PUBLIC RECORD

Dates: 05/10/2026 - 09/10/2026

Doctor:	Dr Gabriela Corina PACURAR
GMC reference number:	7699750
Primary medical qualification:	Doctor - Medic 1992 Universitatea de Medicina si Farmacie 'Victor Babes' din Timisoara

Type of case	Outcome on facts	Outcome on impairment
New – Deficient professional performance	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 12 months
Immediate order imposed
Review hearing directed

Tribunal:

Legally Qualified Chair:	Ms Rachel Jones
Lay Tribunal Member:	Mr Vince Cullen
Registrant Tribunal Member:	Dr Muhammad Dadibhai

Tribunal Clerk:	Miss Maria Khan Ms Lydia Judge

Attendance and Representation:

Doctor:	Not present, not represented
GMC Representative:	Mr Robin Kitching, Counsel Ms Harriet Tighe, Counsel (09/10/2026 PM only)

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 07/10/2026

Background

1. Dr Pacurar qualified in 1992 from the Universitatea de Medicina si Farmacie 'Victor Babes' din Timisoara, Romania, and obtained the equivalent of Certificate of Completion of Training in General Practice in 1994. Dr Pacurar worked as a GP in Romania from 1994 to 2006. Dr Pacurar then moved to USA, where she worked for a number of years in various roles.

2. Dr Pacurar moved to the UK in 2019. She held full registration and licence to practise from June 2019 and was on the General Practice Register from August 2019. She started the NHS England International GP Recruitment ('IGPR') Programme ('the Programme') in October 2019. Under the IGPR she undertook several clinical attachments, the last of which was at Harbourside Medical Practice, North Somerset from May to November 2023. Her educational supervisor in that placement was Dr A. Dr Pacurar was released from the IGPR in early 2024. Following this, a referral was made to the GMC concerning Dr Pacurar's clinical performance, and her relationship with colleagues.

3. The allegations that have led to Dr Pacurar's hearing relate to her professional performance. It is alleged that, in June 2025, Dr Pacurar underwent a GMC assessment of her professional performance. It is alleged that her clinical performance was unacceptable in the following areas: maintaining professional performance, assessment of patients' condition and clinical management. It is further alleged that Dr Pacurar's performance was a cause for concern in relation to working with colleagues.

The outcome of applications made during the facts stage

4. The Tribunal granted the GMC's application, made pursuant to Rules 15, 40 and 31 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to proceed with the hearing in the doctor's absence. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the doctor's response

5. The Allegation made against Dr Pacurar is as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 16-17 June 2025 you underwent a General Medical Council assessment of the standard of your professional performance.
   To be determined

2. Your professional performance was unacceptable in the following areas:

   a. maintaining professional performance;
      To be determined

   b. assessment of patients' condition;
      To be determined

   c. clinical management.
      To be determined

3. Your professional performance was a cause for concern in the following areas:

   a. working with colleagues.
      To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your deficient professional performance. To be determined

6. No admissions were made by Dr Pacurar.

Witness evidence

7. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Dr B, medical assessor for the GMC's PA Team by video link on day one of the hearing, 5 October 2026;

- Dr C, Team Leader of the PA Team, by video link on day two of the hearing, 6 October 2026;
- Ms D, Performance Assessment Officer ('PAO') for the PA Team, by video link on day two of the hearing, 6 October 2026. Ms D also provided a witness statement dated 4 June 2025.

8. Dr Pacurar did not attend her hearing or provide a witness statement.

Documentary evidence

9. The Tribunal was provided with documentary evidence which included, but was not limited to, the following:

- GMC referral from Dr E, and supporting documents, dated 23 May 2024;
- Email from Dr Pacurar to the GMC, dated 3 April 2025, enclosing Part 1 of the Performance Assessment Portfolio;
- Email from Dr Pacurar to the GMC, dated 30 April 2025, confirming attendance at the Performance Assessment;
- Performance Assessment Report, dated 1 August 2025;
- Dr Pacurar's submissions to the Interim Orders Tribunal, dated 28 August 2025;
- Dr Pacurar's Rule 7 response, dated 10 October 2025, and supporting documents.

Submissions

10. On behalf of the GMC, Mr Robin Kitching, Counsel, stated that the GMC's case rested on the Performance Assessment Report dated 1 August 2025 ('PA Report'). Mr Kitching submitted that while the Tribunal had been provided with other information in their hearing bundle for context, the documentary evidence on which the GMC relied was contained in that report, including its appendices.

11. Mr Kitching directed the Tribunal to several areas within the PA report. He submitted that both of the assessors had significant relevant experience. He invited the Tribunal to rely upon the evidence presented in the report and the oral evidence from the performance assessors when coming to its own, independent determination.

The Tribunal's approach

12. In reaching its decision on the facts, the Tribunal was advised to bear in mind that the burden of proof rests with the GMC and it is for the GMC to prove the case that it is presenting against the doctor. There is no burden on the doctor to prove or disprove anything.

13. In reaching a decision on the facts, the Tribunal is required to form its own judgement about the evidence before it, and to reach its own, independent conclusions.

14. The task of the Tribunal is to consider each allegation in turn. Each has to be considered separately.

The Tribunal's analysis of the evidence and findings

15. The Tribunal has considered each paragraph of the Allegation separately and has evaluated the evidence to make its findings on the facts.

Paragraph 1

16. The documentary evidence shows – and Dr Pacurar did not dispute – that between 16 and 17 June 2025, she underwent a GMC assessment of the standard of her professional performance ('performance assessment' or 'PA'). Paragraph 1 was therefore found proven.

17. Dr Pacurar's performance was assessed under the categories listed below and with reference to the professional standards described in the GMC's *Good Medical Practice.* The conclusions in the PA Report were as follows:

- Maintaining Professional Performance – Unacceptable
- Assessment of Patient's Condition – Unacceptable
- Clinical Management – Unacceptable
- Record Keeping – Insufficient evidence
- Relationships with Patients – Acceptable
- Working with Colleagues – Cause for concern

18. The assessment team carried out interviews with Dr Pacurar, a Simulated Surgery involving 10 hypothetical patient cases played by actors, and case based discussions ('CBDs') based on the same ten cases. Dr Pacurar also sat a knowledge test.

Dr Pacurar's submissions about process

19. Dr Pacurar did not attend the hearing or provide a witness statement. The Tribunal was, however, provided with Dr Pacurar's Rule 7 Response and accompanying documents from late 2025. This included Dr Pacurar's submissions about each of the cases considered in the PA Report.

20. The Tribunal considered the points made by Dr Pacurar in full. In the Tribunal's view, some of her submissions raised overarching issues, which could not sensibly be determined when considering each Allegation separately. In particular, Dr Pacurar argued that the process leading to the PA Report was procedurally unfair for the following reasons:

a. The PA relied *"heavily"* on *"testimonies"* from Dr F and Dr E. Dr F was a Training Development Supervisor within the IGPR, i.e. the training programme in which Dr

Pacurar participated between 2019-2023. Dr E was Dr Pacurar's Responsible Officer who made the referral to the GMC which led to the PA. Dr Pacurar alleged that these two doctors had *"coordinated involvement"* and were biased.

b. The PA relied on Consultation Questionnaires ("CQs") from members of the Harbourside practice, including Dr A, Dr Pacurar's former Educational Supervisor. Dr Pacurar alleged that the selection of CQs was *"deliberately narrow"* with no attempt made to 'balance' this with feedback from other colleagues with whom she had worked. She further argued that the evidence in the CQs, but in particular Dr A's, was *"biased and distorted".*

c. The Simulated Surgery cases were unfair because she was only allowed 10 minutes for each.

d. The Knowledge Test was unfair because it was in an *"unsigned, pencil-and-paper format",* the questions were *"hand-selected by a GMC medical adviser, covering rare conditions while neglecting core general practice."*

e. It was unfair that the assessors did not consider her patient records as part of their assessment.

