

Response to the General Medical Council's consultation: *Reforming our fitness to practise investigation and adjudication processes*

May 2015

1. Introduction

- 1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.
- 1.2 As part of our work we oversee nine health and care professional regulators¹ and report annually to Parliament on their performance. We also appeal fitness to practise cases to the courts if outcomes are unduly lenient and it is in the public interest. More information about our work and the approach we take is available at www.professionalstandards.org.uk.
- 1.3 We welcome the opportunity to respond to this consultation. As we have observed on a number of occasions recently, we found that the documents published for this consultation did not provide sufficient information. Some of the proposals are both significant and complex, and would have benefited from more detailed explanations and clearer cross references to the legislation.
- 1.4 We responded to the consultation on the section 60 Order that gave rise to many of the proposals in this consultation. Our response can be found on our website: <http://www.professionalstandards.org.uk/library/document-detail?id=a3a4599e-2ce2-6f4b-9ceb-ff0000b2236b>

2. Responses to questions

Section 1: Formally separating our investigation and adjudication functions

Question 1: We have drafted new rules for the MPTS Committee. Do you agree with the arrangements for the MPTS Committee as set out in these rules?

- 2.1 No. The Constitution Rules do not preclude current or recent GMC employees from being appointed as members. Under *The General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015* (the Order), the Chair of the MPTS is an officer of the GMC. In our view, this, and the potential for current and recent GMC employees to become MPTS

¹ General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.

members could undermine the intention to separate the adjudication function from investigation function run by the GMC.

Question 2: We propose making provision in the rules for the MPTS to be responsible for setting and publishing the criteria for appointing panellists and panel chairs. Do you agree?

2.2 No comment.

Question 3: We propose that where legally qualified chairs advise the panel on a question of law they will do so either in the presence of the parties or, where the parties are not present, they will include their advice in their decision. Do you agree?

2.3 We support this proposal.

Question 4: We propose that the MPTS should send the notice of the hearing and the GMC should send the notice of the allegation. Do you agree?

2.4 No comment.

Question 5: Do you agree that we should change our rules to reflect our current practice of giving doctors at least 28 days' notice of all matters relating to the hearing (including the time and venue)?

2.5 No comment.

Question 6: We propose to remove the rule that provides that the MPTS should tell the GMC when an interim order is due to expire. Do you agree?

2.6 We do not have any concerns about this change. A failure to renew an interim order can create a serious risk to public safety – it is therefore important that this function is performed as effectively as possible.

Section 2: Streamlining and modernising our hearing process

Question 7: We propose clarifying the circumstances in which we can refer a doctor with panel undertakings for a review where the doctor does not agree to changes we want to make to their undertakings. Do you agree?

2.7 We found that the proposals and the way this question was phrased in fact did not clarify the circumstances in which a doctor with panel undertakings who does not agree to a change can be referred for a review.

2.8 Firstly, the new rule 37A(3) gives the Registrar discretion ('may') about whether to refer to a panel if the registrant rejects a proposal to vary undertakings, and it is not made clear how this discretion will be exercised.

2.9 Secondly, it is not clear whether the 'panel undertakings' that are being referred to here are the undertakings that under the current regime can be agreed between a panel and a registrant at the hearing; or whether they are the

undertakings which, under the new rules will be agreed during the hearing between the GMC and the registrant.

- 2.10 If it is the former (panel undertakings under current rules), it is our view that undertakings that had originally been agreed with a panel should be varied only by a panel, regardless of whether a registrant agrees.
- 2.11 In the latter situation (undertakings agreed with the GMC during the hearing), it is hard to imagine a scenario in which a registrant refusing to agree to a variation in their undertakings would not warrant a referral to a panel. In essence, if a registrant is not willing to agree to undertakings, undertakings are not the right outcome.
- 2.12 In both cases, we would expect to see a requirement ('must') in the new rule 37A(3) for the Registrar to refer the decision to a Tribunal, and clarification about how panel undertakings agreed under the old rules will be dealt with under the new rules.

Question 8: We propose making clear that a doctor with undertakings whose language skills either deteriorate or otherwise give rise to further concerns can be referred to a panel. Do you agree?

- 2.13 The consultation document is not clear here. We agree that if the original undertakings relate to a doctor's language skills and there is a deterioration, the GMC should have the power to refer the doctor to a hearing. We assume that if they do not, the information will give rise to new concerns which will need to be investigated afresh.

Further comments on the new undertakings model

- 2.14 Firstly, we note that case examiner undertakings will be available when there is a realistic prospect of a panel imposing a suspension. As we have commented previously, it is not right to dispose of a case that would result in suspension through undertakings. This is because a suspension is a more severe sanction than undertakings, which are roughly equivalent to conditions. Disposing of a 'suspension' case through undertakings is unlikely to fulfil the three functions of fitness to practise – protecting the public, maintaining public confidence, and upholding professional standards.
- 2.15 Secondly, we continue to hold the view that undertakings should not be an option once a case has met the realistic prospect test. Registrants have ample opportunities to agree undertakings before this point, and it is not clear what is to be gained from providing this option after a case has been referred for a hearing. It would have been helpful if the GMC had set out the scenarios in which it envisages this type of undertaking to be used, and what will happen if undertakings are agreed once the hearing is underway.
- 2.16 Thirdly, we note that under the new rules 17(2)(n) and 17(3) and (4), the GMC can agree undertakings with the registrant after the case has been referred for a hearing (as per the new Schedule 4, para 1, (2C) as inserted by section 9 of the Order). However, we could not locate the rules that implement this power (equivalent to the current 17(m)), and set out who has the authority to agree

undertakings, at what stage, and through what process. We trust this is an oversight.

