General Medical Council consultation: Reform of the Fitness to Practise procedures

1. I write with regard to the GMC's consultation on proposed reforms to Fitness to Practise procedures.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952; it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The RCGP broadly supports and welcomes the overall direction of the reforms to Fitness to Practise (FTP) procedures being proposed by the GMC. The reasons for making these reforms, by enabling FTP cases to be resolved through pre-hearing consensual disposal, whilst ensuring public protection, are well understood:

   • Cases can take a long time to come to hearing. This can lead to adverse impacts such as on remediation

   • Hearings, especially of complex cases, can take a long time to be completed
• Long hearings generate adverse publicity and professional humiliation for doctors who may be eventually exonerated

• The number and cost of FTP cases is rising.

4. The majority of procedures and rationale behind them, set out in the proposed reforms, seem logical and appropriate. However, we do have a number of important concerns about the way that the proposed reforms will be implemented. These address possible unintended consequences and issues relating to case handling, remediation, public and professional perception of the new process, and the procedures by which the new process will operate. Crucially whilst delivering cost savings the reforms must be delivered in a way that upholds the quality of investigation of cases. These issues are discussed in more detail later

5. The GMC should consider piloting of the new process. This could be helpful to draw out unintended consequences before full implementation.

6. The GMC should also consider how NHS reforms will affect the framework within which FTP is delivered. Although NHS reforms will not directly impact the ability to implement reforms; they will be delivered within a changing healthcare environment. In particular, the abolition of deaneries and the proposals that education functions will be delivered at local and national levels only will affect the provision of facilitation and mediation training.

Health Issues

7. Remediation and rehabilitation should be taken into account. Whilst we understand that the GMC is not responsible for remediation and rehabilitation of doctors, its FTP procedures should operate as a framework which allows effective remediation services to be delivered. Doctors whose fitness to practise has been called into question because of health issues deserve special consideration. It is likely that such cases will be most suitable for consensual disposal procedures. Taking this approach can mitigate the significant negative consequences for doctors of undergoing investigation and full public hearings. Sensitive case handling is required to ensure that the investigation does not in any way impair the individual’s remediation. This is further discussed later.
Quality of Investigation

8. It is very important that the quality of GMC investigation is maintained, and must not be adversely affected by the shortening of the FTP process. Confidence in the quality of investigation will underpin overall public and professional confidence in the reformed process. The quality of investigation also underpins the effectiveness of the whole FTP process. The GMC needs to make clear to patients and the public that adjudication and investigation functions are strictly separate.

9. Deaneries currently provide a range of support for PCTs related to FTP including training in mediation and investigation – this varies depending on what is commissioned. We are concerned that the removal of deaneries, proposed in the English NHS reforms, could adversely impact on local training support and thus the quality of investigation at that level. GP consortia, who would take the responsibility of commissioning education and training at the local level, need to be supported and incentivised to commission appropriate services. The RCGP would like to work with the GMC, DH and other partners to make sure this happens.

Transparency

10. A key virtue of the current system is its transparency: patients, the public, employers, colleagues can access the evidence concerning a doctor and can therefore form a view in addition to accessing the outcome. There is therefore a risk that, if key stakeholders believe that their access to information about doctors about whom concerns have been raised is seriously reduced, then the new system may be undermined. Having said that, several of our commentators took the view that cases resolved through consensual disposal should not have the same level of details published as for cases that go to public hearing.

How Public Confidence in the Process can be maintained

11. It is important that the FTP process upholds public trust. Medical Colleges and other stakeholders can play a key role in supporting the GMC in developing and promoting messages to maintain confidence in the new process.

12. Messages to the public are needed to mitigate the following risks of negative perception:

- That reforms are mainly to reduce costs not improve outcomes
• Those pre-hearing disposals are “stitch ups by the profession” behind closed doors. This risk is increased by GMC performing investigation & adjudication; even though separated within the organisation, this is not clear to public.

