

Guidance for MPTS Tribunals

Section three: MPT hearings

These tribunals decide if a doctor's fitness to practise is impaired and what action, if any, is needed.

This guidance explains how decisions will be made by tribunals at a medical practitioners tribunal hearing. It should be read alongside the Guidance introduction and Guidance on procedural matters.

This guidance came into effect on 24 November 2025. The guidance was published on 30 September 2025.

Contents

General introduction.....	4
Process of decision making at an MPT hearing	6
Part A: stage one - facts	10
Step 1: make findings of fact	10
Making findings of fact	10
The burden and standard of proof	11
Assessing the reliability and credibility of witness evidence	11
Hearsay evidence.....	13
Inferences	14
Convictions, cautions and determinations	16
The MPT's determination on facts	17
Part B: stage two - impairment.....	19
Step 2: make a decision on impairment	19
Deciding impairment	20
Step 2a: decide whether there is a legal basis for considering impairment.....	21
The grounds of impairment	21
Step 2b: decide where on the spectrum of seriousness the allegation lies	23
Where on the spectrum of seriousness does the allegation lie?.....	24
The nature of the allegation	25
Features which may increase the seriousness of an allegation.....	28
Decision on where on the spectrum of seriousness the allegation lies.....	33
Starting point for assessing risk to public protection	35
Step 2c: consider the impact of any relevant context.....	35
What is the impact of any relevant context known about the doctor and/or their working environment?	36
Step 2d: consider how the doctor has responded to the allegation(s)	42
How has the doctor responded to the allegation(s)?	42
Insight and remediation	43
Has the doctor kept their knowledge and skills up to date?	51

Step 2e: on the basis of the conclusions reached in steps 2b, 2c and 2d decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment.....	54
Deciding if the doctor poses any current and ongoing risk to public protection to reach a decision on impairment	54
Part C: stage three – sanction.....	57
Step 3: decide on sanction	57
Decision on sanction.....	58
Any sanction must be proportionate, transparent and fair.....	59
Outcomes available to the MPT at the sanction stage	60
Sanctions bandings for specific case types	69
Additional evidence that may be relevant to the decision on what sanction is proportionate	72
The MPT’s determination on sanction	74
Immediate and interim orders following sanction	74
Part D: decide if a warning is required	77
Deciding if a warning is required	77
What is a warning?	77
A warning must be proportionate, transparent and fair	78
The test for issuing a warning.....	79
Is a warning appropriate?.....	79
Is a warning required?	79
The MPT’s determination on whether a warning is required.....	81

General introduction

1. The role of a medical practitioners tribunal (MPT) is to protect the public by ensuring that where a doctor is not currently fit to practise, appropriate restrictions are put in place, or the doctor is removed from the medical register.
2. References made to ‘public protection’ throughout this guidance refer to the GMC and MPTS’ legal duty to protect the public which is split into three distinct parts. It means an MPT must act in a way that:
 - ▶ protects, promotes and maintains the health, safety and wellbeing of the public
 - ▶ promotes and maintains public confidence in the profession, and
 - ▶ promotes and maintains proper professional standards and conduct for members of the profession.
3. An MPT hearing has three distinct stages:
 - ▶ **Stage one:** the MPT reaches a decision on the facts.
 - ▶ **Stage two:** the MPT decides if the doctor’s fitness to practise is impaired.
 - ▶ **Stage three:** the MPT decides what regulatory action, if any, is required.
4. At stage one, the MPT will consider evidence provided by both parties (the GMC and doctor) to decide whether the allegations presented by the GMC are proved. To reach a decision the MPT will apply the civil standard of proof. This means the MPT must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged. If the MPT finds some, or all, of the facts are proved, they will go on to consider the doctor’s fitness to practise. Further information about the approach taken to stage one of the hearing can be found in Part A of this section of the guidance [Step one: Make findings of fact](#).
5. At stage two, to decide if a doctor is fit to practise, the MPT must assess whether that doctor poses any current and ongoing risk to one or more of the three parts of public protection. This assessment must be made with reference to the facts found proved at the first stage of the hearing and any further relevant evidence presented to the MPT.
6. An MPT can only assess whether a doctor is fit to practise where there is a legal basis for doing so. There are six legal bases which are known as the grounds for impairment. These are:
 - ▶ misconduct

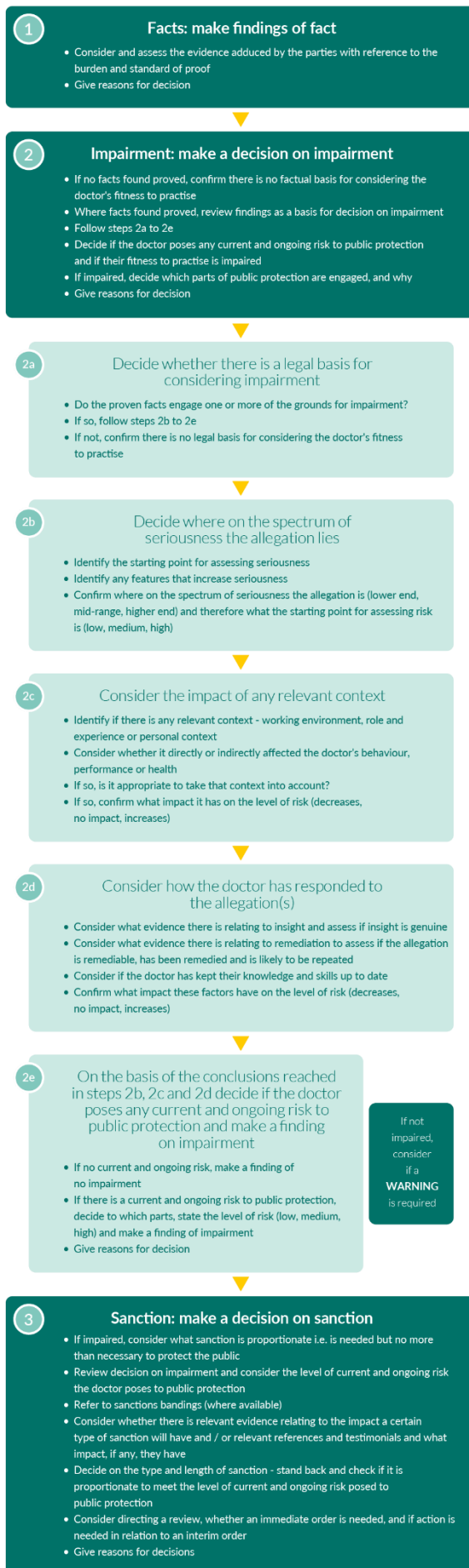
- ▶ deficient professional performance
 - ▶ a conviction or caution
 - ▶ adverse physical or mental health
 - ▶ not having the necessary knowledge of English and
 - ▶ a determination.¹
7. Where there is a legal basis for considering a doctor's fitness to practise, to assess whether that doctor poses any current and ongoing risk to public protection, an MPT will consider:
- ▶ the seriousness of the facts found proved
 - ▶ any relevant context known about the doctor and/or their working environment, and
 - ▶ how the doctor has responded to the allegation(s).
8. The MPT will only make a finding of impairment where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response. Further information about the approach taken to deciding impairment can be found in Part B of this section of the guidance [Step two: Make a decision on impairment](#).
9. At stage three, the MPT will consider their conclusion on impairment, and decide what regulatory action, if any, is needed to protect the public.
10. Where the MPT has decided that the doctor's fitness to practise is impaired, they will then go on to consider what restrictive action is required in response. This is known as a sanction. Further information about the approach to deciding what sanction is a proportionate response can be found in Part C of this section of the guidance [Step three: Decide on sanction](#).
11. Where the MPT has decided that the doctor's fitness to practise is not impaired, but they have found that the doctor has significantly departed from the professional standards, the MPT can decide to issue the doctor with a warning. This is a formal way of indicating that the doctor's behaviour or performance significantly departed from the professional standards and should not be repeated. Further information about the approach to warnings can be found in Part D of this section of the guidance [Decide if a warning is required](#).

¹ Section 35C(2) of the Medical Act 1983 (as amended)

12. The process that the MPT should follow to decide an allegation of impaired fitness to practise and what regulatory action to take, if any, are illustrated in the diagram below.

Process of decision making at an MPT hearing

Process of decision making at an MPT hearing



1. Make findings of fact

- ▶ Consider and assess the evidence adduced by the parties with reference to the burden and standard of proof
- ▶ Give reasons for decision

2. Make a decision on impairment

- ▶ If no facts found proved, confirm there is no factual basis for considering the doctor's fitness to practise
- ▶ Where facts found proved, review findings as a basis for decision on impairment
- ▶ Follow steps 2a to 2e
- ▶ Decide if the doctor poses any current and ongoing risk to public protection and if their fitness to practise is impaired
- ▶ If impaired decide which parts of public protection are engaged, and why
- ▶ Give reasons for decision

2a. Decide whether there is a legal basis for considering impairment

- ▶ Do the proven facts engage one or more of the grounds for impairment?
- ▶ If so, follow steps 2b to 2e
- ▶ If not, confirm there is a legal basis for considering the doctor's fitness to practise

2b. Decide where on the spectrum of seriousness the allegation lies

- ▶ Identify the starting point for assessing seriousness
- ▶ Identify any features that increase seriousness
- ▶ Confirm where on the spectrum of seriousness the allegation is (lower end, mid-range, higher end) and therefore what the starting point for assessing risk is (low, medium, high)

2c. Consider the impact of any relevant context

- ▶ Identify if there is any relevant context - working environment, role and experience or personal context
- ▶ Consider whether it directly or indirectly affected the doctor's behaviour, performance or health
- ▶ If so, is it appropriate to take that context into account?
- ▶ If so, confirm what impact it has on the level of risk (decreases, no impact, increases)

2d. Consider how the doctor has responded to the allegation(s)

- ▶ Consider what evidence there is relating to insight and assess if insight is genuine

- ▶ Consider what evidence there is relating to remediation to assess if the allegation is remediable, has been remedied and is likely to be repeated
- ▶ Consider if the doctor has kept their knowledge and skills up to date
- ▶ Confirm what impact these factors have on the level of risk (decreases, no impact, increases)
- ▶ If not impaired, consider if a warning is required.

2e. On the basis of the conclusions reached in steps 2b, 2c and 2d decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment

- ▶ If no current and ongoing risk, make a finding of no impairment
- ▶ If there is a current and ongoing risk to public protection, decide to which parts, state the level of risk (low, medium, high) and make a finding of impairment
- ▶ Give reasons for decision

3. Make a decision on sanction

- ▶ If impaired, consider what sanction is proportionate i.e. is needed but no more than necessary to protect the public
- ▶ Review decision on impairment and consider the level of current and ongoing risk the doctor poses to public protection
- ▶ Refer to sanctions bandings (where available)
- ▶ Consider whether there is relevant evidence relating to the impact a certain type of sanction will have and/or relevant references and testimonials and what impact, if any, they have
- ▶ Decide on the type and length of sanction- stand back and check if it is proportionate to meet the level of current and ongoing risk posed to public protection
- ▶ Consider directing a review, whether an immediate order is needed and if action is needed in relation to an interim order
- ▶ Give reasons for decisions

Part A: stage one - facts

At Stage one of an MPT hearing, the MPT will consider evidence provided by both parties (the GMC and doctor) to decide whether the allegations presented by the GMC are proved. This is known as making findings of fact.

This stage outlines:

- ▶ the burden and standard of proof the tribunal must apply,
- ▶ how fact finding should be approached and,
- ▶ the need to record reasons for decisions on facts.

Step 1: make findings of fact

1

Facts: make findings of fact

- Consider and assess the evidence adduced by the parties with reference to the burden and standard of proof
- Give reasons for decision

- ▶ Consider and assess the evidence adduced by the parties with reference to the burden and standard of proof
- ▶ Give reasons for decision

Making findings of fact

1. At stage one of an MPT hearing, the MPT will consider evidence provided by both parties (the GMC and doctor) to decide whether the allegations presented by the GMC are proved. This is known as making findings of fact.
2. To reach a decision the MPT will apply the civil standard of proof. This means the MPT must decide whether, on the balance of probabilities, the GMC is able to prove it is more likely than not that the matters occurred as alleged.
3. If the MPT does not find the facts of the allegation(s) proved, the hearing will conclude with no action. In cases where the MPT finds some, or all, of the facts are proved, they will go on to consider if the doctor's fitness to practise is impaired.
4. An MPT should approach fact finding by firstly identifying agreed facts and evidence. To reach a decision on the disputed facts, the MPT should assess the

evidence in the round. They should consider what conclusions and inferences can be drawn from the documentary evidence. Having done so, the MPT should consider the available oral evidence and subject that evidence to critical scrutiny against the agreed facts and documentary evidence to consider a witness' reliability and credibility. The MPT should not decide reliability and credibility based on the demeanour of a witness alone.

5. The MPT will always need to record reasons for their decision on facts. Where the MPT's approach to assessing the evidence departs from the principles in this part of the guidance, the MPT must carefully explain how this is justified, given the specific circumstances of the case. They must also explain how the decision relates to any submissions made by the parties.

The burden and standard of proof

6. The burden of proof lies with the party asserting an allegation of fact. In proceedings before an MPT, the burden of proof rests with the GMC. This means it's for the GMC to prove the case they are presenting against the doctor. There is no burden on the doctor to prove or disprove anything.
7. To reach a decision on the facts, the MPT will apply the civil standard of proof. This means the MPT must decide whether, on the balance of probabilities, it is more likely than not that the specific matters occurred as alleged.
8. Where a doctor admits some, or all, of the alleged facts, these will be treated as proven. The MPT only needs to decide the facts that remain in dispute between the parties (the GMC and doctor).

Assessing the reliability and credibility of witness evidence

9. The MPT will need to consider the reliability and credibility of witness evidence to decide the factual allegations. Reliability relates to the inherent quality of a witness' evidence and how accurate it is. Credibility is about whether the MPT can believe a witness' account based on the individual's veracity or truthfulness.
10. It is important that the MPT assesses the general reliability and credibility of each witness, especially when their accounts are central to the MPT's findings.

Reliability

11. An MPT must make a rounded assessment of a witness' reliability, rather than approaching their reliability in respect of each allegation in isolation from the others.
12. When assessing the reliability of witness evidence, the MPT should identify the consistent and inconsistent features of the evidence, including where inconsistencies are present any reasons given for them, and consider the impact those features have on the overall effect of the evidence.

