Annex B

Adjudication: determining questions about fitness to practise

Introduction

1. Annex A describes the proposed model for investigating concerns about fitness to practise. This section describes how, where necessary, the GMC will adjudicate on such concerns.

2. Adjudication by a panel following a hearing is not necessary in every case: many doctors can be dealt with satisfactorily and safely through the voluntary health and performance procedures. But effective as the voluntary procedures are for many cases, they may break down if a doctor ceases to comply with undertakings given or they may not be appropriate at all.

3. For these reasons, hearings into cases will continue to be required to resolve questions about doctors’ fitness to practise, whether the underlying cause is the doctor’s conduct, performance, health, or combinations of these.

Adjudication in the new GMC

4. Currently, adjudication decisions are taken by committees of the Council: the Professional Conduct Committee, the Health Committee and the Committee on Professional Performance (although the PCC and CPP co-opt non-GMC members selected on merit against competencies to assist them).

5. In 2000 the Interim Orders Committee was established to consider the need for interim restrictions on a doctor’s registration in circumstances where this is necessary for the protection of the public or is in the doctor’s interest or otherwise in the public interest. The IOC does not make any findings of fact on the cases it considers and nor does it make final determinations. However, the orders which it imposes affect or remove – albeit temporarily – a doctor’s right to practise. On that basis, interim orders are best considered as part of the GMC’s adjudication function even though such orders are by definition only temporary.

6. In the new GMC, the adjudication function will operate at arm’s length from the Council, although its costs will be borne by the GMC and it will be under its overall ambit. The Council’s direct role in fitness to practise will be in respect of the investigation function: identifying possible departures from its standards and therefore from safe practice, investigating them, and where necessary bringing them to adjudication. The GMC will still continue to provide the staff to support the adjudication panels although these staff will be in a separate managerial chain from other GMC staff.

7. Because the processes of investigation and adjudication must be kept entirely separate, no member of the new Council (which will, be reduced in size from 104 member to 35) will be permitted to adjudicate on fitness to practise cases. Thus, adjudication decisions will no longer be taken by committees of the Council but by panels entirely separate from the Council drawn from doctors and members of the
public. The GMC’s proposals on governance set out in detail the processes by which potential panel members will be identified.

8. It is essential that no person should sit on adjudication panels – fitness to practise or registration – unless they meet competency criteria and satisfactorily complete an appropriate programme of training.

   Proposal 11: A person will not be eligible to serve on an adjudication panel unless he or she has satisfactorily completed an appropriate programme of training.

9. The competencies required for adjudication purposes must include:
   
   a. Fairness and impartiality.
   
   b. First class analytical and reasoning skills.
   
   c. The ability to communicate clearly and effectively.
   
   d. The ability to contribute effectively to group discussions.
   
   e. The ability to weigh evidence impartially and reach reasoned and independent decisions.

10. The performance of those who serve on panels will be appraised annually to ensure that the required standards are being met. Appraisal will be on the basis of reports drawn up at the end of cases by the panel chairman and legal assessor. Any member whose performance falls below acceptable levels will (if his or her deficiencies cannot promptly be remedied) no longer be eligible to serve on adjudication panels.

   Proposal 12: The performance of panel members will be appraised periodically against agreed competencies. Continued service on a panel will depend on performance being satisfactory.

One process or three

11. Acting fairly to protect patients explored the merits of merging the separate conduct, health and performance procedures into one unified process. However, the document concluded that although this was desirable at the investigation stage, the balance of the arguments lay in retaining separate procedures at the adjudication stage. That was on the basis that differences in the philosophy behind the procedures and in the nature of the evidence used, led to the need for different procedures for incident-based (conduct) and assessment-based (health and performance) investigations.

12. While this approach was generally supported in the consultation process, some respondents argued that the GMC should establish a single fitness to practise panel to adjudicate on every case. Supporters of this model argued that it would allow consideration of all aspects of the doctor’s fitness to practise at the same time
and within the same process, without the need for rather artificial boundaries between questions of conduct, health or performance and that there would be advantages in terms of consistency of approach for the same adjudicators to deal with every case.