Question 9: We propose giving our hearings a more logical order, identifying a doctor at a hearing before hearing any legal argument. Do you agree?

2.17 No comment.

Question 10: We propose allowing both parties to make submissions on the facts before the panel decides which facts are true. Do you agree?

2.18 It is not clear to us what the purpose of this change is, given that parties have the opportunity to make submissions at both the misconduct and the impairment stages of the process.

Question 11: We propose removing the need to refer to transcripts of previous hearings in review and restoration hearings unless this is necessary. Do you agree?

2.19 No. Out of fairness to both parties, members of a review or restoration panel should be given the transcripts so that no evidence is lost. This is the best way to ensure that decisions about current fitness to practise are based on all the relevant information.

Question 12: We propose clarifying that the MPTS arranges recordings of panel hearings and the registrar arranges recordings of Investigation Committee hearings and that, on request, the MPTS or registrar (as the case may be) can provide a written record. Do you agree?

2.20 No comment.

Question 13: We propose clarifying the terminology we use, in particular what we mean by 'witness'. Do you agree?

2.21 No comment.

Question 14: We propose allowing case managers and Investigation Committee members to adjourn hearings that are part heard when either party requests this. Do you agree?

2.22 No comment.

Question 15: We propose that, to protect the public, when the panel has adjourned a review hearing before it has made a finding of impairment, a panel should be allowed to extend a sanction until the panel can reconvene to consider impairment. Do you agree?

2.23 Yes. This is necessary for public protection.

Section 3: Making case management more effective

Question 16: Do you agree with the circumstances we have set out in the draft rules for when case management decisions will not be treated as binding?

2.24 No comment.

Question 17: Do you agree with our proposals for awarding and assessing costs, as outlined in the draft rules?

2.25 No comment.

Section 4: Removing the need for parties to attend review hearings

2.26 There is no question attached to the proposal for all review hearings where the registrant is compliant to be held on the papers. However, we wish to point out that in the majority of cases where a review hearing has been ordered, an assessment by the panel of the registrant in person will be needed. It might be helpful for the original panel decision to indicate whether they consider that the registrant will need to appear before the review panel or whether a hearing on the papers will be adequate.

Section 5: Making our investigation processes simpler and more effective

Question 18: When we make provisional enquiries to decide if we need to carry out an investigation, we propose removing the need to tell a doctor's employer. Do you agree?

2.27 We agree with this change, provided there is clear internal guidance for GMC staff about when it will be necessary for public protection and other reasons to alert an employer at this early stage.

Comment on the five-year rule

2.28 We continue to express our disappointment about the fact that recent changes to the GMC legislation have resulted not in the dropping of this rule, but in it being enshrined in primary legislation. The removal of the 'exceptional circumstances' clause may represent a minor improvement, but even in its new incarnation, it remains unnecessary, contentious and a potential barrier to public protection.

Section 6: Improving compliance and making assessments more effective

Question 19: We propose introducing a process for a new type of non-compliance hearing to deal with substantive non-compliance with assessments or requests for information required in order to enable us to investigate concerns. Do you agree with that process?

2.29 We agree that the GMC should have a process for dealing with non-compliance with assessments and requests for information that provides an incentive for registrants to comply. We presume that the new model is being introduced so

that the GMC does not have to convene an Interim Orders Tribunal to deal with non-compliance cases. It would have been helpful if the consultation document had set out in more detail why the current systems are not fit for purpose.

- 2.30 The information provided also does not explain how a history of non-compliance will be considered. Not complying with a direction to undergo an assessment or to provide information is likely, in more serious cases, to constitute misconduct, and can be an indication of impaired fitness to practise – particularly when you take into account paragraphs 14, 28 and 73 of Good Medical Practice, which state that:

'You must recognise and work within the limits of your competence [...] If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgment or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients. [...] You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.'

- 2.31 The consultation documents do not explain how concerns arising out of non-compliance, as separate from the concerns that gave rise to the assessment or original investigation, will be dealt with.
- 2.32 We also note that the proposals include the power for a non-compliance panel to impose conditions on a registrant for up to three years; and to suspend them indefinitely (presumably through review hearings). It is hard to conceive of any situation where refusing to undergo an assessment over a significant period of time would not indicate impairment and quite possibly warrant striking off.
- 2.33 The GMC must make it clear to registrants and tribunal members that repeated non-compliance with a direction or request for information constitutes a serious breach of the code. It must ensure that it is possible for such behaviour to lead to a referral to a final fitness to practise tribunal.
- 2.34 In addition to the above, it is not clear to us whether the panels will have the power to order a review hearing, what will happen if the registrant complies before the expiry of the non-compliance order, and what will happen if the registrant does not comply with the non-compliance order.
- 2.35 Finally, we note that the Order includes a requirement for the GMC to notify the Authority of directions and decisions imposed by non-compliance panels (see the new paragraph 5A of Schedule 4 to the Medical Act). It is not clear what purpose this will serve, given that our section 29 jurisdiction only applies to final fitness to practise panel decisions.

Question 20: Do you think any of our proposals will adversely affect people from groups with protected characteristics? This could include doctors, patients, and members of the public.

- 2.36 No.

3. Further information

- 3.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

Professional Standards Authority for Health and Social Care
157-197 Buckingham Palace Road
London SW1W 9SP
Email: dinah.godfree@professionalstandards.org.uk
Website: www.professionalstandards.org.uk
Telephone: 020 7389 8030