21. The Tribunal considered these points carefully, and asked questions of the GMC's three witnesses about them. Its conclusions were that none of these points showed that the PA process was procedurally unfair. In summary, because:

(a) It was incorrect to say that the assessors relied heavily on *"testimonies"* from Drs F or E. Neither of these individuals provided any testimonies to the PA. As summarised in the PA report, and confirmed in Dr B's evidence, the assessors did receive a summary of the GMC's referral from Dr E. This included some of the background to Dr Pacurar's case, including that she had been released from the IGPR after IGPR Panel decisions (which was not disputed). The referral also made other allegations which Dr Pacurar disputed. However, both assessors gave oral evidence that, while it was necessary that they were aware of some of the context, in particular that concerns had been raised about Dr Pacurar's clinical competence, they did not consider it necessary to consider the detailed background of Dr Pacurar's educational placements. Dr C's evidence was that the assessors viewed the details of Dr Pacurar's previous clinical placements as *"largely irrelevant"* to carrying out the TOCs, although they were aware that Dr Pacurar felt she had been treated unfairly in some of those placements. Dr B's oral evidence was that she viewed her role as to perform an assessment of Dr Pacurar's clinical competence on the dates when she saw her, without bias or pre-judgment based on previous events.

(b) As to the allegation that the selection of CQs for the PA was *"deliberately narrow",* the Tribunal heard oral evidence, in particular from Ms D, about the process of obtaining feedback from former colleagues. Based on all the evidence, the Tribunal was

satisfied that the CQs were sought to obtain information about working relationships with Dr Pacurar's colleagues, which was one of the concerns raised in the GMC referral. Dr Pacurar provided a list of colleagues with whom she had worked recently, in her clinical placement at Harbourside. Feedback was sought from the colleagues who had worked closely with her. Dr Pacurar was also asked to nominate colleagues to provide information to the PA. She nominated one person, who declined to participate.

(c) One of the CQs which the GMC obtained included Dr Pacurar's former Educational Supervisor, Dr A. The Tribunal did not consider this rendered the process unfair. The breakdown in Dr A's and Dr Pacurar's relationship could affect the weight to be given to the CQs, but it did not require them to be ignored entirely. The Tribunal further noted that Dr Pacurar provided detailed point-by-point responses to the CQs, which were included in the PA Report. Dr C gave evidence that these responses were received some time after the assessment, but the assessment team considered them prior to the PA report being finalised.

(d) Dr C confirmed in her evidence that the Simulated Surgery lasted 10-12 minutes. She explained that this is standard practice for this kind of assessment, and that Dr Pacurar had been informed of the timings in advance. In addition, the doctor was given an opportunity to reflect further on these case studies in the CBDs.

(e) The Tribunal did not consider that the Knowledge Test was unfair, as Dr Pacurar alleged. First, it was clear from the PA Report that some of the questions, at least, were drawn from the relevant college: i.e. the Royal College of GPs. Second, Dr B's evidence was that the questions in the test were set independently of the assessors: so Dr Pacurar's understanding that they were *"hand selected"* was inaccurate. Third, the methodological description in the PA Report explained that the pass mark was set by reference to the "*hypothetical 'just passing' doctor*". Indeed, Dr Pacurar herself compared the test to one which she had sat some years previously.

(f) As to Dr Pacurar's patient records, the GMC's witnesses gave oral evidence that a decision was made not to review these because, at the time of the assessment, the records were several years old. This was supported by email correspondence between Ms D and Dr Pacurar. Dr C explained that she felt it would be more fair to the doctor for the CBDs to be based on Simulated Surgeries during the assessment process itself, rather than patient records from several years ago.

22. As to the process more generally, the Tribunal heard oral evidence that Dr C and Dr B had each formed their own, independent and contemporaneous views about Dr Pacurar's clinical performance during the PA: i.e. their opinions of both the Simulated Surgeries and the CBDs ("TOCs"). Dr C gave oral evidence that they only received the CQs, or "Third Party Evidence" ("TPE"), on the day of the assessment itself. The Simulated Surgery was set prior to this. Dr C's evidence was that the CQs had *"minimal or no impact"* on the questions which

the assessors asked of Dr Pacurar during the CBDs, which were instead focused on issues arising from the Simulated Surgeries.

23. Each of the assessors' independent observations of Dr Pacurar were recorded in a database. Those observations were the basis for the findings about whether various, individual aspects of Dr Pacurar's clinical performance were *"acceptable"* or *"unacceptable"*: i.e. clearly departed from Good Medical Practice. Those findings were then viewed 'in the round' to reach an overall conclusion within a particular category of performance, e.g. Maintaining Professional Performance.

24. Dr C explained in her oral evidence that, in compiling the report, the first task was to review the assessors' contemporaneous observations and record their conclusions about whether Dr Pacurar's clinical performance was *"acceptable"* or *"unacceptable"*. The CQs were looked at only after this exercise. In terms of Dr Pacurar's clinical knowledge, and her competence in assessing and managing patients, the CQs were used primarily as a 'sense check' on conclusions based on the two assessors' independent observations.

25. Dr C and Dr B both also gave evidence that the *"overall"* conclusions of *"unacceptable"* in the report were largely based on the TOCs: which were weighted heavily, as the assessors had directly observed Dr Pacurar's clinical performance, albeit in an assessment setting. By comparison, the CQs were given relatively little weight, and Dr B explained that they were conscious that some of the evidence in the CQs could be characterised as hearsay.

26. The Tribunal accepted the evidence given above. It further bore in mind that its task was not to "review" the conclusions reached by the assessors. Its function was to reach its own, independent judgement about each paragraph of the Allegation. In so doing, it would consider the evidence set out in the PA Report, including its detailed appendices. However, the weight to be given to the different sources of evidence, if any, was a matter for the Tribunal.

Paragraph 2(a)

27. The Tribunal considered carefully whether the GMC had proven that Dr Pacurar's performance was *"unacceptable"* in terms of "maintaining professional performance".

28. "Unacceptable" was defined in the PA Report as:

> *"evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy."*

29. The Tribunal further considered that, in deciding whether Dr Pacurar's performance overall was unacceptable, significant weight should be afforded to clear evidence of performance that may put patients at risk.

30. This Tribunal considered whether the allegation in relation to "Maintaining Professional Performance" was proven. In this respect, three broad categories of evidence were set out in the PA Report:

1. The Knowledge Test. Dr Pacurar's score was less than the standard set mark.
2. Tests of Competence or 'TOCs'. Specifically, Simulated Surgeries and the CBDs.
3. Third party evidence or 'TPE'. This referred to the CQs, based on evidence from former colleagues at Harbourside, including Dr A

31. As to the Knowledge Test, the Tribunal considered that it was relevant that Dr Pacurar's score was 63.33%, below the standard set mark of 63.93%. The Tribunal observed that this mark was not very far below the 'cut-off'. However, it considered there to be some force in the submission by the GMC – relying on the explanation of the assessment method set out in the PA Report, and Dr B's evidence – that the 'cut-off' mark was set in relation to *"the characteristics of a hypothetical 'just passing' doctor".* The Tribunal considered, but rejected, Dr Pacurar's argument that the test was unfair, for the reasons set out above.

32. As to the TOCs, the PA Report set out some evidence of acceptable performance, but other evidence of unacceptable performance. The Tribunal considered the evidence set out 'in the round'.

