PUBLIC RECORD

Dates: 09/06/2025 - 13/06/2025

Doctor:	Dr Allister FRANCKS
GMC reference number:	6128620
Primary medical qualification:	MB ChB 2005 University of Glasgow

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 2 months.

Tribunal:

Legally Qualified Chair	Mr Stephen Killen
Lay Tribunal Member:	Ms Sirah Abraham
Registrant Tribunal Member:	Dr Susan Ellerby

Tribunal Clerk:	Ms Keely Crabtree

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Andrew Colman, Counsel, instructed by MDDUS
GMC Representative:	Mr Paul Williams, Counsel

Attendance of Press / Public

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

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts and Impairment - 12/06/2025

FACTS

1. The Tribunal decided, pursuant to Rule 41 of the General Medical Council (GMC) (Fitness to Practise Rules) 2004 as amended ('the Rules'), that parts of this hearing would be heard in private XXX. It considered that the need to protect both Dr Francks' and Patient A's confidential information outweighs the public interest in holding the hearing in public. As such, this determination will be read in private but a redacted version will be published following the conclusion of this hearing.

Background

2. Dr Francks qualified in 2005 with a Bachelor of Medicine, Bachelor of Surgery (MB ChB) from the University of Glasgow. He was admitted as a member of the Royal College of General Practitioners in 2013.

3. Dr Francks worked in a series of locum positions in general practice, and then worked for a six-month locum period at Wellhall Medical Centre in Hamilton. He joined the partnership in that practice in 2015. Dr Francks remains a GP partner there and currently works eight sessions per week over four days.

4. The Allegation that has led to this hearing can be summarised in the following manner:

- Firstly, it is alleged that, between 1 February 2020 and 31 August 2023, Dr Francks issued a number of prescriptions to Patient A, with whom he had a close personal relationship, when he knew or should have known that he should not prescribe a controlled drug on a non-emergency basis, and he failed to seek independent clinical advice, make a record in Patient A's medical records, or inform Patient A's GP. It is

alleged that Dr Francks issued 23 prescriptions for XXX, two prescriptions for XXX and one prescription for XXX for Patient A.

- Secondly, it is alleged that, between 1 April 2021 and 31 August 2023, Dr Francks self-prescribed medicines and failed to seek independent clinical advice, make a record of the medicines and update his GP of the treatment and progress. It is alleged that Dr Francks issued six prescriptions for XXX for himself.

5. The initial concerns regarding these prescriptions were raised with the GMC by Mr C, Pharmacy Manager for Superdrug Pharmacy. The information provided indicated that Dr Francks was prescribing as outlined above and that these prescriptions were dispensed and given to Dr Francks.

The Allegation and the Doctor's Response

6. The Allegation made against Dr Francks is as follows:

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

1. Between 01 February 2020 and 31 August 2023 you issued the prescriptions as set out in Schedules 1-3 to Patient A ('the Prescriptions'), when you:

   a. had a close personal relationship with Patient A as set out at Schedule 5;
   Admitted and found proved

   b. knew or ought to have known that you should not prescribe a controlled drug on a non-emergency basis when issuing the prescriptions at Schedule 1;
   Admitted and found proved

   c. failed to:

      i. seek independent clinical advice;
      Admitted and found proved

      ii. make a record of the Prescriptions to be included in Patient A's medical records;
      Admitted and found proved

iii. inform Patient A's General Practitioner.
Admitted and found proved

2. Between 01 April 2021 and 31 August 2023 you self-prescribed the medicines in Schedule 4, when you failed to:

a. seek independent clinical advice;
Admitted and found proved

b. make a record of the medicines in Schedule 4;
Admitted and found proved

c. update your own General Practitioner of the treatment and progress.
Admitted and found proved

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

The Admitted Facts

7. At the outset of these proceedings, through his counsel, Mr Colman, Dr Francks made admissions to the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e), the Tribunal announced all of the paragraphs of the Allegation as admitted and found proved.

8. On the basis that Dr Francks admitted to the Allegation in its entirety, the Tribunal moved straight to stage 2 of the proceedings to consider the issues of misconduct and impairment.

IMPAIRMENT

9. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which have been admitted and found proved, Dr Francks' fitness to practise is impaired by reason of misconduct.

Witness Evidence

10. The Tribunal received evidence on behalf of the GMC in the form of witness statements from the following witnesses, who were not called to give oral evidence:

- Mr B, Pharmacy Manager for Superdrug Pharmacy in Newton Mearns;
- Dr C, General Practitioner Partner at Mearns Medical Centre in Newton Mearns, Glasgow; and
- Dr D, Responsible Officer ('RO'), dated 14 April 2025.

11. Dr Francks provided a witness statement in response to the Allegation which included reflections dated 1 June 2025. He also gave oral evidence at the hearing.

12. The Tribunal also received a number of positive testimonials on behalf of Dr Francks.

Expert Witness Evidence

13. On behalf of the GMC, the Tribunal received an expert report dated 12 December 2023 and two supplemental expert reports dated 21 February 2024 and 7 January 2025, prepared by Dr E, General Practitioner.

Documentary Evidence

14. The Tribunal had regard to the documentary evidence provided by the parties. This included:

- Dr Francks' and Patient A's handwritten prescriptions dated 17 August 2023;
- Dr Francks' PMR E-Messages;
- Dr Francks' Prescribing Events;
- Patient A's Prescribing History;
- Patient A's Prescribing Events Various;
- Dr Francks' reflections submitted with his rule 7 response dated 27 August 2024;
- Dr Francks' reflective Summary: Risks and Safe Practices in Prescribing, with a Focus on Controlled Drugs dated 21 November 2024;
- Dr Francks' reflections update dated 1 May 2025;
- Dr Francks' Continuous Professional Development certificates including one relating to a Professional Boundaries course, dated 7 December 2023, and one relating to a Risks and safety in prescribing for Primary Care course, dated 21 November 2024;
- Dr Francks' draft letters of apology.

Submissions on behalf of the GMC

15. On behalf of the GMC, Mr Williams submitted that the matters under consideration amount to serious misconduct, and he stated that the main focus for the Tribunal would likely be the question of impairment.

