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## 5b

*To consider*

### **Fitness to Practise: Consensual Disposal and Voluntary Erasure: Outcome of Consultation**

#### **Issue**

1. Responses to our consultation on proposals to extend the category of cases which can be concluded with undertakings at the investigation stage and proposals to amend the procedure for agreeing voluntary erasure when there are outstanding fitness to practise issues.

#### **Recommendations**

2.
  - a. To note the responses to the consultation (paragraphs 16-39 and Annexes A and B).
  - b. To approve the revised guidance on consensual disposal (paragraphs 40-42 and Annex C).
  - c. To agree that we amend our procedure for considering applications for voluntary erasure when there are outstanding fitness to practise issues (paragraphs 43-44).

#### **Further information**

3. If you require further information about this paper, please contact us by email: [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org) or tel. 0161 923 6602

## Background

4. The proposed amendments to our fitness to practise procedures outlined in this paper support Key Aim Seven of the 2009 Business Plan: To enhance patient safety by dealing fairly and effectively with doctors whose fitness to practise may be impaired. The Business Plan emphasises the importance of the continuous improvement of our fitness to practise procedures.

5. On 25 February 2009 Council agreed that we should consult on proposals to extend the category of cases which can be concluded with undertakings at the investigation stage and on proposals to amend the procedure for agreeing voluntary erasure when there are outstanding fitness to practise issues. Council agreed that the Fitness to Practise Reference Group should oversee the consultation process.

### *Consensual disposal*

6. 'Consensual disposal' refers to the conclusion of conduct cases at the investigation stage of our fitness to practise procedures, by agreeing undertakings with a doctor, as an alternative to referring the case forward for a Fitness to Practise Panel hearing. Case examiners may, in appropriate cases, accept undertakings from the doctor when it appears that the doctor's fitness to practise is impaired but they are satisfied that those undertakings will protect the public interest.

7. Consensual disposal is likely to be appropriate when we consider that there are opportunities for retraining and remediation which would both protect patients and the public and allow the doctor to return to practice.

8. We extended the potential opportunities for agreeing undertakings in 2007 by way of an amendment to the Fitness to Practise Rules 2004. The amendment extended their availability to all cases, except where there is a realistic prospect that the doctor would be erased if referred to a Fitness to Practise panel hearing.

9. However, the 2007 rule change has not had the impact that we envisaged. Only seven cases were concluded under the amended provisions between November 2007 and March 2009.

10. The consultation followed an operational review, aimed at identifying any factors that might be contributing to the small number of cases in which we have exercised our consensual disposal powers. The review highlighted the need to revise the guidance on undertakings for decision makers at the end of the investigation stage.

11. We have carried out a limited modelling exercise to try to gauge the number of cases which might be affected by the proposed change. We reviewed FTP Panel determinations for a three month period to identify those which might have been concluded with undertakings, if the revised guidance was in place. In making the assessment we included cases which resulted in conditions requiring retraining, teaching or ongoing supervision, suspension cases which required the doctor to demonstrate remediation at a further panel hearing and cases which resulted in undertakings at the Panel stage. For all cases we examined the transcripts to identify those cases where the doctor was likely to agree to undertakings where they showed insight and a willingness to co-operate. We anticipate that the proposed change may lead to in the region of 30 additional cases being concluded with undertakings at the investigation stage each year.

#### *Voluntary erasure in fitness to practise cases*

12. The consultation also considered the question of how we handle applications for VE by doctors within our fitness to practise procedures. VE refers to the process of a doctor voluntarily removing their name from the Medical Register. We consider that both consensual disposal and VE have a contribution to make in ensuring that we respond proportionately and appropriately to fitness to practise concerns.

13. In most cases, there are no barriers to prevent a doctor from applying for VE. When there are outstanding fitness to practise issues, however, applications are considered by Case Examiners to assess whether VE should be granted in all the circumstances. We have detailed guidance on how this test should be applied.

14. Our application of the guidance for dealing with applications for VE in fitness to practise cases has been cautious. The consultation paper suggested that greater use of VE in fitness to practise cases could contribute to a proportionate approach to dealing with concerns about doctors; it provides immediate and effective protection to the public by removing the doctor from the Medical Register.

15. We recognise that any process for agreeing VE in fitness to practise cases would need to contain appropriate safeguards if the doctor sought future restoration to the Medical Register. The consultation paper proposed safeguards that included making greater use of formal agreements with doctors including admissions of impaired fitness to practise.