13. This model has some superficial attractions but in practice would not work. Even if the practical and legal obstacles could be overcome, it would not be possible for a single panel to consider every case because of the volume of work. Thus the advantage of consistency would not be realised in practice. Finally, while on the surface the doctor’s fitness to practise would be considered holistically, given that the mode of operating would have to change according to whether the focus was on a concern about conduct, health or performance, it is questionable how reasonable it would be to expect the same adjudicators to adopt an entirely different process, sometimes at the same sitting.

14. A possible alternative to a single process would be to maintain three separate processes but to enable them to look at a quite different aspect of the doctor’s fitness to practise than the one principally referred to them. This might involve, for example, a health panel also dealing with a question about a doctor’s conduct or a conduct panel considering a health issue. The GMC believes that the advantages this would offer in terms of flexibility would be far outweighed by a loss of focus and risk of inconsistency in having the same question investigated by quite different types of panel. Questions about alleged misconduct should continue to be dealt with exclusively through processes designed for that specific purpose, and questions about possible health impairment should remain the exclusive concern of a health panel.

15. Nonetheless, questions about a doctor’s performance may arise in the course of most cases, whether the principal question is health or misconduct. In the future panels will be able to have access to information about performance from the doctor’s revalidation folder and there are real advantages in allowing all the fitness to practise panels to examine concerns about a doctor’s performance. The alternative of requiring every issue of performance to be dealt with by a performance panel would be inflexible, slow and unattractive.

16. Therefore, the GMC proposes that there should continue to be separate types of process for dealing with conduct, health and performance cases. However, both conduct and health panels will have the power to require a doctor to undergo an assessment of current performance (or competence if the doctor has not been practising) and to act on the outcome of the assessment if serious deficiencies are revealed. And Annex E explains why, despite the retention of separate processes, the end point of all the procedures should be the question of whether or not a doctor’s fitness to practise is impaired to a degree requiring action on registration.

Proposal 13: There should continue to be separate types of process for adjudicating on conduct, health and performance cases although all types of panel should have the power to require a doctor to undergo an assessment of performance or competence.
17. The GMC also believes that while there are strong advantages in there being a measure of specialisation among those who serve on health panels, subject to satisfactory training those who adjudicate on conduct panels should also be able to adjudicate on performance panels.

18. There will also be a separate panel for considering cases where it may be appropriate to impose an interim order restricting or suspending the doctor’s right to practise pending a full investigation. These cases, currently heard by the IOC, will be heard by an Interim Orders Panel.

Panel size and composition

19. Those who adjudicate on fitness to practise cases have particular but complementary roles to play. At present every committee or panel has:

   a. One or more doctors.

   b. One or more lay people.

   c. A senior member of the legal profession who acts as legal assessor.

20. Each of these components makes a distinct contribution to the process. All have an overriding duty to act in the public interest. Doctors bring their understanding of the values and principles of the medical profession. Lay people represent, and are seen to represent, the perspective of those who are not doctors. The role of the legal assessor is to provide expert, impartial and transparent legal advice and, increasingly, to assist panels in drafting reasoned decisions, but not otherwise to participate in the decision-making process.

21. In all of the procedures, expert witnesses can be called either by the GMC or by the doctor. However, the Health Committee and the Committee on Professional Performance have the benefit of specialist advice given by, respectively, health assessors and specialist advisers. The purpose of this role is to give the committee advice (whether in public or in camera):

   a. As to what lies within the bounds of acceptable practice.

   b. On detailed or technical issues where the panel require advice or further explanation.

22. The adviser is also able to ask pertinent questions of witnesses (and the doctor).

23. There are arguments for extending this model so that conduct panels would also have the benefit of specialist advice if the case concerned clinical practice. The GMC considers that bearing in mind the expectation that concerns about clinical performance will increasingly be dealt with through the performance procedures rather than through the conduct procedures (see the discussion in Annex A), the current model for conduct cases, which relies on the examination of expert witnesses where this is necessary, should be retained.
24. It is important to appreciate that medical members who adjudicate on fitness to practise cases are not a source of expert medical advice for the committees or panels on which they serve. There is no requirement, or expectation, that there will be a member from the same field of practice of the doctor. However, in cases where there are issues about the quality of clinical care, there will normally be at least one medical member who has an appreciation of the broad context within which the respondent doctor practises, even if the panel member is not from precisely the same field of practice. Wherever possible, it is also good practice for panel composition to have regard to the circumstances of the doctor. For example, there should normally be an overseas qualified doctor on the panel if the respondent doctor qualified overseas.

