
5b - Fitness to Practise: Consensual Disposal and Voluntary Erasure: Outcome of Consultation - Annex A

General Medical Council Consultation Proposals to extend the use of consensual disposal

Introduction

This consultation considers proposals to make more effective use of our powers to conclude appropriate cases at the investigation stage of our fitness to practise procedures, by agreeing undertakings with doctors. We refer to these powers as 'consensual disposal'.

When our new rules were introduced in 2004 they contained a power to agree undertakings with doctors at the end of the investigation stage in cases where a health or performance assessment had been undertaken.

In 2007 we extended these powers to misconduct cases. However, because these powers are subject to a range of criteria which have proved restrictive, we are agreeing undertakings in a relatively small number of cases. Only seven additional cases have been dealt with by consensual disposal since we extended our powers in 2007.

We believe that the agreement of undertakings at the end of the investigation stage provides a more proportionate way to respond to certain types of concerns about doctors, particularly where the concerns are about their performance. For this reason, we would like to extend the use of consensual disposal to all cases involving a doctor's performance, unless the case is so serious that the doctor would be likely to be erased by a Fitness to Practise panel.

In seeking to ensure our procedures are proportionate we are also considering changes to the way we approach the issue of applications for Voluntary Erasure by doctors who are within our fitness to practise procedures. Currently, although our guidance makes provision for Voluntary Erasure to be granted in certain cases we have traditionally taken a cautious approach and we would like to explore whether we could extend the number of fitness to practise cases in which we grant Voluntary Erasure, with appropriate safeguards.

This paper sets out some of the issues raised by these proposals, including an examination of the benefits and drawbacks and seeks views on how we should proceed.

The General Medical Council

The General Medical Council is the independent regulator for doctors in the UK. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do that by controlling entry to the medical register and setting the educational standards for medical schools.

We also determine the principles and values that underpin good medical practice and we take firm but fair action where those standards have not been met.

Our role in dealing with concerns about doctors

Our role as set out in statute is to protect, promote and maintain the health and safety of the public. We are not a complaints handling organisation and this means that our purpose is not to resolve individual complaints but to protect patient safety. In doing so, we focus on the most serious concerns that might require us to remove or restrict a doctor's right to practise.

An individual complaint may be the means by which we are alerted to serious concerns about a doctor that may require us to take action but in other circumstances an individual complaint, whilst valid, may not reveal serious concerns which require action by us. In these cases, the complainant may still have a valid complaint, but resolution of that complaint is the role of other bodies or procedures such as the NHS complaints process, the ombudsman or the court system.

Fitness to Practise panels have a number of sanctions available to them when they find a doctor's fitness to practise is impaired; erasure from the register, suspension from the register and the imposition of conditions on a doctor's registration. These are set out in more detail at Annex A.

What are Undertakings?

As well as imposing the sanctions described above, a Fitness to Practise panel can also agree undertakings with a doctor which allow a panel to restrict a doctor's practice or to set out measures for development and rehabilitation.

Compared with conditions, the significant distinction is that undertakings are agreed with the doctor rather than imposed. For all practical purposes, undertakings are indistinguishable from conditions imposed by a Fitness to Practise panel. Undertakings are managed and monitored by the GMC in the same way and we can act when there is a failure to comply with the undertakings; and we may, if necessary, refer the doctor to a Fitness to Practise panel hearing.

Current undertakings are published on our website via the List of Registered Medical Practitioners and are disclosed to any enquirer, except when they relate directly to a doctor's health.

What is Consensual Disposal?

An important feature of our fitness to practise procedures is our consensual disposal powers which allow us to agree undertakings with doctors at the investigation stage instead of referring the case forward for a hearing before a Fitness to Practise panel. If properly managed, undertakings provide a valuable tool for responding effectively and proportionately to fitness to practise concerns. Consensual disposal enables us to intervene at an early stage and agree measures to protect patients, by restricting the doctor's practice or by setting out measures for rehabilitation and development where appropriate. In order to put undertakings in place at the investigation stage, the doctor must give their agreement.

Our current powers provide for the agreement of undertakings in all types of cases apart from those cases where there is a realistic prospect that the doctor would be erased, if the allegations were referred to a Fitness to Practise panel hearing. However, our current provisions are subject to a range of criteria which have proved restrictive and, as a result, the number of cases in which we agree undertakings is relatively small.

The purpose of our fitness to practise procedures

The primary purpose of our fitness to practise procedures is to protect the public either by removing a doctor from practice or by placing restrictions on their practice. Our purpose is not to punish doctors although our sanctions may sometimes have that effect.

In operating our procedures we aim to respond proportionately to concerns about doctors. We assess the seriousness of the incident reported to us, and the extent to which a doctor has departed from the standards in *Good Medical Practice*.

In relation to concerns that are so serious that formal action is required to remove a doctor's right to practise, either through suspension or erasure, our objective is to take action robustly and effectively. These sanctions are likely to be appropriate, for example, when a doctor has been convicted of a serious offence or when their conduct demonstrates they are unsuitable to continue to practise as a doctor, for example, following a serious sexual assault.

