General Medical Council

Regulating doctors
Ensuring good medical practice

Indicative Sanctions Guidance for Fitness to Practise Panels

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Contents

Section 1: Indicative Sanctions Guidance for Fitness to Practise Panels

Section 2: Supplementary Guidance

Section 3: GMC Guidance on Making Referrals for Educational Intervention to the Postgraduate Dean and GP Director

Annex A:
Guidance issued with the GMC (Fitness to Practise) Rules 2004 (the Rules)

Annex B: Decisions in the Public Interest: Relevant Judgments

Section 1

Indicative Sanctions Guidance for Fitness to Practise Panels

Introduction

1. This guidance has been developed by the GMC for use by its Fitness to Practise Panels when considering what sanction to impose following a finding that the doctor's fitness to practise is impaired. It also contains guidance on the issue of warnings where a panel has concluded that the doctor's fitness to practise is not impaired. It outlines the decision-making process and factors to be considered. The Indicative Sanctions Guidance is an authoritative statement of the GMC's approach to sanctions issues. It aims to promote consistency and transparency in decision-making.

2. The guidance is a 'living document', which will be updated and revised as the need arises. Please email any comments or suggestions for further revisions to pandevteam@gmc-uk.org.

3. Although GMC members do not sit on Fitness to Practise Panels, the GMC is responsible – under the Medical Act 1983, as amended (the Act) – for all decisions taken by the panels. The GMC's functions include, amongst other things, dealing firmly and fairly with doctors whose fitness to practise is questioned. The medical and lay panellists appointed to sit on the panels exercise their own judgments in making decisions but must take into consideration the standards of good practice the GMC has established which have been drawn up after wide consultation and reflect what society expects of doctors.

4. Where necessary, this document refers to *Good Medical Practice* and other core GMC guidance, including the extract from the guidance the GMC issued with the General Medical Council (Fitness to Practise) Rules 2004 (the Rules) which is reproduced at Annex A.

Equality and Diversity Statement

The GMC's responsibilities

5. Doctors practise medicine to serve patients. It is a central function of the GMC through the panels to promote the interests of patients and to protect them by ensuring a good standard in the practice of medicine by doctors who are fit to practise.

6. The GMC is committed to promoting equality and valuing diversity and to operating procedures and processes, which are fair, objective, transparent and free from discrimination. This includes setting out in guidance the attitudes and behaviours expected of a doctor. Promoting equality is also a requirement under current and emerging equality legislation. Everyone who is acting for the GMC is expected to adhere to the spirit and letter of this legislation.

The Doctors' responsibilities

7. Doctors are required to treat both colleagues and patients fairly to the best of their ability and without discrimination. Fuller guidance is in *Good Medical Practice* (in paragraphs 5 and 34).

Impaired Fitness to Practise

8. The Act[1] states:

"A person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of—

(a) misconduct;

(b) deficient professional performance;

(c) a conviction or caution in the British Islands for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence;

(d) adverse physical or mental health; or

(e) a determination by a body in the United Kingdom responsible under any enactment for the regulation of a health or social care profession to the effect that his fitness to practise as a member of that profession is impaired, or a determination by a regulatory body elsewhere to the same effect."

9. The Rules[2] set out the procedure before a Fitness to Practise Panel. Having heard the evidence a panel must first consider and announce its findings of fact before hearing further evidence as to whether, on the basis of any facts found proved, the doctor's fitness to practise is impaired.

10. If a panel find that the doctor's fitness to practise is impaired the panel must announce its decision and the reasons for that decision. The panel may then receive further evidence and submissions as to the appropriate sanction to be imposed (see paragraphs 18-19 below). Where a panel concludes that a doctor's fitness to practise is not impaired, it must similarly announce its decisions and give reasons. In such cases, the panel may then consider whether a warning should be imposed (see Section 2, paragraphs 1 – 4, page S2-1).

11. Neither the Act nor the Rules define what is meant by impaired fitness to practise but for the reasons explained below, it is clear that the GMC's role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practise either with restrictions on registration or at all.

[1] Section 35C (2)
[2] See Rule 17(2)

The Public Interest

12. The Merrison Report[3] stated that 'the GMC should be able to take action in relation to the registration of a doctor..... in the interests of the public', and that the public interest had 'two closely woven strands', namely the particular need to protect the individual patient, and the collective need to maintain confidence of the public in their doctors.

13. The question of whether the Fitness to Practise Panels should consider only 'the protection of members of the public', or whether they could also consider the wider 'public interest' in determining sanctions arose in the 1998 Bristol case. Counsel for the GMC drew attention to a number of relevant Judgments by the Judicial Committee of the Privy Council which illustrate, that in addition to the protection of the public, the public interest includes, amongst other things:

a. Protection of patients

b. Maintenance of public confidence in the profession

c. Declaring and upholding proper standards of conduct and behaviour.

14. Extracts from the relevant Judgments referred to in the Bristol case, and since, which relate to the public interest are at Annex B.

15. The panel must keep the factors set out above, and confirmed in the Judgments at Annex B, at the forefront of their mind when considering the appropriate sanction to impose against a doctor's registration. The public interest may, on occasion, also include the doctor's return to **safe** work but the panel should bear in mind that neither the GMC nor the panel has any responsibility for the rehabilitation of doctors

Proportionality

16. In deciding what sanctions to impose the Panel should apply the principle of proportionality, weighing the interests of the public (see above) with those of the practitioner, which could include returning immediately, or after a period of retraining to unrestricted practice. In addition the Panel will need to consider any mitigation in relation to the seriousness of the behaviour in question. The extent to which mitigation should influence judgement on a finding of impaired fitness to practise and then on sanction, is dependent on the individual circumstances in the case. The Court of Appeal has made it clear that mitigation will normally be more relevant to sanction[4]. Further guidance, including considering references and testimonials is set out in Section 2, paragraphs 16-17, page S2-4.

[3] Report of the Committee of Inquiry into the Regulation of the Medical Profession (1975)
[4] R (on the application of Jennifer Campbell) and GMC [2005] EWCA Civ 250

Sanctions

The purpose of the sanctions

17. The purpose of the sanctions is not to be punitive but to protect patients and the public interest, although they may have a punitive effect.

The role of the panel

18. Where a panel has found that a doctor's fitness to practise is impaired, it must next consider what sanction, if any, to impose on the doctor's registration. The Rules provide[5] for both parties to make submissions on the appropriate sanction. The panel chairman should invite both parties to refer in their submissions to the guidance set out in this document. The Court has endorsed the GMC's role in making submissions on sanction.[6]

19. The decision as to the appropriate sanction to impose is, of course, a matter for the panel. But, the panel must:

a. Be sure that the action it proposes to take is sufficient to protect patients and the public interest (see paragraph 46 of Annex A, page A4).

b. Act within the framework set out by the GMC and reflected in this document.

c. Give reasons for its decisions on the appropriate sanction. Where the panel decides to impose conditions or suspension it must specify the period the conditions or suspension are to apply and explain why it considered that particular period appropriate. Where a panel impose a lesser or higher sanction than that suggested by this guidance it must fully explain why it considered that sanction appropriate. Such information is important so that the doctor fully understands the reasons for the decision. It is also important so that any member of the public can understand how and why the panel reached its decision. Further, in the event that the doctor considers an appeal to the High Court/Court of Session, or if the Council for Healthcare Regulatory Excellence (formerly known as the Council for the Regulation of Healthcare Professionals) is considering a referral to those Courts, it is important that those concerned can reach an informed decision.

Undertakings

20. The Rules[7] provide that a Panel may take into account any **written** undertakings offered by the doctor provided:

a. It is satisfied that those undertakings will be sufficient to protect patients and the public interest, and

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[5] Rule 17(2)(j)
[6] R (Bevan) v GMC [2005] EWHC 174 (Admin)
[7] Rule 17(2)(m)

b. The doctor expressly agrees that the Registrar shall disclose the details of the undertakings (with the exception of any relating exclusively to the doctor's health) to:

i. The doctor's employer or anyone with whom he or she is contracted to provide medical services or has an arrangement to do so.

ii. Anyone from whom the doctor is seeking employment to provide medical services or an arrangement to do so.

iii. Any other person who makes enquiries.

21. A panel should, however, only decide to accept undertakings and take no action on the doctor's registration in circumstances where:

a. All the requirements set out in Rule 17(2)(m) are met, and

b. It is satisfied that the undertakings cover **all** the conditions that they would impose, and

c. It is satisfied that the doctor has sufficient insight to abide by the written undertakings given before the panel.

Conditional registration (maximum 3 years)

22. Conditions may be imposed up to a maximum of three years in the first instance, renewable in periods up to 36 months thereafter. This sanction allows a doctor to return to practice under certain conditions (e.g. restriction to NHS posts or no longer carrying out a particular procedure). A purpose of the imposition of conditions is protection of patients.

