The sanctions 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 their own judgement to make decisions, but must base their decisions on the standards of good practice established in *Good medical practice* and on the advice provided in this guidance.
- 4 In making their decisions on sanction, tribunals must have regard to the overarching objective of protecting the public (see paragraph 13).*
- 5 The sanctions 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.

* 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).

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** – on the GMC website. Copies of tribunals' decisions at hearings held in public are also available on the MPTS website 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.

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*,[†] covers 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 Detailed guidance is provided* on ethical principles that most doctors will use every day, such as consent and confidentiality, and specific guidance on a range of areas

* General Medical Council (2015) *List of Registered Medical Practitioners* available at: www.gmc-uk.org/LRMP (accessed 12/05/15)

† General Medical Council (2014) *Good medical practice* available at: www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 12/05/2015); previous editions are available at: <http://www.gmc-uk.org/guidance/archive.asp> (accessed 12/05/2015)

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 or the public or undermines confidence in doctors, will put a doctor's registration at risk.

Why impose sanctions?

- 13 The main reason for imposing sanctions is to protect the public. This is the statutory overarching objective, which includes:
- a protecting the health, safety and wellbeing of the public
 - b maintaining public confidence in the profession
 - c promoting and maintaining proper professional standards and conduct for the members of the profession.[†]
- 14 Each reference to protecting the public in this document should be read as including the three limbs of the overarching objective set out in paragraph 13 above.
- 15 Sanctions are not imposed to punish or discipline doctors, but they may have a punitive effect.

Maintaining public confidence in the profession

- 16 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 *Good medical practice*, paragraph 65). Although the tribunal should make sure the sanction they impose is appropriate and proportionate,

* General Medical Council *Good medical practice: explanatory guidance* available at: www.gmc-uk.org/guidance/ethical_guidance/index.asp (accessed 12/05/2015)

[†] 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).

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

- 17 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.
- 18 *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.

Taking a proportionate approach to imposing sanctions

- 19 In deciding what sanction, if any, to impose the tribunal should consider the sanctions available, starting with the least restrictive, and have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner (this will usually be an impact on their career, for example a short suspension for a doctor in training may significantly disrupt the progression of their career due to the nature of training contracts).
- 20 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.
- 21 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 order[†] is entirely different from the criteria used by medical practitioners tribunals when considering an appropriate substantive sanction.
- 22 Further guidance on the factors to consider when deciding on specific sanctions is set out in paragraphs 23–141.

* Bolton v The Law Society [1993] EWCA Civ 32

† Medical Practitioners Tribunal Service (2013) *Imposing interim orders: guidance for the interim orders tribunal and the medical practitioners tribunal* available at: http://www.gmc-uk.org/DC4792_Imposing_Interim_Orders_Guidance_for_the_IOT_and_MPT_28443349.pdf (accessed 12/05/2015)

Mitigating and aggravating factors to consider when deciding on a sanction

Mitigating factors

- 23** The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 13–14). 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.
- 24** Examples of mitigating factors include:
- 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 35–42), 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 or by the GMC’s previous committees.
 - c** circumstances leading up to the incidents – for example, inexperience (see paragraphs 26–29) 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.
- 25** 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 Co-operate 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

- 26** 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.
- 27** 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.
- 28** 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 37–42), 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.
- 29** In cases involving serious concerns about a doctor's performance or conduct – for example, predatory behaviour to establish a relationship with a patient (see paragraphs 105–106), or serious dishonesty (see paragraphs 129–137) – 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

- 30** 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.
- 31** 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.
- 32** In such serious cases, the tribunal must fully and clearly explain:
- a** the extent to which the concerns can be remediated
 - b** the steps the doctor has taken
 - c** how the seriousness of the concerns – 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

- 33** Doctors may present references and testimonials to support their good standing in the community or profession. The tribunal should consider whether the authors are aware of the events leading to the hearing and what weight, if any, to give to these documents.
- 34** As with other mitigating factors, any references or testimonials will need to be weighed appropriately against the nature of the facts found proved. 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
 - 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

- 35** 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, honest and apologise.

