

To consider

Consultation on changes to the Indicative Sanctions Guidance and on the role of apologies and warnings

Issue

- 1 Responses to a public consultation on the guidance used by Medical Practitioners Tribunal Service Fitness to Practise Panels and GMC decision makers, which concluded on 14 November 2014. This included changes to the Indicative Sanctions Guidance, and a review of the role of apologies and warnings

Recommendations

- 2 Council is asked to:
 - a Agree the proposed amendments to the Indicative Sanctions Guidance.
 - b Note the outcome of the review of the role of apologies and warnings, following consultation.

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- 3 The consultation on changes to the Indicative Sanctions Guidance, and a review of the role of apologies and warnings ran from 22 August to 14 November 2014. The consultation document is at Annex A. We received extensive feedback including 565 responses to our written consultation, and 1600 responses to the 'Fitness to Practise Panel decisions in action' microsite. Annex B sets out our methodology, the breakdown of responses and our analysis.
- 4 We commissioned an independent external audit of our consultation analysis. The audit report is at Annex C, and confirms that our consultation analysis was robust and accurate.

Changes to the Indicative Sanctions Guidance – proposals to be taken forward

- 5 The majority of our proposals for changes to the Indicative Sanctions Guidance received support from respondents, and some received strong support, although issues of fairness and proportionality were raised. Many respondents emphasised the need to ensure that guidance does not fetter the Panel's discretion and highlighted the need to take account of the impact any health concerns might have on a doctor's practice and level of insight.
- 6 Respondents agreed that Panels should consider taking action where a doctor's fitness to practise medicine is found impaired unless there are exceptional circumstances. The Professional Standards Authority (PSA) agreed that a clear definition of exceptional circumstances would be helpful, but that the focus should be on Panels giving clear and full reasoning as to their considerations and decision.
- 7 There was strong support for our proposal to guide Panels to take more serious action where cases involve a failure to work collaboratively, but concerns were raised about the protection afforded to whistleblowers. We commissioned Sir Anthony Hooper to undertake a review of this area, and will develop the amended Guidance in conjunction with this.
- 8 There was overwhelming support for our proposal to guide Panels to consider removing doctors from the medical Register when abuse of their professional position involves predatory behaviour towards a patient, particularly where the patient is vulnerable. We therefore propose to develop guidance on this.
- 9 Our proposal to guide Panels to consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics, within or outside their professional life, received strong support. We propose to take forward this proposal.

- 10** We set out specific factors Panels should consider when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. There was strong support for these factors, although some respondents commented that misuse of drugs and alcohol can indicate an underlying health issue. We propose guiding Panels to consider the specific factors outlined in the consultation while being mindful of any underlying health condition.
- 11** There was support for our proposal to take action where certain issues arise in a doctor's personal life. However, concerns were raised about the inclusion of the last factor: 'any other behaviour which may undermine public confidence'. We propose to take the proposal forward removing this last factor and making it clear the list of issues is not exhaustive.
- 12** Opinion was divided on whether Panels should be guided to consider taking action to maintain public confidence even when a doctor has remediated. 52% of respondents were opposed, whilst 42% (including 69% of members of the public) were in favour. It is clear that many of the respondents opposed to the proposal were concerned about the GMC taking action in cases where the concerns were not of the most serious kind. This proposal relates only to a small minority of very serious cases where a doctor has failed to heed concerns and patients have been harmed. With that in mind, and on the basis of strong support from the public, we propose to take this proposal forward on that basis.
- 13** Opinion was also divided on the proposal to guide Panels to take more serious action where cases involve a failure to raise concerns. Concerns raised related to the protection afforded to whistleblowers rather than the principle that doctors should raise concerns, so we propose to take this forward and will take account of Sir Anthony Hooper's review when we develop the guidance.

Changes to the Indicative Sanctions Guidance – proposals not to be taken forward

- 14** Where action is necessary to protect patients and maintain confidence in doctors, we proposed guiding Panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor. The majority of respondents (55%) opposed this proposal so we do not intend to take it forward. We will however guide Panels to give careful consideration to the balance between patient protection and public confidence issues and the personal consequences for the doctor.

The role of apologies and insight

- 15** The second part of the consultation sought views on the role of apologies and insight. Only 43% of respondents agreed with the proposal that Panels should be able to require doctors to apologise where patients have been harmed, and of those, the support seemed to be more for apologies in general with many raising concerns that a forced apology would be meaningless. We do not intend to guide Panels to direct an apology, but reflecting responses to the consultation will develop our Guidance to

make sure that when considering the question of insight, Panels and GMC decision makers take account of whether or not an apology has been made, the nature of that apology and when it was made.