Most doctors aim to provide patients with a high standard of care but doctors, like all professionals, may occasionally make mistakes. In cases where a doctor has experienced difficulties in his clinical practise we believe that an emphasis on retraining and rehabilitation may be more appropriate and effective in protecting patients.

The benefits of consensual disposal

There are a number of potential benefits from extending our use of consensual disposal in cases where a doctor's clinical treatment falls below the expected standard.

In relation to underperforming doctors, consensual disposal provides an opportunity, with a doctor's agreement, to develop arrangements to protect patient safety and get retraining and rehabilitation plans in place quickly. This increases the likelihood of the doctor being able to return to safe unrestricted practice in the future and continue to contribute to good quality healthcare for patients.

Retraining and rehabilitation can provide support for doctors who may find themselves in a difficult or vulnerable situation and who most need it. Arguably, a period of suspension for a doctor whose skills are compromised may simply exacerbate the problem by causing their skills to become further compromised and by removing opportunities for any retraining and rehabilitation.

The Government White Paper, *Trust Assurance and Safety*, suggested that an emphasis on retraining and rehabilitation for underperforming doctors would encourage colleagues to report poor practice more often and increase patient safety and standards of healthcare. On balance, we support this view and believe an emphasis on the establishment of quick, effective retraining plans for underperforming doctors together with appropriate restrictions on practice is the best way to protect patients, in appropriate cases.

We believe the agreement of undertakings with a doctor in cases involving poor performance, where retraining and rehabilitation is likely to be effective, is more proportionate than referring them to a Fitness to Practise panel. Do you agree?

Do you think this approach will impact disproportionately on any particular groups?

We believe that undertakings, particularly involving requirements relating to remediation or retraining, are more likely to be effective in performance than misconduct cases. Do you agree?

The Government White Paper suggested retraining and rehabilitation is likely to encourage health professionals to report poor performance in colleagues. What are your views on the advantages and disadvantages of an emphasis on retraining and rehabilitation when dealing with poor performance in doctors?

The potential drawbacks of consensual disposal

Nonetheless, there is another important aspect of professional regulation that needs to be considered. As well as addressing the risk posed to patients by the actions or omissions of an individual doctor, regulatory action also sends a message to the profession about acceptable standards and behaviour and acts as a deterrent.

The sanction of suspension plays an important role in sending a message to the profession about acceptable standards and behaviour. The prospect of a public hearing also plays an important part in the 'deterrent effect'. In relation to the proposed changes, thought needs to be given to whether the extension of consensual disposal will undermine this 'deterrent effect'.

In our experience, underperforming doctors do not generally underperform because they have no desire to deliver good care, but because they encounter difficulties in their professional life. This may be due to lack of appropriate training or supervision or because they lack awareness about their performance. Arguably, the 'deterrent effect' is likely to be less effective in relation to these doctors than in relation to misconduct issues and there is a danger that a period of suspension may exacerbate their shortcomings.

It is also worth noting that undertakings are not without their 'deterrent effect'. Undertakings are published on the List of Registered Medical Practitioners, which for most doctors is a highly significant sanction and can have an effect on their employment prospects, in both the short and long-term.

When will consensual disposal not be appropriate?

That said, there is a category of underperforming doctors where retraining and rehabilitation is likely to be inappropriate, for example, where a doctor refuses to recognise their shortcomings and co-operate with proposals for rehabilitation. The 'deterrent effect' of a public hearing will remain a priority for the GMC in relation to these doctors.

There is also a category of doctors whose shortcomings are so profound that removal from the register is the only appropriate action. We propose that we should retain the current rule Rule 10(5) which provides that decision makers at the investigation stage shall not invite the doctor to agree undertakings, when there is a realistic prospect that the doctor would be erased, if the allegations were referred to a Fitness to Practise panel hearing.

Why do we want to extend consensual disposal?

Ultimately, our objective in seeking to make better use of our consensual disposal powers is to encourage mature, responsible behaviour in doctors whilst at the same time protecting patients. In particular, we hope to encourage doctors to recognise any failings and undertake retraining or rehabilitation at the earliest possible opportunity.

We believe that there is a category of doctors whose shortcomings are so profound that removal from the register is the only appropriate action. Do you have any comment to make on this approach?

We believe that undertakings published on the GMC register and which remain on a doctor's entry on the List of Registered Medical Practitioner's for life are effective in sending a clear message to doctors about acceptable standards and behaviour. Do you have any comment to make on this approach?

Our objective in seeking to extend our use of consensual disposal is to encourage a more mature responsible approach in doctors to recognise their failings and take appropriate action. Do you think this is the right approach?

Our current policy on Voluntary Erasure in fitness to practise cases

Applications for Voluntary Erasure by doctors within our fitness to practise procedures are referred to a lay and medical case examiner. In making their decision the Case Examiners consider whether the public interest will be protected should Voluntary Erasure be granted. The guidance recommends that this is likely to be in cases where the doctor has formally admitted the allegations and the allegations and evidence relate exclusively to health or performance issues, particularly where the doctor is subject to undertakings following a health and performance assessment.

Why do we want to encourage greater use of Voluntary Erasure in fitness to practise cases?