Credibility

13. Credibility, however, can be divisible. This means it is open to the MPT not to rule out the whole of a witness' evidence based on lack of credibility.
14. A witness' credibility should be tested by reference to any objective fact(s) that can be proven independently of their evidence, in particular by reference to documents available in the case.
15. The MPT can consider how a witness presents during the hearing to assess their credibility. But a witness' credibility should not be assessed exclusively on their demeanour when giving evidence. The confident delivery, or otherwise, of a witnesses' evidence is not a reliable guide to whether they are telling the truth. Other information that may be relevant to the MPT's assessment of a witness' credibility includes conflicts in evidence with agreed facts, documentary evidence or another witness, denials of the allegations and reasons why they could not be true, or admissions of lying (on oath or otherwise) on a previous occasion.
16. Good character is not a defence to the facts alleged. However, the MPT must take good character evidence into account in their assessment of a witness' credibility and propensity, where relevant. The assessment of whether a witness is of good character is made on the balance of probabilities, having considered all available information about the witness' character. The weight to be given to a witness' good character is a matter for the MPT and should be explained in their written determination. The MPT may consider that the weight given to an unblemished record may properly be less in the case of a doctor at an early stage in their career than a doctor with an established track record.

17. Cogent evidence of good character is relevant to the MPT's consideration of dishonesty. However, the significance of such evidence should not be overstated; it is not a defence to an allegation and should not detract from the primary focus on the evidence directly relevant to the alleged behaviour or poor performance.

Hearsay evidence

18. Hearsay evidence is a statement made, other than by a person while giving oral evidence in proceedings, which is tendered as evidence of the matters stated.²
19. At an MPT hearing, hearsay evidence may arise:
 - ▶ when a witness recalls an account given to them by a third party, i.e. it is second hand evidence, and/or
 - ▶ where one party notifies the other that they require a witness to attend the hearing for cross examination, but despite this request, the party fails to call the witness or the witness refuses or is unable to attend.
20. Where a party fails to call a witness or the witness refuses or is unable to attend the hearing, the party who wants to rely on evidence contained in a witness statement will need to make an application to the MPT to admit the witness' statement as hearsay. However, in circumstances where the witness' evidence is agreed, neither party will call or require a witness for cross examination. This means the MPT will have a copy of the uncontested witness statement; this is not classed as hearsay evidence.
21. If the MPT identifies hearsay evidence and no application has been made to admit it, the MPT should invite the party seeking to rely on the hearsay evidence to make an application (if they are able to). In the absence of a specific application, the MPT should still go on to consider whether it is fair to admit the hearsay evidence.
22. When assessing whether it is fair to admit hearsay evidence, the MPT should first consider admissibility and then consider the weight to be attached to the evidence, taking into account that it's not been tested in cross examination.
23. To decide whether to admit evidence from an absent witness the MPT should consider:

² Civil Procedure Rules, Part 33.1(a)

- ▶ is there a good reason for the witness' non-attendance and, consequently, for the admission of the absent witness' untested statements as evidence?
 - ▶ does the evidence of the absent witness constitute the sole or decisive basis for a conviction or the factual findings?
 - ▶ are there sufficient counter-balancing factors to ensure a fair hearing?
24. Where the MPT is satisfied that it is fair to admit the hearsay evidence, they should adopt a careful balancing exercise when considering the impact and weight to attach to it, especially where it is key evidence for a particular allegation.

Inferences

25. An inference is a conclusion that an MPT reaches by a process of reasoning, including drawing on common experience, from primary facts i.e. facts which the MPT has accepted based on documentary or witness evidence. As a general rule, an MPT may draw such inferences as it considers appropriate from the primary facts.
26. An adverse inference is where, because of the absence of certain evidence, the MPT reaches a conclusion which is to the detriment of, or unfavourable to, the case of the party which could have provided that evidence.
27. When making findings of fact, the MPT may draw an adverse inference from:
- ▶ the failure of a doctor to attend the hearing, and/or
 - ▶ the failure of a witness, including the doctor, to give evidence or answer a particular question (provide relevant evidence).
28. Where the general principles below apply, it is open to the MPT to draw an adverse inference that a doctor who fails to attend the hearing or to provide relevant evidence has no innocent explanation for some, or all, of the primary facts alleged against them. For other witnesses who fail to provide relevant evidence, the MPT may infer that they have no reasonable or credible explanation to give.
29. If the MPT does decide to draw an adverse inference, it will form only one part of the overall evidential picture. An adverse inference alone cannot amount to determinative proof of a fact alleged without other evidence.

30. The MPT's decision whether to draw an adverse inference will depend on the facts of the individual case. An adverse inference should not be drawn unless:
- a. Where the adverse inference relates to a doctor failing to attend the hearing or failing to provide relevant evidence, that a prima facie case against the doctor has been established. This means that the GMC has presented sufficient evidence to establish the relevant fact(s) unless it/they are disproved or rebutted: the fact a doctor or their representative does not accept that there is a prima facie case is not a sufficient reason for them not attending the hearing, giving evidence or providing a witness statement.
 - b. The doctor or other witness has been given appropriate notice and warning that, if they do not attend and/or provide relevant evidence, an adverse inference may be drawn. A letter sent in advance of the hearing will usually be sufficient. However, it is open to the MPT to repeat or reiterate the warning during the hearing if the individual attends.
 - c. The doctor has been given an opportunity to attend and/or a witness has been given an opportunity to provide relevant evidence or explain why it would not be reasonable for them to do so. Where a doctor does not attend, valid proof of service of the Notice of Allegation and Notice of Hearing will usually be considered to provide sufficient opportunity to attend or explain why it would not be reasonable for them to do so. Where the doctor is present or represented at the hearing, is invited to give evidence and declines, this will usually be considered to provide a sufficient opportunity to provide relevant evidence or explain why it would not be reasonable for them to do so. Similarly, where another witness who is present at the hearing is invited to give evidence on a specific issue and declines, this will usually be considered to provide a sufficient opportunity to provide relevant evidence or explain why it would not be reasonable for them to do so.
 - d. The MPT finds there is no reasonable explanation for the doctor not to attend and/or for a witness, including the doctor, to provide relevant evidence. If either no explanation or no reasonable explanation on behalf of the doctor or witness is provided, the MPT should not speculate as to any possible reasonable explanation.
 - e. There are no other circumstances specific to the case which would make it unfair to draw an adverse inference. For example, where it is evident from the information available to the MPT that a doctor has a health condition that impacts on their ability to attend a hearing (with or without reasonable adjustments), it may be unfair to draw an adverse inference from the doctor's non-attendance.

31. Where a party to the proceedings is present and/or represented at the hearing and the MPT has considered these principles, the MPT should make clear its decision, and the reasons for it, that either:
 - ▶ it would not be appropriate to draw an adverse inference, or
 - ▶ it may be appropriate to draw an adverse inference from the doctor's failure to attend the hearing and/or a witness' failure to provide relevant evidence. In doing so, the MPT should make clear that it is not obliged to draw an adverse inference and the final decision as to whether it will draw such an inference will depend on the totality of the evidence when the MPT comes to make its determination on the facts.
32. If the MPT concludes that it may be appropriate to draw an adverse inference from a doctor's failure to provide relevant evidence and the doctor is present, the doctor should be given a further opportunity to provide the relevant evidence.
33. Where an MPT concludes that it will draw an adverse inference from a doctor's failure to attend the hearing and/or a witness failure to provide relevant evidence, the MPT should make clear in its determination on the facts what adverse inference has been drawn and why.
34. It is for the MPT to decide what weight to attach to the adverse inference being drawn. However, if a credible explanation for a doctor's failure to attend the hearing and/or for a witness' failure to provide relevant evidence was given, but fell short of amounting to a reasonable explanation, this may reduce the weight the MPT attaches to the adverse inference.

Convictions, cautions and determinations

Convictions

35. Convictions refer to a decision by a criminal court in the British Islands, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence.
36. If the MPT receives in evidence a signed certificate of a conviction, unless it also receives evidence to the effect that the doctor is not the person referred to in the conviction, then it must accept the certificate as conclusive evidence that the offence was committed. This means that the GMC does not have to re-prove the facts of the matter giving rise to the allegation.

37. However, before accepting a signed certificate of a conviction from an overseas court as conclusive evidence that the offence was committed, the MPT must first be satisfied that the matter detailed in the certificate amounts to an equivalent offence in England and Wales.

Cautions

38. Cautions refer to offences committed in the British Islands or elsewhere but where no court proceedings took place because the doctor admitted the offence and criminal proceedings were considered unnecessary.
39. Paperwork showing that a doctor accepted a caution is not conclusive evidence that the offence was committed. However, the MPT should have regard to the fact that in accepting a caution, the doctor will have admitted committing the offence.

Determinations

40. Determinations refer to decisions by another health or social care regulatory body, in the UK or elsewhere, that the fitness to practise of the doctor as a member of that profession is impaired (or an equivalent finding).
41. If the MPT receives in evidence a signed determination, unless it also receives evidence to the effect that the doctor is not the person referred to in the determination, then it must accept the signed determination as conclusive evidence that the facts are as found by the determination. This means that the GMC does not have to re-prove the facts of the matter giving rise to the allegation.

The MPT's determination on facts

42. The MPT should give clear and adequate reasons for its conclusions in respect of each allegation to enable the doctor, profession and members of the public to understand their decision.
43. Where an MPT has concluded that it will draw an adverse inference from a doctor's failure to attend the hearing and/or a witness' failure to provide relevant evidence, the MPT should make clear in its decision what adverse inference has been drawn and why.

44. The MPT must also provide clear explanations about the evidence that they accepted and rejected which led to the factual allegation(s) having been found proven or not. This should include the MPT's assessment of the reliability and credibility of witness evidence.

Part B: stage two - impairment

At Stage two of an MPT hearing, the MPT decides if the doctor's fitness to practise is impaired.

This stage outlines:

- ▶ if no facts have been found proved, what steps the tribunal should take,
- ▶ if one or more facts have been found proved, what steps the tribunal should take,
- ▶ how decisions on impairment should be approached and,
- ▶ the need to record reasons for decisions on impairment.

Step 2: make a decision on impairment

2

Impairment: make a decision on impairment

- If no facts found proved, confirm there is no factual basis for considering the doctor's fitness to practise
- Where facts found proved, review findings as a basis for decision on impairment
- Follow steps 2a to 2e
- Decide if the doctor poses any current and ongoing risk to public protection and if their fitness to practise is impaired
- If impaired, decide which parts of public protection are engaged, and why
- Give reasons for decision

- ▶ If no facts found proved, confirm there is no factual basis for considering the doctors fitness to practise
- ▶ Where facts found proved, review findings as a basis for decision on impairment
- ▶ Follow steps 2a to 2e
- ▶ Decide if the doctor poses any current and ongoing risk to public protection and if their fitness to practise is impaired
- ▶ If impaired decide which parts of public protection are engaged, and why
- ▶ Give reasons for decision

Deciding impairment

1. At stage two of an MPT hearing, the MPT decides if the doctor's fitness to practise is impaired.
2. If the MPT has concluded at stage one that no facts have been proved, this means the GMC has not discharged the burden of proof in respect of the allegations that the doctor's fitness to practise is impaired. The MPT should therefore confirm there is no basis upon which to make a finding of impairment, and the hearing will conclude.
3. The MPT will only make a finding of impairment where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response. This assessment must be made with reference to the facts found proved at the first stage of the hearing and any further relevant evidence presented to the MPT.
4. The decision on impairment is one for the MPT alone, exercising their judgment. There is no burden or standard of proof.
5. An MPT can only assess whether a doctor is fit to practise where there is a legal basis for doing so. There are six legal bases which are known as the grounds for impairment. These are:
 - ▶ misconduct
 - ▶ deficient professional performance
 - ▶ a conviction or caution
 - ▶ adverse physical or mental health
 - ▶ not having the necessary knowledge of English, and
 - ▶ a determination.³
6. Where there is a legal basis for considering a doctor's fitness to practise, to assess whether that doctor poses any current and ongoing risk to public protection, an MPT will consider:
 - ▶ the seriousness of the facts found proved,
 - ▶ any relevant context known about the doctor and/or their working environment, and
 - ▶ how the doctor has responded to the allegation(s).

³ Section 35C(2) of the Medical Act 1983 (as amended)

7. If there is more than one legal basis for considering the doctor's fitness to practise i.e. the allegations fall under more than one ground for impairment, an assessment of current and ongoing risk must be made in respect of each of them.
8. The MPT will always need to record reasons for their decision on impairment and be clear about which part(s) of public protection are engaged. Where the MPT's decision departs from the principles in this part of the guidance the MPT must carefully explain how this is justified, given the specific circumstances of the case. They must also explain how the decision relates to any submissions made by the parties.

Step 2a: decide whether there is a legal basis for considering impairment

2a

Decide whether there is a legal basis for considering impairment

- Do the proven facts engage one or more of the grounds for impairment?
- If so, follow steps 2b to 2e
- If not, confirm there is no legal basis for considering the doctor's fitness to practise

- ▶ Do the proven facts engage one or more of the grounds for impairment?
- ▶ If so, follow steps 2b to 2e
- ▶ If not, confirm there is no legal basis for considering the doctors fitness to practise

The grounds of impairment

9. An MPT must be satisfied that there is a legal basis for considering whether a doctor's fitness to practise is impaired, meaning that there is a current and ongoing risk to public protection. The table below explains the grounds of impairment that apply to taking regulatory action in respect of doctors.
10. A finding of impairment can only be made by an MPT where the facts found proved engage at least one of these grounds of impairment and the doctor is assessed to pose a current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response.

11. The GMC will state the grounds for impairment in the charges that are presented to the MPT. Although the MPT is not able to add or change any grounds of impairment, or add any additional allegations, they are able to amend the allegation provided it can be made without injustice to the doctor. Any amendment should have been made at stage one of the hearing.

Ground of Impairment	Description
Misconduct	<p>This is about behaviour. It could consist of acts and/or omissions arising in or outside of a doctor’s working life and includes failing to act appropriately or demonstrating behaviour that falls short of what can reasonably be expected.</p> <p>To amount to misconduct, the behaviour will be a serious departure from the professional standards, as set out in Good medical practice. This includes single clinical acts or omissions that are serious, or a limited number of clinical acts or omissions that taken together are serious.</p>
Deficient professional performance	<p>This is about professional performance. It could consist of acts and/or omissions and includes failing to act appropriately or being unable to provide care to the standard expected.</p> <p>To amount to deficient professional performance, an assessment of a fair sample of a doctor’s work will show that the same clinical act or omission occurs more than once or there is more than one clinical act or omission. Taken together the departures from the professional standards are unacceptable and mean the doctor’s performance falls seriously below the standard(s) expected, as set out in Good medical practice.</p>
Conviction or caution	<p>A conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England or Wales, would constitute a criminal offence can indicate that a doctor poses a current and ongoing risk to public protection.</p>
Adverse physical or mental health	<p>While having a health condition does not of itself mean there is a departure from the professional standards, if it is not being appropriately managed then this may lead to a departure from the professional standards and/or may impact on a doctor’s ability to practise safely.</p>
Not having the necessary knowledge of English	<p>All doctors working in the UK must have the necessary knowledge of the English language in the areas of speaking, listening, reading and writing to provide a good standard of practice and care. This includes being able to effectively engage with patients and other healthcare professionals. If a doctor does not have the necessary</p>

	knowledge of English language to communicate effectively, in all areas, they are unable to practise safely in the UK.
A determination by another health regulatory body	A determination by a health or social care regulatory body that a doctor's fitness to practise is impaired can indicate that a doctor poses a current and ongoing risk to public protection. The determination can be from a body in the UK or overseas.