33. The Tribunal also had regard to the process followed, as set out above and in the report itself. It considered carefully the description in the report of Dr C's and Dr B's relevant clinical and professional expertise.

34. The Tribunal concluded that there was clear evidence in the PA Report, drawn from the TOCs, of *"repeated"* examples of unacceptable performance. In particular, the Tribunal had regard to the assessors' opinions that Dr Pacurar's performance was *"unacceptable"* in respect of Case 1 (a child with a temperature and a sore throat), Case 5 (a woman requesting contraception) and Case 10 (a new patient attending for painkillers).

35. The opinion of the assessors in the PA report was that the absence of knowledge of guidelines in respect of Cases 1 and 5 should be afforded considerable weight, because these were *"very common"* presentations in general practice. The Tribunal agreed with this assessment. It also considered that the doctor's indication that the contraceptive pill was not contraindicated in Case 5, and the failure to mention certain key factors, was of concern from the perspective of patient safety.

36. Viewing the evidence from the TOCs in the round, the Tribunal was satisfied that Dr Pacurar's performance in respect of "maintaining professional performance" was unacceptable.

37. In light of this conclusion, the Tribunal did not consider it necessary to consider the TPE.

Paragraph 2(b)

38. The Tribunal next considered whether the GMC had proven that Dr Pacurar's performance was *"unacceptable"* in terms of "assessment of patients' conditions". It again had regard to the evidence set out in the PA Report.

39. The Tribunal had regard to Case 8 ("Telephone – Assessing a baby with fever over the telephone). The findings in the PA Report were that Dr Pacurar's assessment of the patient in this case was "*unfocused"*, and did not ask about featured red flags or symptoms that needed to be ruled out as they would be in standard practice. The Team noted that the absence of a proper assessment in this case posed the risk of missing serious illness such as sepsis, which was weighed heavily in the PA report.

40. The Tribunal also had regard to the assessors' opinions in respect of Case 6 of Dr Pacurar's simulated surgery ("Depression assessment"). The assessors considered that her assessment for the patient's risk of suicide was very brief, not allowing for a proper history to be taken. The assessors probed this further during a CBD, where they asked Dr Pacurar how she assesses for risk in patients with mental health problems. This question was asked by the Team in order to gain a fuller understanding of Dr Pacurar's assessment abilities in this area, however, her answer did not include many standard factors that would usually form part of a risk assessment. The assessors' opinion was that: *"this lack of structured approach to assessing risk should be weighed heavily".*

41. In her oral evidence, Dr C drew the Tribunal's attention to Dr Pacurar's performance during Case 1 ("Assess and examine child with temperature"), where she explained that both assessors felt that more probing was needed from Dr Pacurar in order to make a full assessment of the patient. Dr C also highlighted to the Tribunal that a doctor must be the one to raise *'red flags'* during a consultation, particularly a consultation involving a child, so they are able to rule out serious conditions such as sepsis. Dr Pacurar did not do this in her assessment.

42. The Tribunal considered, in light of the evidence in the PA Report about the TOCs and the oral evidence of the assessors, that there were clear, repeated examples of Dr Pacurar's assessment of patients' conditions being *"unacceptable".* The deficiencies in her performance would also pose clear risks to patient safety, in particular in cases involving children, where the doctor must proactively assess for *'red flags'*.

43. The Tribunal were satisfied that the evidence provided proved that Dr Pacurar's performance was unacceptable in the area of assessing patients' condition.

44. In light of this conclusion, the Tribunal did not consider it necessary to consider the TPE evidence.

Paragraph 2(c)

45. The Tribunal next considered whether the GMC had proven that Dr Pacurar's performance was *"unacceptable"* in terms of clinical management. It again had regard to the evidence set out in the PA Report.

46. In Case 8 of the assessment, the Performance Team highlighted that Dr Pacurar did not take an adequate history of the baby's condition, did not appropriately safety net during the appointment, and did not arrange to see the baby in a face-to-face appointment to conduct further checks. Both assessors were of the opinion that Dr Pacurar's management in this case was unacceptable – the management (or lack of) provided to the patient was a risk to their safety.

47. The Tribunal also had regard to Case 5 ("Counselling regarding inappropriate contraception") of the assessment. In the report, the Team highlighted that Dr Pacurar "*agreed to prescribe the combined contraceptive pill to a patient in whom this was clearly contraindicated"*, which would have placed the patient at an increased risk of stroke and blood clots due to her age and smoking status. As this risk would have been avoidable by prescribing the correct contraceptive, the Tribunal deemed this action a significant risk to patient safety and concluded that the clinical management provided here was unacceptable.

48. The Tribunal also had regard to the oral evidence provided by Dr C. Dr C drew the Tribunal's attention to Case 6, where the assessor's view was that Dr Pacurar did not appropriately probe the patient when taking a history of any associated symptoms of her depression (e.g. anxiety, psychosis). Dr C also highlighted that Dr Pacurar did not properly assess the risk of self-harm or harm to others in this case due to a lack of professional curiosity and proper history taking.

49. Dr C made it clear to the Tribunal that the cases put forward in Dr Pacurar's performance assessment were those that would commonly be seen in primary care – Dr Pacurar should have been able to appropriately manage the patients in each case. Dr C affirmed her conclusion that Dr Pacurar's clinical management was unacceptable based on the TOCs.

50. The Tribunal were satisfied that the evidence provided proved that Dr Pacurar's performance was unacceptable in the area of clinical management. In light of this conclusion, the Tribunal did not find it necessary to consider the TPE.

Paragraph 3(a)

51. The final allegation against Dr Pacurar was that her professional performance was a *"cause for concern"* in terms of "working with colleagues".

52. *"Cause for concern"* was defined in the PA report as: *"there is not sufficient evidence to suggest deficient professional performance".* By definition, therefore, findings in this respect could not, in themselves, lead to a finding of impairment.

53. The Tribunal considered that the main issue raised by the PA Report, based on the independent assessors' direct observations and assessments of Dr Pacurar, was Dr Pacurar's clinical knowledge, assessment of patients, and management of patients.

54. However, the Tribunal considered whether there was *"cause for concern"* in the sense of *"some instances of unacceptable performance"* by Dr Pacurar in working with colleagues.

55. In terms of the relevant alleged *"unacceptable performance",* the PA Report considered whether Dr Pacurar had difficulties in her working relationships with colleagues: specifically, whether Dr Pacurar had been *"verbally aggressive"* to Dr A in her last clinical placement at Harbourside, on two occasions.

56. The conclusion reached in the PA Report was that Dr Pacurar had been *"verbally aggressive"* to Dr A, and that this showed she had difficulties with responding to constructive feedback.

57. The Tribunal noted that this conclusion was based solely on the CQs obtained from Dr Pacurar's former colleagues at Harbourside. The evidence of both assessors confirmed that while they considered there was *"cause for concern",* this rested on evidence in the CQs, not on their own observations of Dr Pacurar. The CQs themselves were brief, and no former colleagues of Dr Pacurar were interviewed or questioned about their allegations. As set out above, Dr Pacurar also provided detailed written responses to the CQs, which the Tribunal considered carefully.

58. The Tribunal did not consider that the evidence set out in the CQs was sufficient to discharge the GMC's burden of proof. The Tribunal concluded that it had insufficient information to reach any firm conclusion about the verbal altercations between Dr Pacurar and Dr A.

59. The Tribunal noted that it would have been open to the GMC to obtain witness statements from Dr A, Dr G, or any other relevant witnesses. Such statements could have explored in more detail the exact wording which it was alleged Dr Pacurar had used, the context for the conversation, and any other relevant details. The GMC had chosen not to do so.