23. Conditions might be appropriate where there is evidence of incompetence or significant shortcomings in the doctor's practice or insight by a doctor into his or her health problems but where the panel can be satisfied that there is potential for the doctor to respond positively to retraining and supervision of his or her work. The purpose is to enable the doctor to remedy any deficiencies in his or her practice whilst in the meantime protecting patients from harm. When the issues relate to conduct or a criminal conviction, or to untreated health problems, referral to a Postgraduate Dean is not usually a helpful way forward as they are not able to provide any useful remedial help. When assessing whether this potential for remedial training exists, the panel will need to consider any objective evidence submitted, for example, reports on the assessment of the doctor's performance or health, or evidence submitted on behalf of the doctor, or that is otherwise available to them, about the doctor's practice or health.

24. The objectives of any conditions or educational guidance should be made clear so that the doctor knows what is expected of him or her and so that a panel, at any future review hearing, is able to ascertain the original shortcomings and the exact proposals for their correction. Only with these established will it be able to evaluate whether they have been achieved. Any conditions should be appropriate,

proportionate, workable and measurable, and in practical terms should be discussed fully by the panel before voting. Before imposing educational conditions the panel should satisfy itself that:

a. The problem is amenable to improvement through education.

b. The objectives of the conditions are clear.

c. A future panel will be readily able to determine whether the educational objective has been achieved and whether patients will or will not be avoidably at risk.

25. The 'GMC Guidance on Making Referrals for Educational Intervention to the Postgraduate Dean and GP Director' is at Section 3. The document is under review, some paragraphs e.g. those relating to the NCAS have been updated and further revision is ongoing. However, the document contains helpful guidance to which panels should refer when considering imposing conditions with an educational objective.

26. Where a panel has found a doctor's fitness to practise impaired by reason of adverse physical or mental health the conditions should include conditions relating to the medical supervision of the doctor as well as conditions relating to supervision at her/his place of employment.

Suspension (up to 12 months)

27. Suspension can be used to send out a signal to the doctor, the profession and public about what is regarded as unacceptable behaviour. Suspension from the register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension. It is likely to be appropriate for misconduct that is serious, but not so serious as to justify erasure (for example where there may have been acknowledgement of fault and where the panel is satisfied that the behaviour or incident is unlikely to be repeated).

28. Suspension is also likely to be appropriate in a case of deficient performance in which the doctor currently poses a risk of harm to patients but where there is evidence that he or she has gained insight into their deficiencies and has the potential to be rehabilitated if prepared to undergo a rehabilitation programme. In such cases to protect patients and the public interest the panel might wish to impose a period of suspension, direct a review hearing and recommend the type of educational programme the doctor might undergo during the suspension, or action he or she might wish to take. The panel should, however, bear in mind that during the period of suspension the doctor will not be able to practise. S/he may, however, have contact with patients similar to that of a final year medical student, i.e. under the supervision of a fully registered medical practitioner, **and** provided that the patients have been informed of the doctor's registration status, the events which resulted in the suspension of the doctor's registration and given their full consent.

29. As far as doctors with serious health problems are concerned, the option of erasure does not exist unless there are also other factors (such as a conviction,

misconduct or deficient performance), which have resulted in the finding of impaired fitness to practise. In those cases, suspension is appropriate where the doctor's health is such that he or she cannot practise safely even under conditions. In such cases the panel may direct a review hearing to obtain further information as to whether the doctor is then fit to resume practise either under conditions or unrestricted.

30. The length of the suspension may be up to 12 months and is a matter for the panel's discretion, depending on the gravity of the particular case. If, however, in a health case the doctor's registration has been suspended for at least two years because of two or more successive periods of suspension, it is open to the panel to suspend the doctor's registration indefinitely.

Review hearings

31. Where the panel decides that a period of conditional registration or suspension would be appropriate, it must decide whether or not to direct a review hearing immediately before the end of the period. The panel must give reasons for its decision so that it is clear that the matter has been considered and the basis on which the decision has been reached. Where a review hearing is to be held the panel must make clear what it expects the doctor to do during the period of conditions/suspension and the information s/he should submit in advance of the review hearing. This information will be helpful both to the doctor and to the panel considering the matter at the review hearing.

32. It is important that no doctor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the panel can be certain that he or she is safe to do so. In some misconduct cases it may be self-evident that following a short period of suspension, there will be no value in a review hearing. In most cases, however, where a period of suspension is imposed and in all cases where conditions have been imposed the panel will need to be reassured that the doctor is fit to resume practice either unrestricted or with conditions or further conditions. The panel will also need to satisfy itself that the doctor has fully appreciated the gravity of the offence, has not re-offended, and has maintained his or her skills and knowledge and that patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.

Erasure

33. The panel may erase a doctor from the Register in any case, except one which relates solely to the doctor's health, where this is the only means of protecting patients and the wider public interest. The Privy Council has, however, stated that [a panel] should not feel it necessary to erase:

> "an otherwise competent and useful doctor who presents **no danger** to the public in order to satisfy [public] demand for blame and punishment[8] [emphasis added].

[8] Dr Willem Bijl v GMC (Privy Council appeal No. 78 of 2000)

34. This must, however, be weighed against the words of Lord Bingham, Master of the Rolls, in the case of Bolton v The Law Society and adopted in the case of Dr Gupta[9]:

> 'The reputation of the profession is more important than the fortunes of an individual member. Membership of a profession brings many benefits, but that is part of the price.'

35. The Gupta Judgment emphasised the GMC's role in maintaining justified confidence in the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk:

> "The appellant's behaviour had demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession".

36. In the case of Dr Crabbie[10] (which was considered under the previous rules relating to the Professional Conduct Committee) the Privy Council stated:

> "The PCC should not, in their Lordships' view, refer a case to the Health Committee unless and until satisfied that a direction of erasure would not be the right decision to make".

37. To some extent the Crabbie judgment will no longer be directly applicable under the new procedures where all fitness to practise issues are considered together under a single charge of impaired fitness to practise. However, the panel, in a case where health issues are raised as well as other factors (such as a conviction, misconduct or performance issues) must take all the factors into consideration and, if the factors other than health are sufficiently serious may erase the doctor's name from the register notwithstanding that one of the factors resulting in the doctor's impaired fitness to practise relates to his or her health.

38. A doctor who has been erased cannot apply to be restored to the register until five years have elapsed. At that stage the panel will have to decide whether the doctor is fit to resume unrestricted practise.

39. There are some examples of misconduct where the Privy Council has upheld decisions to erase a doctor despite strong mitigation. This has been because it would not have been in the public interest to do otherwise given the circumstances concerned. The three most serious areas of concern are:

a. Sexual misconduct.

b. Dishonesty.

c. Failing to provide an acceptable level of treatment/care.

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[9] Dr Prabha Gupta v GMC (Privy Council Appeal No. 44 of 2001)
[10] Elizabeth Morag Crabbie v GMC (Privy Council Appeal No. 7 of 2002)

40. Whether erasure is appropriate in cases of this kind will depend on the particular facts of each case and other relevant factors.

Sexual misconduct

41. This encompasses a wide range of conduct from criminal convictions for sexual assault, sexual abuse of children (including child pornography) to sexual misconduct with patients, colleagues or patients' relatives. The misconduct is particularly serious however, where there is an abuse of the special position of trust, which a doctor occupies, or where a doctor has been required to register as a sex offender. The risk to patients is important. In such cases erasure has therefore been judged the appropriate sanction:

> 'The public, and in particular...patients, must have confidence in the medical profession whatever their state of health might be. The conduct as found proved... undoubtedly undermines such confidence and a severe sanction was inevitable. Their Lordships are satisfied that erasure was neither unreasonable, excessive nor disproportionate but necessary in the public interest.'[11]

42. Given the increase in cases involving child pornography that have been reported to the GMC as a result of Operation Ore, further guidance on this issue is set out in Section 2 at paragraphs 8 – 14, pages S2-2/3.

Dishonesty

43. The GMC's guidance, *Good Medical Practice* states that registered doctors must be honest and trustworthy, and must avoid abusing their position as a doctor. It also states, under the heading of 'probity':

> "- You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals...
>
> - ...If you manage finances, you must make sure that the funds are used for the purpose for which they are intended and are kept in a separate account from your personal finances." (Paragraph 54).

44. Dishonesty, even where it does not result in direct harm to patients but is for example related to the doctor's private life, is particularly serious because it undermines the trust the public place in the profession. Examples of dishonesty in professional practice could include defrauding an employer, improperly amending patient records or submitting or providing false references, inaccurate or misleading information on a CV and failing to take reasonable steps to ensure that statements made in formal documents are accurate. The Privy Council has emphasised that:

> '...Health Authorities must be able to place complete reliance on the integrity of practitioners; and the Committee is entitled to regard conduct which

[11] Dr Mohamed Shaker Haikel v General Medical Council (Privy Council Appeal No. 69 of 2001). See also Dr Christopher Dare v General Medical Council (Privy Council Appeal No. 19 of 2002).

undermines that confidence as calculated to reflect on the standards and reputation of the profession as a whole.'[12]

45. Research misconduct is a further example. The term is used to describe a range of misconduct from presenting misleading information in publications to dishonesty in clinical drugs trials. Such behaviour undermines the trust that both the public and the profession have in medicine as a science, regardless of whether this leads to direct harm to patients. Because it has the potential to have far reaching consequences, this type of dishonesty is particularly serious.