36 A doctor's apology of 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*^{*} provides that an apology, an offer of treatment or other redress, shall not of 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 concerns raised have occurred in these countries. For the purposes of fitness to practise proceedings, an apology of itself will not be treated as an admission of guilt (whether as to facts or impairment).

The doctor's insight into the concerns

37 Expressing insight involves demonstrating reflection and remediation.

38 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 paragraph 32) and apologise at an early stage[†], before the hearing
- c demonstrate the timely development of insight during the investigation and hearing.

39 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

^{*} *Compensation Act 2006* available at: www.legislation.gov.uk/ukpga/2006/29/contents (accessed 05/05/2015)

[†] *Openness and honesty: the professional duty of candour (GMC/NMC 2015)*

- d** fail to tell the truth during the hearing.
- 40** 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.
- 41** 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.
- 42** The tribunal should be aware of, and sensitive to, these issues when assessing whether the doctor has insight.

Aggravating factors

- 43** Aggravating factors that are likely to lead the tribunal to consider taking more serious action include:
 - a** The circumstances surrounding the events – for example, a doctor who abused their position of trust by taking advantage of a vulnerable person (breaching paragraphs 53 and 54 of *Good medical practice*) or previous findings of impaired fitness to practise where sanctions have been imposed on the doctor's registration either by the GMC or another regulator.
 - b** Certain conduct in a doctor's personal life, such as (this list is not exhaustive):
 - i** misconduct involving violence or offences of a sexual nature (see paragraphs 107-08)
 - ii** concerns about their behaviour towards children or vulnerable adults (see paragraphs 103-04 and 109-17)
 - iii** concerns about probity – ie being honest and trustworthy and acting with integrity (see paragraphs 129-37)
 - iv** misuse of alcohol or drugs leading to a criminal conviction or caution (see paragraphs 118-28)
 - v** 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 97–99).

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

- 44 Where a tribunal finds a doctor's fitness to practise is **not** impaired, it can:
- a take no action
 - b issue a warning if the doctor's conduct, behaviour or performance has significantly departed from our guidance in *Good medical practice*.
- 45 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 area the tribunal wishes to address.
- 46 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*.*
- 47 When deciding the wording of a warning, the tribunal should refer to the *Guidance on warnings*.
- 48 It is important that the tribunal gives clear reasons for issuing, or for not issuing, a warning.

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

- 49 Where a tribunal finds a doctor's fitness to practise is impaired, it can:
- a take no action (see paragraph 51-53)
 - 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 54–59)

* General Medical Council (2012) *Guidance on warnings* available at: www.gmc-uk.org/Guidance_on_Warnings.pdf_25416870.pdf (accessed 12/05/2015)

- c** impose conditions on the doctor's registration for up to three years (see paragraphs 60–71)
 - d** suspend the doctor's registration for up to 12 months (see paragraphs 72–85)
 - 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 86–90).
- 50** The tribunal's written decision (known as the determination) 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

- 51** Where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (see paragraphs 13–14). But there may be exceptional circumstances to justify a tribunal taking no action.
- 52** To find 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 they are therefore unlikely on their own to justify a tribunal taking no action.
- 53** 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?

- 54** 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 re-training. 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 sanction.*

In which cases can undertakings be agreed?

55 Undertakings are likely to be appropriate 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 concerns
- c the tribunal is satisfied that the doctor will comply with them
- d the doctor has the potential for remediation.

56 The tribunal may wish to see evidence that the doctor has taken responsibility for, or has taken steps to mitigate, their actions (see paragraphs 23–42).

57 The tribunal should consider the guidance *Undertakings at medical practitioners tribunal hearings*[†] when deciding whether to accept undertakings.

Deciding what the undertakings should be

58 The tribunal must be satisfied that the undertakings are sufficient to protect patients and the public interest (see paragraphs 13–14), 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.

* *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)*.

[†] [http://www.mpts-](http://www.mpts-uk.org/DC4253_Undertakings_at_Medical_Practitioners_Tribunal_hearings.pdf)

[uk.org/DC4253_Undertakings_at_Medical_Practitioners_Tribunal_hearings.pdf](http://www.mpts-uk.org/DC4253_Undertakings_at_Medical_Practitioners_Tribunal_hearings.pdf) 3799534.pdf

59 Undertakings should normally follow the wording in *Agreeing a doctor's undertakings*.*

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

What are conditions?