60. In the absence of such evidence, the Tribunal found Allegation 3(a) not proven.

The Tribunal's overall determination on the facts

61. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 16-17 June 2025 you underwent a General Medical Council assessment of the standard of your professional performance.
Determined and found proved

2. Your professional performance was unacceptable in the following areas:

   a. maintaining professional performance;
   Determined and found proved

   b. assessment of patients' condition;
   Determined and found proved

   c. clinical management.
   Determined and found proved

3. Your professional performance was a cause for concern in the following areas:

   a. working with colleagues.
   Not proved

And that by reason of the matters set out above your fitness to practise is impaired because of your deficient professional performance. **To be determined**

Determination on Impairment - 09/10/2026

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether Dr Pacurar's fitness to practise is impaired by reason of deficient professional performance.

2. The Tribunal has reviewed its findings of fact and the evidence which it received at Stage 1. It also received a Stage 2 bundle. This comprised:

- Email correspondence between Dr Pacurar and the GMC, 29 July – 02 August 2026, attaching documents regarding her experience and professional standing, e.g. confirmation of employment as a GP in Romania;
- Email exchange between the GMC and Dr Pacurar confirming the above documents could be provided to the Tribunal, dated 24 September 2026.

Submissions

3. Counsel for the GMC, Mr Kitching, submitted that the Tribunal should consider whether Dr Pacurar's failings, as identified in the PA, amounted to deficient professional

performance at the time of that assessment. He submitted that this is clearly the case, based on the Tribunal's findings at Stage 1. The Tribunal should then consider whether Dr Pacurar's fitness to practise is impaired as at today's date.

4. Mr Kitching reminded the Tribunal of the three strands of public protection, and submitted that all three strands were engaged in this case.

5. Mr Kitching drew the Tribunal's attention to the 2024 version of *Good medical practice* ('GMP'). He invited the Tribunal to focus on 'Domain 1: Knowledge, skills and development', which was principally relevant to this case. In summary, Mr Kitching submitted that Dr Pacurar's performance had fallen below the standards expected in multiple areas of Domain 1.

6. Mr Kitching reminded the Tribunal that, in three of the seven categories of assessment in the PA Report, Dr Pacurar's professional performance was found to be unacceptable overall. Mr Kitching took the Tribunal through those three categories: Maintaining Professional Performance, Assessment, and Clinical Management. He said that a doctor whose level of performance in these three key areas was unacceptable, had fallen seriously below the standards to be expected of them.

7. Mr Kitching submitted that examples of unacceptable individual cases within the report were numerous. Some were more serious than others. The GMC's position was that some of the failings identified in the PA Report could clearly have created significant risk to patients if they had not been in the assessment context.

8. Mr Kitching referred the Tribunal to the MPTS guidance on impairment. He invited the Tribunal to consider Steps 2a-2e. He pointed to the definition of "*deficient professional performance"* at p.22 of the MPTS Guidance. In this respect, the GMC's case was that the performance assessment process was a fair, representative sample of the doctor's work, and that a PA could in principle, by itself, justify a conclusion of deficient professional performance. He relied on *Arora v GMC* [2012] EWHC 1560 (Admin), and *Sulaiman v GMC* [2011] EWHC 1903 (Admin).

9. By reference to the guidance, Mr Kitching's position was that Dr Pacurar's performance was at least a 'medium' level on the spectrum of seriousness, taking the most generous approach to the doctor. He submitted that the guidance did not fit the circumstances of a PA neatly and was not easily applicable to these facts. Further, Mr Kitching submitted there was no relevant context to consider. There was a significant lack of insight in this case, and Dr Pacurar had not provided evidence of insight. In the GMC's view, Dr Pacurar's attitude was a matter of concern, because remediation required a willing doctor who recognised deficiencies. This lack of insight increased the level of current and ongoing risk to public protection to 'high'.

10. Mr Kitching submitted that there was no evidence of any remediation before the Tribunal. He referred to the Stage 2 bundle of documents, and the email correspondence

stating that Dr Pacurar was working as a doctor in Romania. However, evidence of remediation would require her to acknowledge the problems and to have targeted retraining at the specific areas of concern raised by the PA. Although the evidence she had provided was of some relevance, little weight ought to be attached to it.

11. Mr Kitching told the Tribunal that, if it reached the view that Dr Pacurar poses a current and ongoing risk to public protection requiring restrictive action in response, they should make a finding that the doctor's fitness to practise is impaired, notwithstanding the fact that Dr Pacurar was now working abroad. The Tribunal must approach this on the basis that Dr Pacurar will seek to return to work in the UK.

12. Overall, the GMC's position was that the Tribunal should find Dr Pacurar's deficient professional performance poses a 'high' risk to public protection, and her fitness to practise is currently impaired.

The relevant legal principles

13. There is no burden or standard of proof at this stage of the proceedings. The decision on impairment is a matter for the Tribunal's judgement alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and if it concludes that the doctor poses a current and ongoing risk to public protection. The Tribunal was advised to have regard to all three parts of public protection, as set out in s.1 Medical Act 1983: to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

14. The Tribunal was also invited to have regard to the 2024 version of GMP in force at the time of the PA.

15. The Tribunal was advised to consider section 35C(2)(b) of the Medical Act 1983 and the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), especially paragraphs 27-28, 39. To demonstrate "deficient professional performance", Dr Pacurar's performance needed to be "seriously" deficient.

The Tribunal's determination on impairment

The Tribunal's approach

16. The Tribunal determined to first consider whether the allegations it had found proven gave rise to "deficient professional performance". Next, it would consider Steps 2a-2e of the MPTS guidance referred to in the GMC's submissions: *'Part B: stage 2 – Impairment'* ('Impairment Guidance').

Deficient professional performance

17. The Tribunal considered the case *of Calhaem v General Medical Council* [2007] EWHC 2606 (Admin), in particular paragraph 39:

> *"'Deficient professional performance' within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work."*

18. Further, the doctor's performance needs to be "*seriously*" deficient (paragraphs 27-28). A single instance of merely negligent treatment, "*unless very serious indeed*", is unlikely to constitute deficient professional performance (paragraph 39(4)).

19. The Tribunal also considered p.22 of the Impairment Guidance, which stated that deficient professional performance requires "*an assessment of a fair sample of a doctor's work"* that shows "*that the same clinical act or omission occurs more than once or that there is more than one clinical act or omission."*

20. At Stage 1, the Tribunal has found there were repeated incidents of "*unacceptable*" performance during the PA. However, the GMC's allegation based on Dr Pacurar's final placement in the IGPR was found not proven ('working with colleagues'). It was clear from the PA Report that Dr Pacurar had been aware, for some time, that there were concerns about her professional performance. She had been released from the IGPR in early 2024, following an extension to that training programme in 2023. As Dr Pacurar had explained in written submissions to the PA assessors, an evaluation in the middle of that extension had shown that many targets still needed to be met. The PA was arranged following allegations of deficiencies in the doctor's clinical knowledge, assessment, and management of patients, as recorded in the PA Report.

21. Against this background, the Tribunal considered whether Dr Pacurar's performance in the PA in June 2025 amounts to a "*fair sample of the doctor's work*".

22. The Tribunal had regard to the GMC's submissions. Counsel for the GMC submitted that, first, in principle a doctor's performance may be deficient by reason only of a PA, without more. Secondly that, in this case, the assessments to which Dr Pacurar was subject in the PA represented a "*fair sample*" of her work. The GMC's position was that the PA was a proper basis for finding "*deficient professional performance"*.