Failing to provide an acceptable level of treatment/care

46. Cases in this category are ones where a practitioner has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards. Such cases may involve factors identified on page S1-15 of this guidance. A particularly important consideration in such cases is whether or not a doctor has, or has the potential to develop, insight into these failures. Where this is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.[13]

Immediate suspension or conditions

47. The doctor is entitled to appeal to the High Courts (in Northern Ireland, England and Wales and the Court of Session in Scotland) against any decision to affect his or her registration. Therefore, no such decision takes effect until either the appeal period (28 days) expires, or any appeal is determined. During this time, the doctor's registration remains fully effective unless the panel also imposes an immediate order.

48. The panel has the power to impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is in the public interest, or is in the best interests of the practitioner. The interests of the practitioner may include for example avoiding putting her/him in a position where s/he may come under pressure from particular patients, or may repeat the misconduct, such as irresponsible prescribing (or where this may also put the doctor at risk of committing a criminal offence). This should be balanced against the doctor's wider interest, which may be to return to work pending the appeal, and the wider public interest, which may require the imposition of an immediate sanction.

49. Where the panel has directed erasure or suspension as the substantive outcome of the case, it may impose an immediate order to suspend registration. The matter will be at the discretion of the panel based on the facts of each case. However, given the serious nature of the matter that led to the direction for erasure or suspension, the panel should consider most carefully whether it is appropriate for the doctor to continue in unrestricted practice pending the disposal of an appeal.

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[12] Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001).

[13] See judgement in the case of Dr Purabi Ghosh v General Medical Council (Privy Council Appeal No. 69 of 2000). Also Dr John Adrian Garfoot v General Medical Council (Privy Council Appeal No. 81 of 2001).

50. Where the panel has directed a period of conditional registration as the substantive outcome of the case, it may impose an immediate order of conditional registration. The test for imposing an order of immediate conditional registration is the same as those for imposing immediate suspension and although the matter is one for the discretion of the panel, the GMC is of the opinion that immediate conditional registration is highly likely to be necessary in order to protect the patients, if not the doctor him or herself.

51. The panel must always give reasons for its decision to impose or not to impose an immediate order.

The Sanctions

Undertakings

Undertakings may be appropriate where:

- Given in writing
- The doctor has consented to disclosure of the undertakings, with the exception of any relating exclusively to his or her health, to his/her employer or anyone with whom he or she is contracted to provide medical services, anyone from whom the doctor is seeking employment to provide medical services, or has an arrangement to do so and any other person.
- The doctor has agreed to abide by the undertaking for a specific period or for an expressly indefinite period.
- The doctor has consented to monitoring of the undertakings by the GMC.

AND

When most or all of the following factors are apparent (this list is not exhaustive):

- No evidence of harmful deep-seated personality or attitudinal problems.
- Identifiable areas of doctor's practice in need of assessment or retraining.
- Evidence that doctor has insight into his or her problems and is willing to respond positively to retraining.
- No evidence of general incompetence.
- Patients will not be put in danger either directly or indirectly as a result of the undertakings.
- The undertakings will protect patients.
- It is possible to formulate undertakings, which are appropriate, proportionate, workable and measurable.

Conditional registration (maximum 3 years)

This sanction may be appropriate when most or all of the following factors are apparent (this list is not exhaustive):

- No evidence of harmful deep-seated personality or attitudinal problems.
- Identifiable areas of doctor's practice in need of assessment or retraining.
- Evidence that doctor has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision.
- No evidence of general incompetence.
- Potential and willingness to respond positively to retraining.
- Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.
- The conditions will protect patients during the period they are in force.
- It is possible to formulate appropriate and practical conditions to impose on registration.

Consider: will the imposition of conditions on the doctor's registration be sufficient to protect patients and the public interest?

If no, then consider suspending the doctor from the register, either to automatically restart at the end of the period, or for the case to be resumed at a review hearing where further appropriate action may be taken (see paragraphs 27-31, S1-6/7).

If it appears to the panel that there may be reasons (either in the public interest or in the interests of the doctor) for imposing an immediate order of conditional registration, the panel must invite representations on this question before considering this in camera. This determination is to be delivered separately.

Suspension (maximum 12 months)

This sanction may be appropriate when some or all of the following factors are apparent (this list is not exhaustive):

- A serious instance of misconduct but where a lesser sanction is not sufficient.
- Not fundamentally incompatible with continuing to be a registered doctor.
- No evidence of harmful deep-seated personality or attitudinal problems.
- No evidence of repetition of behaviour since incident.
- Panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour.
- In cases where the only issue relates to the doctor's health, there is a risk to patient safety if the doctor were allowed to continue to practise even under conditions.

Consider: Will a period of suspension be sufficient to protect patients and the public interest?

If no, then the doctor must be erased, except in cases that relate **solely** to the doctor's health where erasure is not available as a sanction.

If it appears to the panel that there may be reasons (either in the public interest or in the interests of the doctor) for imposing immediate suspension, the panel must invite representations on this question before considering this in camera. This determination is to be delivered separately.

Erasure

This sanction is likely to be appropriate when the behaviour is fundamentally incompatible with being a doctor and involves **any** of the following (this list is not exhaustive):

- Serious departure from the relevant professional standards as set out in Good Medical Practice.

- Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.

- Abuse of position/trust (particularly involving vulnerable patients) or violation of the rights of patients.

- Offences of a sexual nature, including involvement in child pornography.

- Offences involving violence.

- Dishonesty (especially where persistent and covered up).

- Persistent lack of insight into seriousness of actions or consequences.

Erasure is **not** available in cases where the **only** issue relates to the doctor's health.

Section 2

Supplementary Guidance

Issuing a warning

1. If the Panel find that fitness to practise is **not** impaired, they may nevertheless issue the practitioner with a warning as to his or her future conduct or performance. A warning can be issued subject to the Panel having found a significant departure from *Good Medical Practice* (or other GMC guidance) or where there is significant cause for concern following an assessment of the doctor's performance. There is no appeal against a panel's decision to issue a warning.[1]

2. A warning therefore, may be appropriate where the offence is at the lower end of the spectrum of misconduct, or performance, in order to mark the fact that the behaviour was unacceptable and must not happen again. A warning will remain on the doctor's record for five years and will feed into the appraisal and revalidation process. It will be disclosed to the doctor's employers/future employers, to the party who brought the complaint and to any other enquirer.

3. Before issuing a warning, the panel will need to be satisfied that most of the following were present:

a. Evidence that behaviour would not have caused direct or indirect patient harm.

b. Insight into failings.

c. Isolated incident that was not deliberate.

d. Genuine expression of regret/apologies.

e. Evidence that the doctor was acting under duress.

f. Previous good history.

g. No repetition of behaviour since incident.

h. Rehabilitative/corrective steps taken.

i. Relevant and appropriate references and testimonials.

4. As with all their other decisions, the panel should give reasons for its decision to impose a warning.

(Warnings are not available in cases that relate solely to the doctor's health.)

[1] Although it would be subject to judicial review.

Guidance on considering conviction or caution allegations

5. Convictions refer to a determination by a criminal court in the British Isles, or a finding by an overseas court of an offence, which, if committed in England and Wales, would constitute a criminal offence. Cautions refer to offences committed in the British Isles or elsewhere but where no court proceedings took place because the doctor has admitted the offence and criminal proceedings were considered unnecessary. A conviction or caution gives the panel jurisdiction even if the offence did not involve misconduct in the course of medical practice.

6. If the conviction is admitted, then the panel is bound to accept the fact that the doctor has been convicted as conclusive evidence that they were guilty of that offence. In cases relating to a caution, the doctor will already have admitted to the offence. In such cases the proceedings are concerned only to establish the gravity of the offence and to take due account of any mitigating circumstances.

7. The purpose of the hearing therefore, is not to punish the doctor a second time for the offences of which he or she was convicted, but to protect the public who might come to the doctor as patients and to maintain the high standards and good reputation of the profession.[2] The panel's role is therefore to balance the nature and gravity of the offences and their bearing on the doctor's fitness to practise as a doctor against the need for the imposition of a sanction and its consequences upon the ability of the doctor to practise his profession. The panel should, however, bear in mind that the sentence imposed by a court is not necessarily a definitive guide to the seriousness of the offence. There may have been circumstances[3] that led the court to be lenient e.g. an expectation that the regulatory body would erase the doctor or matters relating to the doctor's particular family circumstances.

If it appears to the panel that there may be reasons (either in the public interest or in the interests of the doctor) for imposing an immediate order, the panel must invite representations on this question before considering this in camera. This determination is to be delivered separately.

Guidance on considering cases involving child pornography or other cases involving doctors where the courts have imposed sanctions such as registration as a sex offender or rehabilitation or therapy.

8. Child pornography involves the exploitation or abuse of a child. Accessing, storing or distributing such material is illegal and regarded in society as morally unacceptable. For these reasons any involvement in child pornography by a registered medical practitioner raises the question whether the public interest demands that his or her registration be affected.