16. Mr Williams submitted that the paragraphs of the Allegation which relate to Dr Francks' self-prescribing, and those which relate to prescribing Patient A, are similar in nature and in both respects are contrary to the GMC guidance. Mr Williams submitted that the issues in this case do not arise just from the '*bare fact'* of Dr Francks' prescribing, but also from the *'concentric ring of failures that flow from that*'.

17. Mr Williams referred the Tribunal to the GMC expert reports of Dr E. He reminded the Tribunal of Dr E's opinion that Dr Francks' actions fell seriously below the standard expected of a reasonably competent GP. Mr Williams stated that, given the lack of impartial oversight, Dr Francks' actions could have caused both Dr Francks and Patient A to be on a sub-optimal or even unsafe treatment plans.

18. Mr Williams reminded the Tribunal of the extensive period of time over which Dr Francks' actions occurred, some three and a half years regarding prescriptions for Patient A, and over two years for prescriptions for himself.

19. Mr Williams referred to aspects of Dr Francks' oral evidence, such as his explanation that *'[Patient A] would run out of medications, and I would fill the gap'*. Mr Williams submitted that, while one could imagine a situation where [Patient A], perhaps once or twice, on a rare occasion, forgot to renew their prescription, Dr Francks' actions in prescribing over and over again without saying no, really did fall very far below the required standard. Mr Williams said that this was a highly unusual situation and was an indication of the reckless approach Dr Francks took to the prescribing guidance.

20. Mr Williams referred to Dr Francks' evidence that he had been *'arrogant'* at the time of the index events and that part of his thinking was *'other doctors do it'*. Mr Williams said that Dr Francks had also used the term *'rigmarole'* in his initial reflections, which goes towards his attitude at the time.

21. Mr Williams stated that Dr Francks was not in any way forced, driven or compelled to continue his repeated and persistent actions. They were entirely actions of his own free choice.

22. Mr Williams reminded the Tribunal of Dr E's expert report in which he opined:

> '*Due to the potential harmful nature of such prescribing, I am of the view that each and every issue of these medications (XXX) fell seriously below the standard expected of a reasonably competent GP. It would be expected that these medications being prescribed by a non-impartial clinician may not have been in Patient A's best interests.*'

23. Mr Williams stated that there was a real risk of potential harm to Patient A, as there was no independent clinical oversight and XXX carries with it the risk of being addictive. Mr Williams said that, whilst it was accepted in one sense that Dr Francks had [Patient A's] best interest at heart, the reality was it was not in her best interests at all, and he should not have repeatedly prescribed for her over that extended period of time.

24. Mr Williams stated that Dr Francks had drawn other professionals into his actions. He reminded the Tribunal of the witness statements of Mr B and Dr C and submitted that Dr Francks had put both of them in a very difficult and professionally embarrassing situation.

25. Mr Williams stated that once Dr Francks was *'caught'*, he accepted the situation. He submitted that it is proper to acknowledge that Dr Francks did accept responsibility during the course of this hearing and at earlier stages during the investigation. However, Mr Williams submitted that Dr Francks ought not to have needed to be caught and he could and should have brought his course of conduct to an end by his own volition. In this regard, Mr Williams submitted that Dr Francks accepted that he knew at the time that he was prescribing that he was doing so in breach of the applicable guidance.

26. Mr Williams submitted that Dr Francks does have some insight and has been working on this. However, he invited the Tribunal to conclude that he was not quite '*there*' yet, and his insight is not full or well-embedded. Mr Williams said that this issue goes to the risk of repetition, albeit that he submitted that the risk of repetition is relatively low in the current circumstances.

27. Mr Williams submitted that the passage of time and evidence of reflection and remediation do not meet the nature, seriousness and gravity of Dr Francks' actions in this case. He referred to Dr Francks' actions as blatant and wilful breaches of GMP.

28. Mr Williams reminded the Tribunal of the overarching objective. He said that part of the Tribunal's role was to declare and uphold proper standards of behaviour and provide a benchmark of what is expected of the profession as a whole.

29. Mr Williams submitted that a finding of impairment is necessary to underline that Dr Francks' conduct was deeply inappropriate and fell seriously below the required standard.

Submissions on behalf of Dr Francks

30. On behalf of Dr Francks, Mr Colman submitted that, although it is a matter for the Tribunal's judgment, Dr Francks does not dispute that the admitted facts amount to serious misconduct.

31. Mr Colman submitted that Dr Francks had developed deep and sincere insight into his misconduct, as demonstrated by the evidence provided of his extensive and impressive reflections. Further, he submitted that Dr Francks had thoroughly absorbed the lessons of the targeted remedial education that he has undertaken, and had taken that learning profoundly to heart.

32. Mr Colman stated that Dr Francks has acknowledged each of his actions as set out in the Allegation.

33. Mr Colman submitted that, what matters today is not how Dr Francks thought at the time of his actions, but how his insight has grown and developed since. He submitted that a description of Dr Francks as having only some insight is '*ungenerous*'.

34. Mr Colman submitted that professional regulation is a protective, not punitive, regime, and one of its aspirations is to encourage a degree of reflection and remediation in practitioners who have transgressed. He submitted that the public can understand how a repentant doctor who has thoroughly learnt from his mistakes is unlikely to repeat them, particularly having *"undergone a rigorous disciplinary assessment of his fitness to practise, resulting in a finding of misconduct on his record*". Mr Colman submitted that the regulatory process, of itself, can be sufficient to maintain public confidence in the medical profession.

35. Mr Colman submitted that fellow professionals too can, in that way, be reminded of the need to uphold proper standards, while at the same time being assured that they are not expected to maintain some inhuman level of perfection in their practice. If they make

mistakes or errors of judgment, they can learn from them and their regulator will appreciate that and make appropriate allowance.

36. Mr Colman submitted that, having read the detail of Dr Francks' reflections, and having heard his honest admissions and genuine testimony, the Tribunal may have no doubt that the health, safety and well-being of the public are safe in his hands. He stated that Dr Francks' GP partners, who know him best, certainly take that view in their testimonials; describing how his behaviour was not in line with his normal, meticulous character, and they speak of his deep embarrassment and extreme remorse. Mr Colman submitted that there will be no repeat of Dr Francks' misconduct.

37. Mr Colman submitted that the Tribunal may think that Dr Francks has done everything possible to rectify his errors and to make amends. He said that Dr Francks' draft apologies to the referring pharmacist, his own GP, [Patient A's] GP and to his partners are humble, gracious and perceptive. Mr Colman stated that Dr Francks has held off sending the letters of apology only so that there could be no suggestion he was trying to sway the witnesses while his regulatory process is ongoing.

