Private & Confidential

GMC-MPTS FTP procedures, 2005-16

British medicine reserves to itself the right to erase a doctor from the medical register. "Difficult" doctors are usually "weeded out" in the competitive career structure though, occasionally, the GMC-MPTS jurisdiction is necessary. Any doctor threatening vested interests (Wakefield, 2010) or, expressing a minority view (Squier, 2016) may be subject to arbitrary standards by the medical profession and deprived of their livelihood through the GMC-MPTS jurisdiction.

In 2005, Smith LJ expressed the view that the GMC was a "leopard that would never change its spots" (Shipman 5th Report). Between 2005-13 there were a minimum of 114 deaths of doctors with "open" GMC investigations (and many more with closed cases). The low threshold for prosecution, unsatisfactory procedures, and, an overbearing prosecutorial atmosphere resulted in disproportionate sanctions for many doctors. Doctors with *any* sanction (conditions or suspension) can usually only work as short term agency locums because of pre-employment declaration forms of the monopoly, NHS employer. The consequences of any GMC-MPTS sanctions are, therefore, *very* serious for an individual doctor. Many doctors, experiencing GMC-MPTS-FTP processes believe that a "nexus of malice" ran amok in the jurisdiction during these years.

The present chair, Professor Stephenson, has done a great deal in a short time, to excise the key elements of the nexus of malice though its roots run wide and deep within the organization. Many of the persisting problems in the jurisdiction, are not immediately obvious to GMC staff, though may be minimised by *simple* measures.

(1) Mortality associated with GMC MPTS FTP procedures.

1.1 The GMC MPTS FTP jurisdiction continues to result in the deaths of many doctors (114 deaths from 2005-13). Add another 25 deaths for 2014-2016 and a large, though unrecorded, number of deaths occurring outside GMC-MPTS FTP procedures. For the full period 2005-2016, as many as 200 doctors may have died as a consequence of GMC MPTS FTP procedures.[1],[2]

1.2 The GMC submits that "most of these doctors had pre-existing psychiatric conditions.[3] There is no evidence to support this assertions. Many of these doctors may have committed suicide purely because of their "handling" by the GMC FTP Directorate in GMC MPTS FTP procedures. There are a number of examples of deaths within 24 hours of communications from GMC FTP directorate staff.[4] There is published evidence of "delay" with significant numbers of FTP procedures taking beyond 4 years to come to hearing.[5]

1.3 There have been two reports in relation to these deaths. The first was written by Sarndrah Horsefall who acknowledged 28 deaths in the period 2005-14, that has been described as a "classic whitewash" (1). The second, directed at the mental health of these doctors, written by Professor Louis Appleby confirmed 114 deaths and made a number of recommendations (2). There has been a recent, "broad-brush", critique of GMC procedures by Civitas in 2015.(4)

1.4. Throughout this account there is a clear distinction between clinical and non-clinical allegations. The author contends that the GMC-MPTS jurisdiction is ill-equipped to investigate clinical allegations. There is no insight into the circumstances of the doctors' workplace, bullying is endemic in the medical profession and in many Trusts, rota gaps are everywhere, morale is poor, and, there are many cross-currents and other motives for "getting rid" of a doctor through GMC-MPTS procedures. Non-clinical allegations regarding abuse of alcohol, drugs, sex, fraud, dishonesty, etc should all be fully prosecuted.

(2) The "nexus of malice" in the GMC, 2005-2016.

This group included three senior lawyers (no longer employed by GMC), a former Director of FTP (no longer employed by GMC), a small group of senior, medical panel chairs appointed as long ago as 2001, and some members of the FTP directorate. They established a culture of malice within the organization that regarded referred doctors as "bad doctors" rather than "doctors facing allegations".

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[1] http://www.gmc-uk.org/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf

[2] http://www.gmc uk.org/Suicide_review___Final_Draft_Proposals_for_Publication___FINAL___20160418.pdf_65748529.pdf

[3] N Dickson, Chief Executive, oral evidence to Health Select Committee, 10th December 2013

[4] Civitas Report, 2014 "GMC – Fit to Practise ?" Williams H, Lees C, Boyd M.