23. At the impairment stage, the GMC provided the Tribunal with two cases, both involving PAs: *Arora v GMC* [2012] EWHC 1560 (Admin), and *Sulaiman v GMC* [2011] EWHC 1903 (Admin). In particular, §24 of *Arora* in which it was said that the "*performance assessment system is standard and has been independently validated."* The Tribunal's opinion was that each of these two cases turned on their own facts. For example, in *Arora*,

the doctor's performance was found "*to be seriously deficient over a long period of time*" (§22).

24. The Tribunal considered that, inevitably, a PA was an artificial environment. However, it noted that Dr Pacurar had not been practising medicine in the UK at the time of her PA. A PA was a means of assessing her professional performance.

25. The Tribunal also considered its conclusions at the fact stage, in which it had rejected Dr Pacurar's argument that the PA was procedurally unfair in various respects. It also had regard to evidence it received at the facts stage. Dr Pacurar had asked the GMC to be assessed as a GP (rather than an FY2) as she considered this better reflected her experience. The PA was carried out on that basis, by two independent assessors. The oral evidence of those assessors, as well as the PA Report, made clear that the point of the PA was to test whether the doctor had the minimum level of competence to practise safely as a GP. As Dr B explained, describing the standard by which Dr Pacurar's performance was being judged:

> "*It does not need to be good: it just needs to be competent, so that patients remain safe under the care of the doctor we are assessing".*

26. In the circumstances, the Tribunal considered that, in principle, Dr Pacurar's performance could be "*deficient*" by reference only to her performance in the PA.

27. However, before reaching a conclusion on "*deficient professional performance"*, it was necessary to consider the seriousness of the findings in respect of Dr Pacurar's performance in the PA.

Good Medical Practice (2024) ('GMP')

28. At Stage 1, the Tribunal had concluded that there were "*repeated"* examples from the PA of Dr Pacurar's clinical performance being *"unacceptable*", i.e. clearly failing to comply with relevant standards in GMP. Further, that Dr Pacurar's professional performance was, overall, "*unacceptable"* in terms of her knowledge/ maintaining professional performance, assessment of patients, and management of patients.

29. The following paragraphs of GMP, in particular, were cited in the PA Report (all in Domain 1):

> *3 You must keep up to date with guidelines and developments that affect your work.*
>
> *6 You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options*

7 In providing clinical care you must:

a. *adequately assess a patient's condition(s), taking account of their history, including*
   i. *symptoms*
   ii. *relevant psychological, spiritual, social, economic, and cultural factors*
   iii. *the patient's views, needs, and values*

b. *carry out a physical examination where necessary*
c. *promptly provide (or arrange) suitable advice, investigation or treatment where necessary*
d. *propose, provide or prescribe drugs or treatment (including repeat prescriptions) only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment will meet their needs*
e. *propose, provide or prescribe effective treatment based on the best available evidence*
f. *follow our more detailed guidance on professional standards, Good practice in proposing, prescribing, providing and managing medicines and devices, if you prescribe*
g. *consult colleagues or seek advice from your supervising clinician, where appropriate*
h. *refer a patient to another suitably qualified practitioner when this serves their needs.*

11 You must keep your professional knowledge and skills up to date.

Seriousness of departures from GMP

30. The Tribunal considered whether it was satisfied that there had been sufficiently serious departures from the principles in GMP. It reminded itself of all the oral and written evidence it had received at Stage 1, and its determination at that stage. In assessing seriousness, the Tribunal gave appropriate weight to the expert opinions of the two independent assessors, Dr C and Dr B.

31. As set out in the Stage 1 determination, the Tribunal considered that the PA Report contained numerous examples of both acceptable and unacceptable performance by Dr Pacurar. It bore this in mind in assessing the seriousness of Dr Pacurar's departures from GMP.

32. The Tribunal observed that the assessors made multiple findings of "*unacceptable*" performance across all 10 of the cases which were the subject of the Simulated Surgery and CBDs. However it considered that, in relation to Case 4, this was significantly mitigated by an

error where the role-playing patient had handed over all the assessment cards at once. That error was pointed out in the PA Report itself, and accepted by the assessors in their oral evidence. The Tribunal considered that limited weight should be given to Dr Pacurar's unacceptable performance in Case 4.

Maintaining knowledge: seriousness of departures from GMP

33. GMP, Domain 1, paragraphs 1 and 3 require that doctors keep "*professional knowledge and skills up to date"* and that doctors "*keep up to date with guidelines and developments"*. Dr Pacurar scored below the standard set mark in the Knowledge Test. As set out in its Stage 1 determination, the Tribunal considered that some weight must be given to this result, albeit that it was only just below the set mark. In respect of knowledge, Dr Pacurar's performance was also found to be deficient in respect of Cases 1, 5, 7, and 10. The Tribunal had concluded that the absence of knowledge of guidelines in respects of Cases 1 and 5, in particular, should be weighed heavily.

34. Taking the TOCs and the Knowledge Test in the round, the Tribunal considered that the deficiencies in Dr Pacurar's performance in this respect were serious. It noted again its concern, from the perspective of patient safety, about the doctor's lack of knowledge of guidelines for "*very common*" presentations.

Clinical assessment: seriousness of departures from GMP

35. Good Medical Practice, Domain 1, paragraphs 6 and 7(a)-(c) require that doctors perform competently in respect of history-taking, examination, and reaching a diagnosis. Each of these were considered in turn in the PA Report.

36. Overall, the Tribunal considered that under the clinical assessment heading there were "*repeated*" clear, serious departures from GMP:

a. In terms of history-taking, there were serious deficiencies in Dr Pacurar's performance in respect of Cases 1, 3, 5, 6, 8 and 10,
b. In terms of examination, there were serious deficiencies in Dr Pacurar's performance in respect of Cases 6, 7 and 10,
c. In terms of reaching a diagnosis, there were serious deficiencies in respect of Cases 1, 2, 3, 7 and 10.

Therefore, the clinical failings under this heading were both numerous and serious.

37. The Tribunal reminded itself of its conclusions, at the facts stage, that some of the deficiencies in Dr Pacurar's performance in this respect could pose clear risks to patient safety in a real-life scenario. For the reasons set out in the facts determination, the Tribunal weighed the failings in respect of Cases 1, 6 and 8 particularly heavily because of the

particular risks to patient safety involved: risks of potentially very serious illnesses for children, and of suicide.

Clinical management: seriousness of departures from GMP

38. Good Medical Practice, Domain 1, requires that doctors prescribe safely with awareness of contraindications (paragraphs 7(d)-(f)), refer patients or consult colleagues appropriately (paragraphs 7(g)-(h)), provide advice competently (paragraph 7(c)), arrange review and follow-up of patients (paragraph 7(c)), and make good use of resources (paragraphs 14 and 20).

39. Overall, the Tribunal considered that under the clinical management heading there were "*repeated*" clear, serious departures from GMP:

a. In terms of prescribing and awareness of contraindications, there were serious deficiencies in Dr Pacurar's performance in respect of Cases 1, 2, 3, 5, 6, 9, and 10,
b. In terms of referrals, there were serious deficiencies in respect of Cases 3 and 7,
c. In terms of providing advice, there were serious deficiencies in respect of Cases 1, 3, 5, 6, 8, and 9,
d. In terms of review and follow up, there were serious deficiencies in respect of case 1, 3, 6, 8, and 9.

40. As to use of resources, while the Tribunal accepted the experts' opinions that there was unacceptable performance by Dr Pacurar in this respect as well, it felt that the examples given were not sufficiently serious to amount to "*deficient performance*".

41. As set out in its Stage 1 determination, the Tribunal agreed with the opinion of the two expert assessors that Cases 8 and 5 were particularly clear and serious failings, in terms of Dr Pacurar's clinical management. These involved not arranging to see an unwell baby face-to-face to conduct further checks, nor adequately 'safety netting' the baby during the telephone appointment; and agreeing to prescribe the contraceptive pill to a patient in whom this was clearly contraindicated, which would place the patient at an increased risk of stroke and blood clots.