#### **Discussion**

16. We consulted for a period of three months from 19 May to 19 August 2009. We wrote to a range of key interest groups and the consultation was published on our website. A copy of the consultation paper is at Annex A.

17. In developing the consultation paper, we recognised that a particular difficulty would involve explaining and justifying the approach to some key interest groups and to the wider public.

## *Reference Community seminar*

18. In order to ensure that we captured a patient and public perspective, we held a seminar event with a number of lay members of our newly formed Reference Community. The seminar used a number of case studies to look at how we might respond to different types of concern and in particular, the types of case in which consensual disposal might be appropriate.

19. While they saw the public nature of hearings as a strength, the group thought that delay, expense and stress for complainants were significant shortcomings, making them less suitable for the majority of performance related cases. The group drew a distinction between cases that were about the doctor's performance and those that were primarily a question of conduct.

20. They felt that undertakings were likely to be the appropriate response in many cases, particularly where the concerns were about the standard of the doctor's practice. The group was unanimously of the opinion that it would be inappropriate for the GMC to take a punitive approach to poorly performing doctors and they thought that the priorities in responding to the majority of performance related concerns should be speed of response, transparency and a means of directly addressing a doctor's shortcomings.

21. Participants indicated publication of undertakings (which are effectively restrictions on the doctor's registration) on the online register and monitoring and enforcement were important in maintaining public confidence.

22. However, there was agreement among those attending that consensual disposal would not be appropriate in all cases. In some cases, the nature of the issues meant that a public hearing would be required, in particular, because where there was a likelihood of the doctor being erased.

## Written responses to the consultation

23. We received 31 written responses to the consultation. A summary of responses is attached at Annex B. Dr Hamish Wilson, a member of the Fitness to Practise Reference Group, reviewed the responses to the consultation, and verified that the summary of responses reflects the range of responses.

24. The majority of those who provided written responses supported the proposals to extend the use of consensual disposal. The majority of written responses were submitted by medical organisations and by individual practitioners.

25. Many welcomed the opportunities for what they perceived to be a more appropriate and potentially speedier response to concerns. Many respondents concluded that undertakings were, in many cases, preferable to suspension which would remove the doctor from practice and from opportunities for remediation.

26. All respondents agreed that there would remain a cohort of cases which, because of the nature of the concerns, would need to proceed to a Fitness to Practise Panel hearing. In addition, a common view was that the process needed to be supported by a robust framework, in particular for ensuring compliance with any undertakings agreed.

27. The Council for Healthcare Regulatory Excellence, while acknowledging that use of consensual disposal and voluntary erasure could provide a more proportionate response in some cases, also expressed some reservations about any extension of its use. CHRE considered that the approach could give the impression that concerns were being dealt with '*behind closed doors*'.

28. We have subsequently had productive discussions with CHRE where we were able to provide clarification about this aspect of our process and explain in more detail the intention behind the proposal.

29. Action against Medical Accidents, an organisation providing advocacy and legal representation for victims seeking redress, expressed concern about any extension of the use of consensual disposal; in particular that it requires the decision maker to second guess what might happen at a panel. It is worth noting that the case examiners base all decisions at the investigation stage on the likelihood of establishing impairment at a panel hearing so this aspect is not specific to consensual disposal. It is also a characteristic common in most tribunal processes including the court process.

30. A number of parties emphasised the importance of ensuring that there was proper funding and opportunities for retraining and remediation. Several organisations made the point that it can be difficult for doctors who are subject to restrictions to find placements.

31. There were a number of critical comments about the fact that undertakings are published indefinitely. This is based on our well established policy that, once fitness to practise information about a doctor has been placed in the public domain, we should continue to publish it. Many parties commented that this was counter to the aims of remediation and argued that publication should cease once the undertakings had come to an end.

32. Council previously agreed that the publication of undertakings is important in terms of transparency. Any move to change this approach may attract criticism that the agreement of undertakings involves cases being dealt with '*behind closed doors*'. The Fitness to Practise Reference Group has asked that the publication and disclosure of historic undertakings should be considered again, as part of a wider review of our publication and disclosure policies.

33. The majority of respondents also supported the proposed extension of our use of voluntary erasure in fitness to practise cases. Many of the respondents commented that voluntary erasure represented a sensible and proportionate option in many cases.