25. Currently, all the committees have a quorum of five (including one lay person apart from the IOC which must have two lay people). For long cases many committees sit in panels of seven or even more members in order to provide sufficient cover for the quorum in cases sickness or other unavoidable cause requires a member or members to stand down.

26. The key factor in the quality of decision-making is the approach followed by the decision-maker and the clarity and appropriateness of the criteria which are applied. The involvement of a large group in a decision cannot guarantee an appropriate outcome and may actually hinder it if over-lengthy discussions make it difficult for a panel to operate coherently. For obvious practical reasons it is very difficult to assemble a panel of seven or more members to hear a case which may last many weeks or months. It is an inefficient use of scarce resources, is extremely costly and is not proportionate to the task.

27. There is no reason why, in principle, fitness to practise cases could not be heard by much smaller panels than this. Panels are not juries assembled at random whose sole purpose is to make findings of fact. They are more akin to expert tribunals, selected for a specific purpose to make findings of fact (in conduct cases), and arrive at judgements on whether fitness to practise is affected and, if so, on sanction.

28. The use of very large panels could only be justified if there was no satisfactory alternative. But in fact there is an effective alternative. The main reason for large panels is to provide insurance for the current quorum of five. The GMC considers that the operating norm for panels should be no fewer than five and that no case should begin with fewer than five members on the panel.

29. However, if the legal quorum was reduced to three members (including at least one medical and at least one lay member), but the GMC’s policy was still to empanel at least five members, in practice most cases will still be heard by panels of five but it would be unnecessary to assemble larger panels than this. A panel of five (plus a legal assessor) would still be larger than the majority of tribunals (which generally have three members) but small enough to allow the panel to work together effectively.
The GMC therefore proposes that all its adjudication panels should normally continue to have at least five members (excluding the legal assessor and – in health and performance - specialist adviser) but that the legal quorum should be reduced from five members to three.

**Proposal 14: No hearing should begin unless there are five or more members on the panel but the legal quorum shall be three (including at least one medical and at least one lay member).**

The selection of panel chairmen (apart from in the case of the legally-qualified chairmen for certain conduct panels discussed in paragraphs 57-60 below), will be made on merit from among those eligible to serve on the panels.

**Standard of proof**

The Professional Conduct Committee currently uses the criminal standard of proof (traditionally worded as 'beyond reasonable doubt'; now sometimes expressed as 'satisfied so as to be sure'), rather than the civil standard, based on a 'balance of probabilities'. There is no statutory requirement to use the criminal standard - it is a matter of custom and practice, though legal judgements\(^1\) have supported the use of a criminal standard for the most serious cases, while allowing for the possibility of a lower standard in less serious ones.

The NHS Plan for England, published in July 2000, said that the GMC should explore the introduction of a civil standard of proof. This followed the report the previous month of the inquiry into the case of Mr Rodney Ledward, chaired by Miss Jean Ritchie QC, which recommended a range of changes in the procedures followed by the PCC, including the introduction of a civil standard of proof 'on the strong balance of probabilities'.\(^2\) Regulatory practice elsewhere and the courts recognise that a civil standard of proof need not be a simple balance of probabilities but can be a 'sliding scale' where the threshold of proof varies according to the seriousness of the allegation.

In December 2000 the GMC held an experts' conference chaired by Lord Lester of Herne Hill QC, a leading expert in human rights law. Lord Lester submitted a report setting out the main points made and added his own observations.\(^3\)

Lord Lester was reflecting the near-unanimous view of the conference when he concluded that 'it would be unwise for the GMC to develop proposals in relation to the standard of proof which were not part of a much wider package of change'. He exhorted the GMC to look at the concerns which had prompted demands for change.

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1. For example, the Privy Council case of McAllister v GMC (per Lord Jauncey)
3. The full text of Lord Lester's report is at: www.kingsfund.org.uk/gmc.
These included, in addition to the specific question of the standard(s) of proof to be applied by the various committees:

a. Criticism of the style of PCC hearings, which were regarded as too adversarial and daunting for witnesses.

b. Some support for considering legally-qualified chairs for the PCC, but not for performance or health committees.

c. Interest in developing a facility to deal with misconduct below the level of 'serious professional misconduct' (spm), but not in a way which opened the floodgates to thousands of comparatively trivial complaints.

d. Lack of confidence by patients' representatives and some doctors in the fairness and consistency of PCC decisions.