9. The Court of Appeal in the case of Oliver heard in November 2002, identified five levels of seriousness. This makes clear that for the lower grade offences a fine or conditional discharge may be appropriate. Custodial sentences are appropriate where more serious offences are involved.

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[2] Dr Shiv Prasad Dey v General Medical Council (Privy Council Appeal No. 19 of 2001).
[3] CHRP v (1) GDC and (2) Mr Fleischmann [2005] EWHC 87 (Admin)

10. Whilst the courts properly distinguish between degrees of seriousness, **the Council considers any conviction for child pornography against a registered medical practitioner to be a matter of grave concern because it involves such a fundamental breach of patients' trust in doctors** and inevitably brings the profession into disrepute. It is therefore highly likely that in such a case the only proportionate sanction will be erasure but the panel should bear in mind paragraphs 12-16 in Section 1 (page S1-3) of this guidance, which deal with the options available to the panel, and the issue of proportionality. If the panel decide to impose a sanction other than erasure, they must take particular care to explain fully the reasons and the thinking that has led them to impose this lesser sanction so that it is clear to those who have not heard the evidence in the case.

11. The panel should be aware that any conviction relating to child pornography will lead to registration as a sex offender and possibly to court ordered disqualification from working with children. The Council has made it clear that no doctor registered as a sex offender should have unrestricted registration. The panel will therefore need to ensure that, in cases where it imposes a period of suspension, the case should be resumed before the end of the period of suspension to consider whether a further period of suspension is appropriate or whether the doctor should be permitted to resume practice subject to conditions.

12. The Council has also expressed the view that, in order to protect the public interest, the panel should consider whether any such conditions ought to include no direct contact with **any** patients during the period the doctor is registered as a sex offender. (Doctors may of course be registered as sex offenders following other sexual offences not related to child pornography.)

13. The panel should also consider whether doctors registered as sex offenders should be required to undergo assessment, for example by a clinical psychologist, to assess the potential risk to patients before they may be permitted to resume any form of practice.

14. In the case of CHRP v (1) GDC and (2) Mr Fleischmann [2005] EWHC 87 (Admin) the Court has given some guidance on the handling of cases involving Internet child pornography.

Mitigation

15. In any case before them, the panel will need to have due regard to any evidence presented by way of mitigation by the doctor. This could include evidence that the doctor has not previously had a finding made against him or her by a previous panel or by any of the Council's previous committees, time lapsed since the incident(s), any apologies to the complainant/person in question, efforts to avoid such behaviour recurring or efforts made to correct any deficiencies in performance. Mitigation could also relate to the circumstances leading up to the incidents as well as the character and previous history of the doctor.

Guidance on considering references and testimonials

16. Often the doctor will present references and testimonials as to his or her standing in the community or profession. These will have been provided in advance of the hearing and the authors may be unaware of the events leading to the hearing. In any event, references written in advance of the hearing may not stand as an accurate portrait in light of the facts found proven.

17. As with other mitigating or aggravating factors any references and testimonials will need to be weighed appropriately against the nature of the facts found proved. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend on the standing of a practitioner. There may be cultural reasons for not requesting them and the panel should also be aware of this. In addition, acquiring references and testimonials may pose a difficulty for newly arrived overseas-qualified doctors. The panel will need to consider all such factors when looking at references and testimonials.

Expressions of regret and apology

18. *Good Medical Practice* states that when things go wrong, doctors:

> '...Should act immediately to put matters right, if that is possible and ...must explain fully and promptly to the patient what has happened and the likely long and short-term effects. (Paragraph 22).

This reflects a number of expectations on behalf of the profession and the public, including that:

a. Patients should be protected from similar events re-occurring, and

b. Doctors should take positive steps to learn from their mistakes, or when things go wrong.

Good Medical Practice continues, 'when appropriate...offer an apology' (ibid), reflecting that in this society, it is almost always expected that a person will apologise when things go wrong. However, the emphasis on 'when appropriate' reflects the fact that to some individuals (and this may or may not depend on their culture), offering an apology amounts to an acceptance of personal guilt which depending on the facts, a doctor may regard as inappropriate or excessive.

19. This 'insight' - the expectation that a doctor will be able to stand back and accept that with hindsight, they should have behaved differently, and that it is expected that he or she will take steps to prevent a reoccurrence - is an important factor in a hearing. But the panel should be aware that there may be cultural differences in the way that insight is expressed, for example, how an apology or expression of regret is framed and delivered and the process of communication.

20. Cross-cultural communication studies show that there are great variations in the way that individuals from different cultures and language groups use language to code and de-code messages. This is particularly the case when using a second

language, where speakers may use the convention of their first language to frame and structure sentences, often translating as they speak and may also be reflected in the intonation adopted. As a result, the language convention, subtleties or nuances of the second language may not be reflected. In addition, there may be differences in the way that individuals use non-verbal cues to convey a message, including eye contact, gestures, facial expressions and touch. Awareness of and sensitivity to these issues are important in determining the following:

a. How a doctor frames his or her 'insight'.

b. How a doctor offers an apology.

c. The doctor's demeanour and attitude during the hearing.

21. The main consideration for the panel therefore, is to be satisfied of patient protection and the wider public interest and that the doctor has recognised that steps need to be taken, and not the form in which this may be expressed.

Section 3

GMC Guidance on Making Referrals for Educational Intervention to the Postgraduate Dean and GP Director

1. The purpose of this guidance is to clarify the role of the Postgraduate Dean or GP Director in dealing with referrals from the GMC. In the remainder of this guidance a reference to the PG Dean is also intended to refer to the GP Director although there are very specific issues relating to General Practice in making referrals, which are also outlined in the guidance. References to 'decision-makers' apply to those within the GMC who are able to make such referrals as a result of the GMC's fitness to practise procedures. This is discussed in detail at paragraphs 13-15, pages S3-3/4.

2. The guidance aims to identify the types of cases in which educational intervention is and is not likely to be productive and in the best interests of the doctor and the public. It aims to provide a framework for those charged with making decisions and covers the following areas:

a. Who can use this guidance?

b. The purpose of educational intervention.

c. Restricting the doctor's registration.

d. The terms in which a referral is made.

e. The role of the Postgraduate Dean / Director of General Practice.

f. The National Clinical Assessment Service (NCAS).

g. The meaning of fitness to practise.

Who can use this guidance?

3. This guidance has been developed by the GMC for use in its fitness to practise procedures when consideration is being given to whether it is appropriate to refer a doctor for educational intervention. Fitness to Practise Panels and Case Examiners can therefore refer to it.

4. The guidance can also be used by Performance Assessors, doctors, the general public and other interested organisations (Medical Defence Organisations for example) as a source of general information.

5. The status and purpose of this document remains primarily however, to help GMC fitness to practise decision-makers. It does not have any binding status, as it is guidance, and ultimately, all cases must be decided on the facts of each individual case at the decision-makers' discretion and in accordance with the relevant rules and regulations.

The purpose of educational intervention

6. Doctors are expected to practise in accordance with the standards as set out in the GMC's publication, *Good Medical Practice*[1] and to maintain their knowledge and skills throughout their working lives. Doctors whose performance or behaviour is found to fall short of these standards can become subject to a range of actions by the GMC through its fitness to practise procedures. Where appropriate, educational intervention can be one such option. This guidance aims to identify factors in deciding whether educational intervention could be used to play a role in rehabilitating the doctor. Where such factors are taken into account, such intervention can be a useful and productive way forward.

7. The guidance has been produced with input from postgraduate medical education and training providers, and other relevant organisations.[2] As it is new, the guidance will be amended in light of relevant experience. The next section looks at the role of the doctor, the GMC and the PG Deans in making and taking forward a recommendation for remedial training.

The role of the doctor in remedial training

8. One factor essential to a successful programme of remedial retraining is the doctor's own commitment to putting right the deficiencies that have been identified. It is self-evident that so long as a doctor lacks insight and denies that a serious problem exists, despite this having been demonstrated through a rigorous and objective fitness to practise process, remedial training is not a practicable solution. The onus should be on the doctor to show a willingness to take the necessary remedial action, and to audit his or her progress. Whilst the GMC is not responsible for implementing a recommendation that a doctor should seek advice on educational retraining from the PG Dean, this guidance attempts to outline steps that can be taken to rationalise this process.

9. First, in deciding whether conditions would be the appropriate sanction on registration, decision-makers may find it useful to ask whether (based on the facts of each case) it would be in the interests of the public to allow the doctor to be directly involved in the care of patients. If not, then this will raise the question of whether conditions will actually be appropriate and if in fact, the doctor's behaviour or actions are compatible with continuing to practise as a doctor. The

[1] Also available at www.gmc-uk.org

[2] See paragraphs 48-52, page S3-11/13 for information on one of these, the National Clinical Assessment Service (NCAS).

statement of general policy about the meaning of fitness to practise (see paragraphs 53-56, pages S3-13/14), which has been agreed by the GMC, may be helpful when decision-makers are considering how best to address the different kinds of dysfunction.