60 Similar to undertakings, conditions restrict a doctor's practice or require them to do something (see paragraph 54). 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.

61 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.

In which cases can conditions be imposed?

62 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.

63 Conditions are likely to be appropriate and workable where:

- a** the doctor has insight into the concerns
- b** a period of retraining and/or supervision is likely to be the most appropriate way of addressing any concerns
- c** the doctor has the potential to respond positively to remediation, or retraining or to their work being supervised.

* General Medical Council (2015) *Agreeing a doctor's undertakings* available at: http://www.gmc-uk.org/DC4351_Undertakings_Bank_25416205.pdf (accessed 12/05/15)

- 64** When deciding whether remedial training is possible, the tribunal needs to consider any objective evidence 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.
- 65** Depending on the type of case (eg health, language, performance or misconduct), the tribunal needs to be satisfied that the doctor meets most or all of the following criteria (this list is not exhaustive):
- a** no evidence of harmful deep-seated personality or attitudinal problems
 - 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 22–23 on safety and quality)
 - 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

- 66** Conditions should be appropriate, proportionate, workable and measurable.
- 67** Conditions should normally follow the wording in *Imposing conditions on a doctor's registration** to maintain a clear distinction between conditions on a doctor's practice (which are published) and 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 *GMC glossary for fitness to practise*.†

* General Medical Council (2015) *Imposing conditions on a doctor's registration* available at: http://www.gmc-uk.org/DC4326_MPT_Conditions_Bank_25415696.pdf (accessed 12/05/15)

† General Medical Council (2015) *GMC glossary for undertakings and conditions* available at: http://www.gmc-uk.org/DC4327_Glossary_of_Terms_used_in_Fitness_to_Practise_Actions_25416199.pdf (accessed 12/05/15)

- 68 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 which are not set out in *Imposing conditions on a doctor's registration*, in order to minimise any impact on the doctor.
- 69 The tribunal should consider whether the conditions imposed should take effect immediately,* taking into account any evidence received and any submissions made by the parties. The tribunal should explain fully the reasons for their decision. Further guidance on when an immediate order might be appropriate is set out in paragraphs 148–52.
- 70 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 concerns and the exact proposals to resolve them, and to evaluate whether the concerns have been resolved.
- 71 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 (up to 12 months, but may be indefinite in cases relating solely to a doctor's health and/or knowledge of English)

- 72 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 period of suspension, although this is not its intention.
- 73 Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order 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

* 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)*.

practise again either for public safety reasons or in order to protect the reputation of the profession). 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 23–42).

- 74** 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. 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 undertaken during the period of suspension, may help the tribunal's evaluation at any subsequent review hearing. The tribunal should, however, bear in mind that during the period of suspension the doctor will not be able to practise.
- 75** 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, the events that resulted in the doctor's registration being suspended and have given their full consent.

Determining the length of suspension

- 76** 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.
- 77** 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 concerns and any mitigating or aggravating factors (as set out in paragraphs 23–42)
 - c** ensuring the doctor has adequate time to remediate.
- 78** The tribunal's primary consideration should be public protection and the seriousness of the concerns. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.

79 The table below 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:

Knowledge, skills and performance	<ul style="list-style-type: none">•The extent to which the doctor departed from principles of <i>Good medical practice</i>•Whether the doctor is reluctant to take remedial action
Communication, partnership and teamwork	<ul style="list-style-type: none">•Whether the doctor is reluctant to apologise•The extent to which the doctor failed to comply with restrictions/requirements
Safety and quality	<ul style="list-style-type: none">•The extent to which the doctor failed to address serious concerns over a period of time•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•Whether the doctor showed a deliberate or reckless disregard for restrictions/requirements
Maintaining trust	<ul style="list-style-type: none">•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•Whether the doctor failed to be open and honest with GMC and local investigations•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

- 80** 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* where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the medical register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public 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 which relate to the doctor's health, where the doctor's judgement may be impaired and where there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions, or the doctor has failed to comply with restrictions or requirements.
 - d** in cases which relate to knowledge of English, where the doctor's language skills impact on 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 of harmful, deep-seated personality or attitudinal problems
 - 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.
- 81** The tribunal must also consider, as required by Rule 17(2)(o)*, 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 their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 148–52.
- 82** Where a doctor is suspended because of concerns about their knowledge of English, a six-month period of 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 IELTS assessment. In cases which relate solely to either health or

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

knowledge of English (where erasure is not available as a sanction) the tribunal can suspend a doctor's registration indefinitely where necessary (see paragraph 84).