- 16** Our proposal to introduce more detailed guidance on the factors that indicate a doctor has or lacks insight was met with strong support from the majority of key interest groups. However, a small number of respondents raised concerns about a doctor's right not to incriminate themselves under Article 6 of the European Convention on Human Rights. On that point an apology is not an admission of guilt. Our procedures are compliant with Article 6 and the Sanctions Guidance will only be engaged if the Panel has found facts proved and the doctor's fitness to practise impaired, so this concern will not arise.
- 17** Respondents across all key interest groups expressed strong support for our proposal to guide Panels to consider the stage of a doctor's UK medical career when determining insight. The Patients Association however raised concern that this 'may be misinterpreted to indicate poor practice may be acceptable because the doctor is inexperienced'. We will ensure the Guidance makes our position clear on this.
- 18** There was overwhelming support from all key interest groups for our proposal to introduce verification checks for testimonials which often attest to, amongst other things, a doctor's insight and remediation, and on the factors to be used to determine their relevance, with the exception of reference to personal friendship. A minority of respondents raised concerns about the issue of timing of submitting testimonial evidence. We will consider this carefully when we introduce verification checks.
- 19** There was strong support for requesting a statement from a doctor's Responsible Officer (RO) (or Suitable Person) during our investigation, to establish, amongst other things, level of insight and remediation. However, based on feedback we will consider the impact this might have on ROs with large area teams. A minority of respondents raised concerns that ROs are not sufficiently objective to carry out this task. However, we feel this proposal is appropriate because ROs have a statutory responsibility to ensure regular appraisals are carried out on a doctor's practice; investigate concerns about fitness to practice; and monitor compliance with restrictions imposed by the GMC.

Changes to guidance on suspension

- 20** The third part of the consultation sought views on changes to our guidance on suspension to help Panels make consistent decisions about length of suspension, and on how doctors can keep their clinical skills up to date whilst suspended. The proposals received strong support across all key interest groups.
- 21** Although broadly supportive, respondents raised concerns about the inclusion of factor two 'the impact on public confidence in doctors' and factor four 'sending a message to the medical profession that standards must be upheld', in guidance to

Panels when determining the length of suspension. While these matters are dealt with generally in the Guidance, based on this feedback we don't intend to include these factors specifically on this point.

- 22** There was strong support for our proposal to guide Panels that, where concerns are solely about a doctor's health, the factors that might suggest a suspension is appropriate are where it is required to protect patients or if the doctor fails to comply with any restrictions on their registration. Based on feedback from respondents we will ensure guidance highlights the need for proportionate action.
- 23** There was strong support for our proposal to guide Panels to take account of a previous interim order of suspension in their substantive sanction decision on suspension where the sanction is considered necessary solely to uphold public confidence in doctors. The minority that did not support this proposal included the PSA. The PSA consider it inappropriate because the decisions are for a different purpose based on different tests. We acknowledge that the two decisions are based on different tests, but given the strong support in the consultation we propose exploring this further.

Giving patients a voice

- 24** We explored ways to enhance the role of patients in our fitness to practise procedures, and received support across key interest groups. Comments were made about the need for clarity around where this sits within our regulatory function. We will take this proposal forward but will be clear that our role is a facilitative one and that this is part of our wider work on handling of complaints rather than a fitness to practise outcome.

Changes to our powers to give warnings

- 25** The majority of respondents considered warnings to be an effective and proportionate means of dealing with low level concerns that involve a significant departure from *Good medical practice* (GMP).
- 26** It was the majority view across all key interest groups that warnings should be used to deal with low level concerns (no impairment) and misconduct (impairment), if different terms are used to describe them. There was also consensus that more serious action should be taken where there are repeat low level concerns involving a significant departure from GMP. We will take this forward in developing our future warnings model which will require legislative changes.
- 27** The majority of respondents agreed that the GMC should issue guidance to case examiners and Panels on determining the length of publication on a case by case basis up to a maximum of five years. There was strong support for this discretion being extended to the disclosure period as well, and we intend to develop this further.

- 28** Some respondents also suggested that we should consider a wider range of tools for dealing with low level concerns, for example, a first informal warning to deal with more minor concerns where the warning would not have a significant impact on the doctor's career but would be a means to flag up issues early. In light of the fact that our data (as presented in the *State of medical education and practice* Report 2013) shows that low level concerns are an indicator for more serious concerns in the future we intend to develop this idea further.