13. Messages to the public about the new process (and FTP overall) could include

• That the FTP process is robust, transparent and independent
• Adjudication and investigation are separate processes
• New processes are to reduce unnecessary cost and rehabilitate doctors where possible but with primary goal of public protection
• New process reflects the existing move towards mutual resolution of employment concerns at an early stage
• Lay members are involved in investigation and adjudication

Case Handling

14. There is a risk that under certain circumstances doctors could be put into an invidious position. If the doctor does not dispute the facts, but does dispute the seriousness of the facts and therefore the appropriate sanction (for example), the doctor may feel that accepting a sanction that they regard as disproportionate is better than the stress of the wait and then a public hearing. This issue is not satisfactorily addressed in the consultation document and should be further considered.

Other options for reform

15. In addition there is one option not discussed in the consultation. Even if these reforms were adopted, there is an argument that GMC FTP hearings are not courts of law, but of professional regulation, and therefore reporting of the hearings should be restricted to the charges and the fact of their happening until the resolution of the hearing, when all the evidence could be reported. This would mean that the reports of the hearing would commence with the outcome and the evidence would be presented in that context. This would appear to meet the requirement of transparency while reducing the reputational damage from hearings in which the doctor is cleared.
Remediation and Rehabilitation

16. As we have stated previously, we understand that the GMC FTP process is primarily responsible for public protection not the remediation of doctors. However, the GMC’s process should create a framework that enables remediation to be delivered and one that does not unduly hinder it. Employers of doctors have a key role to play in remediation and the GMC should aim to design conditions that take account of services available through them and others for remediation. It is desirable for the FTP process to be better aligned with remediation interventions; this could reduce costs and, anxiety to the individual which may impair rehabilitation.

17. Further, it is likely that cases where purely health concerns have resulted in FTP procedures being triggered are also the ones most likely to be resolved by the new consensual disposal being proposed by the GMC. This makes it even more important for remediation needs to be taken account of,

Please see below answers to the specific questions posed in the consultation document.

**Question 1.** Do you agree that, where there is no significant dispute about the facts, we should explore alternative means to deliver patient protection other than sending cases to a public hearing? If you disagree, please give reasons for your answer.

18. Yes, but the process must ensure transparency, integrity and public trust. The doctor under investigation should not be unduly penalised for not agreeing to the proposed conditions and sanctions. Such non-agreement in itself should not be interpreted as non-cooperation that may prejudice the case.

**Question 2.** Do you agree that it would be appropriate for the GMC to have discussions with doctors in order to foster cooperation? If you disagree, please give reasons for your answer.

19. Yes, as long as undue pressure is not placed on the doctor to do so. It should also be made transparently clear that the GMC’s adjudication and investigation functions are separate.

20. If properly handled this approach, which is less adversarial, can produce more trustworthy outcomes than at present and be less stressful for those under investigation.
Question 3. Do you think that doctors:

a. Should be able to share information on a ‘without prejudice’ basis?

b. Should not be able to share information on a ‘without prejudice’ basis?

c. Should be able to share information on a ‘without prejudice’ basis where the GMC cannot directly use that information in a later hearing but can conduct further investigation and use any information uncovered by such investigation?

21. We are unable to offer a strong case for any of the above options. Commentators on this raised a number of pros and cons with each of the options. Piloting, specific legal advice and evidence of how these options work in different jurisdictions may help in choosing which route to choose. Whichever option is chosen it is crucial that the doctor under investigation understands the full implications.

Option A

22. Option A could allow doctor under investigation to be more open and honest with the GMC and would fit with a non-adversarial approach which the new process could foster. However, this would mean that information that could lead to further investigation would have to be disregarded which could risk the core aim of public protection.

Option B

23. This option would allow further investigation resulting from disclosed information. However, doctors may be less likely to fully disclose all information for fear of future investigations and trust between the GMC and doctors would be adversely affected.

Option C

24. This appears to be a good compromise position allowing doctors to share information on a “without prejudice” basis but with the GMC having the ability to further investigate to ensure public protection. However, this option could be difficult to implement and could be confusing to those being accused. Because of the possibility of further investigation that could result in a hearing it can be argued that doctors, already in a stressful situation, would be almost as unlikely to share information as if option B were followed.
**Question 4.** Do you agree that we should consider ways to access practical facilitation skills to support constructive discussion with doctors?

25. Yes. We agree with the distinction between mediation and facilitation; facilitation seems reasonable and un-contentious. It is important that people involved in discussions with doctors under investigation have the appropriate skills to ensure that cases, especially where health issues are concerned, are sensitively and properly handled.