38. Mr Colman submitted that it was unfortunately all too easy for Dr Francks to slip into breaching the boundaries which circumscribe prescribing. It has been harder for Dr Francks to come to terms with what he did, but he has done so with rigorous candour and resolve. Mr Colman said the Tribunal might therefore conclude that, despite the numerous instances of this misconduct over an extended period, it is nevertheless conduct which is easily remediable, that has been remediated and that it is highly unlikely to be repeated. Mr Colman submitted that, if the Tribunal considered Dr Francks' remediation to be sufficient, not just to ensure patient safety, but also to meet the wider public interest, then there would be no need and no basis for a finding of impairment.

The Tribunal's Approach

39. The Tribunal reminded itself that, at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

40. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: firstly it must consider whether the facts as found proved amount to misconduct which was serious; and secondly, whether such misconduct leads to a finding of impairment.

41. In deciding whether Dr Francks' fitness to practise is impaired, the Tribunal has exercised its own judgement and borne in mind the statutory overarching objective of the GMC set out in Section 1(1B) of the Medical Act 1983 to:

> *'a. Protect, promote and maintain the health, safety and well-being of the public,*
> *b. Promote and maintain public confidence in the medical profession, and*
> *c. Promote and maintain proper professional standards and conduct for members of that profession.'*

42. The Tribunal must determine whether Dr Francks' fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then.

43. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the Fifth Shipman Report, as endorsed by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin.* The Tribunal should therefore consider whether the practitioner:

> *'a. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> *b. Has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> *c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
> *d. Has in the past acted dishonestly and/or is liable in the future to act dishonestly in the future.'*

The Tribunal's Determination on Impairment

Misconduct

44. The Tribunal first considered whether the proved facts amounted to serious misconduct. It noted that Mr Colman did not seek to persuade the Tribunal that Dr Franck's admitted actions were not such that they would amount to serious misconduct.

45. The Tribunal had regard to GMP (2013), and it considered that the following paragraphs were engaged and breached by Dr Francks in this case:

'12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work

15 you must provide a good standard of practice and care. If you diagnose or treat patients, you must:

…

c refer a patient to another practitioner when this serves the patient's needs

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs

…

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

46. The Tribunal also had regard to GMC Guidance on *Good practice in proposing, prescribing, providing and managing medicines and devices April 2021,* and it considered the following paragraphs to be engaged and breached by Dr Francks:

'66 Wherever possible, you must avoid prescribing for yourself or anyone you have a close personal relationship with.

67 If you prescribe any medicine for yourself or someone close to you, you must:

a. *make a clear record at the same time or as soon as possible afterwards; the record should include your relationship to the patient, where relevant, and the reason it was necessary for you to prescribe*

b. *follow the advice on information sharing and safe prescribing in paragraphs 26 to 32 and 52 to 57.*

68 You must not prescribe controlled drugs for yourself or someone close to you unless:

a. no other person with the legal right to prescribe is available to assess and prescribe without a delay

b. emergency treatment is immediately necessary to avoid serious deterioration in health or serious harm.'

47. The Tribunal had regard to, and accepted, the unchallenged evidence of Dr E in his expert report dated 12 December 2023, as follows:

'…self-prescribing should be avoided 'wherever possible,' I opine that Dr Franck's alleged ongoing self-prescribing of [XXX] on an ongoing basis fell seriously below the standard expected of a reasonably competent GP. There was no independent clinical oversight of Dr Francks' condition to ensure that the medication was being prescribed safely and effectively, and that no other medications or modalities of treatment would be more suitable to ensure Dr Francks' symptoms, whatever they were, were being treated in the best possible way and that he was not likely to come to harm due to under treatment.

…

It is certainly against GMC prescribing guidance, … to be issuing medication to family/friends on an ongoing basis, in the way it is alleged that Dr Francks did. This being the case, I deem Dr Francks' ongoing prescribing to fall seriously below the standard expected of a reasonably competent GP, due to the fact that there is a lack of impartiality between the prescriber and the recipient which may mean that the treatment plan provided is not truly in the patient's best interests. My contention for this is strengthened in this case given that, as noted above, prescribing controlled medication (which includes XXX) on anything other than an emergency basis contravenes explicit GMC guidance.

…

I contend that the ongoing prescribing by Dr Francks' of [XXX] for himself, and XXX for [XXX], Patient A, lead his overall care of himself and Patient to fall seriously below the standard expected of a reasonably competent GP, given that the lack of impartial oversight may have led both himself and Patient to be on a suboptimal, or even unsafe, treatment plan.'

48. Taking the available evidence into account, the Tribunal concluded that Dr Francks' actions in prescribing for himself during a period of over two years, and in prescribing for [Patient A] over a period of three and a half years, fell far below the standards expected of a doctor, and were in breach of GMP guidance, which Dr Francks accepts that he was aware of. They brought the profession into disrepute and placed both Patient A and himself at risk, in circumstances in which there was no objective clinical oversight of his prescribing XXX. No substantial reasons were offered by Dr Francks for his actions other than, in short summary, convenience and arrogance. The Tribunal was in no doubt that the misconduct in this case amounted to serious professional misconduct, of a nature that it would be regarded as very serious by members of the public and the profession generally. It considered that Dr Francks' actions were such that they engaged all three limbs of the overarching objective.

49. The Tribunal therefore concluded that Dr Francks' actions as set out in the Allegation amounted to serious misconduct.

Impairment

50. Having determined that the facts found proved amounted to serious misconduct, the Tribunal went on to consider whether, as a result, Dr Francks' fitness to practise is currently impaired.

51. As outlined above, the Tribunal considered Dr Francks' misconduct to be very serious. It was concerned by the repeated and persistent nature of his misconduct, occurring as it did over the course of some three and a half years in respect of Patient A, and over two years in respect of himself. The Tribunal considered that there were many opportunities for Dr Francks to desist in his course of action and to adopt a different approach. However, it was only when his actions were identified by others that he ceased his improper conduct. Dr Francks' actions served to undermine the necessary systems in place to ensure that medications, in particular controlled medications, are properly dispensed and recorded. As indicated above, no significant reason was advanced for Dr Francks prescribing for himself or Patient A, and there were clear risks to himself and Patient A associated with his actions.