Supporting information

How this issue relates to the corporate strategy and business plan

- 29** Strategic Aim 2: to give all our key interest groups confidence that doctors are fit to practise. To achieve this, it is crucial that the action we take in response to concerns about doctors is perceived as fair, proportionate and adequate to protect the public and maintain confidence in the medical profession.

How the issues support the principles of better regulation

- 30** The guidance used by MPTS Fitness to Practise Panels supports transparent and consistent decision making. The development of new guidance is expected to help to ensure the action we take is targeted and proportionate.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

- 31** MPTS Panellists and GMC/MPTS staff were provided with an opportunity to input via a series of policy workshops, drop-in sessions, webinars, teleconferences and a survey during 2013.
- 32** During the consultation we hosted a microsite on the website using case studies to gather views from respondents on the key themes in the consultation. 1600 responded to the case scenarios on the microsite. We held five national stakeholder events (London, Edinburgh, Manchester, Belfast and Cardiff), introduced by the Chair of the MPTS, David Pearl, reaching around 120 people, and our Regional Liaison Service organised 16 further events across the country, obtaining the views of around 225 people. In addition to this, we engaged with 42 Responsible Officers through the GMC Responsible Officer Reference Group to seek their views on some of our proposals.

What equality and diversity considerations relate to this issue

- 33** We have considered the three aims of the equality duty at each stage of updating the Guidance. Our equality analysis has informed the development of our recommendations for the way forward.
- 34** There are a number of equality and fairness issues that relate to the Guidance, for example, cultural variations in expressing insight. Some of these were raised with us during the consultation. Our consideration of the equality duty in developing the recommendations was based on the following principles:
- a** Ensuring that decision making in our procedures continues to be fair and consistent with our standards.

- b** Assessing the potential of our proposals to disadvantage doctors, complainants and other people from the protected groups.
- c** Taking steps to understand the views of people who share protected characteristics, and considering their feedback in developing our recommendations.

- 35** We have considered the potential impact on people from protected groups. The changes may have a disproportionate impact on groups of doctors who are already overrepresented in our procedures, for example, male doctors, doctors who qualified overseas, doctors from a black and minority ethnic (BME) background, and older doctors. There were some concerns raised during the consultation about whether some changes could affect doctors with some health conditions that are classified as disabilities under equality legislation. We will continue to review our data to track any trends.
- 36** We also recognise that some of these changes may have a disproportionate impact on unrepresented doctors, many of whom share a number of the characteristics that increase the likelihood of a doctor being involved in our fitness to practise procedures. To mitigate the impact on this group, we will work closely with the MPTS to ensure that unrepresented doctors are provided with detailed guidance to support them through the hearing process.
- 37** Our recommendation to introduce more detailed guidance on the link between apologies and insight may impact on doctors who qualified outside the UK where cultural differences may arise in relations to the role of apology in insight. Given the strong support for this proposal in the consultation, the findings of Robert Francis's report into the failings at Mid-Staffordshire NHS Foundation Trust, and the statutory duty of candour, introduced last year, we consider that any potential impact is outweighed by the role this will play in improving patient care and public confidence in doctors.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director of Policy, Business Transformation and Safeguarding, arowland@gmc-uk.org, 020 7189 5077.

Consultation document

Reviewing how we deal with concerns about doctors

A public consultation on changes to our sanctions guidance and on the role of apologies and warnings

General
Medical
Council

Foreword

This consultation has been commissioned by the Council of the General Medical Council (GMC), which has overall responsibility for the sanctions guidance. His Honour David Pearl, Chair of the Medical Practitioners Tribunal Service (MPTS), chaired the sanctions guidance project board. Staff across the MPTS and the GMC have worked together to develop this consultation document.

After full consultation, a new version of the sanctions guidance will be agreed and published by the Council of the GMC.

The GMC's Registrar and other staff with delegated powers, the MPTS Chair, and fitness to practise panels, will use the new guidance to inform their decisions.

A handwritten signature in black ink, reading 'Peter Rubin'.

Sir Peter Rubin
Chair, General Medical Council

About this consultation

We are consulting on changes to what action we take when we believe a doctor may be putting the safety of patients, or public confidence in doctors, at risk.

This document sets out proposed updates to our sanctions guidance, which MPTS panels use to decide the outcome of cases at fitness to practise hearings. The guidance is also available to our other decision makers when deciding whether to refer a case to a hearing. The consultation also looks at the role of apologies and warnings in our processes, and changes to our guidance on suspension. The principles within this document will also help to inform our guidance for case examiners who make a decision on cases at the end of our initial investigation.