36. The conference concluded that the specific question of the standard of proof applied only to findings of fact - not to judgements panels make (such as which sanction may need to be imposed). Such judgements demand that the panel have a high degree of confidence in their decision. Being satisfied to a high degree that a judgement is correct is not the same, however, as applying a standard of proof to it. In practice, fact-finding is largely confined to conduct cases. However, if other types of panel have to make findings of fact the same principles should apply as in conduct cases.

37. From time to time PCC judgements are criticised on the grounds that the doctor 'got off' unjustifiably. However, the issue of the standard of proof is something of a red herring in this context: in many of the cases perceived as overly lenient, the panel decided that the facts did not amount to spm, or imposed a sanction which some commentators deemed inappropriate. Thus, the reason for the outcome perceived as being lenient had nothing to do with the standard of proof applied to the findings of fact. There are cases where the standard of proof may make a difference to the findings of fact (for example, allegations of sexual assault with conflicting evidence and no other witnesses), but these are often the most serious cases, for which there is clear advice (see below, next paragraph) that the higher, criminal, standard should be retained.

38. With regard to findings of fact, the choice is between a criminal standard and a civil 'sliding scale'. Lord Lester's report explored the arguments for and against each approach. Any proposals must comply with the European Convention on Human Rights (ECHR). There is no clear ruling on what that means with regard to the standard of proof, but Lord Lester opined:

‘…. The safer view in my opinion is that the most serious allegations the PCC hears and certainly those which are tantamount to criminal offences should attract a criminal standard of proof. However, it would not be unfair, for less serious allegations, particularly those which did not call into question a doctor's registration, to be judged by a sliding civil standard.’
39. The GMC’s proposals seek to apply that advice in a way that is appropriate to its caseload.

What standard of proof should apply to fact finding?

40. The GMC accepts the advice that the ECHR probably requires the use of the criminal standard for the most serious charges, notably those which are tantamount to criminal allegations. This document proposes that conduct panels should deal only with charges which are sufficiently serious to call the doctor’s registration into question. Those factors make a persuasive case for conduct panels to retain the criminal standard of proof for findings of fact. There are also telling practical arguments. Many conduct cases involve a long list of charges and it would not be practicable to apply varying standards of proof to the charges on the list.

41. To the extent that other types of panel may need to make findings of fact in circumstances where a doctor’s registration is in question, the standard of proof they apply shall also be the criminal standard.

Proposal 15: The standard of proof for all findings of fact where a doctor’s registration is in question should be the criminal standard.

Less serious conduct charges

42. Annex D considers a new facility to issue a reprimand in response to misconduct allegations which, after investigation, are found to fall short of calling registration into question. The matters considered may well have been dealt with by the NHS complaints procedure or an employer-based disciplinary hearing. The GMC considers that, as the doctor’s registration would not be at stake, and in view of the lesser seriousness of the charges, a sliding civil standard of proof (which might vary in proportion to the seriousness of the matters alleged) should be used. This approach, which is widely used in the civil courts and elsewhere, would meet the test of proportionality and fit with employer-based processes.

Proposal 16: The standard of proof for findings of fact where a doctor’s registration is not in question should be the civil standard.

Standard of proof: summary of conclusions

43. In summary, the conclusions on the standard of proof are:

a. It applies only to findings of fact. It is not relevant to judgements that panels make.

b. Fitness to Practise adjudication panels should continue to use the criminal standard for findings of fact.

c. The facility to issue a caution proposed in Annex D should be on the basis of the sliding civil standard.
44. The GMC considers that it would be helpful for the relevant standard of proof to be made explicit in legislation.

Conduct hearings

An inquisitorial or adversarial process?

45. An inquiry into allegations of misconduct is a mixture of an adversarial and an inquisitorial process. The adversarial element is perhaps more obvious to the casual observer, but the value and significance of the inquisitorial element – the facility for panel members directly to question witnesses – should not be overlooked. It is particularly helpful where clinical issues are raised, as it is often as a result of questions from the medically-qualified panel members that significant facts are established.