**Question 5.** Do you agree with the approach outlined for communicating with complainants about our discussion with doctors? Please give reasons for your answer.

26. The approach outlined seems broadly correct, but sensitive and careful handling will be required. The needs of the complainant to be kept informed need to be balanced with the requirement to be fair and just to the doctor under investigation. The complainant needs to be informed about the case in a way that maintains their confidence in the procedure and allows them some form of closure from the case resolution. Careful explanation is needed of why a particular case may have been resolved through consensual disposal rather than a public hearing.

27. The proposal to write to the complainant prior to a meeting with the doctor is reasonable to inform them of procedure with the case, but should be neutral in terms of content or outcome. The meeting may illuminate some factual areas that lead to a revision in the GMC’s intended course of action, in which case the pre-meeting letter should not detail the GMC’s provisional position. Subsequent correspondence needs careful thought so that the right balance is struck between the needs to inform the complainant and the process of natural justice.

**Question 6.** Do you think the term ‘by mutual agreement’ correctly reflects the outcome of discussions with doctors? If not, what term would you prefer and why?

28. Yes. As outlined elsewhere it is important that undue pressure is not applied to doctors to accept an agreement which would render the term disingenuous. The GMC should also develop messages that help explain what is meant by “mutual agreement” and the fact that agreement is voluntarily accepted but carries robust sanctions and conditions that are legally enforceable.
**Question 7.** *Do you think that publication of the sanction accepted by the doctor will maintain public confidence in the profession? If not, are there other steps we should take?*

29. Yes. However, this needs clear explanation about the process and why a consensual disposal has been reached rather than a formal public hearing being sought. There must be sufficient transparency in the process so that the public can understand how and why a course of action has been followed.

**Question 8.** *Do you believe we should publish a description of the issues put to the doctor? What other information (mitigation taken into account, etc) should we publish?*

30. This is a difficult issue; a balance needs to be struck between the need for transparency and public confidence with the need for fairness to the doctor and an acceptable level of privacy such as in relation to personal health issues. Information that could potentially be published include:

- The statement of facts mutually agreed by the doctor and GMC
- Mitigating factors
- Reasoning that a consensual disposal was sought
- The sanctions and conditions agreed to

**Benefits of Full Transparency**

31. The public, patients, complainant, employers and colleagues will want to have access to the equivalent information as at present. This could include the background, context, description, mitigation, and overall summary of the agreed facts; the interpretation of those facts within the framework of Good Medical Practice; and the sanctions imposed. Without this clarity, there will be risks of complaints from the public or from the profession about a cover-up.

**Problems with full transparency**

32. However, there are also strong arguments to suggest that it would not be fair to publish the full set of details about the investigation and outcomes as this could be seen as unfair to a doctor who has not been found guilty in a hearing. Disclosure of information relating to a case could have significant negative consequences for the individual doctor. This could cause undue stress and anxiety adversely affecting remediation and rehabilitation. This is a great concern in the case of doctors whose
fitness to practise has been investigated because of ill health, and especially where mental health issues are involved. Public disclosure could also be seen as humiliating and could make the take up of consensual disposal less likely.

33. To minimise the risks outlined here, the information relating to an individual doctor’s case could be shared on a “need to know” basis. This will mitigate the risk from public disclosure that can cause such great undue anxiety – as currently happens to doctors who undergo public hearings.

34. The College is of the view that doctors with health problems must not be stigmatised long term and the content and outcome of such cases with a consensual outcome must be considered carefully. Serious or controversial cases (and these terms would need clear definition) should always go to a hearing. In terms of standards, the College should work through the Academy and directly with the GMC to support the development of a clear declaration of the standards to be applied in GMC Fitness to Practise processes:

- When the issue is of competency, the standard should be of equivalence to the MRCGP (or equivalent for other disciplines)
- When the issue is conduct or health, the standard should be of equivalence to the statements in Good Medical Practice for General Practitioners (or equivalent for other disciplines)

**Question 9.** Do you think our proposals above are a reasonable way to deal with any risk of deterioration of evidence? Do you have any other suggestions?

35. Yes. However, there may be a greater risk if the process drags on, for instance if consensual disposal is attempted but in the end cannot be agreed upon, leading to a hearing being needed.