12. If the MPT is satisfied there is a legal basis for considering the doctor's fitness to practise, they will need to decide whether the doctor poses any current and ongoing risk to public protection.
13. The following questions should be used to inform the MPT's assessment of whether a doctor poses any current and ongoing risk to public protection, and if so, what level of risk (low, medium or high):
- ▶ Where on the spectrum of seriousness does the allegation lie?
 - ▶ What is the impact of any relevant context known about the doctor and/or their working environment?
 - ▶ How has the doctor responded to the allegation?
14. The MPT should answer these questions with reference to the facts found proved at the first stage of the hearing and any further relevant evidence considered at stage two of the hearing.

Step 2b: decide where on the spectrum of seriousness the allegation lies

2b

Decide where on the spectrum of seriousness the allegation lies

- Identify the starting point for assessing seriousness
 - Identify any features that increase seriousness
 - Confirm where on the spectrum of seriousness the allegation is (lower end, mid-range, higher end) and therefore what the starting point for assessing risk is (low, medium, high)
- ▶ Identify the starting point for assessing seriousness
 - ▶ Identify any features that increase seriousness

- ▶ Confirm where on the spectrum of seriousness the allegation is (lower end, mid-range, higher end) and therefore what the starting point for assessing risk is (low, medium, high)

Where on the spectrum of seriousness does the allegation lie?

15. Within the range of matters that are serious enough to pose a current and ongoing risk to one or more of the three parts of public protection, some matters are more serious than others. This means that allegations about a doctor's fitness to practise fall on a spectrum of seriousness (the lower end, mid-range or higher end).
16. The starting point for assessing the level of current and ongoing risk to public protection posed by a doctor (low, medium or high) is based on where on the spectrum of seriousness the allegation lies.
17. The assessment of where on the spectrum of seriousness the allegation lies is based on the facts found proved at stage one of the hearing. To reach a view on where on the spectrum of seriousness an allegation lies (the lower end, mid-range or higher end), an MPT will need to consider the nature of the allegation and any features of the allegation that increase seriousness.
18. Where the allegation relates to a doctor's behaviour, performance or how they are managing the impact of a health condition, the MPT needs to consider the extent of any departure from the professional standards expected. These can be found in [Good medical practice](#) and the more detailed guidance.
19. Having a health condition is not a departure from the professional standards expected of doctors. But where the impact of a health condition is such that it can pose a risk to patients, doctors are expected to take steps to manage that risk. Where those steps have not been taken, this can amount to a serious departure from the professional standards.
20. In a health case, the primary consideration for the MPT when assessing where on the spectrum of seriousness the allegation lies (the lower end, mid-range or higher end) is the impact, or likely impact, of the health condition on the doctor's ability to practise safely and effectively – see the specific case types section on health in the [Introduction](#).

21. In a clinical concerns case, expert evidence will often have been presented to the MPT at the facts stage where the allegation relates to the doctor's performance. Where available, it can be used to inform the MPT's view on seriousness based on the extent of the departure from the professional standards.
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.
23. The risk to patients and members of the public arising from the doctor's departure from the professional standards will be the primary consideration to the MPT's assessment of where on the spectrum of seriousness an allegation lies (the lower end, mid-range or higher end). This means the actual consequences or outcome for an individual patient should not be considered in isolation and the MPT should attach more weight to evidence about the risk to patients and members of the public associated with the specific departure from the professional standards.

The nature of the allegation

24. A view on the starting point for assessing the seriousness of a proven allegation should be reached based on the nature of the allegation by looking at the individual circumstances of the case.
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.

27. The MPT's initial view on the apparent seriousness based on the nature of the allegation can then change in light of the full evidential picture, including the presence of any [features which may increase seriousness](#).

Allegations usually falling at the lower end of the spectrum of seriousness

28. Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:
- ▶ clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes
 - ▶ a departure from the professional standards relating to a health condition that is having, or likely to have, an impact on the doctor's behaviour or performance
 - ▶ insufficient knowledge of English language where patient safety has not been directly compromised or where the risk to patients is capable of being addressed locally
 - ▶ an incident of violent or abusive behaviour which is limited in nature and had limited impact, such as where it occurred outside of the doctor's professional role and did not cause any significant physical injuries or any significant physical, emotional or psychological harm
 - ▶ an incident of dishonest behaviour which is limited in nature and had limited impact, such as where it occurred outside of the doctor's professional role and the value of any financial or other benefit derived was low
 - ▶ an incident of discriminatory behaviour which is limited in nature, had limited impact and is not unlawful
 - ▶ a conviction or caution for a minor criminal offence that results in a discharge or fine.
29. The above list is not exhaustive and includes allegations that fall within different grounds of impairment. The examples given may also assist an MPT to reach a view on the starting point for assessing the seriousness of allegations that are similar in nature.

Allegations falling in the mid-range of the spectrum of seriousness

30. Seriousness is determined across a continuous spectrum. Whilst a view on where on the spectrum of seriousness an allegation lies will need to be reached based on the individual circumstances of the case, behaviour or poor performance falling between the types of examples listed above and below may fall at the mid-range level of seriousness as a starting point before features that increase seriousness are considered.

Allegations usually falling at the higher end of the spectrum of seriousness

31. Allegations that are likely to fall at the higher end of the spectrum of seriousness include, but are not limited to:
- ▶ sexual assault, indecency or sexual harassment
 - ▶ an improper sexual or emotional relationship with a patient or someone close to a patient
 - ▶ an improper sexual or emotional relationship with a colleague, often seen where there is a close working relationship with an imbalance of power
 - ▶ violence, other than where it occurred outside of the doctor's professional role and was limited in nature, and did not cause any significant physical injuries or any significant physical emotional or psychological harm
 - ▶ dishonesty, other than where it occurred outside of the doctor's professional role and was not persistent or repeated, and the value or other benefit derived was not significant
 - ▶ unlawfully discriminating in relation to characteristics protected by law
 - ▶ where a doctor has deliberately misled patients or others about their licensing status
 - ▶ clinical failings that are not considered to be easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients
 - ▶ where a doctor's lack of knowledge of the English language is compromising patient safety and the risk to patients has not been, or cannot be, addressed locally
 - ▶ a criminal conviction or other court sanction resulting in a custodial sentence (whether immediate or suspended)
 - ▶ a criminal conviction for encouraging or assisting suicide
 - ▶ a criminal conviction, caution or other disposal that has resulted in a doctor being required to register on the sex offenders register

- ▶ a determination case where the regulatory body ordered the suspension or erasure/removal of the doctor from the relevant register.

32. The above list is not exhaustive and includes allegations that fall within different grounds of impairment. The examples given may also assist an MPT to reach a view on the starting point for assessing the seriousness of proven allegations that are similar in nature.
33. Although cases of violence and dishonesty will often fall at the higher end of the spectrum of seriousness, they can involve a range of behaviour with the circumstances giving rise to the allegation often occurring outside the doctor’s professional practice. In these cases, the MPT will need to decide where on the spectrum of seriousness the violence or dishonesty sits.

Features which may increase the seriousness of an allegation

34. In all cases, there may be specific features about the allegation and departure from the professional standards which may increase its seriousness. These features may be seen in any type of case and where present may increase where on the spectrum of seriousness the allegation lies.
35. The MPT should identify any relevant features and consider the extent to which they are present to decide how much weight to attach to them. This will help the MPT explain what, if any, impact each relevant feature has and decide where on the spectrum of seriousness the allegation falls.
36. Features of the allegation that may increase seriousness include, but are not limited to:

<p>The behaviour or poor performance was persistent or repeated</p>	<p>Behaviour or poor performance will be persistent or repeated where the same, or similar, act(s) or omission(s) occur(s) multiple times and/or where an act or omission continues over a prolonged period.</p> <p>Persistent or repeated behaviour can be seen inside or outside a doctor’s working life, whereas persistent poor performance can only arise inside a doctor’s working life.</p>
--	--

<p>Relevant fitness to practise history</p>	<p>A previous complaint, concern or finding about an individual’s fitness to practise is relevant to the seriousness of the current allegation where the circumstances are</p>
--	--

	<p>similar in nature or raise similar concerns which indicate a pattern between past and present behaviour or poor performance, meaning the current concern cannot be viewed as isolated.</p> <p>Relevant fitness to practise history includes decisions made by another regulatory body.</p> <p>Doctors are expected to regularly reflect on the standards of practice and care they provide. However, in some instances, a doctor may not have been made aware that a complaint or concern was previously raised (with the GMC or with another body or organisation) and will therefore not have had an opportunity to reflect on it and address any related risk of repetition.</p> <p>However, where a doctor was aware of the previous complaint, concern or finding, or the nature of the behaviour or poor performance is such that they should have been aware of the risks arising from it and they have nevertheless gone on to repeat that type of behaviour or poor performance, this indicates the risk of repetition arising from the previous matter has not been successfully addressed.</p> <p>These considerations may be relevant to deciding how much weight, if any, to attach to evidence of fitness to practise history.</p> <p>Where previous regulatory action (a warning or restrictive action) has been taken in response to a concern or finding that is similar in nature to the current allegation, repetition indicates the doctor has shown disregard for the regulatory framework which exists to protect the public and/or has failed to adequately address the risk that led to the prior action being taken. The amount of weight to attach to this factor will be informed by the type of previous regulatory action put in place and whether the circumstances surrounding the allegation amount to a breach of current restrictions.</p>
--	---

<p>The behaviour was directed towards, or the poor performance involved interaction with, a person with impaired capacity</p>	<p>Most individuals interacting with health services are likely to feel vulnerable to some extent and doctors should not act in a way that exploits patients' vulnerability or lack of medical knowledge.</p> <p>It is important that the person's full personal circumstances are considered in forming a picture of capacity or vulnerability. A person may have impaired capacity or be vulnerable for other reasons because of certain</p>
--	--

<p>or a person with a particular vulnerability</p>	<p>characteristics or their specific circumstances.</p> <p>Certain characteristics indicating vulnerability include the presence of mental health issues, being a child or young person aged under 18, disability or frailty, or a history of abuse or neglect. Specific circumstances indicating vulnerability may include having learning differences or needs, recent bereavement, being unemployed, lonely and/or isolated and whether they otherwise present as being emotionally vulnerable.</p> <p>Where a patient has impaired capacity or a particular vulnerability, or where the doctor perceives them to be vulnerable, there is an even greater duty on the doctor to consider their needs and welfare and not act in a way that amounts to abuse or neglect, or otherwise exploits them. This applies equally to all doctors, regardless of whether they are working in an area of practice that means they regularly treat or interact with individuals with impaired capacity or are otherwise considered vulnerable.</p> <p>Behaviour directed towards a person with impaired capacity or a person with a particular vulnerability may arise inside or outside a doctor's working life. Poor performance involving interaction with a person with impaired capacity or a person with a particular vulnerability can only arise in a doctor's working life.</p>
---	---

<p>Premeditated behaviour</p>	<p>Premeditated behaviour is characterised by the doctor having acted intentionally and with planning. It usually arises where a doctor looks for, or identifies, an opportunity to take advantage of a person or situation and takes steps towards doing so.</p> <p>A doctor may behave in a premeditated way inside or outside their working life.</p>
--------------------------------------	--

<p>Predatory behaviour</p>	<p>Predatory behaviour is characterised by the doctor taking, or attempting to take, advantage of an opportunity to exploit a person or situation. It can involve premeditation or be opportunistic.</p> <p>A doctor may behave in a predatory way inside or outside their working life.</p>
-----------------------------------	--

<p>Abuse of professional position</p>	<p>Abuse of professional position is where a doctor misuses their position of power. It arises because the relationship between the doctor and the individual is not equal.</p> <p>The forms it can take include taking advantage of someone, improperly gaining access to information or opportunities, manipulating an individual or a situation, using their title or status to try to take advantage of opportunities to achieve financial or other personal gain or benefit.</p> <p>Abuse of professional position can occur both inside and outside a doctor’s working life.</p>
--	--

<p>A reckless disregard for patient safety or professional standards</p>	<p>A reckless disregard for patient safety is where a doctor knew, or ought to have known, that their behaviour, poor performance or the impact of a health condition was causing harm, or risked causing harm, to patients and should have taken steps to prevent this, or where they deliberately closed their mind to the existence of such a risk.</p> <p>A reckless disregard for professional standards is where a doctor knew, or ought to have known, they should have followed professional guidance and chose not to do so without having first considered any associated risks and taking reasonable steps to mitigate them. This may include failing to take reasonable steps to check that information provided to others, or written in documents, is correct and that relevant information has not been left out.</p> <p>A reckless disregard for patient safety or professional standards is most frequently seen in a doctor’s working life but can also be seen outside of it.</p>
---	--

<p>Undermining a system designed to protect the public</p>	<p>Doctors can play an integral part in maintaining the integrity of systems designed to protect the public. They may do this by providing information about the health status of individuals to organisations carrying out specific statutory functions, or by providing an assessment about an individual’s ability to participate in certain activities.</p> <p>Where a doctor does not provide accurate information to one of these organisations, their regulator or another body who they’re employed by, or registered with, to provide healthcare services, the ability of those organisations to protect the public or deliver safe care to patients can be</p>
---	--

	<p>undermined. This also applies where a doctor is seeking employment or registration.</p> <p>Behaviour or poor performance that undermines the integrity of a system designed to protect the public can only arise in a doctor's working life.</p>
--	---

<p>Undermining collaborative working</p>	<p>How doctors treat their colleagues, and how they work together in the interests of patients, is essential for good healthcare. Behaviour that undermines colleagues or is otherwise obstructive to effective team working, can directly or indirectly have a negative impact on patient safety. However, a doctor who raises a concern to comply with their professional duty to raise concerns in the public interest should not be regarded as having behaved in a way that undermines collaborative working, even where their doing so has had a negative impact on colleagues or team working.</p> <p>Behaviour that undermines collaborative working can only arise in a doctor's working life.</p>
---	---

<p>Putting their own interests before those of patients</p>	<p>This occurs when a doctor puts their personal interests above those of a patient in a way that could compromise their judgment, decisions or actions. It includes where a doctor has asked for, accepted, or offered inducements or gifts, that may be seen to affect their behaviour at work, including clinical decision making. It also arises where they are not honest in their financial or commercial dealings, do not declare conflicts of interests and/or allow any interests to affect the way they prescribe, treat, refer or commission services for patients. Where a doctor puts their personal beliefs above the delivery of safe care to patients without making other suitable arrangements for treatment, this also amounts to putting their own interests above those of patients.</p> <p>This type of behaviour can only arise inside a doctor's working life.</p>
--	--

<p>An attempt to hide and/or avoid taking</p>	<p>A doctor must be open and honest if things go wrong. Where, at the time of the circumstances giving rise to the allegation, they attempt to hide unacceptable behaviour or</p>
--	---

<p>responsibility for behaviour or poor performance</p>	<p>poor performance or avoid taking responsibility for their behaviour or poor performance by blaming others for their own acts or omissions, this can have a negative impact on patient safety and/or workplace culture.</p> <p>This type of behaviour can only arise in a doctor's working life.</p>
--	--

Decision on where on the spectrum of seriousness the allegation lies

37. The MPT's decision on where on the spectrum of seriousness the allegation lies must reflect (a) the starting point for assessing seriousness based on the nature of the allegation and (b) the impact of specific features about the allegation which may increase seriousness.