52. Dr Francks' account as to why he acted as he did, appeared to the Tribunal to be along the lines that his actions were the result of lapses in judgment as it was inconvenient for him and [Patient A] to follow the correct procedures, and he said that he was '*bridging the gap'* for periods where [Patient A], in particular, had neglected to obtain a repeat prescription. The Tribunal was, as Dr Francks will no doubt expect, unimpressed by this explanation. His approach did indeed demonstrate the hallmarks of what he himself

described as *'arrogance'*. Dr Francks, as an experienced GP, knew of the importance of the prescribing guidance and he knew of the available options for properly obtaining prescribed medication for both himself and [Patient A].

53. However, that being said, having taken all of the available evidence into account in the overall context of this case, the Tribunal did determine that Dr Francks' misconduct is capable of remediation.

54. Dr Francks has engaged openly with his regulator and has also taken steps to remediate his misconduct. The Tribunal also acknowledged that Dr Francks' actions, although repeated, persistent and protracted, occurred in an otherwise unblemished career.

55. The Tribunal noted that there are no clinical concerns regarding Dr Francks' practice, and it also noted from the available testimonials that he is considered to be a skilled and experienced GP. The Tribunal noted that those persons who have provided a testimonial are aware of the issues under consideration by this Tribunal and they have commented that Dr Francks has expressed significant remorse and shame at his actions.

56. Dr Francks has undertaken targeted CPD courses which are relevant to his misconduct and his steps towards remediation. In this regard, however, the Tribunal considered it important to note again that Dr Francks' actions were not borne out of a misunderstanding of the applicable guidance / policies. Rather, Dr Francks knowingly opted to contravene that guidance. In those circumstances, while acknowledging Dr Francks' proactive steps in attending the targeted courses, the Tribunal considered that the real issue in this case is Dr Francks' own insight into his misconduct and why it was so unacceptable.

57. In this regard, the Tribunal considered that Dr Francks provided reasonably detailed and extensive evidence in his witness statement and reflective statements, which it accepted does demonstrate relatively significant insight into his misconduct. It noted that his insight could be said to have been developing across the statements. For example, in his latter statement he reflected upon his own use of the word *'rigmarole'* and other language which could be read as potentially minimising his actions, and clarified that he did not seek to do so. Dr Francks has indicated that he would never repeat his misconduct and he has learned a very significant lesson from these regulatory matters.

58. The Tribunal acknowledged that Dr Francks has from an early stage made full and frank admissions and it considered that he has expressed significant reflection, remorse and

insight in his witness statement and reflective statements. It noted, for example, the following excerpts from this reflections update, dated 1 May 2025:

> *'Reflections Update - 1 May 2025*
> *I fully and wholeheartedly admit the allegations made against me. On deeper reflection, I recognise that my actions constituted a gross breach of professional standards. Self-prescribing and prescribing for [Patient A] were serious lapses in judgement, and I express genuine remorse for failing to follow the proper procedures and guidance.*
> *…*
> *I have felt profoundly embarrassed and ashamed. My professional reputation—once a source of pride—now feels deeply compromised, and I am acutely aware that any erosion of my patients' trust could directly affect the quality of care I provide. I feel diminished in their eyes, and every clinical encounter now carries the weight of my mistake. I am committed to rebuilding confidence through openness, consistency, and a renewed focus on professionalism. This experience has been a course-correcting event and a powerful learning opportunity.*
> *…*
> *I have reflected deeply on how convenience and familiarity blinded me to the essential purpose of independent clinical oversight. …*
>
> *I am grateful for the Case Examiners' feedback and accept their concerns without reservation. They noted that although I acknowledged [XXX] is a controlled drug, I did not provide a detailed account of why this is significant or reflect fully on the implications of prescribing it without oversight. I understand now that this omission undermined the completeness of my insight and appeared to minimise the seriousness of my conduct. [XXX] contains[XXX], an opioid, and is a Schedule 5 controlled drug. Repeated administration of opioids, even at therapeutic doses, carries a real risk of dependence, tolerance, and misuse. Patients may escalate their use to maintain the same effect, develop psychological or physical dependence, and struggle with withdrawal if the medication is reduced or stopped. These risks necessitate structured, regular review—something that can only be achieved through professional detachment and objective monitoring.*
>
> *By prescribing [XXX] for [Patient A], I bypassed this essential oversight. Even though I believed her treatment was stable and familiar, I failed to recognise that long-term*

opioid prescribing demands active evaluation, a questioning of ongoing need, and openness to alternative strategies.

I understand now that she may not have been receiving the optimal care for her condition. Without independent assessment, there was no formal opportunity to consider side effects, functional impact, or potential signs of dependence.

Even with [XXX] knowledge, I was not in a position to objectively evaluate her as a clinician should. This was a failure of clinical judgement and a breach of my duty to protect and promote safe prescribing practice. It is also deeply concerning that I did not ensure any formal records of these prescriptions were kept. There was no communication with her GP, no documentation of my clinical rationale, and no accountability within her medical records. This left gaps in her care, introduced risk, and fell far short of the standards expected of me. Controlled drugs require additional safeguards precisely because of their potential for harm, and I now recognise the gravity of having disregarded these responsibilities.

…

Ultimately, although this has been a painful experience, it has also strengthened my commitment to professional growth and ethical integrity. I am determined to transform my shame into a constructive driver for change. I continue to engage in further CPD and reflective practice, and I am fully committed to restoring confidence in my professionalism and ensuring that I never repeat these mistakes. From this point forward, every step I take in my clinical practice will be guided by transparency, humility, and an unwavering respect for the standards expected of me.

59. The Tribunal also noted evidence of reflection, remorse and insight in his witness statement, as follows:

'5. … This was not a situation where I lacked knowledge of the rules—I was aware of the professional expectations around prescribing for oneself or family members. My failing was not in understanding but in mindset. I had rationalised my actions over time, telling myself I was helping, that it was convenient, that it made no practical difference. … Following the start of the investigation, I revisited the GMC's Good Medical Practice and the supplementary guidance on prescribing and managing medicines and devices. While I had previously read these documents, reviewing them again with the benefit of hindsight and reflection brought home the seriousness of my breach. The guidance is unambiguous: doctors must avoid self-prescribing or prescribing for close family members unless no other suitable medical practitioner is

available, and only in exceptional circumstances. My decision to prescribe for myself and [Patient A] was a clear and unjustifiable breach of these standards.