10. If conditions are deemed appropriate for the protection of the public, when deciding whether the doctor is suitable for remedial training, the GMC should consider whether:

a. The doctor has insight into the problem and the potential and willingness to respond positively to educational intervention and;

b. There are identifiable areas of the doctor's practice in need of educational intervention.

11. Educational intervention is more likely to be appropriate in situations where the above criteria are met. Bearing in mind the aforementioned statement on the meaning of fitness to practise, there will be types of cases where educational referrals will not normally be appropriate. These are likely to include the following:

a. Deep-seated attitudinal or ethical shortcomings.

b. Dishonesty.

c. Abuse of the doctor/patient relationship.

12. There is a fundamental difference between addressing concerns such as keeping up to date for example, and a more deep-seated problem (lack of insight, denial of the problems, or sexual misconduct for example). Even where certain specialties do not involve direct patient contact, the doctor will need to keep patients as his or her central concern in order to function effectively. Decision-makers should therefore bear this in mind when deciding whether conditions and an educational referral would be appropriate.

The role of the GMC

13. The GMC's fitness to practise procedures aim to deal firmly but fairly with doctors whose fitness to practise may be called into question. The overriding aim of the GMC's procedures is to protect patients and the public interest where such an issue arises. The procedures are not intended to be punitive. The public interest includes, but is not limited to, the protection of patients. It also includes the maintenance of public confidence in the medical profession.

14. Subject to this overriding imperative, the procedures can provide a means to facilitate the rehabilitation of the doctor. This is likely to be a particularly

relevant consideration where the concern established is about the doctor's health or performance but may be less so where the concern is about misconduct.

15. Decision-makers should keep in mind that the GMC has a duty to take action in order to maintain confidence in the profession, notwithstanding that the doctor may be otherwise competent or willing to be retrained. This is to protect the special position of trust doctors enjoy by virtue of being members of the medical profession – something that is recognised in legislation.[3]

16. There will however, be cases (including conduct cases relating to misconduct) where the GMC may see that there is potential for rehabilitation and may determine that this is dependent on retraining. When this is the case, the first step is clarity on which areas of deficiency have been identified. Secondly, referrals need to tell the doctor and the PG Dean what changes in the doctor's performance, behaviour and knowledge, are required in order to return the doctor to good standing. In making the referral therefore, what is expected of both the PG Dean and the doctor should always be explicit, reasonable and practicable.

17. It is important that both the GMC decision makers and doctors recognise that the role of the PG Dean is only to provide advice and professional support to facilitate rehabilitation of doctors.[4] With this in mind, referrals from the decision makers should use *Good Medical Practice* as a measure of what the doctor needs to achieve, thereby providing a clear statement and benchmark to measure progress by. Both the doctor and the PG Dean will then know what goals and milestones need to be achieved.

18. As a result, the doctor will be in a better position to provide objective evidence of having tried to address the identified deficiencies. It will then be up to the appropriate decision-makers to determine (based on the evidence and facts of the case) whether the doctor is sufficiently rehabilitated to return to full practice; requires further training or has not achieved the required level of good standing.

19. It is important to avoid raising the expectations of the doctor or others that the PG Dean is under an obligation to provide training or that suitable training is even available. It is particularly important that the terms in which a referral is made could not reasonably be interpreted as placing an implied legal responsibility on the PG Dean to provide particular training. It must also be made clear that educational intervention is not a sanction – particularly in the context of conduct cases involving misconduct. If it is seen in this way, then there is the danger that the doctor may consider that seeing the Dean has addressed the

[3] Rehabilitation of Offenders Act 1974 (currently under review by the Home Office).
[4] Taken from 'Guidelines for Deaneries: GMC Performance Procedures – Guidelines for the Provisions of Advice and Professional Support to Facilitate Rehabilitation of Doctors.' (Issued by the NHS Executive Medical Education Unit, December 1997).

sanction that has been imposed. No real benefit will therefore have been achieved.

The role of the PG Dean

20. When deciding whether a referral would be suitable, the decision makers should bear in mind that the PG Dean can help in the following ways:

a. Provide general careers advice (discuss career direction/suitability for a particular specialty, and advise on practicability of different options).

b. Help format a CV or a personal statement that will encourage potential supervisors or employers to view an application with sympathy.

c. Recognise an appraiser and ensure personal development.

d. Help to identify whether a placement with a health organisation is likely to be suitable and whether there is a supervisor willing to help.

e. Use networks to make introductions to others that may be able to help.

f. Develop immediate objectives (i.e. ones which are a step toward fulfilling the wider objectives defined by the decision makers), to help both the doctor and supervisor.

Restricting the doctor's registration

21. Restricting a doctor's registration (through suspension or conditions) may have implications for the extent to which help can be provided, so it is important to explore whether such restrictions may actually impede retraining. This may be particularly relevant in terms of practice within a particular specialty, one example being that of General Practice. A number of considerations arising from referrals in General Practice are discussed below at paragraphs 29-30, page S3-7.

22. When imposing conditions, it is important to consider the implications of restrictions on practice such that:

a. The conditions/restrictions are compatible with the protection of patients and the public interest.

b. There appears to be a reasonable prospect that the problem is amenable to improvement through education.

c. The conditions/restrictions are practical and will allow the PG Dean sufficient scope to work with the doctor.

d. The objectives of the conditions/restrictions are clearly defined.

e. Future decision-makers will be readily able to determine whether the objectives have been achieved and whether these outcomes are measurable against Good Medical Practice.

23. Paragraph 22(c) is important because although the doctor may be having difficulty in his or her particular speciality, the PG Dean may determine that the doctor could obtain retraining in another specialty. If the restrictions are not sufficiently flexible, this option will not be available to the doctor.

24. PG Deans recommend that a doctor undergoing re-training must be able to practise at a level equivalent to that of a pre-registration house officer (PRHO) or higher. If the doctor's practice is significantly restricted it may effectively make retraining impossible.

25. Each case would however, have to be looked at on its merits. For example, a restriction on prescribing would not be a significant problem for an individual undertaking retraining primarily in Public Health. Logically however, it would still raise wider questions of whether - if the doctor needs to be prevented from prescribing - the restrictions are sufficient to protect patients and the public interest, and whether conditional registration is sufficient?

Drug Abuse

26. Specific issues arise in relation to referring doctors who abuse drugs. If the doctor has a history of drug abuse, the decision makers may wish to restrict the specialties or settings in which the doctor can practise as this will be in the best interests of the doctor and patients. Some specialities are likely to be inappropriate for doctors who have a history of drug abuse. This is because they are areas in which the doctor is likely to be tempted to use drugs again, due to comparatively free access to them. These may include:

a. Accident and Emergency (A&E).

b. General practice.

c. Anaesthetics.

d. Intensive care unit (ICU).

27. Decision-makers should consider, based on the individual facts of a case, whether this would be an issue in the particular circumstances.

Clinical attachments

28. A clinical attachment in medicine refers to an unpaid observership; since it involves observing a senior doctor at work, it does require direct patient contact. It may be appropriate where:

a. A doctor would benefit from the opportunity to observe practice in an unfamiliar setting or specialty.

b. A doctor out of medicine for some time would benefit from observing practice in a modern unit.

General Practice

29. In some cases, the types of restrictions imposed on GP's have caused difficulty in successful retraining. Below is a list of sample conditions, which have been imposed in the past and which in some instances have proved unworkable:

a. A restriction on practising single-handed.

b. A restriction on working out of hours.

c. A restriction on home visiting.

d. A restriction on prescribing certain classes of drugs.

e. A restriction on treating certain classes of patients.

f. A requirement to be supervised:

i. By another registered practitioner.
ii. By a doctor nominated by the Director.
iii. By a trainer appointed by the Director.

g. A requirement to work in a particular setting, e.g. a training practice.

30. Consideration should be given to whether, in individual cases, imposing any of the above conditions would allow for rehabilitation to take place, or whether such conditions may in effect make it difficult for the doctor to retrain. All conditions should be measurable, reasonable and proportionate to the nature and type of offence, but must always aim to protect patients and be sufficient to meet the public interest.

The terms in which a referral is made

31. A referral to the PG Dean should contain a description of the problem to be assessed. This should discuss the nature of the problem, including whether it appears to be an isolated incident or general deficiency, and whether the doctor has any insight. The referral should provide a description of any restrictions on practice and should not be too prescriptive because, for example:

a. If the conditions specified a hospital post that would exclude not only general practice but also a community placement.

b. If they specified an SHO post or an educationally approved training post, then a trust doctor or staff grade post would be excluded.

c. If they specified a NHS post, it would prevent the PG Dean from placing the doctor in a hospice.

Supervision

32. Some conditions can state that a doctor should only practise when supervised. The extent of the supervision can vary from 'adequately supervised' to 'close personal supervision' for example. Decision-makers should be aware that there are differing levels of supervision and select that which is most appropriate in the individual case. The referral should make as clear as possible to the PG Dean to what extent supervision is required.