Lower end

38. Where the nature of the allegation means it usually falls at the lower end of the spectrum of seriousness, the absence of features that may increase seriousness will mean the allegation is likely to stay at the lower end. This means the starting point for assessing current and ongoing risk to public protection is low. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have more impact and carry greater weight. This is because the risk to public protection arising from allegations falling at the lower end of the spectrum of seriousness are generally easier to mitigate and address.

Mid-range

39. Where the nature of the allegation means it usually falls at the lower end of the spectrum of seriousness, the impact of one or more features that may increase seriousness could result in the overall seriousness of the allegation increasing. However, this must be determined on a case-by-case basis, taking into account how remediable the nature of the allegation is.
40. To decide where on the spectrum of seriousness the allegation lies, the MPT should consider the impact the number of features that increase seriousness has, and the extent to which they are present, to decide how much weight to attach to each of them. Where the impact is that the seriousness of the

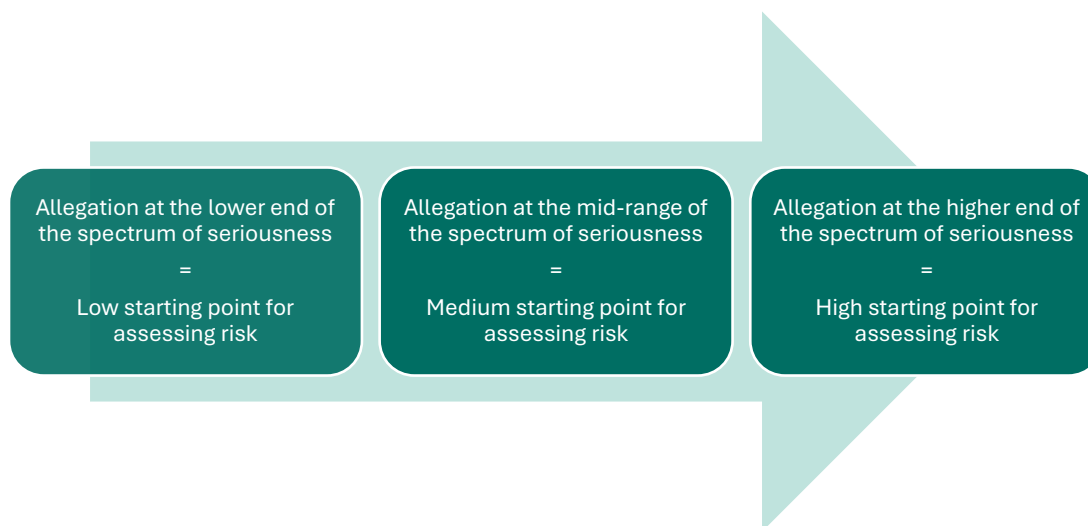
allegation moves up the spectrum to mid-range, the starting point the MPT uses for assessing current and ongoing risk to public protection will need to be medium to reflect this.

41. Where the MPT considers that the nature of an allegation falls at the mid-range of the spectrum of seriousness, the absence of features that may increase seriousness will mean the allegation stays at the mid-range. This means the starting point for assessing current and ongoing risk to public protection is medium.

Higher end

42. Where an allegation falls at the mid-range of the spectrum of seriousness, the impact of one or more features that may increase seriousness could result in the overall seriousness of the allegation increasing. However, this must be determined on a case by cases basis. To decide where on the spectrum of seriousness the allegation lies, the MPT should therefore consider the impact the number of features that increase seriousness has, and the extent to which they are present, to decide how much weight to attach to each of them. Where the impact is that the seriousness of the allegation moves up the spectrum so that it now falls at the higher end, the starting point for assessing current and ongoing risk to public protection will be high.
43. Where an allegation falls at the higher end of the spectrum of seriousness, the presence and impact of one or more factors that may increase seriousness could make the allegation more serious. Either way, it will stay at the higher end of the spectrum.
44. In all cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context known about the doctor and/or their working environment and evidence of how the doctor has responded to the concern that decrease risk, will usually have less impact and carry less weight. This is because the risk to public protection arising from allegations at the higher end of the spectrum of seriousness are generally more difficult to mitigate and address.

Starting point for assessing risk to public protection



- ▶ Allegation at the lower end of the spectrum of seriousness = low starting point for assessing risk
- ▶ Allegation at the mid-range of the spectrum of seriousness = medium starting point for assessing risk
- ▶ Allegation at the higher end of the spectrum of seriousness = high starting point for assessing risk

Step 2c: consider the impact of any relevant context

2c

Consider the impact of any relevant context

- Identify if there is any relevant context - working environment, role and experience or personal context
- Consider whether it directly or indirectly affected the doctor's behaviour, performance or health
- If so, is it appropriate to take that context into account?
- If so, confirm what impact it has on the level of risk (decreases, no impact, increases)

- ▶ Identify if there is any relevant context - working environment, role and experience or personal context
- ▶ Consider whether it directly or indirectly affected the doctor's behaviour, performance or health
- ▶ If so, is it appropriate to take that context into account?

- ▶ If so, confirm what impact it has on the level of risk (decreases, no impact, increases)

What is the impact of any relevant context known about the doctor and/or their working environment?

45. Relevant context about a doctor and/or their working environment can have an impact on the assessment of whether a doctor poses any current and ongoing risk to one or more of the three parts of public protection. There are three types of relevant context: working environment context, role and experience, and personal context.
46. The MPT should consider information known to it about relevant context and consider if, and how, it has impacted the doctor's behaviour, performance, or health. The impact that relevant context might have on a doctor can be negative or positive so, where it does have an impact, it can increase or decrease the level of current and ongoing risk posed to public protection.
47. Where the MPT identifies evidence of relevant context that relates to the facts found proved, the type should be specified. If the MPT decides the type of relevant context identified has had an impact on the doctor's behaviour, performance, or health, they should state how, decide what weight to attach to it and go on to consider what impact, if any, this has on their assessment of the level of current and ongoing risk to public protection posed by the doctor.
48. Where the MPT considers that the type of relevant context has had an impact on the doctor and there has been no change to the specific setting or circumstances that created the context, this could give rise to a risk of the allegation being repeated. Depending on the weight given, this may increase the level of current and ongoing risk the doctor poses to public protection.
49. However, where the context is not ongoing, either because the circumstances have changed, or because steps are now in place to mitigate the impact that the type of context had on the doctor, the MPT may consider that this reduces the likelihood of the allegation being repeated. This may in turn decrease the level of current and ongoing risk the doctor poses to one or more parts of public protection depending on the weight the MPT decide to attach to it.
50. The impact that evidence of relevant context has on the assessment of risk, will depend on the nature of the allegation and individual circumstances of the

case. However, evidence of relevant context that may decrease the level of risk to public protection posed by the doctor will usually carry less weight in cases that fall at the higher end of the spectrum of seriousness. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.

51. The ways in which each type of relevant context about a doctor and/or their working environment could increase or decrease the risk to public protection are set out below.

Working environment context

52. The environment in which a doctor is practising can influence their behaviour, performance, or health. There are two types of working environment context; systems factors and interpersonal factors.
53. Systems factors relate to the physical working environment where the doctor is practising. There are a range of systems factors which can directly or indirectly affect a doctor's behaviour, performance, or health. These include, but are not limited to:
 - a. their immediate workplace, including the systems and processes that exist and the associated training they've received to understand their responsibilities within them, including:
 - i. the quality of induction – this will be particularly relevant where the doctor is transitioning to new social, cultural and professional environments
 - ii. workload issues, such as unmitigated gaps in resources, a crisis or unexpected surge in demand
 - iii. service delivery requirements to work in unfamiliar roles, teams and/or environments at short notice so the doctor has been unable to adequately prepare
 - b. the impact of technologies or other physical influences
 - c. a lack of, or conflicting, clinical practice guidance
 - d. the availability or effectiveness of reasonable adjustments for disabled doctors
 - e. working in a setting or situation where the requirements of patient care are unpredictable or new to the doctor.
54. Interpersonal factors relate to the values and interests of the organisation or team within which the doctor is working, and the relationships between individuals in that working environment. There are a range of interpersonal

factors which can directly or indirectly affect a doctor's behaviour, performance, or health. These include, but are not limited to:

- a. the culture of the organisation, or the specific team or area of practice within the organisation, such as:
 - i. how engaged, positive and accessible the leadership team is
 - ii. how they respond when things go wrong (blame versus learning culture)
 - iii. how they encourage an inclusive and fair working environment, including their approach to identifying insider/outsider groups⁴ and addressing associated risks
- b. the support, supervision and learning experiences provided, or made available, to the doctor, including from more senior doctors, other healthcare professionals or relevant staff
- c. the approach to giving and receiving effective, honest, and timely feedback to help the doctor address any concerns early and for them not to develop further.

Assessing the impact of working environment context

55. The MPT may have information available to them about systems factors or interpersonal factors that are outside a doctor's control, and which had an impact on their behaviour, performance, or health at the time. Where this is the case, the relevant context may decrease the level of current and ongoing risk the doctor poses to one or more of the three parts of public protection where the likelihood of repetition has been removed or reduced, either because the working environment itself has now changed or because steps have been put in place to mitigate the impact on the doctor. This may include where there is evidence to show that workload issues, challenges with technologies or problems caused by poor team or organisational culture have now been addressed, or where the doctor has improved support or supervision arrangements.
56. Where a doctor's behaviour, performance or health was impacted by system or interpersonal factors that were outside of the doctor's control, the fact those factors have not been removed or mitigated by the organisation or individuals responsible for them may mean that the working environment itself

⁴ In groups and out groups exist in medicine including relating to qualifications (including by country and within the UK by medical school) and ethnicity (including within BME populations). Members of ingroups can receive favourable treatment and those in out groups are at risk of bias and stereotyping. (Fair to Refer? June 2019)

poses an ongoing risk. However, this does not have the result of increasing the level of risk posed by the individual doctor.

57. To comply with the professional duty of candour⁵, all medical professionals are expected to raise and act on concerns about patient safety. Where a doctor failed to take reasonable steps to raise concerns about patient safety, this may increase the level of current and ongoing risk the doctor poses to public protection because of the potential risk to patient safety.
58. When the MPT is deciding what amounts to 'reasonable' steps, information available about the systems, processes, and culture in the working environment to support raising concerns should be considered. It's unlikely a doctor will have failed to take reasonable steps in circumstances where they knew that another individual was raising the relevant concern(s), or the concern(s) were already known to management.
59. In cases where there is evidence of working environment context that may decrease risk, this will usually have less impact, and therefore carry less weight, where the allegation falls at the higher end of the spectrum of seriousness. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.

Role and experience

60. Doctors work across a wide range of contexts and roles which require different skills, knowledge, and experience. The professional standards apply to all doctors registered with the GMC, in all fields of practice, in NHS and independent care settings, whether or not a doctor routinely sees patients.
61. Practical experience of working in the relevant health and care system and setting plays a key role in a doctor's development.
62. Where a concern arises about a doctor's fitness to practise, their behaviour or performance will be judged against the standards expected of a reasonably competent doctor working within a similar setting and the same role. This includes grade and specialty.
63. Doctors in leadership positions have specific standards set out in Good medical practice and other detailed professional guidance that they're expected to

⁵ [The professional duty of candour - professional standards - GMC](#)

practice in line with. Where a doctor is in a senior or leading role, the additional impact their poor behaviour or performance has had, or could have had, can be considered.

Assessing the impact of role and experience

64. Failure to meet the professional standards expected is not acceptable simply because a doctor is newly qualified or new to UK practice. However, where they are inexperienced at the time the behaviour or poor performance occurred and can demonstrate that since then they have developed their skills or gained a better understanding of the UK healthcare system, this may decrease the level of current and ongoing risk they pose to public protection because it reduces the likelihood of repetition.
65. A doctor in a senior or leading role is more likely to be capable of influencing others and having an impact on workplace culture. Therefore, where a doctor that is in a senior or leading role frequently demonstrates inappropriate behaviour or poor performance, a departure from the professional standards expected has an additional impact.
66. Where the doctor was in a leadership position at the time the circumstances giving rise to the allegation arose and the behaviour or poor performance had, or could reasonably have had, a negative impact on others in the working environment, this may, depending on the facts of the case, increase the level of current and ongoing risk the doctor poses to public protection. The doctor no longer being in that role will not usually have the effect of reducing the level of current and ongoing risk posed to public protection because it is possible they will return to that, or a similar, position in the future.
67. In cases where there is evidence about the doctor's role and experience which may decrease the level of risk the doctor poses to one or more of the three parts of public protection, this will usually have less impact, and therefore carry less weight, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.

A doctor's personal context

68. Personal context relates only to the individual doctor's circumstances. It is distinct from information about the doctor's good character and standing. Personal context can directly or indirectly affect a doctor's behaviour,

performance, or health condition and includes matters such as a personal emergency.

69. Where a doctor is aware of personal context that may impact on their behaviour, performance, or health at work, they should raise this and seek appropriate support. However, some types of personal context can arise suddenly or cannot be predicted, which may put them outside the doctor's immediate control. This may present challenges that make it difficult for the doctor to deliver good medical practice.

Assessing the impact of personal context

70. For personal context to be relevant to the MPT's assessment of current and ongoing risk to public protection, there must be a direct link between it and the doctor's behaviour, performance, or health.
71. If the personal context that directly influenced the doctor's behaviour, performance or health at the time of the allegation has since resolved, or steps have been put in place to avoid the circumstances arising again and/or to help the doctor cope with those circumstances if they did arise again, this may decrease the level of current and ongoing risk posed by the doctor to one or more of the three parts of public protection because it reduces the likelihood of repetition.
72. Where the relevant personal context was out of the doctor's control, or where they were taking reasonable steps to minimise the impact, this will usually have more of an impact on the assessment of risk. However, where there is an ongoing impact arising from the doctor's personal context and steps are not in place to manage this, the MPT might conclude, depending on the facts of the case, that there may be a risk of repetition which means the level of current and ongoing risk to public protection may be increased.
73. In cases where there is evidence of personal context that may decrease the level of risk the doctor poses to one or more of the three parts of public protection, this will usually have less impact, and therefore carry less weight, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high. This is because the risk to public protection arising from these concerns is generally more difficult to mitigate.