Any change to the range of sanctions available to panels or the circumstances in which we can issue warnings will require further public consultation to introduce legislative change. Later this year, we will also consult on separate explanatory guidance on candour.

Responses to this consultation will help us to understand the impact our proposals could have on groups who are protected under the *Equality Act 2010*. Responses will also inform an equality analysis, which we'll publish before our Council decide whether to make changes to the guidance.

Changes to our sanctions guidance

Our proposed changes guide panels to:

- take appropriate action to protect the public interest without being influenced by the personal consequences for the doctor
- take action in all cases where a doctor's fitness to practise is impaired, unless there are exceptional circumstances which meet a specific definition
- take appropriate action to maintain public confidence in doctors even when a doctor has remediated
- consider more serious action where cases involve a failure to raise concerns, failure to work collaboratively, discrimination or abuse of professional position involving predatory behaviour
- consider the factors that may lead to more serious action where specific issues arise in a doctor's personal life which undermine confidence in doctors (eg criminal or civil proceedings)
- consider specific aggravating and mitigating factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs.

For more information about these changes, see pages 16–27.

The role of insight and apology

Our proposed changes include:

- considering whether panels should have the power to require a doctor to apologise
- clarifying the circumstances in which a doctor's failure to apologise may be considered evidence he or she lacks insight
- introducing more detailed guidance on other factors that may indicate a doctor has or lacks insight
- guiding panels to consider the stage of a doctor's UK medical career as a mitigating factor when making a decision (ie their experience or familiarity with what is expected)
- introducing verification checks for testimonials and new guidance on whether testimonials are relevant evidence of insight at a hearing
- making sure we routinely obtain a statement from a doctor's responsible officer or suitable person during our investigation for the panel to consider at a hearing.

For more information about these proposals, see pages 28–35.

Changes to our guidance on suspension

Our proposed changes are to give clearer guidance to panels on:

- deciding the length of suspension
- when suspension is appropriate for doctors where concerns are solely about their health
- how doctors can keep their clinical skills up-to-date during a suspension.

We are also seeking your views on the following question.

- Should a previous interim suspension order influence a panel's decision about whether or how long to suspend a doctor solely to uphold public confidence in doctors?

For more information about these changes, see pages 36–42.

Giving patients a voice

We are seeking your views on whether we should explore the benefits of meetings between doctors and patients where a doctor's actions have caused serious harm

For more information about this issue, see page 43.

Changes to our powers to give warnings

We are seeking your views on the following questions.

- Do you think warnings are an effective and proportionate means of dealing with low level concerns that involve a significant departure from *Good medical practice*?
- When do you think we should be able to give warnings?
- If we continue to give warnings, do you agree that any further concerns should lead to a more serious response?

For more information about these issues, see pages 44–49.

There are 24 questions in the consultation document. You do not have to answer all of the questions if you prefer to focus on specific issues.

How to take part

- Answer the questions online on our consultation website: www.gmc-uk.org/isg_consultation. Alternatively, you can answer the questions using the text boxes on pages 17–48 of this consultation document and either email your completed response to us at ftpconsultation@gmc-uk.org or post it to us at:

Fitness to Practise Policy team
General Medical Council
350 Euston Road
London NW1 3JN.

- Contact us using the details above if you would like us to send you a printed copy. Send your completed response to the address above.

This consultation runs from **22 August to 14 November 2014**.

Find out more

You can find further information about our fitness to practise processes on our website at www.gmc-uk.org/concerns.

What do we expect of doctors working in the UK?

We maintain a register of doctors who can work in the UK. These doctors must be familiar with and follow the standards set out in our guidance *Good medical practice* and in the explanatory guidance and statements that support it. Serious or persistent failure to follow this guidance will put a doctor's registration at risk.

Doctors must be competent, and keep their skills and knowledge up to date, to practise safely. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately including if they or a colleague fall ill and their performance or conduct suffers. They must also reflect on their practice, including any errors that affect patient safety and care, making use of the outcome of audits, patient and colleague feedback and lessons learnt through other patient safety and monitoring systems to improve the quality of care.

Updating the guidance in 2013

Following an extensive consultation, we published an updated edition of *Good medical practice* and supporting explanatory guidance in March 2013, which came into effect in April 2013.* This edition reflects what doctors and patients think are the important values and principles of good care.

What happens if a doctor fails to follow our guidance?