33. An example of a possible referral to the PG Dean is outlined below. This is only an example and it will always be necessary for the referral to reflect the facts of the individual cases:

'You should restrict practice to posts under the supervision (the level of supervision should be defined) of an appropriately experienced educational supervisor, approved by the PG Dean, with whom you should discuss your training needs and who should approve an educational plan initiated by you. The educational supervisor must be prepared to accept responsibility for your supervision, and for reporting back on your performance, as agreed with the PG Dean.'

34. The rest of this document provides information about the GMC's role in fitness to practise, the role of the Postgraduate Deaneries and the National Clinical Assessment Service (NCAS).

The Role of the Postgraduate Dean / Director of General Practice Education

35. Postgraduate Deans (PG Deans) are responsible to the Secretary of State for Health for the management and delivery of all medical and dental

postgraduate training (PGMDE) in and associated with the NHS. Responsibility for postgraduate training for general practice is delegated from PG Deans to Directors of Postgraduate General Practice Education (Directors). In Scotland, the PG Deans are responsible through NHS Education in Scotland (NES) to the Minister for Health and Community Care. Postgraduate medical and dental education is complex and highly regulated because of the need to continue to train doctors and dentists while they are still working as NHS employees.

36. Historically, PG Deans have been responsible for managing PGMDE in partnership with the health service and therefore planning and controlling the numbers of trainees in accordance with the future medical workforce needs of the NHS. In April 2001, Workforce Development Confederations (WDC) were established as partnership organisations to Strategic Health Authorities (SHAs), in order to give direction to workforce planning and development. WDCs have been formed from pre-existing education consortia (whose expertise was in relation to the non-medical workforce) to work in partnership with Postgraduate Deaneries in order to plan the management and delivery of PGMDE in ways that meet professional requirements and the needs of the service.[5] In Scotland, PGMDE is managed in partnership with employer Health Boards under Training and Service Agreements. NES/Scottish Executive Health Department (SEHD) liaison arrangements, in conjunction with the SEHD Workforce Numbers Group, determine medical training grade supply.

37. In particular, PG Deans commission, develop and quality assure the delivery of PGMDE to standards set by the GMC, General Dental Council and other UK competent authorities (the Specialist Training Authority and the Joint Committee on Postgraduate Training in General Practice). Following recent legislation however, these two competent authorities will become a single body, the Postgraduate Medical Education Training Board (PMETB), due to become operational in late 2005. PG Deans also manage PGMDE in partnership with the relevant universities and the medical Royal Colleges.

38. The office of regional PG Dean in medical education was established in the 1980s and at the time the role varied from region to region. Since the early 1990's the role has expanded, and through coming together at the Conference of Postgraduate Medical and Dental Deans (COPMeD),[6] members are able to meet to discuss current issues, share best practice and agree a consistent and equitable approach to training in all deaneries. A similar forum exists for Directors and is called the Committee of General Practice Education Directors (COGPeD).

39. In Scotland, NES, a Special Health Board of the SEHD, has overall responsibility for organising and managing PGMDE as part of devolved arrangements. The regional Post Graduate Deans and Directors of Postgraduate

[5] See http://www.doh.gov.uk/shiftingthebalance and http://www.doh.gov.uk/workdevcon/guidance.htm for more information on the changes.
[6] Visit http://www.copmed.org.uk to find out more and for links to COGPeD.

Education are a part of NES and are responsible for the regional delivery of postgraduate education. In Northern Ireland, the Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE) has comparable functions. This is different from the supervision of PGME in the UK, which remains a UK competent authority function reserved to Westminster.[7]

The training structure

40. The Pre-registration House Officer (PRHO) year is the final year of basic medical education, and is undertaken by new UK graduates who are granted provisional registration by the GMC, which enables them to work as doctors while completing their basic medical education. This period of training is supervised by the PG Dean and usually takes place whilst employed in approved hospital placements or some general practices.

41. Once basic medical education is complete, the doctor undertakes further training. This is broken into basic specialist training as a Senior House Officer (SHO) followed by either higher specialist training as a Specialist Registrar (SpR) or general practice vocational training as a GP Registrar (GpR). It is the responsibility of PG Deans and Directors (working closely with Royal Colleges and Specialist Training Committees - STC) to oversee and manage the delivery of this training.

Basic Specialist Training

42. With regard to SHO training, PG Deans are responsible for putting in place systems that monitor the progress of all trainees within their region, and identify those who may need further career guidance. They also promote and publicise opportunities for flexible training and develop common approaches to appraisal and the form of references.

Specialist and General Practice Vocational Training

43. PG Deans and Directors manage and deliver the day to day running and organisation of both specialist and GP vocational training. They support the relevant competent authorities (see paragraph 37) that issue doctors with certificates at the end of satisfactory training. These are the Vocational Training Certificate of Prescribed Experience (VT Certificate) and the Certificate of Completion of Specialist Training (CCST). This involves arranging training courses, assessment and selection procedures and extensive guidance for the trainees.

[7] Taken from www.doh.gov.uk/medicaltrainingintheuk

The Deanery

44. Associate deans are appointed, usually by their university, to provide postgraduate deans with support at deanery level. In addition to acting as a deputy PG Dean, associate deans usually hold specific portfolios, for example responsibility for flexible training or for overseeing and monitoring the training of overseas doctors.

45. PG Deans are represented at local level by clinical tutors, who provide an important link between the university and the PG Dean on the one hand, and the Chief Executive and medical director of the NHS trust on the other. They are usually responsible for management of their trust's postgraduate or education centre and for managing the study leave budget devolved to them by the PG Dean. Clinical/Postgraduate tutors normally chair the local medical education committee. They are responsible for guaranteeing, on behalf of their trust, that their PG Dean's education and training contract is fulfilled.

46. Clinical tutors play an important role in co-ordinating the training of Senior House Officers within their trust and do so by liaising with college tutors, educational supervisors and GP course organisers to monitor the training whilst identifying those in difficulty and providing appropriate guidance and support. They also ensure that all SHOs receive appropriate careers guidance by acting as a counsellor and advocate.

47. Directors are supported at local level in their role of organising, co-ordinating and monitoring GP training by course organisers and GP tutors. They have a role in 'Continuing Medical Education' (CME) and 'Continuing Professional Development' (CPD) for established GP Principals and other doctors.

The National Clinical Assessment Service (NCAS) – England, Wales and Northern Ireland

48. The National Clinical Assessment Service replaced the National Clinical Assessment Authority (NCAA) from 1st April 2005. NCAS operates within the National Patient Safety Agency, a Special Health Authority created in July 2001 to co-ordinate efforts to report and learn from mistakes and problems that affect patient safety. NCAS continues the work of the NCAA in providing a service to NHS employers where there are concerns over the performance of individual doctors and dentists. NCAS does this by offering advice and assistance and arranging performance assessments. The purpose of an assessment is to clarify areas of concern, to identify factors that may be contributing to the difficulties and to make recommendations for how these may be addressed. Following assessment NCAS advises the doctor or the Trust on the action plan required to implement recommendations. This may involve, for example, a period of retraining, or coaching or mentoring. NCAS will also advise a Trust regarding

where the use of disciplinary procedures or exclusion is necessary. In this way NCAS complements the work of the GMC, however its main concern will be the practice of an individual within a team and a clinical setting, rather than the fitness of that individual to remain on the GMC Register. Normally the NCAS will assess only those doctors who are not considered to pose a serious risk to patient safety.

49. The GMC has developed good working relationships with the NCAS and a memorandum of understanding has been agreed between the two organisations. (A copy of the memorandum is available on the GMC website, www.gmc-uk.org/ who we work with). NCAS and the GMC have differing but complementary core functions and share a common goal - to improve standards of medical care. Both organisations will co-operate whenever possible in working to meet this common goal. The principles of this co-operation are set out in the memorandum, which also includes the following areas of possible communication between the GMC and NCAS:

a. pre-referral discussion - discussions regarding concerns about individual doctors prior to a formal referral to either body, usually to establish how best to progress the case and which of the two bodies should most appropriately deal with it;

b. post-referral discussions - discussion regarding concerns about individual doctors after one of the bodies has received a referral, usually to avoid unnecessary duplication of assessments and to coordinate activity where necessary;

c. sharing of expertise and experience in the development of assessment methods and use of assessors;

d. joint research projects.

All the above are covered in detail in the annex to the memorandum of understanding.

50. There are cases where, as a result of the exercise of its statutory functions, the GMC receives information, which raises concerns about the competence or performance of a doctor employed or contracted by an NHS organisation, but those concerns are not so serious as to raise an issue of impaired fitness to practise. The GMC may consider it to be in the public interest to communicate those concerns to the appropriate NHS organisation (normally through its medical director), and may also inform the relevant Strategic Health Authority. The GMC will *not*, normally, notify NCAS directly, although the NHS organisation concerned may be encouraged to do so as a result of the information provided by the GMC. The GMC may, if it considers it appropriate, seek informal advice from NCAS about the content of any letter of advice it plans

to send to doctors or NHS organisations. It may also refer cases directly to NCAS where it has a concern that the NHS organisation is not able or willing to act appropriately on an individual case and it appears in the public interest to do so.