Step 2d: consider how the doctor has responded to the allegation(s)

2d

Consider how the doctor has responded to the allegation(s)

- Consider what evidence there is relating to insight and assess if insight is genuine
- Consider what evidence there is relating to remediation to assess if the allegation is remediable, has been remedied and is likely to be repeated
- Consider if the doctor has kept their knowledge and skills up to date
- Confirm what impact these factors have on the level of risk (decreases, no impact, increases)

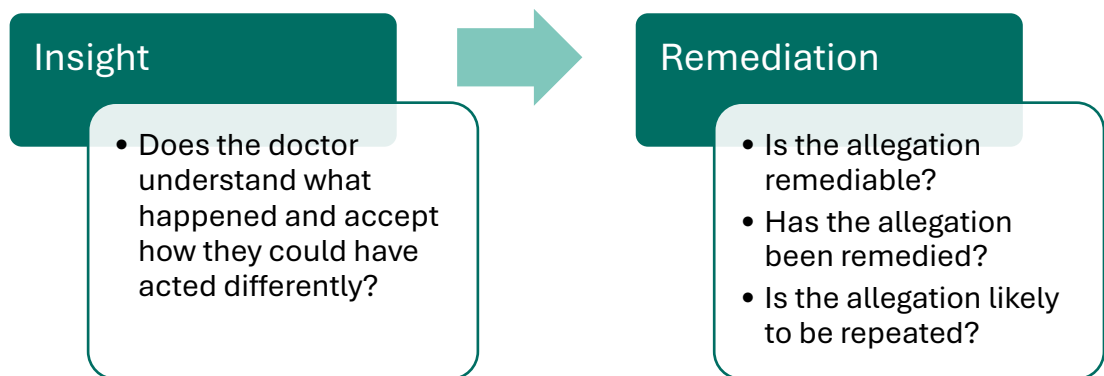
- ▶ Consider what evidence there is relating to insight and assess if insight is genuine
- ▶ Consider what evidence there is relating to remediation to assess if the allegation is remediable, has been remedied and is likely to be repeated
- ▶ Consider if the doctor has kept their knowledge and skills up to date
- ▶ Confirm what impact these factors have on the level of risk (decreases, no impact, increases)

How has the doctor responded to the allegation(s)?

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.
75. The doctor's character and good standing in the community is separate from the doctor's response to the allegation and will usually only be relevant when the MPT has made its decision on impairment and has moved on to consider what regulatory action is necessary to take in response to the findings about the doctor's fitness to practise.

Insight and remediation

76. The MPT should consider what has happened since the time of the events giving rise to the allegation(s), in terms of the doctor's response to the allegation(s) and the level of insight and remediation they have shown. They should indicate how much weight they have attached to evidence of insight and remediation and why. This will assist them to explain their view on whether the doctor poses any current and ongoing risk to public protection.
77. When assessing evidence of insight and remediation, the key considerations are:



Insight

- ▶ Does the doctor understand what happened and accept how they could have acted differently?

Remediation

- ▶ Is the allegation remediable?
- ▶ Has the allegation been remedied?
- ▶ Is the allegation likely to be repeated?

78. Evidence of insight and remediation in response to an allegation can be demonstrated and assessed on the papers. However, where a doctor attends a hearing, the MPT will be able to hear from that individual directly. The ability to test the doctor's evidence through questions may in certain circumstances allow the MPT to make a more thorough assessment of the level of insight and remediation shown.
79. Evidence of insight and remediation will have a different impact on the assessment of current and ongoing risk to public protection in each case, depending on the nature of the allegation and individual circumstances of the case. In many cases, as it can reduce the risk of repetition, it can significantly

decrease the level of any current and ongoing risk to public protection posed by the doctor.

80. However, in cases where the allegation falls at the higher end of the spectrum of seriousness, and therefore the starting point for assessing current and ongoing risk to public protection is high, evidence of insight and remediation will usually carry less weight and therefore will have less impact, if any, on the assessment of current and ongoing risk to public protection. This is because the risk to public protection arising from these allegations is generally more difficult to address, particularly where the allegation is connected to deep seated attitude issues and beliefs.

Insight

81. To demonstrate insight, and insight which is genuine, the doctor will need to show they understand what happened and accept how they could have acted differently. This involves showing, where relevant, that they have:
- ▶ considered the allegation, understanding what went wrong and accept they should have acted differently
 - ▶ fully understood the impact or potential impact of their behaviour, performance, or health condition
 - ▶ empathy for any individual affected, for example by apologising
 - ▶ taken, or are taking, steps to remediate and to identify how they will act differently in the future to avoid similar issues arising
 - ▶ sought appropriate support for a health condition and are seeking and/or following treatment and advice and/or are engaging with local support and any steps put in place to manage any risks to patients
 - ▶ complied with the professional duty of candour
 - ▶ co-operated with earlier investigations into the allegation (if they had the opportunity to do so) and engaged with the GMC's investigation, and/or
 - ▶ self-referred to their employer and/or the GMC.

Evidence of insight

82. Evidence of insight will usually come directly from the doctor in the form of a statement or other material demonstrating their reflection.
83. During the investigation, the GMC cannot require a doctor to provide copies of material produced for the purpose of professional development or produced while reflecting on their professional practice to improve it (reflective notes), but they can be invited to provide evidence of insight and remediation as part

of their response to the allegation. Whether the doctor does this, and the form it takes, is for them to decide.

84. When assessing the doctor's insight at hearing, the MPT cannot require the doctor to provide reflective notes. However, if the doctor has chosen to provide them, they can be considered.
85. The MPT may be provided with objective evidence of insight in the form of a statement from a doctor's responsible officer. Further information about this can be found in the [remediation section](#)).

Assessing the impact of insight

86. When the MPT is deciding what impact evidence of insight has on the assessment of current and ongoing risk to public protection, it will be relevant to consider how complete or developed the doctor's insight is.
87. While all evidence of insight is important when assessing risk, some factors will enhance the impact of insight which means they may carry more weight. The following are relevant considerations:
 - ▶ the nature and quality – for example, a full acknowledgment of what has occurred and what the doctor needs to do differently, may carry more weight than a simple '...I'm sorry...'. And a detailed, voluntary self-referral and active engagement may carry more weight than a limited self-referral, made in response to a requirement by an individual or organisation to avoid a referral by them, with no onward cooperation.
 - ▶ the timing – for example, an apology given soon after the relevant events to the appropriate person may carry more weight than if it were given following a delay and just before, or at, the decision point, and a self-referral may carry more weight if it is made voluntarily rather than to avoid a referral by a third party.
88. To fully comply with the professional duty of candour, a doctor is expected to be open and honest with patients and people in their care when things go wrong. This includes apologising. However, where there is evidence that a doctor wanted to apologise sooner but has been prevented from doing so by systems or procedures, such as governance or ongoing litigation, or the culture in their place of work, this will be relevant to the weight the MPT give to this information.

89. A doctor has the right to advance a robust defence to an allegation. This includes requiring the GMC to prove their case and bring witnesses to hearings. As a result, an apology may not be forthcoming until after a witness has engaged in the hearing. In other cases, if the defence put forward by the doctor is not successful, it may be unrealistic to expect them to immediately accept every finding, in a fully sincere manner, or apologise.
90. However, in these circumstances it may still be possible for the doctor to provide some evidence of insight without them having fully admitted the circumstances of the allegation. Where a doctor gives evidence at a hearing, the MPT will be able to test evidence of insight through oral testimony to assess whether it is genuine.
91. When deciding what impact evidence of insight has on the assessment of risk, the MPT will need to consider how any differences in culture, faith and communication that are known about may have impacted on the quality of evidence, such as how the doctor has expressed insight, or framed and communicated an apology. Explanations about the relevance of differences in culture, faith and communication are set out in the section on ‘Being fair’ in the [Introduction](#) section of this guidance.
92. In many cases, evidence of complete or well-developed insight will have the impact of decreasing the level of current and ongoing risk to one or more of the three parts of public protection posed by the doctor. However, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high, the impact of insight and remediation and the weight it carries may be less because the risk to public protection arising from these concerns is generally more difficult to address.
93. In some circumstances, it may be reasonable to conclude that a doctor lacks genuine, or any, insight. This may be because there is evidence they have:
- ▶ repeated behaviour or poor performance where the circumstances of a previous complaint or concern are similar in nature or raise similar concerns to the current matter
 - ▶ tried to minimise the seriousness or impact of their behaviour, poor performance or health condition
 - ▶ provided an explanation after the event in which they have tried to minimise their own role or culpability, or otherwise sought to blame others

- ▶ been blatantly dishonest or deliberately sought to mislead the GMC or MPT. This may include, amongst other things, knowingly advancing a case of false primary fact or a defence at the unreal, unreasonable or ludicrous end of the spectrum, and/or
- ▶ failed to comply with a direction to undergo an assessment or a requirement to produce information/documentation, or significantly delayed complying without any reasonable explanation.

94. Where there is a lack of insight, this may have the impact of increasing the level of current and ongoing risk to public protection posed by the doctor.

Remediation

95. For a doctor to successfully remediate, it's important they have insight into the allegation. This is because to actively address an allegation about their behaviour, performance, or impact of a health condition, a doctor must first recognise there is a concern and try to understand how it arose.

96. Where the allegation relates to a doctor's behaviour or performance it is crucial that they have taken, or are taking, steps aimed at reducing the risk of similar allegations occurring again. Where the allegation relates to the impact of a doctor's health condition and they are presently working, to reduce the impact, or likely impact, on their ability to provide safe and effective care, it is important the doctor is seeking and following treatment and advice and taking steps locally to manage any potential risk to patients.

97. In many cases, evidence of remediation can address, or have a significant impact on, the assessment of current and ongoing risk to public protection.

Evidence of remediation

98. There isn't a set way to demonstrate remediation and so the way in which a doctor can show they have actively addressed the allegation(s) will depend on the individual circumstances of the case. Evidence that shows the nature and quality of the steps the doctor has taken to remediate the allegation(s) is key to assessing the impact it has had, or can have.

99. Remediation can take several forms, including, but not limited to:

- ▶ passing an objective assessment related to performance, health, or language

- ▶ where the allegation relates to performance, participating in training, supervision, coaching and/or mentoring relevant to the matters raised and putting that learning into practice
- ▶ where the allegation relates to behaviour, attending courses relevant to the nature of the matters raised and showing that the learning has been applied
- ▶ evidence that shows what the doctor has learnt following the events that led to the allegation, and how they have applied this learning in their practice
- ▶ evidence of good practice in a similar environment to where the allegation arose – this will often be evidence from a doctor’s employer showing that they were aware of the allegation and have evaluated the doctor’s practice
- ▶ treatment or rehabilitation for a health condition resulting in the doctor now being able to practise safely and effectively with or without supportive measures in place
- ▶ steps taken to manage a health condition such that any potential impact on their ability to provide care to a sufficient standard is mitigated, and/or
- ▶ action taken to address language deficiencies which shows the doctor can now communicate effectively in the workplace.

100. Objective evidence of remediation is likely to have more impact and carry more weight than personal statements (self-certification). Objective evidence may include, but is not limited to:

- ▶ certificates from completed training modules
- ▶ continued professional development documentation, including evidence of participation in a college or faculty run ‘Continuing Professional Development’ scheme or a personal development plan
- ▶ reports from supervising medical professionals, and/or
- ▶ a report from the doctor’s treating healthcare practitioner.

101. The length of time between attendance at a course and the decision point will have an impact on the extent to which the doctor can demonstrate how they have put any related learning into practice. Some methods of training, such as trainer-led, where available, can support this better than others.

Statements from responsible officers⁶

102. Evidence that a doctor has taken steps to remediate may be provided in the form of a statement from their responsible officer and will contain a factual account of the doctor's response to the allegation.
103. If available, the statement will detail any factors the author considers relevant, and may include the following:
- ▶ details of any expressions of regret or apology made
 - ▶ information about the doctor's involvement and cooperation with any local investigation
 - ▶ details of practical steps taken to address the allegation, including attendance on professional courses and/or other learning, and/or
 - ▶ an update in relation to the doctor's current practice.
104. The information contained within the statement may assist in determining whether a doctor has shown insight and/or whether the allegation has been addressed. The content of the statement should be weighed appropriately against the nature of the allegation and other available evidence.
105. In some cases, a statement may not be available as evidence because the responsible officer hasn't provided this information. An adverse inference should not be drawn in cases where a statement is not available.

Assessing the impact of remediation

106. When deciding what impact evidence of remediation has on the assessment of current and ongoing risk to public protection, the MPT should have regard to the quality of the steps taken, or put in place, by the doctor.
107. The following should be considered when assessing the impact of remediation:
- a. Is the allegation easily remediable?
 - b. Has the allegation been remedied or is it being remedied?
 - c. Is the allegation highly unlikely to be repeated?

a) Is the allegation easily remediable?

⁶ Alternatively, this may be provided by a doctor's suitable person. A suitable person is a licensed doctor approved by the GMC to make a recommendation to us about revalidation for a doctor who does not have a responsible officer.

108. Allegations about poor performance, the impact of a health condition or insufficient knowledge of the English language are generally more easily remediable than others.
109. Cases involving the following features can be more difficult to remediate:
- ▶ there is a high risk of harm to patients due to the doctor’s deliberate, reckless, persistent, or repeated behaviour
 - ▶ the nature of, or circumstances giving rise to, the allegation suggests there is an underlying issue with the doctor’s attitude, and/or
 - ▶ the allegation falls at the higher end of the spectrum of seriousness and is capable of damaging public confidence in the professions.

b) Has the allegation been remedied or is it being remedied?

110. In all cases, the quality of the remediation will inform the weight that the MPT attaches to it when deciding if the allegation has been remedied or is being remedied.
111. Assessing the quality of remediation involves looking at whether it is:
- ▶ relevant – in that the steps taken to remediate have directly addressed the allegation
 - ▶ measurable – in that there is objective evidence available that shows what has been done and what, if anything, is left to be done, and
 - ▶ effective – in that there is enough information available to see how any learning has been assessed and/or applied in the doctor’s practice.
112. The MPT should be satisfied that remediation addresses any risk of harm to patients. A risk of harm will usually still be present where the doctor’s poor performance or behaviour is not being, or cannot be, safely managed locally, or local management has been tried and has failed.
113. Remedial steps that have been completed will usually have a greater impact and carry more weight than actions started by a doctor that have not yet concluded.