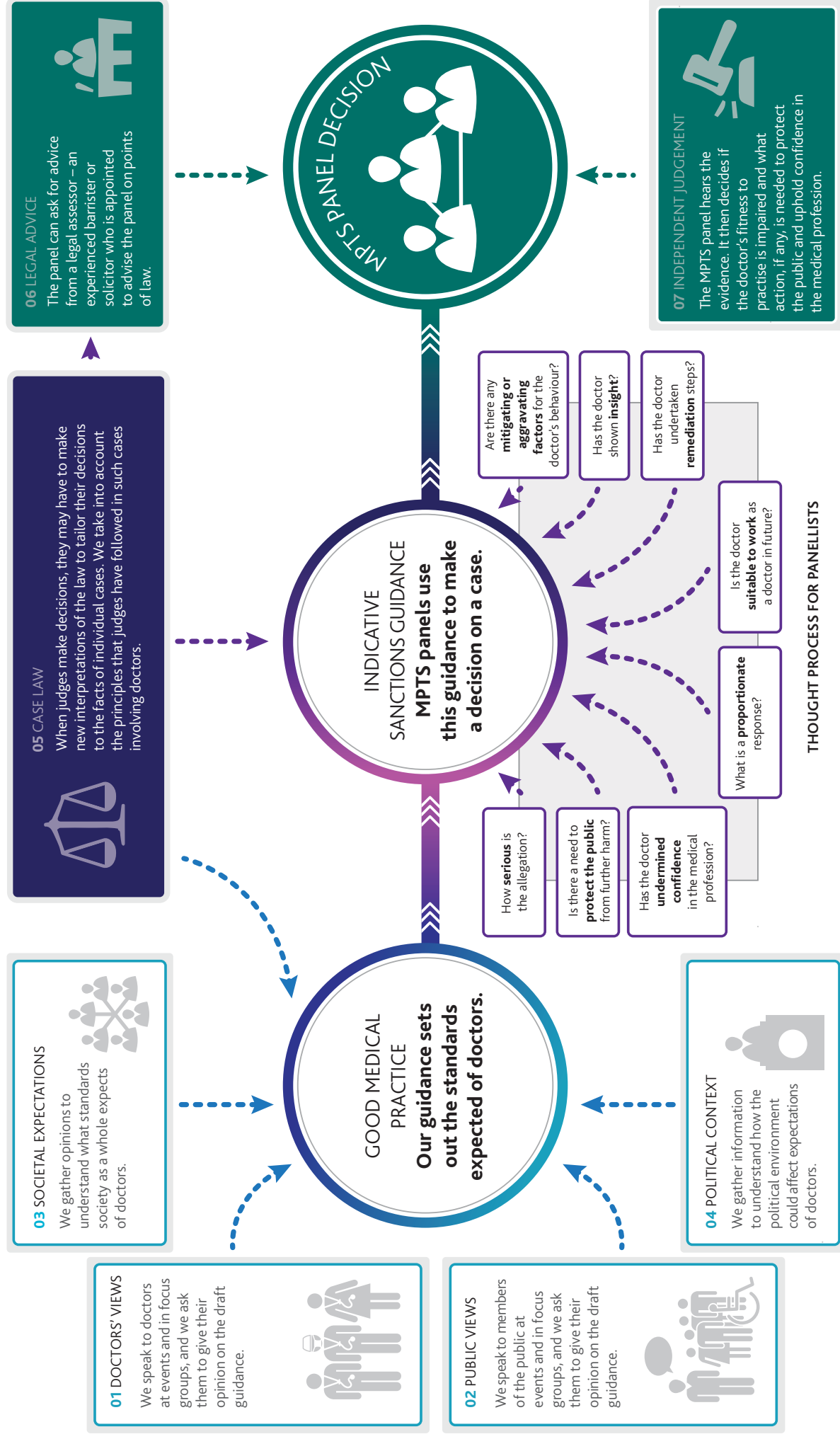
Failure to follow our guidance does not automatically mean we will take action. This is because the guidance sets out the principles of good practice, not thresholds at which we think a doctor is safe to work.

If we receive a complaint about a doctor, we use the guidance as a benchmark to assess whether a doctor's actions or decisions have fallen seriously or persistently below the standards we expect. But we also consider any mitigating or aggravating factors, the current risk that the doctor poses, and whether taking action is in the public interest – for example, to protect patients, maintain public confidence in doctors and to uphold proper standards of conduct and behaviour. To make sure we are consistent in our approach to dealing with concerns, including taking account of mitigating and aggravating factors, we have separate guidance to help the MPTS panels decide whether to take action.

The purpose of any action we take following a serious or persistent breach of our guidance is to protect the public by helping to make sure doctors on our register provide safe care and to uphold public confidence in doctors. It is not our role to punish or discipline doctors.

