Analysis of Responses to the Consultation on Proposed Changes to the GMC’s Fitness to Practise Rules

1. This annex provides an analysis of responses to the consultation on proposed changes to the GMC’s Fitness to Practise Rules.

General comments

2. A number of key interest groups including the Royal College of Radiologists, the Royal College of Physicians and NHS Alliance expressed general support for the proposed amendments and did not make any comments on specific changes.

3. The Board of Community Health Councils in Wales agreed that the proposed changes appeared to meet the stated objectives in terms of ensuring that our FTP procedures are: ‘fair, objective, transparent, effective and efficient.’ The Parliamentary and Health Service Ombudsman (England) commented: ‘Broadly speaking, these changes are straightforward and sensible.’

4. Action Against Medical Accidents (AvMA) expressed concern about what they considered to be ‘a piecemeal approach to tinkering with the rules’ and suggested that it would be preferable to review the rules as a whole.

Specific comments

Rule 2 – Interpretation

5. There were no detailed comments on the proposed amendments of Rule 2.

Rule 3 – Appointment of Specialist Performance Advisers

6. Many respondents expressed concern about the proposed amendment to Rule 3(5)(a). The majority of those who commented argued that if a performance adviser was required and was going to add value, they should be of an appropriate specialty.
7. The Medical Defence Union (MDU) argued that the current wording of Rule 3(5)(a) provides some flexibility and emphasised that ‘There is no requirement to appoint a performance adviser in the same specialty.’

8. The Medical and Dental Defence Union of Scotland (MDDUS) commented: ‘In our experience, the circumstances in which a Performance Adviser can meaningfully comment on performance issues generally without reference to a specialty specific context are relatively rare.’

9. The Medical Protection Society (MPS) also expressed concern about the proposed change and suggested:

‘Whilst specialist knowledge may not be necessary in every case, we suggest that there should be scope for the doctor and his team to have a voice as to whether his case needs and should have a specialist performance adviser.’

10. The Family Doctor Association commented ‘Such a generic approach would reduce the fairness and openness in any investigation of the performance of a GP. A GP’s performance should be judged by his peers.’

11. The Royal College of Physicians of Edinburgh also expressed concerns and commented:

‘If left discretionary, it will be difficult for some panels to predict in advance their need for specialty advice and there may be a delay in proceedings while such advice is sought.’

12. The Academy of Medical Royal Colleges and Faculties in Scotland also argued that it was important to retain the use of specialty specific performance advisers. The Royal College of General Practitioners (RCGP) made the same point, emphasising the different roles of GP’s and hospital doctors. The Royal College of Surgeons of England concurred with that view and also suggested that:

‘Therefore some clearer parameters should be set, perhaps referring to the categories of the specialist register or CCT categories.’

13. The Parliamentary and Health Service Ombudsman (England) commented:

‘From experience of our own casework, natural justice calls for ‘like for like’ assessments of clinical practice where this is being challenged. I agree that if there performance issues under review are clearly unrelated to the doctor’s specialty, then a more flexible approach makes sense, but in view of the seriousness of these procedures, it might be helpful to develop some specific criteria to guide decision-making in this area.’
14. A number of individuals also commented. Dr Terry Collins commented:

‘I fully appreciate the need for greater flexibility and the obvious constraints of requiring a sub-specialist in a busy service to attend a hearing over some weeks. However I feel there should be some regard to the broad specialty to which the allegations relate; for example, in the field of specialist orthopaedic surgery the adviser should have credible clinical experience in orthopaedics and trauma general.’

15. Professor Helen Houston also expressed concern:

‘Performance is only in part due to the knowledge and skills of the individual, as it is also affected by the context in which a practitioner is working. This context includes the specialty in which the practitioner is working. I would have serious concern that someone from a different specialty can understand the context of another - e.g. I doubt that a consultant surgeon would have any understanding of working as a GP through a ‘flu epidemic, and how that might affect the normal quality measures of the specialty; I also doubt whether there can be a genuine understanding of those quality measures from outside the specialty.’

16. Professionals Against Child Abuse (PACA) commented:

‘Regarding the GMC’s invitation to consult on changes to its rules, we would like to express our profound concern at the proposed change to Rule 3 whereby it is planned to dispense with the requirement that the Specialty Adviser to the FTP should be from the same specialty as the doctor under investigation. Indeed in these days of increasing sub specialisation it is even more desirable that the adviser be as familiar as possible with the areas of clinical concern being considered.’