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.
116. The MPT needs to make sure that a low risk of repetition is carefully distinguished from identifying no risk of repetition. This is because a low, but nonetheless real, risk of repetition might be significant and/or have a very serious outcome where the case involves behaviour or poor performance which falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high.
117. Whether the allegation is highly unlikely to be repeated and the impact of this will need to be assessed based on the individual circumstances of the case. In many cases, a conclusion that the allegation is highly unlikely to be repeated will have the impact of decreasing the level of current and ongoing risk to public protection posed by the doctor. However, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high, a conclusion that an allegation is highly unlikely to be repeated may be given less weight and therefore have less impact on the assessment of current and ongoing risk.
118. Where there is no evidence of a doctor having completed or started any remediation, it will often be reasonable to conclude that a risk of repetition exists. This may increase the level of current and ongoing risk to public protection posed by the doctor.

Has the doctor kept their knowledge and skills up to date?

119. To provide a good standard of practice and care, doctors must be competent in all aspects of their work, including, where applicable, formal leadership or management roles, research, and teaching. This means keeping their knowledge and skills up to date and being aware of relevant guidelines and developments that affect their work.

120. Where there is an allegation about one or more aspects of a doctor's professional practice, they need to demonstrate effective insight and remediation to reduce the risk of the same, or a similar allegation, being repeated. Where the circumstances giving rise to the allegation are historical and, since they arose, the doctor can show they have kept their knowledge and skills up to date and been working within their area(s) of competence, the absence of further allegations about their behaviour or performance may decrease the level of current and ongoing risk posed to public protection.
121. Where there is evidence that a doctor's knowledge and skills are not up to date, this may increase the level of current and ongoing risk they pose to public protection. However, it is not for the MPT to add a ground for impairment in these circumstances.

Evidence of knowledge and skills

122. Evidence that a doctor has kept their knowledge and skills up to date can come in different forms, including, but not limited to:
- ▶ documentation showing the doctor has passed an objective assessment related to their performance, health, or knowledge of the English language
 - ▶ certificates from completed training modules
 - ▶ continued professional development documentation, including evidence of participation in a college or faculty run 'Continuing Professional Development' scheme or a personal development plan
 - ▶ where the doctor has been working, competency reports from supervising medical professionals, and/or
 - ▶ a report from a clinical attachment programme.
123. Objective evidence of knowledge and skills being up to date may also be available in the form of a statement from a doctor's responsible officer. Further information about this can be found in the [remediation](#) section.

Assessing the impact of evidence relating to the doctor's knowledge and skills

124. Where a doctor has not been working for a period since the circumstances giving rise to the allegation arose, either at all or in a specific speciality, the MPT may consider that this creates a risk that the doctor's knowledge and skills have deteriorated. It's therefore important that the doctor can evidence they have taken steps to mitigate this risk.

125. Where the doctor can show that their knowledge and skills are up to date despite any break from practice, this will not usually directly impact on the assessment of current and ongoing risk to public protection because being competent in all aspects of their work and able to provide a good standard of practice and care is a key requirement of the professional standards.
126. If a doctor has been working (with or without restrictions) since the circumstances giving rise to the allegation arose and can show their knowledge and skills are up to date and that they have been working within their area(s) of competence, this will not usually directly impact on the assessment of current and ongoing risk to public protection for the same reason.
127. An exception to this may be where the circumstances giving rise to the allegation are historical, there have been no further concerns raised about the doctor's behaviour or performance at work and there is evidence they have kept their knowledge and skills up to date and been working within their area(s) of competence. In these specific circumstances, the MPT may consider that the combination of these factors can decrease the level of current and ongoing risk posed to public protection.
128. However, where the allegation falls at the higher end of the spectrum of seriousness and therefore the starting point for assessing current and ongoing risk to public protection is high, these factors may carry less weight and therefore have less impact on the MPT's assessment of current and ongoing risk.
129. Where there is information that casts doubt over whether the doctor's knowledge and skills are up to date, regardless of whether they have been working since the circumstances giving rise to the allegation arose, this may have the impact of increasing the level of current and ongoing risk they pose to public protection.

Step 2e: on the basis of the conclusions reached in steps 2b, 2c and 2d decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment

2e

On the basis of the conclusions reached in steps 2b, 2c and 2d decide if the doctor poses any current and ongoing risk to public protection and make a finding on impairment

- If no current and ongoing risk, make a finding of no impairment
- If there is a current and ongoing risk to public protection, decide to which parts, state the level of risk (low, medium, high) and make a finding of impairment
- Give reasons for decision

- ▶ If no current and ongoing risk, make a finding of no impairment
- ▶ If there is a current and ongoing risk to public protection, decide to which parts, state the level of risk (low, medium, high) and make a finding of impairment
- ▶ Give reasons for decision

Deciding if the doctor poses any current and ongoing risk to public protection to reach a decision on impairment

130. If there is more than one legal basis for considering the doctor's fitness to practise an assessment of current and ongoing risk must be made in respect of each of them.

131. The MPT's view on whether the doctor poses any current and ongoing risk to public protection, and if so, what level of risk (low, medium, or high), is based on considering the answers to the questions at steps 2b to 2d:

- ▶ Where on the spectrum of seriousness does the allegation lie – lower end, mid-range, higher end?
- ▶ *This provides the starting point for assessing current and ongoing risk to public protection – low, medium or high.*
- ▶ Is there relevant context known about the doctor or their working environment that impacted on the doctor's behaviour, performance or health and what impact does this have on the assessment of current and ongoing risk – decreases risk, has no impact on risk, increases risk?

- ▶ How has the doctor responded to the allegation and what impact does this have on the assessment of risk – decreases risk, has no impact on risk, increases risk?

132. Each of the answers will need to be carefully considered and balanced against one another to inform the MPT's view on risk.

133. In cases where the allegation falls at the lower end of the spectrum of seriousness, and where there is evidence of relevant context about the doctor and/or their working environment and/or evidence of how the doctor has responded that decreases risk, a conclusion may be made that either the doctor does not pose any current and ongoing risk, or still poses a low level of risk, to one of more of the three parts of public protection requiring restrictive action in response. This often arises where there is a clinical concern or where the concern relates to the impact of a doctor's health condition on their ability to practise safely and effectively.

134. In cases where the allegation falls at the higher end of the spectrum of seriousness, the starting point for assessing current and ongoing risk to public protection will be high. Evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may have less impact and carry less weight because these types of allegations can be more difficult to remediate. Evidence of the doctor having kept their knowledge and skills up to date may also be less relevant. This should be considered by the MPT when they are reaching a view on risk and a conclusion that the doctor poses a current and ongoing risk to one of more of the three parts of public protection requiring restrictive action in response may be needed, particularly as the allegation is likely to engage public confidence.

135. Although cases of violence and dishonesty usually fall at the higher end of the spectrum of seriousness, they can involve a range of behaviour, with the circumstances giving rise to the allegation often occurring outside the doctor's professional practice. In deciding whether there is any current and ongoing risk to public protection requiring restrictive action in response, the MPT will need to decide where on the spectrum of seriousness the violence or dishonesty sits. Where the violent or dishonest behaviour is at the lower to mid-range of the spectrum of seriousness, evidence of relevant context that decreases risk and evidence of insight and remediation that decreases risk may carry more weight and have more impact.

136. The MPT must record reasons for their conclusion on whether the doctor poses any current and ongoing risk to one or more of the three parts of public protection requiring restrictive action in response, to explain their decision on impairment.
137. Where the MPT reach a view that the doctor 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. In doing so, they should be clear about which parts of public protection – patient safety, public confidence and/or upholding professional standards – are engaged, making reference to the general guidance and specific case types sections in the [Introduction](#), as appropriate.
138. The MPT should also state the level of risk they've identified – low, medium, or high. This is because the level of current and ongoing risk will be relevant to the MPT's decision on what is a proportionate response. The MPT should then apply the guidance in [Part C Step three: Decide on sanction](#) to decide what action is needed to protect the public.
139. In cases where the MPT decides that the doctor's fitness to practise is not impaired, they may give the doctor a warning as to their future behaviour or performance where the allegation falls below the professional standards expected. To decide whether a warning is a proportionate response, the MPT should apply the guidance in [Part D: Decide if a warning is required](#).

Part C: stage three – sanction

At Stage three of an MPT hearing, the MPT will consider what regulatory action, if any, is needed to protect the public.

This stage outlines the outcomes available to the MPT which are:

- ▶ take no action
- ▶ impose conditions on the doctor's registration for up to three years
- ▶ suspend the doctor's registration for up to 12 months, or
- ▶ erasure the doctor's name from the medical register.

Step 3: decide on sanction

3

Sanction: make a decision on sanction

- If impaired, consider what sanction is proportionate i.e. is needed but no more than necessary to protect the public
- Review decision on impairment and consider the level of current and ongoing risk the doctor poses to public protection
- Refer to sanctions bandings (where available)
- Consider whether there is relevant evidence relating to the impact a certain type of sanction will have and / or relevant references and testimonials and what impact, if any, they have
- Decide on the type and length of sanction - stand back and check if it is proportionate to meet the level of current and ongoing risk posed to public protection
- Consider directing a review, whether an immediate order is needed, and if action is needed in relation to an interim order
- Give reasons for decisions

- ▶ If impaired, consider what sanction is proportionate i.e. is needed but no more than necessary to protect the public
- ▶ Review decision on impairment and consider the level of current and ongoing risk the doctor poses to public protection
- ▶ Refer to sanctions bandings (where available)
- ▶ Consider whether there is relevant evidence relating to the impact a certain type of sanction will have and/or relevant references and testimonials and what impact, if any, they have
- ▶ Decide on the type and length of sanction- stand back and check if it is proportionate to meet the level of current and ongoing risk posed to public protection
- ▶ Consider directing a review, whether an immediate order is needed and if action is needed in relation to an interim order

- ▶ Give reasons for decisions

Decision on sanction

1. At stage three of an MPT hearing, the MPT will consider what regulatory action, if any, is needed to protect the public.
2. Where the MPT has decided that the doctor's fitness to practise is impaired at stage two of the hearing, it will need to go on to consider what is a proportionate regulatory response to protect the public.⁷
3. References made to 'public protection' throughout this guidance refer to the GMC and MPTS' legal duty to protect the public which is split into three distinct parts. It means an MPT must act in a way that:
 - ▶ protects, promotes and maintains the health, safety and wellbeing of the public
 - ▶ promotes and maintains public confidence in the profession, and
 - ▶ promotes and maintains proper professional standards and conduct for members of the profession.
4. At the sanction stage, the outcomes available to the MPT are to:
 - ▶ take no action
 - ▶ impose conditions on the doctor's registration for up to three years
 - ▶ suspend the doctor's registration for up to 12 months, or
 - ▶ erase the doctor's name from the medical register.⁸
5. When making their decision, the MPT should always remind themselves of their earlier conclusions at the facts and impairment stages to ensure that they have been, and remain, consistent with previous findings and have regard to the level of current and ongoing risk to one or more of the three parts of public protection posed by the doctor (low, medium, or high).
6. In most hearings, the sanctions stage will follow immediately after the MPT has made its decision on impairment. But sometimes, in the event of a split listing or an adjournment, there is a time lapse prior to the MPT's consideration of sanction. Where a time lapse occurs, the MPT will need to take particular care to remind themselves of their earlier conclusion on risk before considering

⁷ Section 1(1) of the Medical Act 1983 describes this as the over-arching objective of the GMC and MPTS

⁸ Except in cases relating solely to a doctor's health and/or knowledge of the English language.

what has happened since the case was last before them and assessing the impact of any relevant additional evidence. This amounts to the MPT conducting an updated assessment of the current and ongoing risk to public protection posed by the doctor.

7. When conducting an updated assessment of risk, the MPT must avoid “double counting” evidence that previously informed, and was therefore taken into account in reaching, their earlier decision on impairment. Where there is relevant additional evidence, the MPT must consider it and identify any additional factors capable of increasing or decreasing the level of current and ongoing risk to public protection posed by the doctor. They should do this with reference to the guidance in [Part B Step 2: Make a decision on impairment](#) and clearly state the impact these additional factors have on their previous view of risk. It is this updated assessment of current and ongoing risk that should inform the MPT’s view on what sanction is a proportionate response.
8. For some types of cases, sanctions bandings are available. The MPT should be mindful that these provide a guide, and there may be evidence relevant to the individual circumstances of the case that indicates the appropriate action should be lower or higher than that indicated by the bandings. This can include whether the type of sanction should be less or more restrictive, or where conditions or suspension are imposed, that the length should be longer or shorter than that stated.
9. The MPT will always need to record reasons for their decision on sanction. Where the MPT’s decision departs from the principles in this part of the guidance, which includes the sanctions bandings, the MPT must carefully explain how this is justified, given the specific circumstances of the case. They must also explain how the decision relates to any submissions made by the parties.

Any sanction must be proportionate, transparent and fair

10. A good decision about a doctor’s fitness to practise should protect the public, be proportionate, be transparent and be fair. In the context of deciding what sanction, if any, is required to address the level of current and ongoing risk to public protection posed by a doctor (low, medium or high), being proportionate means:
 - ▶ When deciding what is required but no more than necessary to achieve public protection, approaching the question by considering if the least restrictive action is appropriate, and not making a final decision until the

options immediately above and below the action the MPT is minded to take, have also been assessed.

- ▶ When considering the impact on those affected by the decision, the interests of individual patients and members of the public may include the impact that taking a specific type of action is likely to have on the delivery of health services in a particular speciality or within a defined geographical location. However, whilst there may be a public interest in facilitating a doctor's return to safe practice, the decision on what sanction is required needs to reflect the level of current and ongoing risk to one or more of the three parts of public protection that has been identified, and which takes into account the seriousness of the allegations, and must be consistent with the GMC and MPTS' legal role to protect the public.
- ▶ The interests of the doctor will include the impact on their career. This means when deciding what sanction is required, it may be appropriate to consider any increased impact a specific outcome would have on an individual doctor compared to others, considering their specific circumstances. However, case law is clear that the need to protect the public always outweighs the interests of any individual medical professional. And while restrictive action is not put in place to punish or discipline a doctor, a sanction may have a punitive effect yet still remain necessary.

11. When reaching a view on what is a proportionate sanction, the MPT must demonstrate they have considered any submissions made by the parties.
12. Sanctions are published on the doctor's entry on the register and disclosed in line with the GMC's Publication and Disclosure Policy.

Outcomes available to the MPT at the sanction stage

Taking no action

13. Where a doctor's fitness to practise is impaired, it will usually be necessary for the MPT to restrict the doctor's registration to achieve public protection. But there may be exceptional circumstances to justify an MPT taking no action. Exceptional circumstances are unusual, special, or uncommon, so such cases are likely to be very rare.

14. When making their decision on impairment, the MPT will already have taken into account any relevant context and the doctor's response to the allegation. Therefore, the presence of relevant context and insight and remediation are unlikely on their own to justify an MPT taking no action.
15. Taking no action may be proportionate where the MPT is satisfied that undertakings agreed between the GMC and doctor are sufficient to protect the public. Undertakings can be agreed between a doctor and the GMC at a hearing after the MPT has made a finding of impairment.⁹ If undertakings are agreed, the MPT may take these into account when reaching its decision on sanction,¹⁰ provided that certain conditions are met.¹¹
16. Where an MPT decides to take no action, its determination must fully and clearly explain:
 - a. what the exceptional circumstances are,
 - b. why the circumstances are exceptional, and
 - c. how the exceptional circumstances justify taking no action.