42. For Case 8, Dr C also noted that the context for the absence of adequate clinical advice was the father on the telephone call telling Dr Pacurar that he felt *"out of his depth"*.

Repeated clinical failings

43. There appeared to the Tribunal to be a pattern, based on the cases assessed within the PA, of Dr Pacurar missing what the assessors viewed as key, or basic, information. For example, in Case 5, the doctor did not obtain sufficient information to assess the safety of the oral contraception which she prescribed. In Case 10, a new patient requesting painkillers,

the doctor did not demonstrate awareness of the possibility of drug-seeking behaviour in prescribing the patient various drugs of potential abuse.

44. As explained in the Stage 1 determination, the clear shortcomings in Dr Pacurar's clinical assessment and management in the two cases involving children was of particular concern, as doctors need to positively exclude 'red flags'. In Case 1 for example, the doctor did not ask about a rash, though the mother had said she was worried about meningitis. In Case 8, the doctor's history did not involve asking how the baby was, if he was breathing normally, or whether he had a rash. Further, in her CBD, Dr Pacurar did not recognise the need to exclude 'red flags' of meningitis or sepsis. Both Cases 1 and 8 both also involved "*poor*", "*inadequate*" "*safety netting*" advice. Dr C gave oral evidence that Dr Pacurar's approach to Case 8 was "*cursory*", and that Dr Pacurar's performance led her to believe that she could not safely triage a child by telephone. It was also of significance that Dr Pacurar did not arrange for a face-to-face consultation with the baby. The PA Report weighed this heavily, especially given the inadequate 'safety netting' advice.

45. Dr Pacurar's response to this concern, in written submissions, was that remote assessment was the usual practice during the Covid-19 pandemic. The Tribunal agreed with Dr C that this was of no relevance, as the PA took place in 2025. The Tribunal also found Dr Pacurar's responses to the PA's findings unconvincing in other respects. For example, in response to several cases, the doctor said she had "*documented*" other information, which the assessors had "*ignored*" or "*misrepresented*". However, Dr B explained in her oral evidence that the assessment did not involve reviewing any notes the doctor may have made. It was based on Dr Pacurar's performance in Simulated Surgery cases and in the CBDs.

46. The Tribunal also considered, in accordance with the expert evidence, Dr Pacurar's approach to diagnosis. In her first interview with the assessors, Dr Pacurar explained that she considered it efficient and scientific to very quickly come to a diagnosis "*and prove it*". Dr Pacurar told the assessors she had learned this way of practising medicine in the USA. This was reflected in the assessors' observations of Dr Pacurar in some TOCs. For example, Case 3, where Dr Pacurar did not ask further questions to establish the nature of the patient's pain, despite pain being the reason for the district nurse's call. Rather, having decided what she thought the cause was, she did not consider any other causes of pain. Dr C reflected that unstructured or incomplete history-taking could be related to leaping prematurely to a diagnosis. The Tribunal accepted this evidence, which was consistent with the number of serious clinical failings which the assessors had found.

Conclusion on deficient professional performance

47. The Tribunal was satisfied that there had been repeated, serious departures from the relevant paragraphs of GMP in the PA. Viewed overall, Dr Pacurar's performance in respect of each of the three categories - knowledge/maintaining her professional performance, assessment of patients' condition, and clinical management – clearly fell significantly short of

the standards of performance which could reasonably be expected of a doctor. This amounted to deficient professional performance.

Step 2A: Is there a legal basis for considering impairment?

48. In light of its conclusions above, the Tribunal determined that there was a legal basis for considering impairment, namely deficient professional performance.

Step 2B: Where on the spectrum of seriousness does the allegation lie?

49. The Tribunal had regard to paragraphs 22, 25 and 26 of the Impairment Guidance:

> *22 It is important to note that in all cases the extent of the departure from the professional standards and the consequences or outcome for an individual patient may not be directly related. A less serious departure from the professional standards can sometimes result in significant harm to, or the death of, a patient or member of the public. Alternatively, there can still be a satisfactory clinical outcome for a patient despite a significant departure from the professional standards expected having occurred. …*
>
> *25 All proven allegations about a doctor's behaviour or performance will amount to a serious departure from the professional standards. However, there are differences in the inherent nature of allegations, including whether they are easily remediable, which will affect where on the spectrum of seriousness they fall (the lower, mid-range or higher end).*
>
> *26 Certain types of behaviour or poor performance represent such a serious departure from the professional standards that they will usually fall at the higher end of the spectrum of seriousness. This is often because the departure from the professional standards amounts to an abuse of, or interference with an individual's dignity, and/or breaches the fundamental tenets of the professions such as failing to act with honesty, integrity and uphold the law.*

50. The Tribunal also bore in mind the Introductory MPTS Guidance, 'Case type 5 – clinical concerns', in particular paragraph 164:

> *164 Clinical concerns can include a wide range of matters relating to a doctor's behaviour and/or performance at work. A view will need to be reached about where on the spectrum of seriousness the concern or allegation lies with reference to the nature and extent of the departure from the professional standards and considering the presence of any features that increase seriousness. An expert opinion may be available to assist with this depending on the stage of the fitness to practise process the matter has reached.*

51. In determining the starting point for assessing seriousness, the Tribunal considered all of its previous conclusions about the nature and extent of Dr Pacurar's deficient professional performance, as demonstrated the PA. It had considered the deficiencies found proven in the round. It had concluded Dr Pacurar's performance was *"seriously"* deficient in three, important areas of GMP. The Tribunal recognised its conclusions, for the reasons which it had given, suggested that Dr Pacurar's deficient professional performance could pose a potential risk to patient safety if she were in a real clinical setting. At the same time, it bore in mind that there was no evidence of actual patient harm. The Tribunal also had regard to the gravest types of poor performance and misconduct, referred to in paragraph 26 of the Impairment Guidance. It considered that Dr Pacurar's case did not resemble those examples.

52. Overall, the Tribunal determined that the deficiencies clearly did not fall at the lower end of the spectrum of seriousness, but nor did they fall at the upper end of seriousness. It therefore concluded that the deficient professional performance in this case fell within the mid-range of the spectrum of seriousness.

53. The Tribunal then considered if there were any aggravating or mitigating features that may increase or decrease the seriousness of the allegations. The Tribunal had already taken account of the *"repeated"* nature of the *"unacceptable"* findings, in determining that Dr Pacurar's performance was seriously "deficient". Therefore, the Tribunal concluded that its assessment of seriousness remained within the mid-range of the spectrum.

54. The Tribunal noted that, in accordance with page 35 of the Impairment Guidance, having found that Dr Pacurar's deficient professional performance fell within the mid-range of the spectrum of the seriousness, its starting point for assessing the risk to public protection was medium.

<u>Step 2C: What is the impact of any relevant context known about Dr Pacurar and/or their working environment?</u>

55. The Tribunal acknowledged that the PA had been conducted in a simulated setting and recognised that this may have caused Dr Pacurar to experience some nervousness. However, Dr Pacurar had not provided a witness statement, nor had she attended the hearing, so it was not possible properly to assess the impact of this, if any. The Tribunal had already determined that the assessment process represented a fair sample of Dr Pacurar's work, and that the PA was not an unfair process. It had been tailored to Dr Pacurar's professional background as a GP, at her request, and the TOCs carried out by the independent assessors were heavily weighted, as explained in the Tribunal's Stage 1 decision. The Tribunal further noted that Dr Pacurar had not been working in the UK at the time of the assessment, and the Tribunal had not relied on the TPE of Dr Pacurar's colleagues about her IGPR placement at Harbourside, in their CQs. Accordingly, there was no relevant working environment to consider, as relevant context for the findings. The Tribunal concluded that there was no relevant context which should affect its assessment of the seriousness of her deficient professional performance.