51. Fitness to Practise Panels that can place conditions on a doctor's registration should *not* specify the involvement of NCAS in any conditions. It will normally be for the doctor's employer/contractor to decide whether to seek assistance from NCAS, whereas it is the individual doctor's responsibility to fulfil conditions set by the GMC. Doctors may at any time seek to self-refer to NCAS for assistance. On such occasions, NCAS will normally inform the doctor's employer/contractor.

52. NCAS uses Performance Improvement Plans to ensure that the doctor and the employing Trust are absolutely clear about the objectives for a training or support programme following NCAS assessment. The Trust is then in a position to monitor progress against a plan. At review hearings members of Fitness to Practise Panels may wish to consider evidence provided by a doctor on progress against a Performance Improvement Plan.

The Meaning of Fitness to Practise

This statement of policy has been approved by the GMC

53. To practise safely, doctors must be competent in what they do. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately if they or a colleague fall ill and their performance suffers.

54. But these attributes, while essential, are not enough. Doctors have a respected position in society and their work gives them privileged access to patients, some of whom may be very vulnerable. A doctor whose conduct has shown that he cannot justify the trust placed in him should not continue in unrestricted practice while that remains the case.

55. In short, the public is entitled to expect that their doctor is fit to practise, and follows the GMC's principles of good practice described in *Good Medical Practice*. It sets out the standards of competence, care and conduct expected of doctors, under the following main headings:

Good Medical Practice

Good clinical care – doctors must provide good standards of clinical care, must practise within the limits of their competence, and must ensure that patients are not put at unnecessary risk.

Maintaining good medical practice – doctors must keep up to date with developments in their field, maintain their skills and audit their performance

Relationships with patients– doctors must develop and maintain successful relationships with their patients, by respecting patients' autonomy and other rights.

Working with colleagues – doctors must work effectively with their colleagues.

Teaching and training – where doctors have teaching responsibilities they must develop the skills, attitudes and practices of a competent teacher.

Probity – doctors must be honest and trustworthy.

Health – doctors must not allow their own health condition to endanger patients.

56. Most doctors measure up to these high standards but a small number fall seriously short and thereby put patients at risk, cause them serious harm or distress or undermine public confidence in doctors generally. For that reason, the GMC has legal powers to take action where it appears that a doctor's fitness to practise may be impaired by reason of:

a. Misconduct;
b. Deficient Professional Performance;
c. A conviction or caution in the British Islands for criminal offence or a conviction elsewhere for an offence which, if committed in England and Wales would constitute a criminal offence;
d. Adverse physical or mental health;
e. A decision by another regulatory body in the United Kingdom to the effect that the doctor's fitness to practise is impaired, or a decision by a regulatory body elsewhere to the same effect.

The GMC's role in regulation

57. All human beings make mistakes from time to time. Doctors are no different. While occasional one-off mistakes need to be thoroughly investigated by those immediately involved where the incident occurred and any harm put right, they are unlikely in themselves to indicate a fitness to practise problem. *Good Medical Practice* puts it this way:

'Serious or persistent failures to meet the standards in this booklet may put your registration at risk'.

58. A question of impaired fitness to practise is likely to arise if:

- **A doctor's performance has harmed patients or put patients at risk of harm;**

A risk of harm will usually be demonstrated by a series of incidents that cause concern locally. These incidents will indicate persistent technical failings or other repeated departures from good practice, which are not being, or cannot be, safely managed locally or local management has been tried and has failed.

- **A doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients;**

  An isolated lapse from high standards of conduct – such as an atypical rude outburst– would not in itself suggest that the doctor's fitness to practise was in question. But the sort of misconduct, whether criminal or not, which indicates a lack of integrity on the part of the doctor, an unwillingness to practise ethically or responsibly or a serious lack of insight into obvious problems of poor practice will bring a doctor's registration into question.

- **A doctor's health is compromising patient safety;**

  The GMC does not need to be involved merely because a doctor is unwell, even if the illness is serious. However, a doctor's fitness to practise is brought into question if it appears that the doctor has a serious medical condition (including an addiction to drugs or alcohol); AND the doctor does not appear to be following appropriate medical advice about modifying his or her practice as necessary in order to minimise the risk to patients.

- **A doctor has abused a patient's trust or violated a patient's autonomy or other fundamental rights;**

  Conduct, which shows that a doctor has acted without regard for patients' rights or feelings, or has abused their professional position as a doctor, will usually give rise to questions about a doctor's fitness to practise

- **A doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others;**

  The doctor's behaviour was such that public confidence in doctors generally might be undermined if the GMC did not take action.

59. The advice above is only illustrative of the sort of behaviour, which could call registration into question. *Good Medical Practice* and other published GMC guidance provide a more complete picture of behaviour of this kind, but even it is not exhaustive. The outcome in any case will depend on its particular facts.

Annex A

Extract from guidance issued with the General Medical Council (Fitness to Practise) Rules 2004 (the Rules)

Adjudication Stage

Preliminary Matters

Case Management (Rule 16)

29. The rules introduce a case management mechanism intended to reduce delays, narrow the issues before a Fitness to Practise Panel and to minimise the stress placed on witnesses at a hearing. In certain cases, the Registrar may consider one or more case reviews to be desirable in order to facilitate effective listing of, and consideration at, a hearing before a Fitness to Practise Panel. This is unlikely to be the case where the allegations rely to a large extent on findings on an assessment of the practitioner's health or performance.

30. A case review will, as a general rule, be held by telephone conference, in the presence of the parties and a Case Manager, who is required to act independently of the parties.

31. The Case Manager will issue directions and maintain a record of those directions, and any admissions made or decisions reached. This record may form part of the evidence that the Fitness to Practise Panel will consider at the substantive hearing. Paragraph 30 of *Good Medical Practice* states "*You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure which applies to your work. You must give, to those who are entitled to ask for it, any relevant information in connection with an investigation into your own, or another health care professional's, conduct, performance or health*". Directions issued by the Case Manager should be complied with and any failure to do so may result in evidence not being admitted before the panel or adverse inferences being drawn.

32. Directions issued by the Case Manager may relate to the disclosure of evidence. As a general rule, however, the GMC will in any event disclose evidence supporting its case against a practitioner as and when this becomes available and in advance of any disclosure by the practitioner of the evidence in support of his defence.

Notice of allegation (Rule 15)

33. Following a decision to refer a case to a Fitness to Practise Panel (and after any relevant case review has been held) the Registrar will issue the practitioner with a notice setting out the allegations of impaired fitness to practise and any facts upon which the allegations are based. The findings on assessment of a practitioner's health or performance may comprise the facts underlying an allegation of impairment on the grounds of health or performance. Where appropriate, the GMC will also notify the practitioner of the outcome it will be seeking at the relevant hearing.

34. The practitioner will be notified of the date and location of the hearing at least 28 days before the hearing. Whilst usually the precise time and venue will be notified at the same time, it may be necessary to change such details at short notice, and these may be notified at a later date, so long as this is no later than 7 days before the hearing. A shorter timeframe may be agreed between the parties, or may be applied where appropriate in the exceptional circumstances of the case.

35. Before sending out the notice, the Registrar will undertake such further investigations (including instructing solicitors to procure witness statements and other documentary evidence) as are necessary for the satisfactory presentation of the GMC's case at the hearing.

36. Rules 20 and 23 provide equivalent notice provisions for hearings convened in order to review an initial order for suspension or conditions made by a panel, and to consider whether to restore a practitioner to the register following erasure by a panel (see below).

Procedure before the Fitness to Practise Panel

Powers of the panel

37. A Fitness to Practise Panel may consider at the same hearing two or more allegations of impairment (of any kind), and allegations against two or more practitioners. (Rule 32) Hearings will, therefore, be holistic, in that allegations will be brought forward based on the totality of the evidence obtained during the investigation stage (including, where appropriate, health and performance assessment reports) and may comprise a combination of allegations relating to a doctor's health, performance or conduct, or based on a caution, conviction or determination.

38. The powers of a Fitness to Practise Panel are found at section 35D of the Medical Act 1983. In summary, the panel may issue a warning, impose a period of conditions on a practitioner's registration, suspend his registration for a specified period, or (save where the allegations relate solely to the practitioner's health) erase his name from the medical register. In addition, the panel may accept written undertakings entered into by the practitioner where he agrees that these may be disclosed to his employer and any subsequent enquirer, and where it would be sufficient to protect patients and the public interest to do so.

39. A practitioner is entitled to appeal to the High Court or Court of Session against any such decision and so the determination will not will take effect until either the appeal period (28 days) expires, or any such appeal is determined. Where the panel considers it necessary for the protection of members of the public or in the interests of the public or the practitioner, it may (under section 38 of the Act) order that his registration be suspended or made subject to conditions, as appropriate, with immediate effect and any such order will take effect during this period.