[5]

This attitude created a prosecutorial atmosphere within the GMC that led to many doctor deaths through suicide, and, destroyed many other lives. There are many features of the jurisdiction including a blurring of the powers of investigation and adjudication, the selection of panels and panellists, and, some FTP rules that may be regarded as "unfair" to any doctor facing clinical allegations. These failings call into question the prosecution of many doctors during this period, and, raise concerns about continuing with these prosecutions until the jurisdiction has been put on a proper footing. [6]

(3) The "apparent" separation of investigation and adjudication in GMC-MPTS hearings is incomplete and inadequate.

3.1 Despite the development of the MPTS and an "apparent" separation between the GMC and MPTS there are several, well-worn methods where this boundary is compromised – often before the case arrives in the GMC.

Serving GMC panel chairs and panellists take part in Royal College (or other) investigations that lead to referral of doctors to the GMC. Their initial adverse reports ("sham peer review") sets the trajectory of the case within GMC procedures. On the basis of these reports, some cases may be dismissed inappropriately; others may be delivered to IOP/performance assessment, etc. "sham" peer review is a real, and an undetected, risk in these reports.[7]

3.2 Senior medical panel chairs, who convene and train together, participate in both the investigative and adjudicative functions of the jurisdiction. They are therefore in a position to influence the outcome of their own investigations.[8] This is a clear breach of the separation of powers.[9]

3.3 Evidence of unlawful guidance to panellists that blurred the boundary between investigation and adjudication, and, was unfavourable to doctors was discovered in 2014; it was the *34th piece of such guidance* in that year ! There was no attempt at remediation by the GMC for those doctors that were affected by this unlawful guidance.[10]

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[6] Lady Caroline Swift, High Court judge, takes up appointment as Head of MPTS from 1 January 2017.

[7] **"Sham peer review"** is defined as "an abuse of peer review where a report is produced for personal or political advantage rather than the improvement of healthcare." [7] The GMC leadership does not acknowledge that "sham" peer review exists, nor that it can have on its procedures in either FTP procedures nor appraisal nor 360 degree feedback (N Dickson, oral evidence to Health Select Committee, 2014).

[8] MPTS panellists do not have to make a declaration that they do not participate in the investigations of doctors for the GMC or other organisations

[9] There is a compelling case for investigating these doctors who have deliberately sought to "pervert the course of justice" and may have contributed to doctors' suicides.

[10] It is a recurrent feature of the GMC jurisdiction that it does not take steps to correct the injustices meted out to doctors. It lacks insight into the consequences of its behavior, and, that may be one reason why so many excesses have persisted for so long.

Secret Guidance[11]

The British Medical Journal has reported that, earlier this year, a Medical Practitioners Tribunal Service ("MPTS") guidance document was accidentally disclosed to a solicitor representing a doctor subject to fitness to practice proceedings, that had significant consequences.

The guidance document in question had been circulated by the MPTS to its panelists hearing GMC interim orders cases. Despite the MPTS's alleged independence, the guidance issued was favourable to the GMC, unhelpful to doctors and misstated the correct legal position. For example, the guidance stated that testimonials supporting a doctor's competence were "of limited value at the investigation stage" and "should not be taken into account in determining whether an interim order should be imposed".

Judicial Review

When it learned of the guidance, the Medical Protection Society commenced judicial review proceedings seeking a High Court declaration that the particular piece of guidance was unlawful and should be withdrawn or amended and that all items of guidance issued by the MPTS should be disclosed (the title of the guidance document accidentally disclosed indicated it was the **34th such piece of guidance** issued to panelists by the MPTS during 2013).

Conclusion

These events have undermined the MPTS's alleged independence. Whilst His Honour Judge Pearl, the Head of the MPTS, stated that "it was unhelpful" that MPTS had issued covert guidance to its panelists, this does not remedy the position for the unknown number of doctors who may have been subject to decisions made by MPTS panelists based on the misleading guidance. At the time of writing, the MPTS has not announced any intention to review and/or correct all such decisions.

[11] http://careers.bmj.com/careers/advice/view-article.html?id=20018122
http://www.tpauk.com/main/article/secret-guidance-for-fitness-to-practise-panels-is-withdrawn/

(4) Delay in GMC investigations

There are many circumstances where delays of up to 4 years are common in the period of 2005-16. "Delay" was being used as a weapon against many doctors in the period 2005-16. Parliament specifically set a limit of 18 months for these procedures.[12] In many case the GMC-MPTS waited for two years (18 months of Interim Orders plus 6 months High Court extension – that was almost invariably granted by the court)- before *starting* to investigate a doctor.