13. I have reflected a lot about my behaviour since the GMC investigation began. When I first received the telephone call from the GMC, my perspective shifted immediately.

14. I accept the conclusions of the GMC's expert report from Dr E, in particular, that my conduct was seriously below the standard expected of a registered practitioner.

19. … I acknowledge that prescribing for [Patient A] was inappropriate and potentially placed her at risk by bypassing independent clinical oversight and disrupting the continuity of her care. … I wish to emphasise that my understanding of the seriousness of this breach has deepened significantly since my initial response to the Rule 7 letter.

20. … I was not providing clinical oversight, merely access. My failure to document these prescriptions or communicate with her GP meant that her medical records were incomplete, and her GP was not given the opportunity to assess ongoing need, side effects, or potential alternatives. … I now understand that this was a breach not just of professional boundaries but of mutual respect between colleagues, and I regret placing her GP in this position.

21. I appreciate that my conduct likely caused distress to Mr [B], the pharmacist who raised concerns about my prescribing with the GMC. I am sure he did not take such action lightly and would have been aware of the implications this could have for me professionally. I deeply regret putting him in that position. I recognise that raising concerns about a fellow healthcare professional is extremely difficult and can carry emotional weight.

22. I recognise that my decision to self-prescribe also had an impact on my own GP, who had to take over my [XXX] prescribing in the middle of [XXX] rather than at the start. This denied them the opportunity to assess me from the outset and build a therapeutic relationship over time. I also failed to model the kind of patient behaviour I would expect and encourage in others, by avoiding the proper process.

23. My conduct has also affected my GP partners at Wellhall Medical Centre. I recognise that any concern involving the GMC reflects not only on the individual but also on the practice and the wider team. The trust placed in us by our patients and

community is vital, and I am painfully aware that my actions may have risked undermining that trust. I have discussed the investigation with all my GP partners … I have been open and honest with my GP partners Drs [F], [G], [H] and [I] about the investigation, including the nature of the allegations. I am grateful that they have responded with understanding and support, but I do not take that for granted.

24. I have thought carefully about how my conduct may affect my patients, both directly and indirectly. Patients rightly expect their doctor to uphold the highest professional standards, and to act with integrity, objectivity, and good judgement. By self-prescribing and prescribing for a close family member, I compromised those standards and risked eroding the trust that patients place in me and in the medical profession more widely. Even if patients were not aware of what I had done, any undermining of professional boundaries ultimately weakens the foundation of safety and trust that underpins the doctor–patient relationship. Since these events, I have worked hard to be fully transparent in my clinical practice, ensuring that every interaction is guided by professional integrity, humility, and reflection.

25. … It is difficult knowing that I may have lost the respect of people I work alongside. I hope that, in time, I can demonstrate through my behaviour and commitment to safe practice that I have taken full responsibility for what happened and that I am continuing to learn and grow from it.

26. The experience of self-prescribing, and the GMC investigation that followed, has had a profound impact on me. Personally, I have felt deep embarrassment, shame, and disappointment in myself. Professionally, I feel that I have let down those who trusted me, including colleagues and patients, and I have damaged the reputation I worked hard to build. The emotional toll has been significant; at times I have struggled with the weight of the process and the fear of how it might end. … I accept that my actions were serious, and I am prepared to face the consequences with humility and honesty.'

60. The Tribunal accepted that the risk of repetition of Dr Francks' misconduct in this case is relatively low. The consequences of his misconduct, in and of themselves, are likely to ensure that Dr Francks is very unlikely to repeat his actions. Further, the Tribunal considered that Dr Francks has provided reasonably significant evidence of having fully accepted his actions, of reflecting upon them and having taken steps to remediate them.

61. In addition, as indicated above, the Tribunal was provided with draft letters of apology which Dr Francks has not yet sent, pending conclusion of the regulatory proceedings, which appear to broadly acknowledge his misconduct and the impropriety of his actions.

62. Whilst accepting that Dr Francks is now very unlikely to repeat his misconduct, and whilst accepting that Dr Francks has taken significant steps toward developing insight and remediating, the Tribunal did, however, consider Dr Francks' written evidence was, perhaps, clearer and more unequivocal than his oral evidence, in terms of his insight. For example, when asked in his oral evidence about the risk his prescribing caused to himself or Patient A, Dr Francks did not appear to fully appreciate the implications of his actions. He referred to there being '*a spectrum of risk*' and, when questioned about the risks associated with opioid based painkillers, he focused on the risks associated with tolerance to the medication. However, Dr Francks did not immediately appear to fully identify the risks to his or Patient A's health in circumstances in which his prescribing was not known to his or Patient A's GP and there was no objective oversight.

63. In the circumstances, and taking into account the evidence of Dr Francks' evolving insight within his three statements, the Tribunal considered that, whilst significant steps towards gaining full insight have been taken by Dr Francks, his insight into his misconduct is still developing.

64. Overall, taking all of the available evidence into account, the Tribunal determined that a finding of impairment is currently required to meet limbs 2 and 3 of the overarching objective.

65. Given its findings in respect of the relatively low risk of repetition and the fact that there are no clinical concerns in this case, although limb 1 was engaged by Dr Francks' misconduct, the Tribunal did not feel that a finding of impairment is currently required to meet its objectives.

66. The Tribunal determined, however, that, given its findings in respect of the serious nature of Dr Francks' misconduct, together with those matters outlined above, public confidence in the profession would be undermined if a finding of impairment was not made in this case. A finding of impairment is also necessary to promote and maintain proper professional standards and conduct for members of the profession.

67. The Tribunal has therefore determined that Dr Francks' fitness to practise is impaired by reason of his misconduct.

Determination on Sanction - 13/06/2025

68. This determination will be handed down in private. However, as this case concerns Dr Francks' misconduct, a redacted version will be published at the close of the hearing.

69. Having determined that Dr Francks' fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

70. Where relevant to reaching a decision on sanction, the Tribunal has taken into account the evidence it received during the earlier stages of the hearing, together with its own conclusions on that evidence.