Rule 4 – Vexatious complaints

17. A number of parties expressed support for the proposed power to conclude vexatious complaints at the initial assessment point of our procedures. Organisations including NHS Employers, the MDDUS and the Academy of Medical Royal Colleges and Faculties in Scotland considered that the change would allow the GMC to concentrate on more serious complaints. The latter organisation questioned the GMC’s comments that the power would be used rarely and argued that such a power should be exercised as and when appropriate. The Parliamentary and Health Service Ombudsman emphasised the importance of developing criteria before the power is exercised. The MDU also welcomed the proposed change and indicated that they would wish to be included in any consultation that sought to define the criteria. They also suggested that the criteria should include a stipulation that a doctor who is the subject of a vexatious complaint should have the right to be informed of such a complaint. The MPS also expressed support for the change and underlined the importance of establishing clear parameters.
18. The Royal College of Paediatricians and Child Health (RCPCH) also supported the proposal:

‘We welcome the intention to develop criteria and would propose that this should detect ways of detecting campaigns against individual doctors not just by individual complainants but by a group of complainants acting in concert.’

19. The General Teaching Council of Scotland (GTCS) commented:

‘This would be appropriate provided that the necessary checks and balances are in place so that exceptional circumstances are the only instances when the filtering would come into play at initial consideration.’

20. The RCGP questioned whether it was correct to give assurances that the power would be used rarely; they stated that a decision whether to apply the power should be based on criteria rather than peer referencing.

21. Although the majority of those who responded supported the proposal, a few respondents expressed either reservations about or opposition to the introduction of a power to conclude vexatious complaints.

22. Radcliffes Le Brasseur welcomed the change, but suggested a different approach:

‘We wonder if the better approach would be to adopt as a general principle the wording in the present sub-paragraph (b) and say that complaints should only be investigated if, at the outset, the Registrar is satisfied that the public interest favours an investigation by the Council. We fear that the later development of criteria for exercising the power proposed will lead to dispute, and partly on the ground that there will not be transparency. It may be that this fear would be allayed if the Council gave a commitment to publish the matters it would take into account.’

23. AvMA stated that they strongly disagreed with the proposal:

‘We believe that this would introduce an inappropriate and dangerous element of subjectivity to the decision making process. It is not that we do not believe that there are some complaints which are vexatious. We do not believe that such a power is necessary anyway, as the screening conducted of each and every complaint would in any case ascertain whether or not this complaint should be further investigated (i.e. if it concerns a potential fitness to practise issue).’
POhWER, one of the organisations providing the Independent Complaints Advisory service in England commented:

‘We fully understand that on occasion complainants can be unreasonably persistent and/or adopt behaviours that are unacceptable – and the GMC needs to be able to take appropriate action in such circumstances. However, in our experience, people who fall into this category all too often struggle to express their views and their behaviour is a reflection of their frustration and lack of understanding of process.’

They emphasised the need for clear guidance in a variety of media, including easy read versions.

One doctor commented:

‘This could represent a dangerous potential for the abuse of exercise of power at the very initiation of a complaint. The promise to exercise this power "only rarely" is meaningless. All very concerning if the GMC is to be seen to be protecting the public.’

Rule 4(4) and 4(5) – Five Year Rule

There were very few comments on this proposed change. The few comments received gave support to the proposed amendment. One doctor commented:

‘These changes are likely to be helpful. Considered investigation under 5yr rule, prior to the hearing would hopefully avoid lengthy consideration of such issues by the panel in the hearing.’

The MDU confirmed that they approve of the proposed change.

Similarly, a member of the public commented:

‘I think this will assist in cases where there are matters when more than five years have elapsed as well as other matters that are more recent. In such cases it will be important to have investigated the older matters so that the registrar can decide whether exceptional circumstances prevail, and therefore whether those matters should be added to more recent matters which a panel may consider.’

Radcliffes Le Brasseur expressed some concerns about the types of investigation that might be undertaken before a decision was taken to proceed or not; they suggested that it would be ‘inappropriate and unfair’ for such investigation to include disclosure to the doctor’s employer.

However, AvMA expressed some concerns about the proposed amendment:

We do not believe that rule 4(4) needs to be changed. In our experience, the GMC already exercises its existing power to investigate whether or not a complaint should be investigated which comes under rule 4(5).
32. They also questioned the existence of a time limit within our procedures:

“We believe that more fundamental changes are needed to rule 4(5) (the “five year rule”). Ideally we believe that the GMC should be consistent with the Nursing & Midwifery Council which does not have a time limit. The introduction of a time limit skews the primary focus of the GMC away from protecting the public and the public interest.”