The aim of GMC-MPTS proceedings over this period appeared to be to "destroy" the individual doctor – either by depriving him of his livelihood or doing everything possible to ensure his destitution through delay of FTP proceedings. A number of judges commented on the delays in investigation but extensions of 6 months were invariably granted by the court as a matter of routine.

> Once the GMC had applied interim orders, it failed to evaluate evidence and progress investigations, leaving accused doctors, their livelihoods and reputations in almost perpetual limbo. In one case that has come before the High Court on two occasions, the first judge criticised delays of which a large part "could be explained 'only by inactivity on the part of the GMC for prolonged periods'". The second judge commented on a lack of urgency as astonishing as it is regrettable" and added that such delays were common. [13] [14]
>
> **Mr Justice Stuart Smith**

(5) GMC MPTS FTP procedures are flawed

5.1 The threshold for prosecution in GMC MPTS hearings

The consequences of *any* kind of GMC sanction (conditions or suspension) are "career-ending" for most doctors since the NHS is effectively a monopoly employer and all pre-employment questionnaires require an answer to a question about prior disciplinary proceedings.[15] That answer excludes sanctioned doctors from all employment bar short-term, dangerous, and expensive, NHS jobs advertised by locum agencies (the NHS now employs 16,000 locum doctors). Sanctioned doctors cannot work in the private sector because they have lost their indemnity insurance.[16]

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[12] The aim of GMC-MPTS proceedings over this period appeared to be to "destroy" the individual doctor – either by depriving him of his livelihood or doing everything possible to ensure destitution through delay of proceedings. In many cases the GMC appeared to suspend a doctor at IOP and then wait 2 years before returning to the case to arrange a hearing (18 months IOP suspension plus one 6 months extension from EWHC)

[13] Dyer C. Judge condemns delays at GMC BMJ 2014; 348:g3436

[14] Civitas Report p22 et seq for examples of difficult cases.

[15] It is not clear to this author that the legal profession including the court and GMC staff, understand this important consideration in all GMC hearings.

[16] Lawyers and judges do not express this understanding**.** They appear to believe that once a doctor has survived a GMC hearing with a non-erasure sanction then he/she can return to some form of medical employment. That is not necessarily the case.

The "realistic prospect test" of taking action against a doctors' registration is not the same as that employed by the CPS. It is a low threshold that is engaged by two Case Examiners. Given present problems in the GMC FtP procedures, a much higher threshold is necessary to justify convening an FtP panel with the possibility of removing a doctors' livelihood for the reasons set out above e.g. there is a "realistic prospect of suspending or removing a doctors' license".

5.2 The standard of proof [17]

The key step in the prosecutorial atmosphere of the GMC-MPTS FTP jurisdiction between 2008-16 was the imposition of the civil standard of proof (in place of the criminal standard of proof). This removed significant protection for doctors in GMC-MPTS hearings. The acknowledged "recipe for erasure" in those cases was "2-3 clinical cases plus some allegation that goes towards poor character". Many FtP panels simply made random findings against doctors with multiple allegations, and the NHS Trust made allegations about some, (often-fabricated) aspect of a doctors' character. Erasure or suspension were the inevitable outcomes.

Shortly after the introduction of the civil standard of proof in 2008, Paul Philip, the GMC's Director of Standards and Fitness to Practise, stated confidently that the introduction had been unproblematic, although he did add a caveat: 'We would welcome the opportunity for any directive from the High Court to say what should and shouldn't happen.' Such guidance was indeed forthcoming albeit from a legal source more senior than the High Court. In 2008 the most senior court in the UK, the House of Lords considered whether there was in fact such a sliding scale with respect to the civil standard of proof. Lord Hoffmann confirmed that there was no such thing.

The legal basis on which the GMC made its decision to adopt the civil standard of proof has proven, within a very short time, to be flawed. It is incumbent upon the GMC to review its decision to adopt the civil standard of proof with a view to returning to the criminal standard.

All doctors tried in GMC hearings between 2008-16 were subject to the civil standard of proof. Given that *any* GMC sanction (conditions, suspension, erasure) effectively deprives a doctor of his livelihood because the NHS is a monopoly employer with pre-employment declarations that enquire about disciplinary proceedings. For this reason, and others set out above, many of the clinical convictions during this period (2008-16) may be regarded as disproportionate or "unsafe".