Submissions

On behalf of the GMC

71. On behalf of the GMC, Mr Williams submitted that the proportionate sanction in this case was one of suspension, with a review hearing directed. He said the GMC did not seek to make any submissions in respect of the length of the period of suspension and that this is a matter for the Tribunal's own judgement

72. Mr Williams reminded the Tribunal that the purpose of a sanction is not intended to be a punishment for the doctor, but to reflect the seriousness of the findings. He said that the Tribunal should take in to account the nature and gravity of Dr Francks' misconduct and the wider evidential context, for example, how his actions drew in other professional colleagues, such as Mr B and Dr C, and how they will have been affected.

73. Mr Williams reminded the Tribunal of its findings as set out in its determination on impairment. He referred to paragraph 45 in which the Tribunal referred to Dr Francks' breaches of GMP. He stated that any breach of GMP was relevant at this stage, and that it was important to note that Dr Francks' actions were neither accidental nor reckless breaches of GMP, but were instead both knowing and intentional, which makes the breaches more serious.

74. Mr Williams submitted that Dr Francks knowingly decided to breach the applicable guidelines, and his misconduct therefore represents a behavioural problem which was repeated and persistent over a very extended period of time. He reminded the Tribunal of its finding that there had not been a substantial explanation put forward from Dr Francks other than *'convenience and arrogance'*.

75. Mr Williams referred to the Tribunal's finding that Dr Francks' misconduct was capable of remediation and reminded it of its findings that Dr Francks had engaged openly with his regulator, made full and frank admissions, taken steps to remediate his conduct and expressed significant remorse. He referred the Tribunal to its findings in respect of Dr Francks' insight into his misconduct. Mr Williams reminded the Tribunal that it had determined that Dr Francks had developed relatively significant, but not yet full, insight. Mr Williams referred to the Tribunal's findings that Dr Francks' actions were repeated, persistent and protracted but occurred in an otherwise unblemished career, and to its findings that the risk of repetition was relatively low.

76. Mr Williams submitted that Dr Francks is on a journey and has made quite a lot of progress. However, he said that the journey is not yet complete in terms of his remediation.

77. Mr Williams stated that it would be deeply inappropriate for there to be no action taken in this case given the gravity of these matters.

78. Further, Mr Williams submitted that conditions would not meet the gravity of the concerns in this case, nor the factual circumstances given, for example the persistent nature of the misconduct. He submitted that an order of conditions would not meet the requirement of 'workability' because the issues under consideration relate to behavioural and attitudinal problems.

79. With regard to suspension, Mr Williams referred the Tribunal to paragraph 91 of the Sanctions Guidance (SG). He stated that this was exactly the type of case where suspension would be appropriate, given the context of Dr Francks' misconduct. He submitted that there is a need for a deterrent effect and to send a clear message to the doctor, the profession and the public about what is regarded as behaviour unbefitting a registered doctor.

80. Mr Williams referred the Tribunal to paragraph 92 of the SG. He said that, although Dr Francks' misconduct was serious and prolonged, it was set in the context of him being a good clinician with an unblemished career prior to the index events. He submitted that Dr Francks'

misconduct was not fundamentally incompatible with continued registration and that erasure would be inappropriate.

81. Mr Williams referred the Tribunal to paragraph 93 of the SG and submitted that, given the Tribunal's findings, this case falls square within the guidance in that paragraph. In addition, Mr Williams invited the Tribunal to consider paragraphs 24 to 49 of the SG.

82. Mr Williams referred the Tribunal to paragraph 97 of the SG. He submitted that sub paragraphs a, e, f and g were particularly relevant to the Tribunal's previous findings at the impairment stage.

On behalf of Dr Francks

83. Mr Colman submitted that the Tribunal's finding of impairment is, of itself, a regulatory reproach which will tarnish Dr Francks' reputation. He submitted that the Tribunal may consider that this is sufficient to meet the overarching objective in this case. Mr Colman went on to submit that, if the Tribunal does not agree, and considers that a clearer signal of disapproval is necessary to meet the second and third limbs of the overarching objective, it should go on to consider the available sanctions in ascending order.

84. Mr Colman submitted that conditions can be appropriate where there is evidence of shortcomings in a specific area or areas of the doctor's practice [paragraph 81c of the SG]. He referred the Tribunal to paragraph 84 of the SG as follows:

> *'84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:*
>
> *a no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage*
>
> *b identifiable areas of their practice are in need of assessment or retraining*
>
> *c willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety (Good medical practice, paragraphs 1-5 (Being Competent) and 11-13 (Maintaining, developing and improving your performance) 2*

d willing to be open and honest with patients if things go wrong (Good medical practice, paragraphs 45-46)

XXX'

85. Mr Colman submitted that all of these factors could be applied to Dr Francks' case. He said that Dr Francks has scope, as the Tribunal have found, for developing further insight, beyond that which he displayed when under the pressure of cross-examination. Mr Colman stated that, while Dr Francks' remedial education on boundaries etc may have simply reinforced the simple rules of which he was already aware, the subject of controlled drugs is more complex, particularly in the context of the different schedules.

86. Mr Colman reminded the Tribunal that it had determined that Dr Francks' misconduct is capable of remediation. He submitted that conditions would allow Dr Francks to complete his remediation while sending a message to the public and the wider profession about the unacceptability of his previous misconduct. Mr Colman referred the Tribunal to the MPTS conditions bank, in particular C25, 26 and, C32, he said that these conditions are directly applicable.

87. Mr Colman submitted that, beyond the seriousness of the misconduct, which the Tribunal has already considered when finding impairment, there are no other aggravating features in this case. He said that the description of the misconduct as a behavioural problem, repeated persistently, would be more relevant if the Tribunal were seeking to punish Dr Francks for the nature and duration of his transgressions. However, the Tribunal's role is to consider what is necessary for public protection today, based on how Dr Francks is now, not just on what he did in the past.

88. Mr Colman submitted that there is considerable evidence of mitigation including the degree of remediation already achieved, the evidence of Dr Francks' good character and professionalism, Dr Francks' evident remorse, apologies and the detailed nature of his insightful written reflections.

89. Mr Colman stated that Dr Francks is a skilled, experienced and highly valued GP, working in a time of national shortage. He submitted that suspension would be injurious to his patients and burdensome to his partners, who would have to pick up his clinical and administrative duties. In that way, Mr Colman submitted that suspension could positively undermine the vital first limb of the overarching objective.