Step 2D: How has Dr Pacurar responded to the allegations?

56. The Tribunal had regard to paragraph 74 of the Guidance:

> *74 The MPT should consider the evidence available to them to establish if the doctor has:*
>
> *a. shown insight into their own practice, behaviour and/or impact of a health condition*
>
> *b. taken steps which have reduced the risk of similar allegations occurring again (remediation), such as participating in training, supervision, coaching or mentoring relevant to the allegation, and*
>
> *c. kept their knowledge and skills up to date.*

57. The Tribunal considered the extent to which Dr Pacurar had demonstrated insight into her deficient professional performance and taken meaningful steps towards remediation.

58. The Tribunal recognised that Dr Pacurar was entitled to defend the allegations brought against her by the GMC, which were based on the PA. However, it considered that this made it difficult for her to demonstrate insight. Dr Pacurar had disputed the fairness of the PA. She had not accepted any of the findings of the two independent assessors. She did not accept that there were deficiencies in her professional performance, nor the associated departures from GMP. Dr Pacurar had not provided the Tribunal with a witness statement reflecting on her own clinical performance and ways in which it could be improved. On the contrary, the most recent email correspondence reflected Dr Pacurar's consistent position: that her qualifications and/or professional experience show that there are no issues with her professional performance, and the findings to the contrary in the PA are wrong. The Tribunal therefore concluded that Dr Pacurar had not demonstrated any insight into the failings identified by the PA.

59. In relation to remediation, the Tribunal noted the information in the Stage 2 bundle concerning further work undertaken by Dr Pacurar in Romania. However, the Tribunal considered that there was insufficient evidence for it to understand how Dr Pacurar's current role impacts upon her ability to practise safely in the UK. It considered that the relevant email correspondence (accompanied by documents, some in Romanian) could not be given the same weight as witness evidence, lacked sufficient detail, and were not directed to the deficiencies identified, or why they would not recur. The Tribunal considered that meaningful remediation required Dr Pacurar to demonstrate an understanding of the specific deficiencies identified in the PA, her reflections, and the steps she had taken to remedy them. In the absence of such evidence, the Tribunal was not satisfied that there was any meaningful remediation in this case. It again bore in mind that it had not had the benefit of witness evidence from Dr Pacurar, or of seeing her in person.

60. The Tribunal also had regard to paragraphs 119 and 120 of the Guidance, which related to whether the doctor has kept their knowledge and skills up to date. It concluded, for the same reasons as set out above, that there was insufficient evidence before it to conclude that Dr Pacurar had maintained her knowledge and skills.

61. Turning to the risk of repetition, the Tribunal had regard to paragraphs 114 and 115 of the Guidance:

> *c) Is the allegation highly unlikely to be repeated?*
>
> *114 The extent of the doctor's insight, and whether the allegation is remediable and has been remediated, will inform the MPT's assessment of how likely or unlikely it is that the allegation will be repeated. The environment in which the doctor has been practising may also be relevant.*
>
> *115 Where the doctor has been practising in a similar environment to the one in which the allegation arose and they have been exposed to situations where there was a risk of them repeating the behaviour or poor performance giving rise to the concern, the absence of repetition will be relevant. However, where they have not been practising in a similar environment to the one in which the concern arose, either because restrictions have been placed on their practice, they have been out of work, or for any other reason, the absence of repetition will be of little or no relevance.*

62. The Tribunal noted, again, that it had limited information concerning Dr Pacurar's current clinical practice in Romania. The Tribunal also considered that the absence of demonstrated insight and meaningful remediation meant that it could not be satisfied that the failings were highly unlikely to be repeated.

63. Having regard to its findings on insight, remediation, and the risk of repetition, the Tribunal determined that the current level of risk to public protection increases from medium to high.

<u>Step 2E: Tribunal's decision as to whether Dr Pacurar poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment</u>

64. The Tribunal had regard to paragraph 171 of the Introductory Guidance:

> *171 Where an allegation about a clinical concern leads to a finding of impairment, it may engage one or more of the three parts of public protection. Whilst the MPT must consider the individual circumstances of the case, it will be unusual for a proven allegation about a clinical concern not to impact on patient safety.*

65. The Tribunal had determined that the current level of risk to public protection was high. It concluded that the patient safety limb was engaged, having regard to its earlier

detailed conclusions, in particular that identified deficiencies in Dr Pacurar's professional performance had the potential to place patients at risk of harm.

66. The Tribunal considered that patient safety was the principal concern. However, the nature and seriousness of the deficiencies also engaged the wider public interest of maintaining public confidence in the medical profession and maintaining and upholding proper professional standards. Accordingly, the Tribunal concluded that all three limbs of public protection were engaged in this case.

67. The Tribunal concluded that patient safety, public confidence in the medical profession and the need to uphold proper standards for that profession would be adversely affected if it were not to make a finding of impairment in this case.

68. The Tribunal has therefore determined that Dr Pacurar's fitness to practise is impaired by reason of deficient professional performance.

Determination on Sanction - 09/10/2026

1. Having determined that Dr Pacurar's fitness to practise is impaired by reason of deficient professional performance, the Tribunal must now decide, in accordance with Rule 17(2)(n) of the Rules, what action, if any, it should take with regard to Dr Pacurar's registration.

The evidence

2. The Tribunal received no new evidence for Stage 3. It reviewed its findings at the facts and impairment stages, and the evidence received at those stages, where relevant to reaching a decision on sanction.

Submissions

3. Counsel for the GMC, Mr Kitching, submitted that sanction was a matter for the Tribunal's independent judgement. In the GMC's view, the only appropriate sanction in this case was suspension, and the duration should be "*the upper end of the 12 months available*". He submitted that the seriousness of the departures from GMP identified in the Tribunal's findings on seriousness and risk to public protection was important. All three limbs of public protection were engaged by the impairment decision, in particular public safety.

4. Mr Kitching drew the Tribunal's attention to the MPT guidance: *'Part C: stage 3 – Sanction'* ('Sanctions Guidance'). In particular: paragraphs 7, 10, 13, 17, 23, 41, 45, 46, and the sanctions banding table under paragraph 62.

5. With respect to the sanctions banding table, Mr Kitching pointed out that the appropriate sanction started from six months suspension, but emphasised the doctor's lack

of insight, and that she had taken no obvious steps to address her professional deficiencies. He argued that, insofar as the doctor had engaged in the process at all, she had done so "*unsatisfactorily*". Coupled with the high risk of harm to patients, Mr Kitching submitted that a period of suspension up to the maximum period of 12 months was available to the Tribunal.

6. Finally, on behalf of the GMC, Mr Kitching said that conditions were not workable, principally because of Dr Pacurar's lack of insight, and also because she was now practising in Romania and had limited engagement in the process.

The relevant legal principles

7. The Tribunal's decision as to the appropriate sanction to impose is a matter for its independent judgement. There is no burden or standard of proof on either the GMC or the registrant. The Tribunal advised itself to impose a sanction which was proportionate.

8. The Tribunal was referred to the Sanctions Guidance and Introductory Guidance, 'Case type 5 – clinical concerns', in particular paragraphs 74-77. It was advised to give clear reasons for any departure from the guidance.

9. The Tribunal also bore in mind that the purpose of imposing a sanction is to address the risk to public protection. It is not intended to be punitive. However, a sanction may have a punitive effect.