- 83** 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.
- 84** In cases which 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, although the doctor can request a review after a period of two years has elapsed from the date when the indefinite suspension took effect.
- 85** The tribunal must provide reasons for the period of suspension chosen, including the factors that led them to conclude that the particular period of suspension, whether the maximum available or a shorter period, was appropriate.

Erase the doctor's name from the medical register

- 86** The tribunal may erase a doctor from the medical register in any case - except one which relates solely to the doctor's health and/or knowledge of English - where this is the only means of protecting the public.
- 87** 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.
- 88** **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 138–41 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 109–17)
 - g offences involving violence
 - h dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 129–37)
 - i putting their own interests before those of their patients (see *Good medical practice* – “Make the care of your patient your first concern” at paragraph 1 and paragraphs 77–80 regarding conflicts of interest)
 - j persistent lack of insight into the seriousness of their actions or the consequences.
- 89** When directing erasure, the tribunal must also consider, as required by Rule 17(2)(o),* whether to make an order suspending 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 their decision. Further guidance on when an immediate order might be appropriate is set out at paragraphs 148–52.
- 90** A doctor who has been erased cannot apply to be restored to the medical register until five years have elapsed.† At that stage the tribunal will have to decide whether the doctor is fit to resume unrestricted practice. Further guidance on

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

† Section 41(2)(a) Medical Act 1983 as amended

doctors' restoration to the medical register is provided in the *Guidance for doctors on restoration following erasure by a medical practitioners tribunal* *

Cases that indicate more serious action is likely to be required

Failure to raise concerns

- 91** 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 *Good medical practice* (paragraphs 24–25) and in the explanatory guidance *Raising and acting on concerns about patient safety*[†]. These duties apply to all doctors and not just those with specific management or leadership responsibilities.
- 92** 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)).
- 93** Where the doctor has repeatedly failed to raise concerns over an extended period of time, and/or has failed to raise concerns which present a serious risk to patient safety, the tribunal should consider whether or not it is appropriate to remove or suspend the doctor to maintain public confidence.

Failure to work collaboratively with colleagues

- 94** Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in *Good medical practice* (paragraphs 35–37).
- 95** Colleagues include anyone a doctor works with, whether or not they are also doctors.

* http://www.gmc-uk.org/DC4432_Guidance_for_doctors_on_restoration_following_erasure_by_an_MPT_25416789.pdf (accessed 12/05/15)

† http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp (accessed 12/05/15)

- 96 More serious outcomes are likely to be appropriate if there are serious concerns which involve:
- a bullying
 - b sexual harassment
 - c physical violence towards colleagues, or
 - d unlawful discrimination (see paragraphs 97–99).

Discrimination against patients, colleagues and other people

- 97 Doctors must treat their colleagues and patients fairly, whatever their life choices and beliefs. The guidance on this can be found in paragraphs 48, 54 and 57 of *Good medical practice*.
- 98 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 legislation* (*Good medical practice*, paragraph 59).
- 99 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*[†]).

Abuse of professional position

- 100 Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in *Good medical practice* (paragraph 53) and in the explanatory guidance

* 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, sexual orientation.

[†] http://www.gmc-uk.org/guidance/ethical_guidance/21171.asp (accessed 12/05/15)

Maintaining a professional boundary between you and your patient and Ending your professional relationship with a patient^{*}.

101 Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them[†].

102 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*[‡])
- c** the vulnerability of the patient (see paragraphs 103–04), and
- d** whether the doctor is caring for other members of the family.

Vulnerable patients

103 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** children and young people aged under 18 years
- c** disability or frailty
- d** bereavement
- e** history of abuse or neglect.

104 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.