**Question 10.** How do you think we might ensure that unrepresented doctors fully understand the implications of signing a statement of agreed facts?

36. There should be a presumption that all doctors are represented. If they are not, the GMC must explain, in a language that they understand, the implications of being unrepresented, and then the doctor should accept any adverse effects for being unrepresented. There are special concerns for those doctors with health issues either alone or in combination with behavioural/competency issues. The GMC will need to
be sure that such doctors are “fit to plead”. This is essential to the fairness of the process.

37. We also have concerns about the dilemma a doctor may face between agreeing to a sanction which they believe to be inappropriate or disproportionate and opting for a hearing. There may be a need for a period of reflection following an agreement on facts to ensure that a doctor has a chance to reflect before signing.

**Question 11.** Are there cases which should be referred for a public hearing even where the doctor is willing to agree the sanction proposed by the GMC? If yes, what types of cases and what criteria should the GMC apply to identify such cases?

38. There are secondary advantages from public hearings which may be lost under these reforms. The current system of public hearings enables education of the public and other doctors concerning appropriate behaviour and ethical issues (research fraud etc); the possibility of publicity leading to other complainants coming forward; and public debate leading to refinements to FTP. There may be some cases deemed to be, therefore, in the public interest to be heard in public. It would seem reasonable to apply a consistent “public interest” test.

39. Clearly serious cases of misconduct, and those where the doctor is being uncooperative and there are no mitigating circumstances, will need to be resolved through public hearing.

**Question 12.** Do you agree that there are some convictions that are so serious that the behaviour is incompatible with continued registration as a doctor and that there should be a presumption that the doctor be erased?

40. Yes, though there may need to be a process for this to be challenged.

**Question 13.** Do you agree that the convictions we have identified are convictions which fall into this category?

41. The list seems reasonable.

**Question 14.** Are there any other convictions you think should fall into this category?

42. Legal advice and evidence from other jurisdictions will help in answering this question.
**Question 15.** Do you agree that doctors within our fitness to practise procedures who refuse to engage with our investigation, where we have made every attempt to seek their engagement, should be automatically suspended from the register?

43. Yes but there may be mitigating circumstances such as issues for those doctors temporarily overseas or unable to respond because of serious health conditions who have not notified the GMC of this. Some safeguards are required. Further, the consequences of non-cooperation should be made clear to the individual at the start of procedures.

**Question 16.** Do you think that these proposals will benefit or disadvantage any groups of people who are involved in our fitness to practise procedures?

44. This needs to be considered. There is a risk that doctors who undergo FTP procedures because of mental health issues may feel pressurised into agreeing to conditions which they may not actually agree with. Because of anxiety and pressure on the doctor in this circumstance mitigating circumstances may not adequately be presented; it is important that good representation and sensitive case handing occurs in such cases. As previously stated the GMC should ensure that doctors are “fit to plead” to ensure fairness.

45. Some international doctors may also be at a potential disadvantage. They may feel more pressure to accept conditions than others because of a relative lack of understanding of the system, and less access to personal and other support through the process.

46. Piloting of the reformed FTP process prior to full implementation could provide helpful insight into how this group could be affected as well as identifying other unintended consequences and issues.

**Question 17.** Do you think these proposals will impact on the confidence in our procedures of any particular groups of people? If so, which groups and why?

47. Yes, there is a risk that if not properly handled, especially in terms of public communication, there could be a risk to public confidence in the process. This has been discussed at greater length at the start of this response. Factors affecting this include the transparency of the system, including the content of the agreed statements, and effective explanation of the reasons a consensual disposal has been pursued.
48. There also needs to be good communication with the profession and employers about the reformed process. Such communications need to be mitigate possible risks of negative perception such as:

- Unfair collusion between employer and GMC.

- Feeling that they are unfairly being asked to agree to sanctions / statement of events at risk of worse outcome or under undue pressure.

- That reforms are mainly to reduce costs not improve outcome.

49. Communication with the profession should ensure mitigation of these negative perception risks. Messages could also state that the primary motivation is to ensure public protection and trust through more efficient processes and not to unjustly punish or humiliate.

50. Thank you for asking us to contribute to this consultation.

Yours sincerely

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Honorary Secretary of Council