* You can read more about developing the updated guidance on our website at www.gmc-uk.org/guidance/9879.asp.

The relationship between *Good medical practice* and our fitness to practise process



How do we deal with concerns about a doctor's fitness to practise?

If we receive a complaint about a doctor, we may need to investigate the concerns and take prompt action if we believe the doctor is putting the safety of patients, or public confidence in doctors, at risk. We can issue a warning, agree undertakings with the doctor that limit the type of work they can do or refer the case to an MPTS panel for a hearing. The MPTS was established in 2012 to separate our role in investigating concerns about doctors from the adjudication of cases, including holding hearings.

At a hearing, a fitness to practise panel will review the evidence to decide whether the doctor's fitness to practise is impaired. If it is, the panel will decide the appropriate action to take – it can take no action, agree undertakings with the doctor, impose conditions, or suspend or remove the doctor from the medical register. If appropriate, immediate action can also be taken to protect the public by imposing an interim order while we are investigating the concerns or the MPTS is holding the hearing.

If, following a hearing, a panel decides that a doctor's fitness to practise is not impaired, the panel decides whether to issue a warning or close the case with no action.

Possible actions to deal with concerns about a doctor

Warnings

What is a warning?

A warning tells a doctor and the wider medical profession that standards must be maintained and misconduct must not be repeated. It does not change a doctor's right to work in the UK.

When does this apply?

Warnings are issued to doctors at the end of an investigation or at a hearing if there is a significant departure from the principles set out in *Good medical practice* and supporting explanatory guidance, but their fitness to practise medicine in the future is not impaired.

Undertakings

What are undertakings?

Undertakings mean a doctor can continue to work in the UK, but only under certain restrictions – eg working under supervision.

When does this apply?

Undertakings may be agreed at the end of an investigation or at a hearing. Undertakings may be agreed when a doctor's fitness to practise medicine may be impaired, but the doctor can work safely if they are properly monitored and restricted.

Conditions

What are conditions?

Conditions are the same as undertakings except restrictions have been imposed on the doctor's registration without his or her agreement.

When does this apply?

Conditions are imposed by a panel at a hearing where a doctor's fitness to practise medicine is found to be impaired, but he or she can work safely if properly monitored and restricted.

Suspension

What is suspension?

Suspension is when a doctor is temporarily removed from the medical register and so cannot work as a doctor in the UK for a specified period of time. Doctors can be suspended for up to 12 months.

When does this apply?

Suspension is imposed by a panel at a hearing where a doctor's fitness to practise medicine is found to be impaired and restrictions are not sufficient to protect patients or maintain public confidence in doctors.

Removal from the medical register

What is removal?

A doctor's name is removed from the medical register and so they cannot work as a doctor in the UK. In such circumstances, there is no intention to restore the doctor's ability to practise medicine in the future.*

When does this apply?

This sanction is imposed by a panel at a hearing where a doctor's fitness to practise is found to be impaired and concerns are so serious they are considered to be incompatible with continued registration.

Interim orders

What is an interim order?

An interim order is a decision to immediately stop or restrict a doctor's right to practise on a temporary basis while we are investigating the concerns or the MPTS is holding the hearing.

When does this apply?