^{*} http://www.gmc-uk.org/guidance/ethical_guidance/21170.asp (accessed 12/05/15)

[†] A definition of 'someone close to them' is provided in the explanatory guidance on maintaining a professional relationship between you and your patient (paragraph 6) available at www.gmc-uk.org/guidance/ethical_guidance/21170.asp (accessed 12/05/15)

[‡] http://www.gmc-uk.org/static/documents/content/Maintaining_a_professional_boundary_between_you_and_your_patient.pdf (accessed 22/06/15)

Predatory behaviour

105 Where a doctor demonstrates 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.

106 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, involves a vulnerable patient, or constitutes a criminal offence.

Sexual misconduct

107 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 109–17.

108 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

109 Any doctor who has been convicted of, or has received a caution for, a sexual offence listed in Schedule 3 of the Sexual Offences Act 2003 is required to notify the police ("register") under S80 of the Sexual Offences Act 2003 and may be required to undertake a programme of rehabilitation or treatment. Sexual offences include accessing and viewing or other involvement in child pornography, which involves the exploitation or abuse of a child. 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).

- 110** 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.
- 111** 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 19–22 and 44–90 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.
- 112** 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).^{*} The Council has made it clear that no doctor registered as a sex offender should have unrestricted registration. The tribunal will therefore need to ensure that, in cases where it imposes a period of suspension or conditions, the case should be reviewed before the end of this period to consider whether a further period is appropriate.
- 113** In order to protect the public, the tribunal should consider whether any conditions they impose should direct no contact with any patients during the period the doctor is registered as a sex offender. (Doctors may of course be registered as sex offenders following other sexual offences not related to child pornography).
- 114** The tribunal should also consider whether doctors registered as sex offenders should be required to undergo assessment, for example by a clinical psychologist, to assess the potential risk to patients before they may be permitted to resume any form of practice.
- 115** 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 the following factors:

^{*} <http://www.legislation.gov.uk/ukpga/2006/47/contents> (accessed 12/05/15)

- 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 re-offending
- e the possible risk to patients and the wider public if the doctor was allowed to resume unrestricted practice
- f the possible damage to the public's trust in the profession if the doctor was allowed to resume unrestricted practice.

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

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

Drug and alcohol misuse linked to misconduct or criminal offences

118 Doctors are expected to act with honesty and integrity and uphold the law and this includes in relation to 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.

119 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).

120 While misuse of drugs and 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 121–28).

Other issues relevant to sanction

Considering conviction, caution or determination allegations

- 121** Convictions refer to a decision by a criminal court in the British Isles, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence.
- 122** Cautions refer to offences committed in the British Isles or elsewhere but where no court proceedings took place because the doctor admitted the offence and criminal proceedings were considered unnecessary.
- 123** Determinations refer to decisions by another health or social care regulatory body, in the United Kingdom or elsewhere, which has made a determination that the fitness to practise of the doctor as a member of that profession is impaired (or an equivalent finding).
- 124** Where the tribunal receives a signed certificate of the conviction or determination, unless it also receives evidence to the effect that the doctor is not the person referred to in the conviction or determination, then the tribunal is bound to accept the certificate as conclusive evidence that the offence was committed, or that the facts are as found by the determination. In accepting a caution, the doctor will have admitted committing the offence.
- 125** 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 in order to protect the public (who might come to the doctor as patients) and to maintain the high standards and good reputation of the profession. The tribunal should take account of the paragraphs in *Good medical practice* (paragraphs 65–67) regarding the need to be honest and trustworthy, and to act with integrity.
- 126** The tribunal should, however, bear in mind that the sentence or sanction previously imposed is not necessarily a definitive guide to the seriousness of the offence. There may have been personal circumstances that led the court or regulatory body to be lenient. For example, the court may have expressed an expectation that the regulatory body would erase the doctor. Similarly, the range

of sanctions and how they are applied may vary significantly amongst other regulatory bodies.

127 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.”

128 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.

Dishonesty

129 *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.

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

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

131 *Good medical practice* (paragraphs 78–80) and the separate guidance on *Financial and commercial arrangements and conflicts of interest*,* further emphasises the duty to avoid conflicts of interest.