40. Where a practitioner has failed to comply with reasonable requests made by an Assessment Team in relation to the assessment of his professional performance, the Fitness to Practise Panel may suspend, or impose conditions on, his registration as a direct result. Where a practitioner otherwise fails to cooperate with a request that he undertake an assessment of his health or performance, this failure may be taken into account by the panel in reaching a view as to whether or not his fitness to practise is impaired. In addition, where the practitioner suffers from a physical or mental condition which is in remission, the panel may nonetheless consider him to be impaired by reason of ill health, where it considers any likely recurrence will render his fitness to practise impaired.

Review

41. An order for suspension or conditions will generally be reviewed by the Fitness to Practise Panel prior to the end of the period imposed. An early review

hearing may be held, at the discretion of the Registrar, where new information received by the GMC indicates that to do so would be desirable.

42. On review, the panel will consider compliance with any conditions previously imposed, in reaching a decision as to whether to conclude the case against the practitioner or impose a further sanction, and may accept undertakings in the same circumstances as set out at paragraph 38 above. In cases relating solely to the practitioner's health, and where a practitioner has been suspended for a period of two or more years, the panel may indefinitely suspend his registration. An order for indefinite suspension may be reviewed at the request of the practitioner provided at least two years have elapsed since the order took effect or since the date of the last review.

Restoration

43. Where a practitioner has been erased from the Register, he may apply for his name to be restored to the register after a period of five years. If a Fitness to Practise Panel rejects his application for restoration, the practitioner cannot apply again for at least 12 months after that decision. If he is unsuccessful on more than one occasion, the GMC may suspend indefinitely his right to apply for restoration to the register. The practitioner can invite the Panel to review that determination not less than three years after the decision is made.

Procedure

44. The procedure to be adopted by a Fitness to Practise Panel, at an initial hearing, review hearing, or restoration hearing, is set out at Rules 17, 22 and 24 respectively. Under Rule 41, all such hearings will be held in public, unless the circumstances of the individual case suggest that there is an overriding public interest reason to do otherwise. Issues relating solely to a practitioner's health will be heard in private.

45. The panel will sit with a Legal Assessor (who may provide legal advice) and may also be joined by a specialist health or performance adviser (who may provide medical advice). Any such advice must be given or repeated in the presence of the parties attending the hearing.

46. Where it is making a finding of disputed facts, the panel must be sure of its decision. The issue of whether the practitioner's fitness to practise is impaired, and the imposition of a sanction, or warning, are matters of professional judgment. The panel must be sure that any proposed action (whether to close a case with or without a warning, or to impose a sanction on the doctor's registration) is sufficient to protect patients and the public interest, failing which it must consider taking action against the practitioner's registration or imposing a more severe sanction, as appropriate.

General provisions relating to hearings before the Investigation Committee, Fitness to Practise Panel or Interim Orders Panel

Applications for Cancellation, Postponement or Adjournment (Rules 28 and 29)

47. At any time prior to the opening of a hearing before a Fitness to Practise Panel, an Interim Orders Panel or the Investigation Committee, a member of the Committee, or the President, may decide that the referral for adjudication should be cancelled, or that the hearing itself should be postponed. A decision whether to adjourn a hearing, once it has commenced (for example, in order that further evidence may be obtained, or on the application of a party to the proceedings), will be made by the Committee or panel itself.

48. In considering whether to postpone or adjourn a hearing, the GMC will take into account all material circumstances, including any likely inconvenience to witnesses and the effect of any delay on the fairness of the proceedings.

Attendance (Rules 31 and 33)

49. Practitioners are expected to attend any hearings held by the GMC. A practitioner may attend in person or be represented at the hearing by a legal or professional representative. On a case-by-case basis, the Committee or panel may allow a practitioner to be represented by another person, such as a friend, colleague or family member, unless this person is also giving evidence at the hearing.

50. Where the practitioner does not attend, the Committee or panel may proceed to hear the case in his absence. In deciding whether or not to proceed in the absence of the practitioner, they will consider:

- the need to protect patients and to have regard to the public interest and the interests of the practitioner
- whether or not all reasonable efforts have been made to serve the notice on the practitioner in accordance with the Rules
- the seriousness of the case
- the risk of reaching the wrong conclusion about the reasons for the practitioner's absence
- the risk of reaching the wrong decision on the merits, as a result of not hearing the practitioner's account
- any medical evidence about the health of the practitioner, and any challenges to such evidence

Witnesses (Rules 35 and 36)

51. Save for the practitioner who is the subject of the allegations in question, or where the Committee or panel decides otherwise, no witness of fact will be allowed to attend or watch proceedings at a hearing until after they have completed giving evidence and have formally been released by the Chairman.

52. The Committee or panel may, on the application of the party calling a witness, agree that any personal details which reveal the identity of the witness should not be disclosed in public. Any reasonably practicable measures will be taken to enable and assist a witness defined as vulnerable under the Rules (for example, as a result of their physical or mental condition, their age, or the fact that they are an alleged victim of sexual misconduct by the practitioner) in giving evidence where their ability to do so is disadvantaged as a result. Where the witness is an alleged victim of sexual misconduct, the practitioner may not cross-examine the witness on his own behalf and must instruct a legal representative to do so. In default, the GMC may instruct a legal representative to cross-examine the witness on his behalf.

Publication of decision

53. The decision reached by a Committee or Panel, together with reasons, will be notified to the practitioner, his employer and any person or body who brought the allegation to the GMC's attention. In addition, the decision will be published on the GMC's website. The sole exception to this practice will occur in relation to confidential information relating to the practitioner's physical or mental health.

Annex B

Decisions in the Public Interest: Relevant Judgments

1. In the case of Dr Mohinder Singh (13 May 1998), who had been convicted on 10 counts of dishonesty, the Judicial Committee of the Privy Council stated:

> 'This was a case in which the Committee was entitled to take the view that the policy of preserving public trust in the profession prevailed over the strong personal mitigation which Dr Singh was able to put forward.....they were entitled to conclude, as Miss Foster said, that there is no room for dishonest doctors.'

2. In the case of Mr Duncan Lindsay McMillan (24 May 1993) the Judicial Committee said:

> 'It is of course well known that not only sentences of erasure and suspension, but also the imposition of conditions such as that in the present case may have a severe impact no only upon the doctor himself, but also upon innocent persons who may be affected... It is, however, recognised that from time to time, it is nevertheless necessary to impose such penalties, in the public interest, for the purpose of registering disapproval of unprofessional conduct and for maintaining high standards of conduct in the medical profession..... In their Lordships' opinion, the [Professional Conduct] Committee were not required, in the circumstances of the present case, to limit such protection in the manner proposed... They were entitled to take a broader view of the matter....'.

3. In the case of Dr Mohammed Ali Reza (4 March 1991) the Judicial Committee said:

> 'The whole picture is of a committee which is to be informed of all the facts alleged and all the background which could help them to determine in the interests of the public and the profession what, if anything, is to be done by way of erasure or suspension or the imposition of conditions'.

4. In the case of Bolton-v-The Law Society, the Court of Appeal held:

> 'that the Solicitors Disciplinary Tribunal's orders were not primarily directed to punishment but to the maintenance of a well-founded public confidence in the trustworthiness of all members of the profession and the discharge of any professional duty with less than complete integrity would attract severe sanctions.... A profession's most valuable asset is its collective reputation and the confidence which that inspires..... The reputation of the profession is more important than the fortunes of any

individual member.... Membership of a profession brings many benefits, but that is part of the price'.

5. The case of Bolton-v-The Law Society has regularly been cited in the Privy Council and in the case of Dr Gupta (21 December 2001) the Judicial Committee made clear that the same approach should be applied when considering the sanction of erasure:

> 'It has frequently been observed that, where professional discipline is at stake, the relevant committee is not concerned exclusively, or even primarily, with the punishment of the practitioner concerned. Their Lordships refer, for instance, to the judgment of Sir Thomas Bingham MR in *Bolton v Law Society* [1994] 1 WLR 512, 517H-519E where his Lordship set out the general approach that has to be adopted. In particular he pointed out that, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension that the practitioner may be unable to re-establish his practice when the period has passed. That consequence may be deeply unfortunate for the individual concerned but it does not make the order for suspension wrong if it is otherwise right. The Master of the Rolls concluded at p519E
>
> > "The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price"
>
> Mutatis mutandis the same approach falls to be applied in considering the sanction of erasure imposed by the Committee in this case'.

6. In the case of Dr Marinovich (24 June 2002) the Judicial Committee said:

> 'Their Lordships appreciate that, having regard to his age, it would not be realistic to expect the appellant's name ever to be restored to the register in the event of its erasure. In the appellant's case the effect of the Committee's order is that his erasure is for life. But it has been said many times that the Professional Conduct Committee is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the Committee in the light of its experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession.

That is not to say that their Lordships may not intervene if there are good grounds for doing so. But in this case their Lordships are satisfied that there are no such grounds. This was a case of such a grave nature that a finding that the appellant was unfit to practise was inevitable. The Committee was entitled to give greater weight to the public interest and to the need to maintain public confidence in the profession than to the consequences to the appellant of the imposition of the penalty. Their Lordships are quite unable to say that the sanction of erasure which the Committee decided to impose in this case, while undoubtedly was wrong or unjustified.'