46. Acting fairly to protect patients proposed moving towards an inquisitorial process, whilst maintaining the defendant’s right to a fair hearing. The underlying concern was to explore whether there were opportunities to allow thorough and fair testing of the allegations made against the doctor but without having to mimic the procedural rules of criminal trials. There was also a need to address the concern raised by some commentators (although others disputed it) that conduct hearings are oppressive and upsetting for witnesses.

47. Following the consultation process, the GMC examined whether there are working and effective examples of inquisitorial processes which the GMC could draw on. The models examined included employment tribunals (including the appellate body the Employment Appeal Tribunal), oral hearings of the Personal Investment Authority Ombudsman (PIAO), coroners’ inquests and the inquisitorial mode of investigating criminal matters used in some European countries.

48. These models differ from GMC conduct hearings in fundamental respects. For example, employment tribunals, the Employment Appeals Tribunal and the PIAO are essentially dispute resolution procedures and coroners’ inquests aim to establish the facts about a person’s death. By contrast conduct hearings are concerned with establishing whether a named individual did not or did not commit certain acts and, where the allegations are made out and are judged to be serious, the panel has the duty of determining whether the doctor’s registration (and therefore livelihood and reputation) should be affected.

49. But even the ‘inquisitorial’ models allow for vigorous cross-examination of witnesses. The key difference is that the panel has more responsibility for conducting an investigation but in circumstances where serious allegations against a named individual are not the main focus.

50. The GMC has concluded that the current hybrid style of conduct hearings is fit for purpose and should be retained.
Improvements to conduct hearing processes

51. However, there are significant changes which should be made to make the processes in conduct cases more effective and less intimidating.

52. The consultation document explained that the GMC planned to pilot proposals developed by a working group chaired by Lord Carlile QC to introduce systematic case management of the planning of conduct cases. That pilot is expected to begin shortly on a voluntary basis and will involve the GMC and the doctor and his representatives working to a pre-hearing protocol intended to ensure the case proceeds according to an agreed timetable. This will be accompanied by full bi-lateral disclosure between the GMC and doctor of the information on which each side intends to rely. The principles of case management recommended by Lord Carlile’s group are already standard practice in the courts and elsewhere, and are generally recognised as valuable by those who use them.

53. This pre-hearing process, which is expected to reduce the length of the hearings themselves and wasted hearing days, will be overseen by a legally qualified assessor. He or she will be a senior barrister or solicitor of many years standing. It would be sensible for those who supervise the pre-hearing process to be drawn from the list of appointed Legal Assessors (as by virtue of that appointment they would have the necessary seniority, independence and knowledge).

54. Provided that the pilot is successful, the GMC proposes to build on it. This would go further than the mere exchange of evidence by the parties and involve the legally qualified assessor in determining what points were agreed, identifying issues which were in dispute and agreeing with the parties the witnesses they would call. Both prosecution and defence would have unrestricted rights to call witnesses.

55. The documentation emerging from this process would be copied to the panel members before they sat on the case. This would in itself be a significant step forward since at present panel members arrive at the hearing with no knowledge other than the name of the doctor and the details of the charge. This requires the laborious ‘reading into the record’ of all the evidence, a process which can be very time-consuming and for which there is no good reason bearing in mind that panel members will not have had any involvement in the preparation of the case. The opportunity to read the evidence in advance will not be prejudicial.

56. These changes will enable more orderly timetabling of cases, more efficient use of resources, more focused hearings and a far more effective process overall.

Proposal 17: The process for conduct hearings should be re-modelled, in particular, to facilitate the exchange of evidence between the parties before the hearing and the disclosure of evidence to panel members.

Chairing conduct cases

57. The consultation document invited views on whether conduct hearings should be chaired by a senior lawyer or by a GMC medical or lay member. The arguments for using a lawyer in this role were essentially about suggestions by certain
commentators that some counsel are unwilling to accept the authority of non-lawyer chairmen, that the increasing technicality of the proceedings requires legal expertise in charge of them and that legally-qualified chairmen would command greater confidence than member chairmen. Responses on this issue were quite evenly divided, although a small majority considered that the chairman should be legally-qualified. It is striking that those who have advocated the need for legally-qualified chairmen are drawn both from groups representing doctors and groups representing patients and consumers. It is also clear, however, that many of those in favour of legally-qualified chairmen have not appreciated the extent to which the separation of the investigation and adjudication functions, in particular, the exclusion of Council members from participating in adjudication panels (see paragraph 7) will transform the reality and perception of panels at a stroke. The arguments for legally-qualified - and therefore 'independent' - chairmen look less persuasive once the entire panel has no direct GMC connection.