132 In relation to providing and publishing information about their services *Good medical practice* (paragraph 70) 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”

133 Although it may not result in direct harm to patients, dishonesty related to matters outside the doctor’s clinical responsibility (for example 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

* http://www.gmc-uk.org/guidance/ethical_guidance/21161.asp (accessed 12/05/15)

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 dishonesty which is serious and/or persistent.

134 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 ensure that statements made in formal documents are accurate.

135 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*^{*}.

136 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*[†])

137 Dishonesty, if persistent and/or covered up, is likely to result in erasure (see further guidance at paragraph 129-37).

^{*} http://www.gmc-uk.org/guidance/ethical_guidance/21188.asp (accessed 12/05/15)

[†] http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp (accessed 12/05/15)

Failing to provide an acceptable level of treatment or care

- 138** 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 patient your first concern" (*Good medical practice*, paragraph 1).
- 139** A particularly important consideration in these cases is whether or not a doctor has, 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.
- 140** 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.
- 141** 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.

Review hearings

- 142** 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.
- 143** In some misconduct cases it may be self-evident that following a short period of suspension, there will be no value in a review hearing. 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, and

- d patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.

Should there be a change of circumstances in the future and a review hearing hasn't been directed, under Section 35D (4B and 11B) of the Medical Act, 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 for not directing might help inform any decision under this section. It is therefore important that tribunals fully explain any instance where they decide not to direct a review hearing.

144 Where a tribunal has found that the doctor has not complied with the conditions on their registration* 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.†

145 Where a doctor's registration is suspended, the tribunal may direct that the current period of suspension is extended (up to 12 months), that the doctor's name is erased from the medical register (except in cases which relate solely to the doctor's health and/or knowledge of English) or impose a period of conditions (up to three years).‡ In cases involving solely the doctor's health or language, it is also open to the tribunal to suspend the doctor's registration indefinitely§ (see paragraph 85).

146 Where a review hearing cannot be concluded before the expiry of the period of conditional registration or suspension, the tribunal may extend it for a further short period** to allow for re-listing of the review hearing as soon as practicable, to maintain the status quo pending the outcome of the review hearing.

147 The tribunal may, when considering sanction, take into account any written undertakings offered by the doctor, which it considers sufficient to protect members of the public and the public interest, 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

* Section 35D (9) and (10) Medical Act 1983 as amended

† Section 35D (11) and (12) Medical Act 1983 as amended

‡ Section 35D (5) Medical Act 1983 as amended

§ Section 35D (6) Medical Act 1983 as amended

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

- b anyone from whom the doctor is seeking employment to provide medical services or has an arrangement to do so, and
- c any other person enquiring.

Immediate orders (suspension or conditions)

148 The tribunal may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. * The interests of the doctor 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. These factors should be balanced against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require the imposition of an immediate order.

149 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 is required to protect public confidence in the medical profession.

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

151 Where the tribunal has directed a period of conditional registration as the substantive outcome of the case, it may impose an immediate order of conditional registration. Where the tribunal has directed suspension or erasure as the substantive outcome of the case, it may impose an immediate order to suspend registration.

* Section 38 of the Medical Act 1983 as amended

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

Annex A

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](#)

(Previous and no longer current versions of Good medical practice, published in 2001, 1998 and 1995 respectively, can be downloaded from our archive section at <http://www.gmc-uk.org/guidance/archive.asp>)

[Supplementary ethical guidance](#)

[Guidance to the Fitness to Practise Rules](#)

[Meaning of Fitness to Practise](#)

[Guidance on agreeing undertakings at the investigation stage \(*Consensual Disposal*\)](#)

[Case Management Procedure - Guidance for Parties and Representatives](#)

[Guidance for Specialist Advisers](#)

[Guidance on warnings](#)

[Undertakings at medical practitioners tribunal hearings](#)

[Undertakings bank](#)

[MPT conditions bank](#)

[Medical career structure – Doctors in training](#)

[Glossary of terms used in FTP actions](#)

[Guidance on the use of clinical attachments](#)

[International Classification of Diseases \(ICD10\)](#)

[Imposing interim orders – Guidance for the interim orders tribunal and the medical practitioners tribunal](#)

[Interim conditions bank](#)

[Voluntary Erasure – Guidance for decision-makers](#)

[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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