[17] GMC:Time to reconsider the standard of proof http://www.justice4drkeilloh.org.uk/docs/e.pdf, 2013

5.3 Judicial capacity of GMC MPTS FTP panels.

Despite the widespread use of judicial templates MPTS panels fail to write adequate reasons for their judgments. Those cases that reach an appeal at the court _are regularly overturned _because of a failure to write sustainable reasons e.g. Lawrence v GMC, Walker-Smith v GMC, Meadow v GMC. The tendency of some panels to find random facts "proved" from a welter of allegations further brings the jurisdiction into disrepute. There are compelling reasons to appoint lawyers, exclusively, as MPTS panel chairs. Doctors as panel chairs are an unnecessary risk to the integrity of the jurisdiction.

5.4 Selection & empanelment of GMC MPTS FTP panellists

Unless panellists are randomly selected, there is a clear risk of appointing panels of "hawks" and "doves" in MPTS proceedings. There is clear evidence that a "hawkish" panellist frequently sits on IOP panels *guaranteeing* GMC sanctions for up to 18 months before the GMC needs to arrange a substantive FTP hearing. There is no published audit of the outcomes of sanctions delivered by individual panelllists, nor IOP proceedings. Similar considerations apply to FtP hearings.[18]

5.5 The "test of insight".[19]

Doctors can be subject to allegations resulting from their unrepresented meeting with two hospital managers, who write a separate, record of the meeting that is unfavourable to the doctor. The doctor cannot, under present MPTS rules, contest this evidence at first instance for fear of the risk of paragraph 37-38 of "Indicative Sanctions Guidance, 2014". The doctor has to accept an MPTS sanction, which may be as severe as suspension of erasure without being able to contest the primary, "fabricated" evidence upon which the sanction has been based. This evidence is endemic in GMC-MPTS proceedings and an article of faith among panellists and defence lawyers.

There is now clear evidence within NHS management that promotion to senior levels in an NHS Trust might require "being able to manage a senior doctor out of the organisation". At present this would be undetectable in MPTS proceedings for the reasons set out above. The GMC has no means of knowing about the widespread, (or otherwise) use of these other procedures (NCAS, Ombudsman, capability) against doctors by a particular NHS Trust or department. There is clear evidence that some NHS Trusts that have learned to use these procedures, and, continue to use them with enthusiasm.

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[18] A colleague who survived three separate FTP panels had the same panellist (a known "hawk") appointed in all three hearings even though they were five years apart. This suggests a "controlling" hand within the GMC that arranged prosecutions of some doctors differently from others with the empanelment of known "hawks" to guarantee an outcome in IOP and FTP cases

[19] This is an item of fact and faith among MPTS panellists and defence lawyers. The practical result of this provision is that doctors cannot present primary evidence to a panel for fear of being held guilty of a "lack of insight" that doubles their sanction. It is the "Kafka-esque" measure in the jurisdiction.

(6) GMC Performance Assessment Procedures

GMC Performance Assessment procedures are a series of written, and oral assessments with OSCE's and actor-consultations that some doctors are invited to attend. Their results are measured, using complex statistics, against groups of paid, examination candidates prior to their respective College entrance examinations. They do not relate to the context of most doctors' clinical practice. A 55 yr consultant practices an entirely different "brand" of medicine to a 28 yr trainee undertaking postgraduate examinations. The latter is dominated by textbooks and guidelines; the former will, hopefully, be dominated by an individualised and tailored approach. All doctors have access to information through the computer terminal on their desk during the consultation. (See panel findings in Chakravarti v GMC).

These performance procedures are unvalidated, and, lack the context of a doctors' medical practice in evaluating his or her fitness to practice. [20] They should be abandoned. The only form of evaluation that might be considered is a clinical evaluation in the doctors' workplace if the doctor retains the confidence of his employer.

(7) "Doctor –killers"

GMC FTP proceedings are open to any sectional interest or vexatious individual that wishes to attack a doctor with a chance of ending his, or her, career. This may be a large corporate concern such as a pharmaceutical company, individual clinicians with an "axe to grind", or, an "angry" patient who may have been misled by a clinical director.

And in the new age of managerialism there are a number of clinical directors with the dismantling of 10-20 consultant careers "on their cv". More worryingly, managing a consultant out of an NHS trust is also a necessary line on the curriculum vitae before achieving the most senior managerial ranks – it is usually called "rooting out poor performance".