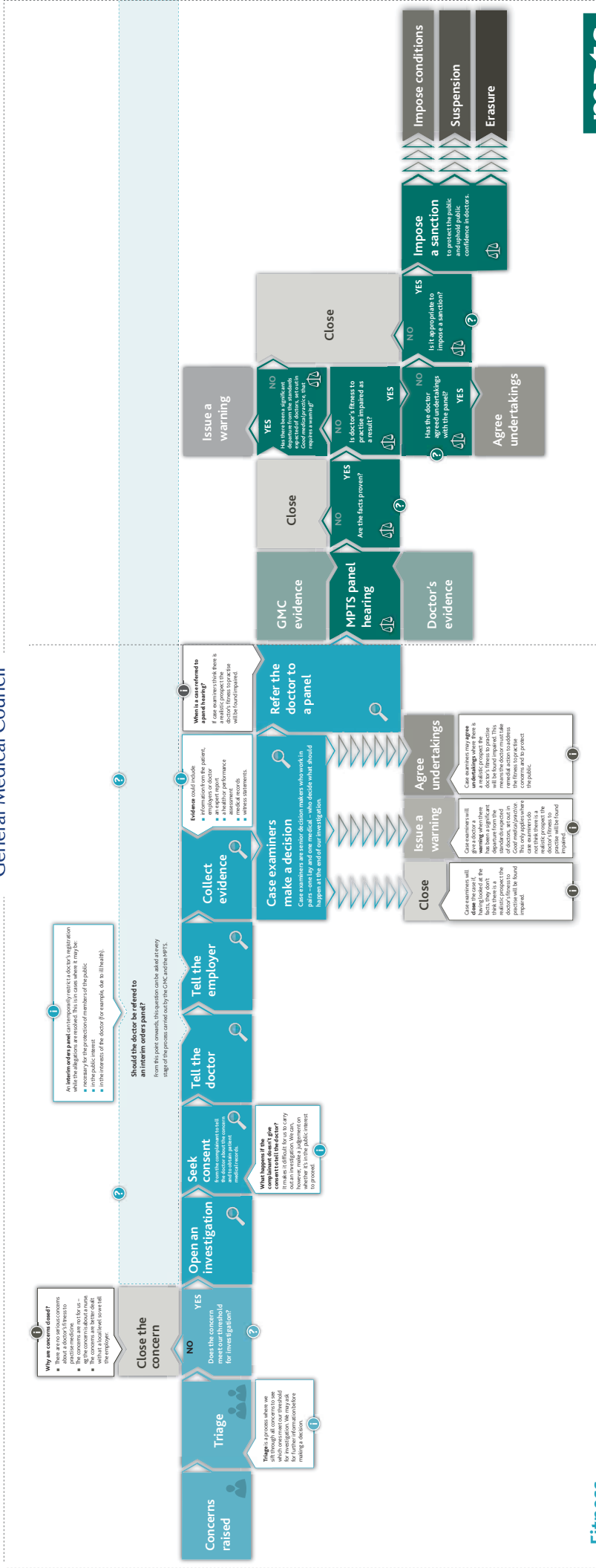
Interim orders are imposed by a panel at an interim orders hearing when concerns about a doctor's fitness to practise are so serious that it is in the public interest to intervene before the case ends. At this point, no facts have been proved.

* Erased doctors may apply for restoration after five years. However, the onus is on the doctor to demonstrate they are fit to practise medicine again.

Our sanctions guidance

To make sure panel decisions are transparent, fair and consistent, we provide guidance to help panels decide what sanction is appropriate. This is called our *Indicative Sanctions Guidance for the Fitness to Practise Panel* and it is published on our website at **www.mpts-uk.org/sanctions_guidance**.

The sanctions guidance sets out the issues panels should take into account when making a decision, including whether a doctor's actions have fallen below the standards we expect, any mitigating or aggravating factors, the current risk that the doctor poses, and whether we need to take action in the public interest.

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Section 1: Changes to our sanctions guidance

We propose a range of changes to our sanctions guidance to make sure it reflects society's values and expectations of doctors, which are set out in the updated edition of *Good medical practice* and supporting explanatory guidance, published in 2013. In particular, these changes will better guide panels on the types of concern where it may be appropriate to permanently remove a doctor's registration. There are nine questions in this section.

Not being influenced by personal consequences of sanctions on doctors

Sanctions can sometimes have an unintended punitive effect on doctors. For example, suspending a doctor to protect the public may reduce their earnings during that period or put them at risk of losing their job. But the panel's first duty must be to protect patients and maintain public confidence in doctors.

Case study: Dr Manchester lost his temper and physically assaulted a patient during a home visit. If the panel decides to remove his right to work as a doctor, he faces losing his job and being evicted from his home.

Proposed change: where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor?

1 Do you agree with this proposal?

☐

Yes

☐

No

Do you have any comments?

Taking action in all cases where a doctor's fitness to practise is impaired unless there are exceptional circumstances

Patients should be treated by doctors who are properly supervised, monitored and actively supported to address any deficiencies in their performance, health or conduct. We believe that, where a doctor's fitness to practise is impaired, we have a duty to consider appropriate steps to address this.

Doctors sometimes argue that, even where their fitness to practise has been found to be impaired, it is in the public interest to allow them to continue working without restriction, because they provide a particularly valuable service to the community. In order to make sure employers and healthcare commissioners can make arrangements for adequate patient care if a doctor's fitness to practise medicine is found impaired, they are given several months' notice of a hearing.

Where a doctor's fitness to practise is impaired, we propose to guide panels to take action unless there are exceptional circumstances.

Case study: Dr Cardiff was convicted of embezzling £100,000 from a charity he set up to raise money for sick children. He is now extremely ashamed and sorry. Because it is not unusual for doctors to express regret for their actions, this is not an exceptional circumstance, so the panel decides to impose a sanction.