33. They went on to say that if the five year rule is retained, then there was a need to review how it is applied and to develop clear criteria and guidance and suggested that the current guidance should be reviewed. Finally, AvMA also questioned whether the Registrar should be involved in these decisions.

34. GTCS also commented: ‘This is difficult especially when the matter might be associated with an allegation of child protection … Again it is a matter of checks and balances and the nature and work of the profession concerned.’

Rule 10 – Undertakings

35. Again, there were very few comments on this proposed amendment. The MDU stated that they considered it reasonable to give the Registrar powers to lift or vary undertakings agreed at the adjudication stage. One doctor commented:

‘I support this as it will reduce stress for the doctor and reduce expense. I also support the change to Rule 11.’

36. Radcliffes made two points about this proposal. They suggested that the provision should refer to the decision being made by ‘case examiners’ rather than the Registrar. They also expressed concern about the power being used to subvert FTP panel decisions.

Rule 11 – Warnings

37. There were no detailed comments on this proposed amendment.

Rule 12 – Review of decisions

38. There were a number of comments on the proposed changes to Rule 12. The MDDUS expressed concern that the proposed revised wording of Rule 12 ‘places virtually no limit on the power to review even with the caveat that there would still have to be a public interest reason before a review was undertaken. As there is a public interest in ensuring that every case is properly dealt with this is unlikely in practice to be a limiting factor. In our view, the expectation must be that a responsible regulator will deal properly with the vast majority of its cases in the first instance and that reviews will be an exceptional occurrence.’

39. The MDU suggested that the wording of the proposed sub-paragraph 12.2 should be amended to read:

‘(a) the decision is or is likely to have been flawed.’
40. In terms of the process, the MDU argued that the respondent should have an opportunity to comment before the Registrar decides whether to review a decision under Rule 12.

41. The MPS stated that they considered the proposed change to be ‘extremely unfair and unreasonable’. They suggested that the grounds for reviewing a case should be placed in a different order, so that public interest and protection would be placed ahead of a flawed decision as the primary grounds for reviewing a case. The MPS also questioned the proposal to delegate this power to the Registrar.

42. The RCPCH commented:

‘This has a potential for introducing something analogous to ‘double jeopardy’ for investigated and ‘cleared’ doctors. However, if used sensibly, this could also prevent injustice to the practitioner where the decision made is obviously erroneous.’

43. Radcliffes Le Brasseur expressed a number of concerns about the proposed change, in particular, that the proposed change means that the ‘the practitioner never has finality,’ and suggested that a decision to reinvestigate a complaint was likely to do disproportionate damage to a doctor’s reputation.

44. The Parliamentary and Health Service Ombudsman (England) commented:

‘I particularly welcome the suggested revisions to Rule 12, which will widen the categories of decisions which may be reviewed and extend the grounds for a review to cover any decision which may be “flawed” through error of judgement or reasoning, as well as through administrative handling.’

45. The Royal College of Surgeons of England were concerned that:

‘We are also worried that this rule change puts this process at risk of being manipulated if someone outside the process doesn’t like the decision.’

46. AvMA also supported the proposal to extend the circumstances in which decisions can be reviewed. They also argued that ‘it should be a right for complainants/makers of allegations to have a review of a decision by the Registrar and to receive a written explanation of the Registrar’s decision following the review.’ They suggested that the proposed change is not a substitute for providing an independent appeal for complainants and suggested that CHRE should exercise such a role.

47. Parties also expressed concern that a time limit of two years was too long. The MDDUS commented:

‘We suggest that one year would be fairer and would provide ample time in which to identify an error or receive new information. In the rare cases where a review is undertaken, there should be a requirement on the GMC to conclude this expeditiously.’
48. The MDU also argued that a review period of two years was unreasonable.

49. One doctor commented:

‘In general I worry about one implication of this Rule as re-written. The old version allowed (insisted) that someone independent of the original decision was consulted before a change was made. The new version gives this function to the Registrar who was (at least nominally) responsible for the original decision. Thus the Registrar is reviewing his own decision. Would it not be better (and fairer) to include an independent person to have the final say at this stage? Similar provisions already exist for cancellations and postponements.’