34. A number of respondents underlined the importance of appropriate safeguards, including guidance on the circumstances in which voluntary erasure would not be appropriate, the publication of relevant information about the issues and a requirement for a clear record of the issues and any relevant evidence which could be reconsidered in the event of the doctor applying for restoration to the Medical Register.

35. Both AvMA and the General Optical Council expressed some concerns about the proposal. The GOC recognised the benefits to the registrant, but questioned whether it added to the protection of the public interest. The GOC argued that it would be essential to have a robust framework and that there should be limits on the types of case in which voluntary erasure might be agreed without a formal admission by the doctor.

36. AvMA suggested that voluntary erasure should not be allowed where there are outstanding concerns, unless there is a full admission by the doctor which remains part of his record.

37. CHRE also expressed some concern about any increased use of VE in fitness to practise cases and were keen that safeguards should include guidance on the process for restoration.

38. We agree that we will need a robust framework setting out the limits on the types of cases in which VE might be agreed without a formal admission by the doctor. As suggested by CHRE an agreed statement of facts may be a useful way forward in cases where the doctor has not provided a formal admission of impairment.

39. We will also ensure that our restoration guidance is clear about how applications for restoration following VE will be dealt with.

**Recommendation:** To note the responses to the consultation.

*Revised guidance on consensual disposal*

40. The revised guidance on agreeing undertakings is at Annex C. It includes a requirement to seek the views of the complainant before agreeing undertakings in misconduct cases. While case examiners will not be bound by the views of the complainant, it will allow them to take them into account when considering the case.

41. We have amended the guidance to ensure it is clear about the types of cases which can be resolved by consensual disposal.

42. In order to address the comments and concerns raised in response to the consultation paper we are also proposing that a number of specific safeguards are introduced when we implement the change:

a. Undertakings are likely to be appropriate when the doctor shows some insight by acknowledging the failings leading to invitation to accept undertakings. However, there may be different ways of demonstrating insight. When implementing the change we propose to provide training for decision makers on how to approach the issue of insight.

b. A number of responses to the consultation suggested that undertakings are somehow a softer option than other sanctions. We are proposing to raise awareness of the fact that undertakings are published on the doctor's online record and are closely monitored, including referrals to a Fitness to Practise Panel where we believe that the doctor may have breached the undertakings.

c. We are proposing to amend our standard letters to explain the proposals for agreeing undertakings to doctors and complainants in appropriate cases.

**Recommendation:** To approve the revised guidance on consensual disposal.

#### *Revised VE procedures*

43. We are also seeking Council's approval of the revised procedures for granting VE in fitness to practise cases. We remain of the view that in appropriate cases VE provides an effective opportunity for removing a doctor from the register, and ensuring patient safety.

44. In order to address the comments and concerns raised in the consultation paper we propose to include a number of specific safeguards:

a. Clear guidance should be developed on the types of cases where VE would be appropriate.

b. VE should only be permitted in those fitness to practise cases which might otherwise proceed to a hearing, when there is an agreed written admission of impairment or an agreed statement of facts signed by the doctor on which the GMC could rely should the doctor later apply to be restored to the Medical Register.

c. A review of our restoration guidance will provide clear guidance for decision makers should a doctor who has accepted VE under these proposals make an application for restoration.

**Recommendation:** To agree that we amend our procedure for considering applications for voluntary erasure when there are outstanding fitness to practise issues.

45. We are in the process of drafting the revised guidance for dealing with applications for VE where there are outstanding fitness to practise concerns and the draft guidance will be brought to the next meeting of the Fitness to Practise Reference Group for agreement on 15 December 2009.

## **Next Steps**

46. Subject to agreement by Council, the revised guidance for consensual disposal and VE will be published on our website. We will also be writing to relevant key interest groups to provide details of our plans for implementing the changes.

47. It will also be important to monitor the impact of the proposed changes to our consensual disposal and VE procedures. We propose to do so through our ongoing quality assurance programme.

## **Resource implications**

48. Implementation of the changes can be met out of the existing budget allocation. Once implemented, the changes should result in more cases being disposed of consensually at the end of the investigation stage and therefore fewer cases being referred for a hearing. This will reduce the number of hearings accordingly although, as undertakings require agreement with the doctor, the numbers may not be substantial. We will monitor the impact once any changes have been introduced.

## **Equality**

49. We have completed an Equality Impact Assessment which was reviewed by the Fitness to Practise Reference Group following the consultation.