Conditions

17. Conditions are suitable for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period of time, with the aim they should be able to safely return to unrestricted practice in the future.
18. Where a sanction of conditions is imposed on a doctor's registration, the MPT must specify the period for which it is to remain in force, up to a maximum of three years.¹²

What are conditions?

⁹ Undertakings can also be agreed by the doctor and GMC case examiners before a matter is referred to a hearing.

¹⁰ Provided for by Schedule 4 paragraph 1(2C) of the Medical Act 1983 (as amended)

¹¹ The MPT should consider the guidance [Undertakings at medical practitioner tribunal hearings](#) and undertakings should normally follow the wording in [Agreeing a doctor's undertakings](#).

¹² Section 35D(2)(c) of the Medical Act 1983 (as amended)

19. Conditions restrict a doctor's ability to practise and/or require them to do something. The purpose of putting in place a sanction of conditions is to provide a doctor with time to address identified failings to demonstrate they are fit to practise on an unrestricted basis, whilst ensuring that the current and ongoing risk posed to public protection is being adequately managed.
20. Where conditions are put in place, they should be appropriate, workable, and measurable.

Appropriate

21. To be appropriate, conditions must address the specific findings about the current and ongoing risk to public protection posed by the doctor.

Workable

22. To be workable, conditions must be capable of producing the desired result of addressing the specific findings about the current and ongoing risk to public protection posed by the doctor.
23. Conditions are likely to be workable where:
 - a. the doctor has shown insight
 - b. time is needed for the doctor to take steps to address the findings (remediate), for example through retraining, study, supervision and/or seeking medical treatment
 - c. the doctor is willing to remediate, and
 - d. the MPT is satisfied the doctor will comply with them.
24. When deciding whether remediation is possible, the MPT should carefully consider any objective evidence that is available to them. This may include the outcome of assessments, or other independent evidence of the doctor's performance, health, or knowledge of the English language.
25. Sometimes evidence is provided that a doctor's employer, or another relevant body, will not support certain conditions if they were to be put in place, which means that a specific condition(s) is not workable in that environment. Where alternative conditions can be identified that are workable, proportionate and achieve the overall aim of conditions, and they adequately address the current and ongoing risk to public protection posed by the doctor, consideration can be given to putting those in place instead.

26. However, where alternative conditions are not appropriate or proportionate, the conditions considered necessary to protect the public in a timely way should be imposed, despite the fact they may not be supported by the doctor's current employer or relevant body. A lesser or greater sanction than that which is necessary to protect the public should not be imposed simply because certain conditions may not be supported by a specific body.

Measurable

27. A condition must be described in specific terms to make it measurable. Conditions must be measurable so that the doctor can be clear about what is required of them. Having measurable conditions also means that when an assessment of whether the doctor poses any current and ongoing risk to public protection is next made to reach a view on impairment, the extent to which the doctor has complied with the conditions, and the question of whether the conditions have had the desired result, can be considered.

When are conditions likely to be proportionate?

28. Conditions may be proportionate in cases where the doctor has shown a degree of insight into the allegation and some, or all, of the following factors are present:
- a. the doctor has demonstrated they are willing and/or able to remediate
 - b. identifiable areas of the doctor's practice need prohibiting, monitoring, or retraining
 - c. the doctor has demonstrated they are willing to be open and honest with patients and others they work with if things go wrong
 - d. the doctor will not put patients at harm, either directly or indirectly, by having conditions on their registration.
29. A doctor may have demonstrated they are willing and able to remediate where they've provided evidence that they're committed to improving their knowledge and skills and keeping them up to date throughout their working life, improving the quality of their work and seeking and responding to feedback. They may not have demonstrated they are willing and/or able to remediate where there is evidence there have been previous unsuccessful attempts to remediate, or where there is evidence the doctor has been unwilling to engage.
30. Conditions are unlikely to be a proportionate response in cases where the nature of the allegations about the doctor's behaviour fall at the higher end of

the spectrum of seriousness and/or suggest an underlying problem with their attitude.

Imposing conditions on a doctor's registration

31. When imposing conditions, as well as giving reasons for the need for this type of restrictive action, the objectives of the conditions should be clearly set out, so they are measurable.
32. Conditions should be drawn from the suite of conditions detailed in the conditions bank Imposing conditions on a doctor's registration. The wording of conditions in the bank should be retained unless, unusually, it is necessary to amend or add to them, considering the individual circumstances of the case.
33. The MPT will need to decide the appropriate length of time that conditions should be put in place for, up to the maximum of three years. The following factors will be relevant:
 - a. the assessment of the level of current and ongoing risk to public protection posed by the doctor (low, medium, or high)
 - b. the reasons for assessing conditions as being the proportionate response
 - c. the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or
 - d. the amount of time the parties will reasonably need to prepare for a review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response, meaning their fitness to practise remains impaired, or is safe to return to unrestricted practice.
34. Where a condition has been imposed that requires a doctor to complete an assessment of their performance, health or knowledge of English language, the time needed to complete the assessment should be accounted for.¹³
35. Any time spent under an interim order of conditions or suspension is unlikely to be relevant to deciding the appropriate length of conditions. This is because the type of action and the length of time conditions are put in place for both need to adequately address the finding of impairment based on the decision

¹³ Usually nine months for performance assessments and three months for health and English language assessments.

that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response.

36. Interim orders serve a very different purpose to sanctions; when imposing an interim order, an interim orders tribunal (IOT) makes no findings of fact and the test for considering whether to impose an interim order is entirely different from the criteria that applies when considering what, if any, is an appropriate sanction to impose on a doctor's registration following a finding of impairment.
37. To take into account previous time spent under an interim order before any decision to impose a sanction of conditions is made, would likely leave a public protection gap, as reducing the length of time that any conditions are put in place for would not wholly reflect the assessment of the level of current and ongoing risk to public protection that has now been made by the MPT.
38. The question of whether the doctor can safely return to unrestricted practice will need to be considered before a period of conditions concludes and so a review should be directed.
39. Where an interim order is in place at the time that a sanction of conditions is imposed, this should usually be revoked. The exception is where the interim order relates to other concerns or allegations in the fitness to practise process that have not yet been determined.
40. The MPT's decision to impose a sanction of conditions will take effect at the conclusion of the 28-day appeal period. The MPT may impose an [immediate order](#)¹⁴ in the interim where they consider it is necessary to do so.

Suspension

41. Suspension is for those cases where the doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively, is currently incompatible with unrestricted registration. This means the current and ongoing risk to public protection posed by the doctor needs to be managed by restricting their registration for a period, with the aim they should be able to safely return to unrestricted practice in the future.

¹⁴ Under section 38 of the Medical Act 1983 (as amended)

42. Where suspension is imposed on a doctor's registration, the MPT must specify the period for which it is to remain in force, up to a maximum of 12 months.¹⁵

What is suspension?

43. Suspension restricts a doctor's registration and prevents them from practising during the period it is in effect. The purpose of suspending a doctor's registration is to protect the public by removing them from practice to manage the current and ongoing risk they pose to public protection.
44. Restrictive action of suspension is intended to address the level of current and ongoing risk to public protection and is not intended to be punitive. However, as it prevents a doctor from working and earning a living within that profession, it can have this effect. Suspension can also have a deterrent effect and be used to send a signal to the individual doctor, the profession and public about what is regarded as behaviour unbecoming a registered doctor.

When is suspension likely to be proportionate?

45. Suspension may be proportionate in cases where some, or all, of the following factors are present:
- a. conditions are not appropriate, measurable and/or workable
 - b. the level of current and ongoing risk to public protection is such that it cannot be safely managed with conditions and suspension is necessary to stop the doctor from working and putting patients at risk while they gain insight into any deficiencies and remediate, or undergo medical treatment, and/or
 - c. the level of current and ongoing risk to public protection is such that, although patient safety is not an issue, suspension is needed to maintain public confidence in the profession and/or maintain professional standards.

Imposing suspension on a doctor's registration

46. The MPT will need to decide the appropriate length of time that suspension should be put in place for, up to the maximum of 12 months. The following factors will be relevant:
- a. the assessment of the level of current and ongoing risk to public protection posed by the doctor

¹⁵ Section 35D(2)(b) of the Medical Act 1983 (as amended)

- b. the reasons for assessing suspension as being the proportionate response
 - c. the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or is likely to have, an impact on their ability to practise safely and effectively, and/or
 - d. the amount of time the parties will reasonably need to prepare for any review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.
47. A short suspension may be appropriate in cases where: the doctor's behaviour fell at the higher end of the spectrum of seriousness; there was evidence of relevant context and/or evidence of insight and remediation that decreased the level of current and ongoing risk to public protection such that there are no outstanding patient safety considerations; and suspension is being imposed on public confidence grounds and/or to maintain professional standards. It might also be appropriate in relation to a very small number of clinical cases where a doctor's performance was such that although unlikely to recur, the nature of the allegation was so serious as to undermine the public's trust in the profession.
48. Where a doctor is suspended because of findings in relation to insufficient knowledge of English, a short suspension is unlikely to be suitable in the first instance because they will need sufficient time to improve their language skills, take an English language assessment and for the parties to consider the results.
49. Any time spent under an interim order of conditions or suspension is unlikely to be relevant to deciding the appropriate length of a suspension. This is because the type of action and the length of time it's put in place for both need to adequately address the decision that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response.
50. Interim orders serve a very different purpose to sanctions; when imposing an interim order an IOT makes no findings of fact and the test for considering whether to impose an interim order is entirely different from the criteria that applies when considering what, if any, is an appropriate sanction to impose following a finding of impairment. To take into account previous time spent under an interim order before any decision to impose a suspension is made would likely leave a public protection gap, as reducing the length of time that

suspension is put in place for would not wholly reflect the assessment of the level of current and ongoing risk that has now been made.

51. However, time spent under an interim order of suspension may be relevant when determining the proportionate period of suspension to be imposed purely on the grounds of public confidence. In many of these cases, given the different purposes of interim orders and sanctions, a previous interim order of suspension is unlikely to have a significant impact. Nevertheless, it must still be considered.
52. The question of whether the doctor can safely return to unrestricted practice will need to be considered before a period of suspension concludes and so a review should be directed. The exception to this is where a short suspension (usually three months or less) has been imposed on public confidence grounds and/or to maintain professional standards.
53. Where an interim order is in place at the time that suspension is imposed, this should usually be revoked. The exception is where the interim order relates to other concerns or allegations in the fitness to practise process that have not yet been determined.
54. The MPT's decision to impose a sanction of suspension will take effect at the conclusion of the 28-day appeal period. The MPT may impose an [immediate order](#) in the interim where they consider it is necessary to do so.

Erasure from the medical register

55. Erasure is action available for those cases where a doctor's behaviour, performance, or the impact that a health condition is having on their ability to practise safely and effectively,¹⁶ is incompatible with continued registration at this point in time. It means the level of current and ongoing risk the doctor poses to public protection is so significant that they should not be allowed to practise.

What is erasure?

¹⁶ The sanction of Erasure is not available where the only grounds for impairment are adverse physical or mental health and/ or not having the necessary knowledge of English; Erasure is available when there is one or more additional grounds for impairment found.

56. Erasure takes away a doctor's registration which means they are no longer entitled to practise in the UK at all, or anywhere else where they are required to hold GMC registration. It is used to protect the public in the most serious cases. It also has a deterrent effect as it sends a signal to the individual doctor, the profession and public about what is regarded as behaviour unbecoming a registered doctor.

When will erasure be the only proportionate response?

57. Erasure may be the proportionate response where:
- a. conditions are not appropriate, measurable and/or workable and suspension is not sufficient to protect the public
 - b. the doctor's behaviour or performance is such that it caused serious harm, and the risk of harm recurring cannot be mitigated sufficiently through putting conditions or suspension in place
 - c. the doctor has shown a persistent lack of insight into the seriousness of the allegation about their behaviour or performance and the potential or actual consequences, and/or
 - d. the seriousness of the facts found proven and/or impact of any relevant context that increased the current and ongoing risk to public protection mean the effect of the doctor continuing to hold registration is such that it will undermine public confidence in the profession.

Erasing a doctor from the medical register

58. The MPT's decision to erase a doctor will take effect at the conclusion of the 28-day appeal period. The MPT may impose an [immediate order](#) of suspension in the interim where they consider it is necessary to do so.
59. Where an interim order is in place at the time that erasure is imposed, this should usually be revoked. The exception is where the interim order relates to other concerns or allegations in the fitness to practise process that have not yet been determined. This is to avoid a public protection gap in the event the doctor appeals the decision to erase them from the register.

Sanctions bandings for specific case types

60. At the impairment stage, the MPT will have assessed the current and ongoing risk to one or more of the three parts of public protection arising from all the facts found proved. Sometimes those facts and the finding of impairment will relate to a range of allegations. Where this is the case, the MPT should

consider, where available, the sanctions bandings for all the specific case types relating to the proven allegations.

61. When assessing the level of current and ongoing risk to public protection, the MPT will have considered the seriousness of the facts found proved, any relevant context known about the doctor and/or their working environment and how the doctor responded to the allegation. The level of risk (low, medium, high) identified by the MPT should be used to inform where within the sanctions bandings the case falls.
62. Below are the sanctions bandings for some case types commonly seen at hearing.

Case type	Lower level of risk to public protection	Medium level of risk to public protection	Higher level of risk to public protection
Sexual misconduct	Suspension up to 6 months	Suspension 6 to 12 months	Suspension 12 months to Erasure
Dishonesty	Suspension up to 3 months	Suspension 3 to 9 months	Suspension 9 months to Erasure
Violent or abusive behaviour	Suspension up to 3 months	Suspension 3 to 12 months	Suspension 12 months to Erasure
Discrimination	Conditions up to 12 months to Suspension 3 months	Suspension 3 to 9 months	Suspension 9 months to Erasure
Clinical concerns	Conditions 12 to 24 months	Conditions 24 to 36 months to Suspension 6 months	Suspension 6 months to Erasure
Impact of a health condition	Conditions 6 to 12 months	Conditions 12 to 36 months to Suspension	Suspension
Insufficient knowledge of English language	Conditions up to 6 months	Conditions 6 to 12 months	Suspension
Convictions, cautions, misconduct arising from breach of	Conditions up to 12 months to Suspension up to 3 months	Suspension 6 to 12 months	Suspension 12 months to Erasure

court sanctions and determinations by other regulatory bodies			
---	--	--	--

63. In all cases, once the MPT has identified the level of banding, they will need to decide the appropriate length of sanction to impose within that range provided they are satisfied it is the most proportionate type of action considering the individual circumstances of the case. The following factors will be relevant to deciding the appropriate length of time that conditions or suspension should be put in place for:
- a. the reasons for assessing conditions or suspension as being the proportionate response
 - b. the amount of time the doctor is likely to need to remediate, complete treatment for and/or recover from a health condition that is having, or likely to have, an impact on their ability to practise safely and effectively
 - c. where a condition has been imposed that requires a doctor to complete an assessment of their performance, health or knowledge of the English language, the time needed to complete the assessment, and/or
 - d. the amount of time the parties will reasonably need to prepare for a review of whether the doctor continues to pose a current and ongoing risk to public protection requiring restrictive action in response or is safe to return to unrestricted practice.
64. Once the MPT has applied the bandings to reach a provisional view on what sanction is appropriate, before finalising their decision they must consider if there is any additional evidence that may be relevant to deciding what sanction is proportionate. They should also remind themselves of their decision on how the case engaged one of more of the three parts of public protection with reference to their decision on impairment and the general guidance and specific case types section in the [Introduction](#).
65. Where the type of case is not covered by the sanctions bandings, the MPT should apply the general guidance on [Outcomes available to the MPT at the sanction stage](#).