Our application of the guidance for dealing with applications for Voluntary Erasure in fitness to practise cases has been cautious and very few cases are agreed. We believe that greater use of Voluntary Erasure in fitness to practise cases could contribute to a proportionate approach to dealing with concerns about doctors. Voluntary Erasure provides immediate and effective protection to the public by removing the right of a doctor to practise.

However, any process for agreeing Voluntary Erasure in fitness to practise cases would need to contain appropriate safeguards if the doctor sought future restoration to the register. We would propose to make greater use of formal agreements with doctors containing admissions of impaired fitness to practise. In relation to doctors where such an admission cannot be achieved we would seek to develop guidelines about the sorts of cases where, should the doctor apply for restoration at a future date, the evidence of any alleged misconduct would remain intact so that the investigation into that alleged misconduct could be successfully revived. Flags would be placed against the doctor's name within our database so that any future restoration application was referred into our fitness to practise procedures.

There may be an argument that the public interest may also be served by complaints against doctors being heard in public and Voluntary Erasure would prevent this from happening. On balance we believe that, where doctors have applied for erasure from the register, there is insufficient benefit in terms of public protection in taking such doctors to a formal hearing, particularly in view of the stress for any witnesses involved.

Do you agree that we should extend our use of Voluntary Erasure as described in this consultation paper?

If not, please explain why.

Do you have any other comments to make on this proposal?

Do you think this proposal will impact disproportionately on any particular groups?

How would we take the changes forward?

Our consensual disposal powers are contained in Rule 10 of the Fitness to Practise Rules 2004. Rule 10 is supported by detailed guidance for our decision makers which sets out the circumstances in which undertakings should be agreed. The current approach to consensual disposal has been influenced significantly by the guidance and by the criteria for agreeing undertakings contained in that guidance, which have proved to be unduly restrictive.

Extending our use of consensual disposal would require amendment to that guidance and a re-examination of the criteria for seeking to agree undertakings with a doctor. The proposed revised guidance is attached as an Annex B to this consultation paper. It places more emphasis on the importance of considering options for retraining and rehabilitation and states that where the concerns are primarily about the doctor's clinical practice, case examiners should seek where appropriate to resolve the case by consensual disposal.

Rule 10 reflects the fact that there are some categories of concern which are potentially so serious that erasure is likely to be the only appropriate response in order to maintain wider public confidence both in the profession and in our procedures. We consider that this remains an important safeguard and we are not proposing to amend this rule.

Extending our use of Voluntary Erasure in fitness to practise cases would require a review of our guidance and our processes.

Do you agree we should extend our use of consensual disposal as described in this consultation paper? Do you have any other comment to make on this proposals?

Revised guidance on undertakings is attached to this consultation. Do you agree with the approach taken in the guidance? How could it be improved? Do you have any other suggestions to make regarding the guidance?

We are proposing to retain the rule that provides that decision makers at the investigation stage shall not invite the doctor to agree undertakings, when there is a realistic prospect that the doctor would be erased, if the allegations were referred to a Fitness to Practise panel hearing. Do you agree with this approach?

Do you agree that we should extend our use of Voluntary Erasure as described in this consultation paper? Do you have any other comments to make on this proposal?

Do you have any comments to make about any of the proposals in this paper in relation to how they might impact on particular groups, either to their advantage or disadvantage?

Why is this consultation process taking place?

We wish to seek views on our proposals to extend the use of consensual disposal. We would welcome your comments on any aspect of the changes.

How to comment

You can take part in an online version of the consultation, or you can download the main consultation document and respond in writing, either by e-mailing or by sending your response to:

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This consultation runs from 19 May 2009 to 19 August 2009.

Further information

If you have any questions about the consultation please contact Michael Cotton on 020 7189 5168 or by e-mail to ftpconsultation@gmc-uk.org

Annex A

Our current powers for responding to concerns about doctors

If a Fitness to Practise panel makes a finding that a doctor's fitness to practise is impaired following a hearing, it can impose a range of sanctions depending on the seriousness of the issue.

Erasure

In the most serious cases a panel can erase a doctor from the register. This means that the doctor cannot practise in the UK for at least five years and the expectation is that he or she is unlikely to practise again. Erasure is the appropriate response when a doctor's conduct or behaviour falls so far below the standard set out in *Good Medical Practice* so as to be fundamentally incompatible with continuing to practise as a doctor.

Suspension

Our powers allow a panel to suspend a doctor for a period of up to twelve months which can be extended upon review. Suspension is an appropriate response to a concern which is so serious that action is required in order to protect patients and maintain public confidence in the profession by preventing the doctor from practising during the period of suspension.

While suspending a doctor is effective in ensuring patient safety, by removing the doctor's right to practise, suspension also removes any opportunities for retraining and development.

Conditions

A Fitness to Practise panel can also impose conditions on a doctor's registration. Conditions may restrict a doctor's practice or set out the steps for retraining or development that the doctor must undertake in order to address the concerns that have been identified. Conditions are appropriate when concerns about the doctor's practice are such that a period of retraining and/or supervision is likely to be the most appropriate way of addressing them.