50. Similarly another respondent commented:

‘There is a serious risk that reviewing of cases outside the public arena will give the impression of unfairness. Cases should never be reviewed by the Registrar or President once a panel has made a decision (subject to the legal routes for challenge). Internal review would give a poor impression.

This will provide a better safeguard of the public interest and the interest of the practitioner. I would like to see "exceptional circumstances" defined more clearly.’

Rule 13 – Action following Referral

51. There were very few specific comments relating to this proposed amendment. The MDU argued that it would be inappropriate for the Registrar to have the power to direct an assessment of a doctor’s health, for example, in a purely conduct case.

52. Radcliffes questioned whether the proposed power was required and suggested that it is preferable to rely on the FTP Panel’s power to adjourn their consideration of a case.

53. NHS Employers emphasised the importance of ensuring that employers were kept informed.

Rule 17 – Procedure before a Fitness to Practise Panel

54. There were very few comments regarding Rule 17. The MDDUS commented that the proposed changes to 17(2)(m) are sensible.

55. The MDU argued that there may be a minority of cases in which undertakings may be relevant when considering whether a doctor’s fitness to practise is impaired. They suggested that applying the Cohen principles, the offering of an undertaking may be relevant in certain cases at Stage 2.
56. The MPS expressed similar reservations:

‘Given the recent judicial observations on factors relevant prior to a determination of impairment, we do not see the order of the paragraph as sufficient justification for the proposed “clarification”.

57. Radcliffes also argued that written undertakings may be highly relevant to the issue of impairment.

Rule 28 – Cancellation of a hearing

58. There were very few substantive comments on Rule 28.

59. Radcliffes expressed their opposition to the proposed change:

‘If a case is cancelled for any of the reasons referred to within Rule 28, a practitioner should be entitled to treat that decision as final and it would be inappropriate and improper for the GMC to be able to seek to reopen cases once a decision to conclude has been reached.’

60. One doctor commented:

‘These seem eminently sensible. In 28(1) it appears that all decisions to refer to the Investigation Committee can be reviewed, although the other documentation suggests that this is only intended to be used when doctors have been offered a warning, have exercised their right to a hearing and then changed their mind. Is it intended that this covers referrals under Rule 8(5) as well and if so what is the reasoning?’

Rule 40(2) – Service

61. A number of parties, in particular, the medical defence organisations commented on the proposed amendments regarding the service of documents.

62. In particular, they commented that service on solicitors or defence organisations as an alternative to service on the registrant must happen only by prior agreement that it is appropriate in a particular case. The MDU approved of the amendments, on the understanding that service would be to a named solicitor whom the GMC knows to be instructed.

63. GTCS commented: ‘Any strategy which balances the regulator’s right to proceed where service is being used to evade prosecution with the respondent’s right to a fair hearing with due notice is supported.’
64. Similarly, organisations commented that service of documents by email should only be used where there is prior agreement in a particular case that it is appropriate. An individual doctor who responded commented:

‘The doctor’s solicitor should only be contacted this way if they have given prior consent. If notice is sent by email, a paper copy should also be sent to their address. Email is not always reliable.’

65. The MPS expressed reservations about the proposed provision for service by email:

‘We feel that the email serving of papers is inappropriate unless there are safeguards to ensure it is completely secure.’

General – Reference to GMC Unique Identifier

66. There were no comments on this.

Impact on particular groups

67. None of the responses indicated that the proposed amendments were likely to have a particular impact on specific groups apart from the comment made at paragraph 24 by POhWER.

Additional comments

68. One party expressed concern about the delegation of additional powers to the Registrar:

‘These amendments significantly enhance the Registrar’s powers in the Fitness to practice process. It would be useful at this stage to also define the process by which the decisions taken by the Registrar are reviewed and the accountability framework for the Registrar.’

69. Although this Rule was not discussed in the consultation paper, the MDU suggested an amendment of Rule 7(1)(c) to allow the registrant to apply for an extension of the 28-day period. They suggested that ‘there should be a procedure for giving fair consideration to such requests and that the decision to grant an extension should be made by someone who is not the caseworker, who may have contributed to delay in the investigation of a case to date.’

70. Similarly, although this issue was not discussed in the consultation paper, AvMA suggested that the rules should be changed or preclude FTP Panels from adjudicating over claims of abuse of process. They argued that:

‘It is not in their terms of reference and they are not trained or experienced to make such decisions. The current practice also means that doctors’ lawyers have an opportunity to convince a panel to drop a case about a doctor over whom there are serious concerns because of a technicality/earlier abuse of process.’