(8) FTP sanctions

8.1 After erasure, the most serious sanction for a doctor is the reporting of his case by large news organizations e.g. BBC, regional newspapers, etc. that will be held on Google indefinitely. The GMC Press Office has been overactive in the communicating sanctions of individual doctors to the press. They should have no place in arbitrarily adding sanctions to those of a GMC MPTS Panel.

8.2 Not only does reporting of cases in local newspapers result in an internet record, but it may also be used to stir up spurious complaints against a doctor from patients hoping to receive compensation. There are a number of cases where a doctor survives a

[20] The GMC fails to present statistics associated with these procedures; it appears that many doctors' careers are dealt serious or fatal blows by this approach to performance. The GMC plays no role in remediation.

primary GMC MPTS hearing, that was intended to erase the doctor, and the GMC Press Office simply whips up a storm in the local press to attempt to generate further allegations.

8.3 Posting of sanctions on the GMC website has now been set for an arbitrary 20 years. This piece of disproportionate, arbitrary and gratuitous violence was one of the last acts of the "nexus of malice" before its partial dismantling. Any doctor that survives a GMC sanction for five years, maintains his clinical practice with five appraisals, should have all publication of is sanctions revoked after 5 years and permitted a clean slate to re-establish himself in good standing with the GMC and clinical practice.

8.4 A second act of gratuitous violence by the prior administration was to impose a costs regimen on doctors facing MPTS sanctions. The motive may have been the persistent number of successful appeals to the court – which is always a source of restraint on panels. However it is hardly in the interests of justice. There is no justification in installing barriers to justice in this arbitrary jurisdiction.

(9) Doctors relationships with Medical Defence Unions

It is not widely known within the medical profession that all the medical defence unions have articles within their constitutions that enable the defence union to drop the support of a doctor "at any time". And this is frequently used against doctors with GMC MPTS sanctions. As a general principle the defence unions generally pay for procedures up until the conclusion of one FtP sanction. They do not necessarily support the doctor during an appeal. They do not support the doctor during recurrent FtP procedures. This is important in this jurisdiction.

(10) Communications with doctors

The nature and timing of communications with doctors has been a major source of concern in GMC investigations. Several suicides took place within 24 hours of the receipt of GMC communications of different sorts. GMC communications often include every sheet of paper in the case; they therefore may consist of 5 reams of paper for every IOP when the only justification for the communications was to inform the doctor of the date of his next IOP. It provides a source of distress for the doctor, a problem of disposing of large volumes of duplicated, confidential information. It is significant source of PTSD following GMC investigations and sanctions.

Conclusions

1. There have been a large number of doctor's deaths in the period 2005-16. The causes may be multifactorial though the common feature was they were undergoing GMC investigations. Contrary to assertions by GMC staff, few of these doctors have been shown to suffer from mental ill-health prior to their GMC investigation. Removing key elements of the "nexus of malice" is helpful though not sufficient. The adverse prosecutorial atmosphere within the FTP jurisdiction runs much wider and deeper.

2. Many of the structures, processes and outcomes of the GMC-MPTS jurisdiction are unfair, unjust and an abuse of power. The GMC claims there has been a separation of powers between the GMC (investigation) and the MPTS (adjudication) yet many of the personnel and procedures remain unchanged and operate on both sides of the jurisdiction. GMC procedures have been widely criticized by senior members of the court e.g. Mr Justice Collins, HHJ Pelling, Mr Justice Mitting, Mr Justice Stuart-Smith, etc. There are technical problems with the threshold for investigation, the standard of proof, the "test of insight", etc.

3. Too many GMC-MPTS decisions result in successful appeals. All MPTS panels should be chaired by lawyers. They are familiar with writing judgments with reasons. Doctors are not. This imposes further protection against doctors being investigated and adjudicated by a member of their own Royal College because they have "unpopular" views. This may also minimize challenges to MPTS decisions in the courts.

4. There is a small group of medical panel chairs that have operated on both sides of the jurisdiction - as investigators and adjudicators – for many years (2001-16). This is clearly unsatisfactory. It provides the mechanism for short-circuiting the jurisdiction, "sham peer review" reports, and, setting the trajectory of the case within the jurisdiction. This small handful doctors should be investigated, and, where appropriate, prosecuted for "perverting the course of justice" as they have knowingly contributed to judicial and extra-judicial sanctions of many doctors.