Additional evidence that may be relevant to the decision on what sanction is proportionate

66. The following matters are not relevant to the assessment of current and ongoing risk to public protection which will have informed the MPT's decision on impairment, but can be considered at this stage when deciding what sanction is proportionate:
- a. evidence about the impact that taking a specific type of action may have on patients or members of the public, or the doctor themselves, and/or
 - b. references and testimonials about the doctor's character.
67. Where the MPT considers it is appropriate to take such evidence into account, they must explain the weight given to it and the impact this has had on their decision on sanction. This will include justifying any departure from a sanctions banding, if one is available for the specific case type.

Evidence about the impact of a specific type of action

68. The following should inform the MPT's consideration of whether evidence about the impact of a specific type of action is relevant to the decision on what sanction to impose:
- a. the extent to which the information provided can be corroborated or verified, and
 - b. what is known about the doctor's future career plans and prospects.
69. Evidence about the impact a specific type of action will have on patients and members of the public will usually only be relevant where it is likely the doctor will stay working in their area of specialty or the same geographical area.
70. Where the MPT concludes that the impact a specific type of action will have is relevant to their decision on sanction, the weight to be given to it is a matter for their judgment, having regard to their earlier assessment of the current and ongoing risk to public protection posed by the doctor. But in most cases, particularly those where the allegation fell at the higher end of the spectrum of seriousness, this type of evidence may have limited, if any, impact because it will be outweighed by the need to protect the public.

References and testimonials

71. References and testimonials may support the doctor and/or provide a view on their character. The following should inform the MPT's consideration of

whether any references or testimonials are relevant to the decision on what sanction to impose:

- a. whether the reference or testimonial is relevant to the specific findings about the doctor's fitness to practise – to be relevant, the person providing the reference or testimonial needs to be fully aware of the circumstances of the allegation(s)
- b. the extent to which the views expressed in the reference or testimonial are supported by other available evidence
- c. how long the author has known the doctor and the relationship between them
- d. how recently the author has had experience of the doctor's behaviour or performance at work, and
- e. whether there is any evidence that the author has a conflict of interest in providing the reference or testimonial.

72. Whilst greater emphasis can usually be placed on testimonials that have been verified,¹⁷ the question of how much weight to be given to evidence provided in references and testimonials is a matter for the MPT's judgment, having regard to their earlier assessment of the level of current and ongoing risk to public protection posed by the doctor. But in most cases, particularly in those where the allegation fell at the higher end of the spectrum of seriousness and the level of current and ongoing risk to public protection remained high, this type of evidence may have limited, if any, impact because the need to protect the public will outweigh any relevant evidence about the doctor's character.

73. An adverse inference should not be drawn in cases where references and testimonials are not presented by the doctor. This is because there may be a range of reasons why they are not available, including, but not limited to:

- a. a variation in the quantity, quality and spread of references and testimonials between cases does not necessarily relate to the doctor's character
- b. there may be cultural reasons for not requesting references and testimonials - for example some doctors may be less likely to discuss the fact they are under investigation with colleagues because of the significant reputational consequences for their family and networks in their communities, and/or

¹⁷ The GMC will confirm whether testimonials have been verified. This involves checking they are authentic, and the authors are aware of the circumstances of the allegation(s) about the doctor's fitness to practise. Verification may have been completed by the GMC or the doctor's legal representative.

- c. those who qualified outside of the UK and have just started working in the UK may find it more difficult to obtain them, as may individuals who have recently changed employer or are working on a locum basis.

The MPT's determination on sanction

- 74. The MPT's determination should show that the MPT has considered their earlier conclusions at the facts and impairment stages and had regard to the level of current and ongoing risk posed by the doctor (low, medium, or high) with reference to the parts of public protection that are engaged; patient safety, public confidence and/or maintenance of professional standards.
- 75. The MPT should give reasons as to why the selected sanction is sufficient to protect the public, and why a more restrictive sanction is not necessary. The decision should include a separate explanation as to the length of sanction and why it should last for a particular period, if relevant.
- 76. Where the MPT's decision is to impose a sanction that is lower, or higher, than that suggested by this guidance and any relevant sanctions bandings, the MPT should provide reasons as to why this is justified given the individual circumstances of the case. They must also explain how their decision relates to any submissions made by the parties.
- 77. Any decision not to direct a review of a sanction of conditions or suspension should also be clearly recorded and explained.

Immediate and interim orders following sanction

- 78. A sanction imposed by an MPT only takes effect at the end of the 28-day appeal period. Therefore, where the MPT imposes a sanction, it must consider if an immediate order is needed and/or if any action is required in respect of any existing interim order that may be in place.

Immediate orders

- 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.¹⁸ Where the MPT has imposed a sanction of conditions, it may impose an immediate order of conditions. Where the MPT has imposed

¹⁸ Section 38 of the Medical Act 1983 (as amended)

a sanction of suspension or erasure, it may impose an immediate order of suspension.

80. In the context of an immediate order, the best interests of the doctor includes avoiding putting them in a position where they may come under pressure from patients and/or may repeat the behaviour or poor performance giving rise to the allegation, particularly where this may also put the doctor at risk of committing a criminal offence. It may also include where the doctor's ability to practise safely and effectively may be impacted by an ongoing health condition.
81. When deciding if an immediate order is needed, the MPT should balance these considerations against the other interests of the doctor, which may be to return to work pending the outcome of any appeal, and against the wider public interest which may require an immediate order is put in place.
82. Representations are sometimes made by the doctor that no immediate order should be imposed by the MPT on the basis the doctor needs time to make alternative arrangements for the care of their patients before a sanction of suspension or erasure takes effect. Whilst the issue of how much weight to attach to representations made by the parties is a matter for the MPT, this argument is unlikely to be persuasive. This is because the doctor will have been aware of the date of the hearing for some time, and consequently of the risk of a sanction being imposed. The doctor will therefore have already had reasonable time to plan for the care of patients before the hearing, should the need arise. Additionally, the GMC also notifies the doctor's employers or, in the case of general practitioners, the relevant body, of the date of the hearing. They themselves have a duty to make sure that appropriate arrangements are in place for the care of the doctor's patients should an immediate order be imposed.
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.

- 85. The MPT must give reasons for their decision on whether to impose an immediate order, with reference to any submissions made by the parties. The MPT should also refer to its decision on sanction and the reasons for it and ensure that any decision reached on whether to impose an immediate order is consistent.

- 86. Where the doctor is present and/or represented at the hearing, any immediate order imposed on their registration will take effect immediately. Where the doctor is not present or represented, the immediate order takes effect once notification of the order is served.

Interim orders

- 87. Interim orders are used to manage risk while a concern or allegation about a doctor's behaviour, performance or the impact of a health condition goes through the fitness to practise process.

- 88. Where an interim order is in place at the time that a sanction is imposed at the conclusion of the fitness to practise process, this should usually be revoked and any immediate risk to one or more parts of public protection should be managed through an immediate order. The exception is where the interim order relates to other concerns or allegations in the fitness to practise process that have not yet been determined.

Part D: decide if a warning is required

If not impaired, consider if a **WARNING** is required

If not impaired, consider if a warning is required.

Deciding if a warning is required

1. Where the MPT has decided that the doctor's fitness to practise is not impaired at stage two of the hearing, they may give the doctor a warning as to their future behaviour or performance where the allegation falls below the professional standards expected. This is to maintain public protection.
2. References made to 'public protection' throughout this guidance refer to the GMC and MPTS' legal duty to protect the public which is split into three distinct parts. It means an MPT must act in a way that:
 - a. protects, promotes and maintains the health, safety and wellbeing of the public,
 - b. promotes and maintains public confidence in the profession, and
 - c. promotes and maintains proper professional standards and conduct for members of the profession.
3. When making their decision on whether a warning is required, the MPT should always remind themselves of their earlier conclusions at the facts and impairment stages and invite submissions from the parties where they are in attendance.
4. The MPT must also carefully record the reasons for its decision.

What is a warning?

5. A warning is a formal response which indicates to a doctor that any given behaviour or poor performance represents a significant departure from the professional standards expected¹⁹ and should not be repeated. Although a warning does not place any restrictions on a doctor's registration, it should still be viewed as a serious regulatory response.

¹⁹ Set out in [Good medical practice](#) and the more detailed guidance

6. Where an MPT imposes a warning, this signals to a doctor that repeating the same, or similar, behaviour or poor performance is likely to result in a future finding of impairment i.e. a conclusion that the doctor poses a current and ongoing risk to public protection and that restrictive action (conditions, suspension or erasure) on registration is required in response.
7. Warnings are issued in the interests of maintaining public confidence in the profession and upholding professional standards. They highlight to the wider profession and public that certain behaviour or poor performance is not acceptable.
8. A warning does not prevent a doctor from holding a licence to practise.

A warning must be proportionate, transparent and fair

9. The [Introduction](#) explains that a good decision about a doctor's fitness to practise should protect the public, be proportionate, be transparent and be fair.
10. In the context of deciding whether a warning is proportionate, the MPT should consider the impact on those affected by the decision, including the doctor, the interests of members of the public and the interests of other professionals. When doing so, the MPT should have regard to how a warning highlights to the wider profession that certain behaviour or poor performance is unacceptable. This is likely to outweigh the interests of the individual doctor.
11. References and testimonials that support the doctor and/or provide a view on their character may be available to the MPT. This type of evidence can be considered but may have limited, if any, impact on the decision on whether a warning is proportionate because the need to protect the public will outweigh any relevant evidence about the doctor's character.
12. To be proportionate, fair and transparent, where a warning is imposed it must:
 - a. be worded in a way that clearly highlights the behaviour or poor performance that led to the warning
 - b. state how that behaviour or poor performance impacts on one or more of the three parts of public protection, and
 - c. place the doctor on notice about their future behaviour or performance, including explaining what the behaviour or performance is that should not be repeated, and why.

13. Where the MPT wishes to draw the doctor's attention to one or more specific professional standards, this should be done with reference to the professional standards that apply at the time the warning is being imposed.
14. Warnings are published on the doctor's entry on the register and disclosed in line with the [GMC's Publication and Disclosure Policy](#).

The test for issuing a warning

15. A warning will be appropriate where facts have been found proved that indicate the doctor's behaviour or performance has fallen below the professional standards expected, the MPT has determined the doctor's fitness to practise is not currently impaired, but it is necessary to signal to them that repeating the same, or similar, behaviour or poor performance is likely to result in a future finding of impairment.

Is a warning appropriate?

16. A warning cannot be imposed where a conclusion has been reached at stage two of the hearing that the doctor's fitness to practise is impaired.
17. Warnings are appropriate for allegations that amount to a significant departure from the professional standards and just fall short of the MPT finding that the doctor's fitness to practise is impaired.
18. A warning will not be appropriate where:
 - ▶ the MPT has decided at stage two of the hearing that none of the grounds of impairment are engaged, or
 - ▶ the allegation relates solely to the impact of a health condition, or solely to the doctor's insufficient knowledge of the English language, given the nature of those types of allegations.

Is a warning required?

19. To decide whether a warning is required, the MPT should consider the following questions and answer them based on the individual circumstances of the case:

Has there been a clear and specific departure from the professional standards?

20. As a warning must place the doctor on notice about their future behaviour or performance, it must relate to a clear and specific departure from the current professional standards.
21. During the MPT's assessment of the facts and decision on impairment at stages one and two of the hearing, the MPT will have identified and considered evidence relating to any departures from the professional standards that applied at the relevant time. They should therefore consider how these relate to the current professional standards, if different.
22. In the absence of a clear and specific departure from the current professional standards expected, a warning will not be required and the MPT should take no further action. However, if there has been a clear and specific departure from the current professional standards, the next question should be considered.

Did the allegation about the doctor's behaviour or poor performance just fall short of a finding that their fitness to practise is impaired?

23. If the MPT is satisfied that the evidence clearly supported a finding that the doctor's fitness to practise is not impaired, a warning will not be appropriate, and no further action should be taken.
24. Where the decision was finely balanced but just fell short of the MPT reaching a conclusion that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response – and therefore finding that their fitness to practise is impaired – this will usually indicate that the departure from the professional standards was significant and so a warning may be required. The next question should therefore be considered.

If the behaviour or poor performance was repeated, would it likely result in a finding that the doctor's fitness to practise is impaired?

25. The MPT's view on the impact of repetition should be reached having in mind the assessment of current and ongoing risk to public protection that informed their decision on impairment. In that assessment the MPT will have considered the seriousness of the allegation, any relevant context known about the doctor and/or their working environment and how the doctor responded to the allegation.

26. If repetition of the same, or similar, behaviour or poor performance would not likely result in a conclusion that the doctor's fitness to practise is impaired, a warning will not be required, and the MPT should take no further action.
27. However, if repetition would likely result in a conclusion that the doctor's fitness to practise is impaired, a warning will usually be required to formally record the allegations and indicate to the doctor that restrictive action may be needed if the behaviour or poor performance were to be repeated.
28. Whilst a range of factors will inform the MPT's view on the impact of repetition, the following may be particularly relevant:
 - ▶ whether the incident giving rise to the allegations was isolated or repeated
 - ▶ whether there was relevant fitness to practise history
 - ▶ any other indicators as to the likelihood of the allegations being repeated
 - ▶ the doctor's level of insight into the allegations, including whether there has been a genuine expression of regret/apology from the doctor, and
 - ▶ evidence of remediation.
29. When deciding if a warning is required, the MPT should also refer to the specific case types section in the [Introduction](#) section of this guidance.

The MPT's determination on whether a warning is required

30. The MPT's determination should show that the MPT has considered their earlier conclusions at the facts and impairment stages, had regard to the purpose of warnings and carefully considered the questions above.
31. The MPT should give reasons for their decision on whether a warning is required. They must also explain how their decision relates to any submissions made by the parties.