58. The consultation document presented the options as mutually-exclusive alternatives. The GMC has concluded that this is rather simplistic and, instead, it is useful to look at a more flexible approach accepting that there are instances where a legal chair would be appropriate and some where it would not be necessary. Examples of the former might include:

a. Long or complex cases (where the evidence was voluminous and difficult to master without legal training).

b. Cases involving many difficult legal or procedural issues.

c. Cases which in advance of the hearing were the subject of widespread public or professional concern or comment, for example, because the events involved had previously been the subject of a public inquiry or other high-profile or controversial investigation.

59. It may be objected that it will be difficult to predict which cases should have a legally-qualified chair. If the process were to remain as it currently is that objection would have force. However, the decision as to the category of chairman will become part of the case-management process, during which both the nature and quantity of the evidence and the issues in dispute will be known well before the hearing begins. It will be open to either party, in advance of the hearing, to make a submission that one or more of the criteria identified in the previous paragraph applies and that a legally-qualified chairman would be appropriate. The final decision will rest with the legal supervisor.

60. The legally-qualified chairman would need to be a senior member of the legal profession and be of similar standing and experience to those who serve as legal assessors.

Proposal 18: Conduct cases which meet appropriate criteria should have a legally-qualified chairman.

61. There would be no need for a legal assessor in addition to the legally-qualified chairman. He or she would be the committee’s source of expert legal advice. The
GMC also considers that a legally qualified chairman, like other chairmen, should have a vote. The arguments for not allowing him a vote seem to stem from concerns that he would exercise disproportionate influence on other panel members. The GMC understand why this argument is made but does not accept it. Members of adjudication panels are obliged to follow their own conscience and judgement in making decisions. They are not susceptible to being influenced in this way. To exclude the Chairman of a panel from voting, whatever his background, would diminish his standing and make it impossible for him to discharge his function effectively.

Role of the complainant in conduct cases

62. Currently, complainants have a right to be heard at any fitness to practise hearing triggered by their complaint. That is often an essential and valuable part of the process. However, the procedure rules of the Professional Conduct Committee (although not the Health Committee or CPP) also allow individual complainants to present their own cases or to instruct the GMC’s solicitors or other solicitors to represent them. This has led to significant difficulties in some cases due to unfamiliarity with the process on the part of complainants or their legal representatives (who may themselves be presenting a case at the GMC for the first time) or unfamiliarity with GMC guidance on professional standards or the meaning of fitness to practise. There are also particular practical difficulties in handling cases where there are a number of complainants, each of whom may be presenting their own case.

63. At times these problems have jeopardised the presentation of cases to such an extent that there has been a real risk that a dysfunctional doctor could be able to carry on practising because facts or arguments which should have been put forcefully to the committee have been advanced ineptly or not at all. That cannot be right or be in the public interest.

64. The presentation of conduct cases must be on the basis of the public interest in protecting patients from unfit doctors. The right of complainants in pursuing grievances form part of the wider public interest, but must not overtake it altogether. It is essential that complainants retain the right to be heard, but the presentation of any fitness to practise case, including conduct, is a specialist and complex regulatory function best undertaken by the regulator.

65. The GMC recognises that this proposal will attract some controversy. But it needs to be seen in a broader context. That context includes:

a. The removal of the requirement for a sworn statement, making access to the procedures far easier than before.

b. The separation of the presentation and adjudication functions.

c. The fact that this will bring the conduct procedures into line with the health and performance procedures.
d. The continuing right of the complainant to be heard at an appropriate point in the process.

e. The fact that no other regulator with the scale of responsibilities which the GMC has provides a facility for complainants to present their own cases.