5. The "test of insight" at para 37-38 of the GMC MPTS Indicative Sanctions guidance should be reserved for review hearings. Doctors must be allowed to contest primary evidence against them. This provision is precisely why GMC-MPTS proceedings are held to be Kafka-esque. At present, when a doctor faces allegations in front of a GMC MPTS Panel it is not a question of innocence or guilt, it is a question of "how guilty are you ?" Both contribute to the over-zealous, prosecutorial reputation of the jurisdiction and the appalling outcomes between 2005-16.

6. Delay in GMC MPTS proceedings. If a case cannot be investigated within 18 months then a doctor should be returned to supervised work, or, any excessive time taken off the sentence of the doctor (time served in lieu of sanction).

7. GMC Performance Assessment procedures are wholly acontextual and deployed in a wholly unsatisfactory manner. It is not fair or reasonable to compare a "stressed" doctor facing allegations that could end his livelihood, with a group of paid candidates preparing for their higher examinations (See the panel in GMC v Chakravarti). The GMC should only attempt to assess the doctor in his workplace and only in exceptional circumstances. There should be an audit of contemporary GMC Performance assessment procedures to see how many doctors have passed these procedures without fault. For the period 2005-16, these procedures simply heaped allegations on doctors, who had to cope with all sorts of malfeasance within the jurisdiction.

8. The GMC is allegedly responsible for the education of doctors. Failures of education may be one important reason for clinical referrals to the GMC for disciplinary reasons. Even after sanctions the GMC makes no attempt at remediation of doctors. There may be a compelling case for inviting locum doctors, in particular, to attend GMC educational events for their continuing professional development.

9. The GMC frequently receives complaints from vexatious or recurrent complainants. Some clinical and medical directors have accounted for the careers of 10-20 doctors for personal reasons. The GMC should investigate the origins of these complaints. Any doctor-manager participating in such activities should face appropriate charges.

10. Consideration should be given to a full judicial inquiry into the conditions that pertained in the GMC-MPTS jurisdiction, 2005-2016. Given, the recurring concerns over the integrity of the GMC jurisdiction, the judge should be asked to consider whether the GMC should play any role in the investigation and disciplining of doctors, or, whether it should be removed to another organisation e.g. as a branch of the tribunal service.

11. Doctors surviving the GMC jurisdiction with sanctions that did not amount to erasure, should have all notices of their sanctions removed from the GMC website after five years. This, particularly applies to doctors receiving sanctions during the period 2001-16 where the jurisdiction has been seriously flawed in terms of its procedures and the administration of justice.

Recommendations

(1) The GMC-MPTS FTP jurisdiction is not fit to investigate most clinical allegations as it has no insight into the context of the doctors circumstances or employment.

(2) GMC-MPTS IOP and FTP hearings should be chaired exclusively, by lawyers who understand the civil and criminal standards of proof, and, are familiar with giving reasons for judgments.

(3) All panellists appointed before 2010 should be replaced immediately. Consideration should be given to a term limit of five years for panellists which may be renewed in exceptional circumstances. Legal panel chairs may be appointed for two, five year terms depending on their audited outcomes.

(4) The threshold for prosecution, standard of proof and the "test of insight" should be re-organised. The threshold for prosecution should present a higher hurdle to GMC Case Examiners. The standard of proof should revert to the criminal standard in all hearings owing to the serious consequences of *any* adverse finding on an individual doctors career and livelihood. The "test of insight" should be reserved for review hearings.

(5) Delay in GMC investigations should be minimized. There needs to be safeguards to protect a doctors' career if investigations take more than 18 months.

(6) GMC Performance Assessment procedures should largely be dispensed with. The sole form of clinical assessment should be within the doctors' workplace.

(7) Sanctions should not include arbitrary announcements to news organisations by the GMC Press Office.

(8) The recent, decision to publish sanctions on the GMC website for 20 years is arbitrary and disproportionate. All clinical sanctions prior to 31 December 2016 are potentially unsafe. They should be removed from the GMC website after 5 years and consideration given to affected doctors being returned to good standing and allowed to return to substantive work in the NHS. There may be a case for specific review of the cases of some categories of doctors sanctioned during this period.

(9) The costs regimen imposed in the last year should be abolished.

(10) Remediation should be offered to doctors receiving sanctions.