90. Mr Colman also submitted that that the Tribunal should take into account the effect of a period of suspension on Dr Francks himself. He said that such a sanction would deprive him, at least for the period of the sanction, of the ability to earn his living by exercising his profession. Mr Colman submitted that suspension was neither necessary nor proportionate, where the sanction of conditions can better promote all three of the aims of regulation. Further, Mr Colman referred to the nature of the medication Dr Francks' self-prescribing, XXX. Mr Colman submitted that this may be relevant as Dr Francks' XXX may have had a bearing on his judgment at the relevant time.

The Tribunal's Approach

91. The Tribunal reminded itself that the decision as to the appropriate sanction, if any, to impose is a matter of its own judgement, and that there is no burden of proof on any party and no standard of proof to be met.

92. In reaching its decision, the Tribunal has given careful consideration to the SG. It has borne in mind that the purpose of a sanction is not to be punitive although it may have a punitive effect. The Tribunal recognises that every case will necessarily turn on its own set of circumstances and facts.

93. The Tribunal has borne in mind that in deciding what sanction, if any, to impose, it should consider the sanctions available, starting with the least restrictive.

94. Throughout its deliberations, the Tribunal has taken into account the overarching objective, and it has applied the principle of proportionality, balancing Dr Franks' own interests with the public interest.

95. When considering the principle of proportionality, the Tribunal has had regard to the judgment in the case of *Bolton v. Law Society* [1994] 1 WLR 512, in which Sir Thomas Bingham stated that '*the reputation of the profession is more important than the fortunes of any one individual member. Membership of a profession brings many benefits, but that is part of the price'.*

96. The Tribunal has also had regard to the case of *Raschid and Fatnani v. The General Medical Council* [2007] 1 WLR 1460, in which Laws LJ stated that the functions of a fitness to practise tribunal are quite different from those of '*a court imposing retributive punishment'*

since *'the panel ... is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor'.*

97. The Tribunal had regard to the statutory overarching objective in section 1 of the Medical Act 1983 throughout its deliberations.

The Tribunal's Determination on Sanction

98. Before considering what action, if any, to take in respect of Dr Francks' registration, the Tribunal considered the aggravating and mitigating factors in this case.

Aggravating factors

99. The Tribunal considered the following to be aggravating factors in this case:

- Dr Francks misused his position as a doctor for his own personal convenience in prescribing medication for himself and Patient A;
- Dr Francks' conduct was persistent and protracted over a three and a half year period;
- Dr Francks put both himself and Patient A at risk of harm;
- Dr Francks was an experienced GP at the time of the index events, and his actions were wilful breaches of the applicable guidelines.

Mitigating factors

100. The Tribunal considered the following to be mitigating factors in this case:

- Dr Francks has taken reasonably significant steps to remediate his misconduct;
- Dr Francks has developed significant insight during the regulatory process, albeit that the Tribunal considered that insight into the risks to himself and Patient A is not yet fully developed;
- Dr Francks made full and frank admissions at an early stage and has expressed regret and remorse;
- Dr Francks has no previous adverse findings against him;
- Dr Francks has provided testimonials which indicate that he is a skilled, experienced and valued clinician.

101. The Tribunal also had regard to the witness statement of Dr Francks' RO, in which the following was stated:

> *'Dr Francks continues to work as a GP principal in Wellhall Medical Centre in Hamilton, Lanarkshire. This is a large urban practice of approximately 12,000 patients. He has reported at appraisals over the last two years that he continues to keep his partners in the practice updated on the ongoing GMC investigation.*
>
> *Outwith the concerns which have been raised regarding Dr Francks's self-prescribing and prescribing to others, he is in good standing, and no other concerns have been raised with me regarding his current clinical practice or personal integrity.'*

102. The Tribunal had regard to Mr Colman's submissions regarding Dr Francks' XXX and it considered whether any material weight could be placed on this as a mitigating factor. The Tribunal noted that it did not receive any expert or objective evidence relating to the nature of Dr Francks' XXX, or the potential or actual impact of it on his actions. Although some reference to these issues is made in Dr Francks' letters of apology and Dr C's witness statement, neither Dr Francks' written statement evidence, nor his oral evidence, appeared to the Tribunal to suggest that he considered his judgment was adversely affected at the relevant times. In those circumstances, the Tribunal did not feel that it could attach any significant weight to Dr Francks' XXX as a mitigatory factor.

103. Throughout its deliberations on the appropriate and proportionate sanction to impose, if any, the Tribunal had in mind the aggravating and mitigating factors. It also reminded itself that Dr Francks' misconduct is capable of remediation. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

No action

104. The Tribunal first considered whether to conclude the case by taking no action. The Tribunal determined that there are no exceptional circumstances in this case which would justify the taking of no action. The Tribunal considered that, in the context of the admitted misconduct which involved repeated serious departures from GMP and other guidance over a protracted period of time, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

105. The Tribunal next considered whether to impose conditions on Dr Francks' registration. In so doing, it bore in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable. It had regard to the SG, in particular paragraphs 80 to 82 and 84.

106. The Tribunal determined that the imposition of conditions on Dr Francks' registration would not be appropriate in light of the wilful, repeated and persistent nature of the misconduct under consideration, occurring as it did over the course of some three and a half years.

107. The Tribunal noted that condition C32 in the MPTS Conditions Bank would be of potential application in this case, as was referred to by Mr Colman. However, taking into account the overall circumstances of Dr Francks' misconduct, the Tribunal considered that the imposition of conditions on his registration would not be appropriate as such a sanction would not be sufficiently robust as to promote and maintain public confidence in the medical profession and promote and maintain proper professional standards and conduct for members of the profession.

108. In the circumstances, the Tribunal determined that the imposition of conditional registration would not meet the public interest in the circumstances of this case. It considered conditions would not be sufficient to mark the seriousness of Dr Francks' misconduct.

Suspension

109. The Tribunal next considered whether it would be appropriate and proportionate to suspend Dr Francks' registration.

110. The Tribunal considered the SG in relation to suspension including paragraphs 91 and 92, which state:

> *'91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*

92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).'