The Tribunal's Determination on Sanction

10. The Tribunal first considered the sanction bandings table at paragraph 62 of the Sanctions Guidance. In light of its conclusions at the facts and impairment stages, the starting point for its consideration of the appropriate sanction was 6 months suspension to erasure.

11. The Tribunal also considered the Introductory Guidance, paragraphs 75-77. Suspension of a doctor in response to clinical concerns is "*only likely to be needed where the assessment of risk is high … and/or because the doctor has shown a lack of insight and/or is not willing or able to remediate.*"

12. The Tribunal reminded itself of its conclusions at the previous stages. The level of risk posed to public protection in this case was high. All three limbs of public protection were engaged. While the Tribunal bore in mind that concerns about a doctor's professional performance *should*, in principle, be capable of being remedied, in this case the doctor lacks insight. The Tribunal was also not satisfied there had been any remediation of the specific failings identified in the PA, to date. The evidence about Dr Pacurar's current clinical practice in Romania was insufficient to form any reliable conclusions. In all the circumstances, the Tribunal was not satisfied that those deficiencies are unlikely to be repeated. The Tribunal also bore in mind that it had not had the benefit of hearing from the doctor about her circumstances and plans.

13. The Tribunal also considered that, for the reasons set out in its facts and impairment determinations, the professional deficiencies identified are serious, numerous and wide-ranging. They engage three important areas of GMP. The Tribunal's impairment determination also identified some 'patterns' to the doctor's repeated poor performance in the PA. All these matters needed to be addressed.

14. For these reasons, having had regard to both paragraphs 28 and 45 of the Sanctions Guidance, the Tribunal considered conditions are neither proportionate or workable, and that a period of suspension was clearly needed in the interests of public protection. The Tribunal considered that Dr Pacurar should be afforded a period to reflect on the deficiencies identified and take meaningful steps towards remediation. It therefore concluded that erasure would be disproportionate at this stage.

15. The Tribunal was concerned that the suspension should be no longer than the minimum period reasonably needed for the doctor to develop insight (including by reflecting carefully on the PA and the Tribunal's determination), and to engage in efforts to remedy the serious professional deficiencies identified.

16. The Tribunal considered that the insight, reflection and remediation required was likely to take a considerable period of time in the circumstances of this case. The Tribunal also considered that a review hearing would need to be directed before the end of the period of suspension, which would reduce the amount of time available to Dr Pacurar to remedy the serious deficiencies in her performance.

17. In all the circumstances, the Tribunal determined to suspend Dr Pacurar's registration for a period of 12 months.

Review Hearing

18. The Tribunal determined to direct a review of Dr Pacurar's case. A review hearing will convene shortly before the end of the period of suspension.

19. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Pacurar to demonstrate how she has developed her insight and the steps she has taken to remediate the concerns identified. It therefore may assist the reviewing Tribunal if Dr Pacurar provides evidence of these matters, which may include but is not limited to:

- Evidence of insight into, and remediation of, her deficient professional performance;
- Up-to-date testimonials and references;
- Evidence of how she has kept her knowledge and skills up to date.

Determination on Immediate Order - 09/10/2026

1. Having determined that Dr Pacurar's registration should be suspended for 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Pacurar's registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Harriet Tighe, Counsel, submitted that an immediate order of suspension was necessary in light of the Tribunal's findings at the sanction and impairment stages.

The Tribunal's determination

3. The Tribunal had regard to paragraphs 79, 83 and 84 of the MPTS Guidance: *'Part C: stage 3 – Sanction'*

> *79 The MPT may impose an immediate order where it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed a sanction of suspension or erasure, it may impose an immediate order of suspension.*
>
> *….*
>
> *83 The decision whether to impose an immediate order is at the discretion of the MPT based on the facts of the case. When deciding if an immediate order is needed the MPT should consider the seriousness of the proved allegation and the level of current and ongoing risk to public protection posed by the doctor.*
>
> *84 It will not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effect in cases where:*
>
> *a. the doctor poses a risk to patient safety*
>
> *b. the risk to one or more parts of public protection is high, and/or*
>
> *c. immediate action is needed to maintain public confidence in the medical profession.*

4. The Tribunal considered the MPTS Guidance: *'Part C: stage 3 – Sanction'*, in particular, paragraphs 83-84. The Tribunal considered, in light of its findings at previous stages of the hearing, that the level of current and ongoing risk posed to public protection is high. Paragraph 84 sets out some circumstances when it will "*not usually be appropriate for a doctor to hold unrestricted registration until a sanction takes effec*t…" The Tribunal considered, by reference to subparagraphs (a) and (b) of this paragraph, that in this case, an immediate order is both appropriate and necessary given the high risk which it has identified to public protection.

5. Accordingly, the Tribunal determined that an immediate order of suspension was necessary to protect the public.

6. Given that the doctor is neither represented nor present at the hearing, the immediate order will take effect at the time when notification of the order is served on her: section 38(5) of the 1983 Act (and see paragraph 86 of the MPTS Guidance, Section 3).

7. The Tribunal, having regard to this and to its power to revoke interim orders at section 41A(3)(a) of the 1983 Act, therefore directed that Dr Pacurar's interim order of conditions should be revoked at the point when the immediate order of suspension takes effect.

8. That concludes this case.

ANNEX A – SERVICE AND PROCEEDING IN ABSENCE – 07/10/2026

1. Dr Pacurar was neither present nor represented at the hearing. The Tribunal therefore considered whether to continue with the hearing in her absence.

Submissions

2. The Tribunal was provided with a service bundle by the GMC, which included various emails between the GMC and Dr Pacurar.

3. Counsel for the GMC, Mr Kitching, drew the Tribunal's attention to the emails sent to Dr Pacurar by the GMC and the MPTS regarding the Notice of Allegation and Notice of Hearing, and Dr Pacurar's responses via email to both. He submitted that the emails were sent to Dr Pacurar's registered email address.

4. Counsel for the GMC submitted that Dr Pacurar was clearly aware of the proceedings and had repeatedly confirmed that she did not intend to attend.

The Tribunal's Decision

5. The Tribunal considered Rule 31 of the Rules:

> *'31 Where the practitioner is neither present nor represented at a hearing, the Committee or Tribunal may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing in accordance with these Rules.'*

6. The Tribunal also had regard to the new *Guidance for MPTS Tribunals*, Section 1 on procedural matters, specifically the paragraphs on proceeding in a doctor's absence.

Service

7. The Tribunal first considered whether the relevant documents had been served in accordance with the Rules, and paragraph 8 of Schedule 4 to the Medical Act 1983.

8. The Tribunal considered the emails sent by Dr Pacurar, indicating that she had received the Notice of Hearing by email. In particular, an email of 19 August 2026. There was, further, express confirmation by Dr Pacurar, in several emails, that she was aware of the hearing and had chosen not to be present.

9. Accordingly, the Tribunal was satisfied that the Notice of Hearing had been properly served.

Proceeding

10. The Tribunal next considered whether it would be appropriate to proceed with this hearing in the doctor's absence, in all the circumstances. The Tribunal again had regard to the email correspondence in which the doctor made clear that she did not wish, or intend, to attend. She had not requested an adjournment.

11. The Tribunal took into consideration that there may be potential disadvantage to the doctor in proceeding in her absence, but balanced this against the wider public interest. It considered that she had made a voluntary decision not to attend the hearing or to provide a witness statement. The Tribunal considered that to adjourn these proceedings would not serve any purpose, as there was no evidence that the doctor would attend if the hearing were postponed, given that she had voluntarily absented herself.

12. The Tribunal therefore concluded that it would be both fair and in the public interest for this hearing to proceed in the doctor's absence, exercising its discretion under Rule 31.