**Proposal 19:** The presentation of all fitness to practise cases should in future be undertaken by the GMC.

**Public access to fitness to practise hearings**

66. Conduct hearings generally take place in public (although there is provision for part of the proceedings to take place in private if there is strong public interest justification due to the nature of the evidence, for example, highly confidential information about the doctor’s health or information that could prejudice a forthcoming criminal trial) It is entirely proper that conduct hearings should continue to take place in public.

67. By contrast, performance hearings take place in private unless the doctor requests a public hearing. The justification for this has been that the performance procedures are rehabilitative and that this principle would be undermined if hearings took place in public. This argument has force, but there are powerful counter-arguments to it. Where appropriate, the performance procedures provide a process through which, without publicity, a doctor can remedy his deficiencies within a framework which ensures that patients are not put at risk. However, if following assessment the deficiencies appear to be too serious to adopt that approach and the case is referred for adjudication, the GMC considers that there is a legitimate public interest in the outcome of the adjudication which justifies the proceedings being held in public. The GMC therefore considers the presumption should be that performance panels will meet in public but, as with conduct panels, they should have the power to hear part or all of the proceedings in camera on the application of the doctor or the GMC (or as result of a decision by the panel itself). This might be necessary, for example, to protect patient confidentiality. It would be for the party making the application to justify why the normal expectation of a public hearing should be set aside. Even where some or even all of the evidence was heard in private, however, the determination should be delivered in public.

68. However, the GMC sees no case for health panels to meet in public unless the doctor specifically requests a public hearing and the panel is satisfied that the doctor is in a position to make a responsible judgement about what is in his own interests.

**Proposal 20:** Fitness to Practise adjudication panels should normally meet in public, other than in health cases which should continue to be heard in private.

**Witness care**

69. The fact that conduct hearings (and in the future performance hearings) take place in public means that giving evidence is inevitably going to remain a difficult
experience for many witnesses (including the doctor whose fitness to practise is in question). That is unavoidable. It is not possible to prevent witnesses from being vigorously cross-examined. In fact, it is both necessary and desirable, even if a wholly inquisitorial style were adopted, given the issues at stake. It is essential that witnesses are not browbeaten but it should not be overlooked that both Chairman and the legal assessor can and do intervene where questioning by counsel oversteps the mark.

70. The GMC has already made significant progress towards ensuring that witness are properly supported, for example, by appointing Witness Liaison Officers to provide a comprehensive support and information service to witnesses. But the GMC recognises the need for explicit standards of witness care similar to those now used in the courts. The National Standards of Witness Care in England and Wales, developed by the Trials Issues Group, provides a suitable model which could be adapted to the circumstances of PCC hearings. The purpose of committing to explicit standards would be to enable potential witnesses to know precisely what to expect and to provide a benchmark for measuring performance. Although questions about the standards of care for witnesses have arisen in the context of conduct panels they are equally applicable to witnesses giving evidence to other panels.

Proposal 21: The GMC should commit to explicit standards of service for witnesses.

Location of hearings

71. Another factor which is a source of stress for doctors and complainants is the need to travel to London where, by custom and practice all committee hearings have normally taken place. The GMC is currently exploring the option of holding some hearings away from London at locations closer to the communities within which the doctors and other witnesses involved live and work. This proposal would potentially apply to hearings of all the adjudication committees. As a first step, the GMC intends to hold a pilot to assess the feasibility of holding hearings outside London. Further details will be announced as soon as they are available.

Media reporting of fitness to practise proceedings

72. Historically there has been tension around the pre-reporting of GMC cases. Unlike the court, fitness to practise panels have no powers to prevent prejudicial material being published before a case is heard. Nor is it possible to guarantee the anonymity of witnesses in sensitive cases and – regrettably – there have been cases where vulnerable witnesses have been named in the media despite the details having been anonymised for the purposes of the hearing.

73. Slightly different issues arise about the reporting of certain IOC cases. Where an interim order is imposed the details are published on our website. There have been concerns in cases where there is also an ongoing police investigation that those inquiries could be prejudiced because of the absence of a GMC power to restrict reporting.
74. The GMC sees a case for limited reporting restrictions in some cases both before and during proceedings, but recognises the need for a wider public debate. The issue is likely to be of concern to other healthcare regulators and may be one which the proposed Council for the Regulation of Healthcare Professionals may wish to consider once it is established.