111. The Tribunal recognised that a sanction of suspension does have a deterrent effect and can be used to send a signal to Dr Francks, the profession and the public about what is regarded as behaviour unbefitting a registered doctor. It also acknowledged that suspension is an appropriate response to misconduct which is sufficiently serious that action is required in order to maintain public confidence in the profession, but which falls short of being fundamentally incompatible with continued registration.

112. The Tribunal also had regard to paragraph 97 of the SG which sets out some of the circumstances in which suspension may be the appropriate sanction. The Tribunal considered sub paragraphs a, e, f and g to be engaged in this case:

'97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than suspension would not be sufficient to protect the public or maintain confidence in doctors.

…

e No evidence that demonstrates remediation is unlikely to be successful, e.g. because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

113. The Tribunal was in no doubt that Dr Francks' misconduct was sufficiently serious that action is required to maintain public confidence in the medical profession, and proper professional standards. The Tribunal considered that a message must be sent to Dr Francks, the medical profession and the public that this behaviour is unacceptable in order to uphold professional standards and public confidence.

114. The Tribunal reminded itself that it has previously concluded that Dr Francks' misconduct is remediable and, while serious, it is not fundamentally incompatible with continued registration. As previously indicated, the Tribunal considers that Dr Francks' misconduct is unlikely to be repeated. Further, the Tribunal noted again that Dr Francks has developed relatively significant insight into his misconduct which, as previously indicated, was clearly demonstrated in his written evidence. He has fully engaged in the regulatory process and has taken responsibility for his actions. The Tribunal was satisfied that Dr Francks' apologies and expressions of remorse are wholly genuine. In addition, the Tribunal noted that Dr Francks has attended targeted learning courses since his misconduct came to light and there has been no repetition.

115. In the circumstances, taking into account all relevant matters, to include the identified aggravating and mitigating factors, the Tribunal determined that a period of suspension is the appropriate and proportionate sanction in this case, and that such a sanction is the minimum required to meet the needs of limbs two and three of the overarching objective. It considered that a period of suspension would balance Dr Francks's interests with the need to send a clear message that his behaviour was wholly unacceptable for a member of the medical profession in order to uphold professional standards and public confidence in the profession.

116. For completeness, while the Tribunal took account of Mr Colman's submissions that a period of suspension might act to undermine limb one of the overarching objective in that it has the effect of removing an otherwise skilled and competent doctor from practice to the potential detriment of patients, the Tribunal considered that the circumstances of this case require such a sanction to meet the needs of limbs two and three.

117. The Tribunal concluded that erasure would be a disproportionate sanction in the circumstances of the case and would be significantly more punitive in nature.

118. The Tribunal proceeded to consider the length of the period of suspension to impose. It took into account the following paragraphs of SG in this regard:

'99 The length of the suspension may be up to 12 months and is a matter for the tribunal's discretion, depending on the seriousness of the particular case.'

'100 The following factors will be relevant when determining the length of suspension:

a the risk to patient safety/public protection

b the seriousness of the findings and any mitigating or aggravating factors […].

c ensuring the doctor has adequate time to remediate.'

'101 The tribunal's primary consideration should be public protection and the seriousness of the findings. Following any remediation, the time all parties may need to prepare for a review hearing if one is needed will also be a factor.'

'102 The table on the next page gives examples of aggravating factors that will also be relevant to the length of suspension, under broad categories, depending on the nature of the case.'

119. The Tribunal took into account the overall circumstances of this case, together with those aggravating and mitigating factors identified above.

120. The Tribunal noted that Dr Francks made serious departures from GMP and risked patient safety and public confidence in the profession. Dr Francks' misconduct was protracted and repeated.

121. As against that, the Tribunal noted again that Dr Francks has taken remedial action and has developed relatively significant insight into his misconduct. The risk of repetition is low, and the Tribunal previously determined that there are no risks to patients or the public.

122. Overall, the Tribunal determined that suspension for a period of two months is the minimum sanction which could be imposed which would be sufficient to mark the seriousness of Dr Francks' misconduct and meet the public interest. Such a period also provides Dr Francks with sufficient opportunity to further reflect on his misconduct and fully develop his insight.

123. The Tribunal concluded that this period would send a clear message to the medical profession and to the wider public that Dr Francks' misconduct was unacceptable. It determined that a reasonable and fully informed member of the public would regard a two-month suspension as a sufficient marker of the gravity of this particular case.

124. The Tribunal determined that suspension for two months represents an appropriate balance between satisfying the overarching objective and providing an opportunity for Dr Francks to return to practice, recognising that he is an otherwise competent and experienced doctor whose misconduct was entirely out of character.

125. The Tribunal determined to direct a review of Dr Francks' case. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Francks to demonstrate how he has remediated and developed full insight. It therefore may assist the reviewing Tribunal if Dr Francks provides:

- A further reflective statement to include how Dr Francks' insight has developed and addressing, in particular, his reflections on the risks to himself and Patient A arising from his misconduct; and
- Evidence of Dr Francks' letters of apology having been sent.
- Dr Francks may also provide any other information that he considers will support his case in showing that his fitness to practise is no longer impaired.

Determination on Immediate Order - 13/06/2025

126. Having determined to suspend Dr Francks' registration for a period of 2 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Francks' registration should be subject to an immediate order.

Submissions

127. On behalf of the GMC, Mr Williams submitted that the GMC does not consider that an immediate order is required in Dr Francks' case.

128. On behalf of Dr Francks, Mr Colman agreed.

The Tribunal's Approach

129. In reaching its decision, the Tribunal has exercised its own judgement and has taken account of the principle of proportionality. The Tribunal has borne in mind that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the best interests of the practitioner. It has also considered the guidance given in paragraphs 172, 173, and 178 of the SG relating to immediate orders:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *…*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.*

130. The Tribunal also had regard to its previous determinations and the submissions made by Mr Williams and Mr Colman.

The Tribunal's Determination

131. The Tribunal determined that it would not be necessary to impose an immediate order to *"protect members of the public"*, *"in the public interest"*, or *"in the best interests of the doctor"*. It was not of the view that immediate action is needed to be taken to protect

public confidence in the medical profession, particularly given the mitigating and other factors which the Tribunal has outlined in its determination on Sanction. The Tribunal was conscious of the seriousness of the misconduct but determined that this was adequately addressed by the substantive suspension.

132. This means that Dr Francks' registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Francks does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

133. That concludes this case.