Proposed changes: to guide panels to consider taking action where a doctor's fitness to practise medicine is found to be impaired unless there are exceptional circumstances.

To define exceptional circumstances as those that are unusual, special or uncommon. For example, it is not unusual for doctors to express regret for their actions, so this is not an exceptional circumstance.

2 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Maintaining public confidence even when a doctor has remediated

In deciding whether a doctor's fitness to practise is impaired, panels focus on the care patients are likely to receive in the future and not on disciplining the doctor for past misconduct. Sometimes a doctor recognises their own failings and makes sure they do not pose a risk to future patients before we get involved. In these situations, we may not need to take any further action.

But a doctor's failings may be so serious or persistent that, even if they have fully remediated the concerns, the public may find it difficult to accept that no action is taken. In these cases, the doctor knew or should have known they were causing harm to patients and should be held accountable for that – as a result we believe panels should take action to maintain public confidence in doctors.

Case study: Dr Glasgow has been using outdated techniques to fix leg fractures for a number of years despite concerns raised by colleagues. This has caused poor recovery rates and high rates of post-operative infections. Several elderly patients have died as a result of infections contracted due to surgery. Many other patients needed further surgery to correct her errors. When questioned by senior hospital staff she blamed nursing staff. Since the GMC commenced investigating, the doctor has undergone retraining to resolve any issues with her performance.

Proposed change: to guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors.

3 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Taking more serious action in specific cases

The current version of the sanctions guidance says it may be appropriate to remove a doctor from the medical register where their behaviour is fundamentally incompatible with being a doctor.* Following the update to *Good medical practice*, we propose to change our sanctions guidance to guide panels that they may wish to consider more serious outcomes where doctors have:

- failed to raise concerns where there is reason to believe a colleague's fitness to practise is impaired and may present a risk of harm to patients (*Good medical practice*, paragraph 25)
- failed to raise concerns where a patient is not receiving basic care to meet their needs (*Good medical practice*, paragraph 25)
- failed to work collaboratively with colleagues, respecting their skills and contributions, treat colleagues fairly and with respect, or be aware of how their behaviour may influence others within and outside the team (*Good medical practice*, paragraphs 35–37)
- used their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them (*Good medical practice*, paragraph 53)

- discriminated against patients or colleagues by allowing their personal views to affect their professional relationships or the treatment they provide or arrange (*Good medical practice*, paragraph 59)
- failed to ensure that a doctor's conduct justifies their patients' trust in them and the public's trust in the profession (*Good medical practice*, paragraph 65).

We have set out further detail about the proposed changes below.

Failure to raise concerns

The updated edition of *Good medical practice* introduced a new duty for doctors to take prompt action if they think that patient safety, dignity or comfort is or may be seriously compromised. Where a patient is not receiving basic care to meet their needs, doctors must immediately tell someone who is in a position to act straight away. This principle is key to maintaining a minimum acceptable standard of care for all patients.

All doctors also have a responsibility to promote and encourage a culture that allows all staff to raise concerns openly and safely. This includes responding appropriately to any risks to patients presented by inadequate premises, equipment, other resources, policies or systems. Where a doctor has concerns that a colleague may not be fit to practise and may be putting patients at risk they should seek advice and report the matter if appropriate.

* Such behaviour includes: a reckless disregard for the principles set out in *Good medical practice* or for patient safety; doing serious harm to others, either deliberately or through incompetence, particularly where there is a continuing risk to patients; abuse of position; violation of a patient's rights; exploiting vulnerable people; offences of a sexual nature or involving violence; dishonesty, particularly where persistent or covered up; putting your own interests before those of patients; and persistent lack of insight into seriousness of actions or consequences.

Doctors' duties to raise concerns are set out in *Good medical practice* (paragraphs 24–25) and in our explanatory guidance *Raising and acting on concerns about patient safety*. These duties apply to all doctors and not just those with specific management or leadership responsibilities.

Case study: Dr Belfast works at a mental health in-patient facility. Over a three month period he regularly notices patients lying in soiled sheets complaining they have not been given any water. He is concerned by the mistreatment of patients, but does not take any action either to address the immediate needs of those patients or to raise the issue with management or other staff.

Proposed change: to guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence.

4 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Failure to work collaboratively with colleagues

Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in *Good medical practice* (paragraphs 35–37). Although many low level concerns about a doctor’s working relationships with colleagues can be dealt with effectively through employers’ local systems, we should deal with concerns that cannot be resolved locally or are particularly serious. The most serious concerns involve bullying, sexual harassment or physical violence towards colleagues. Cases where conduct issues affect working relationships and put patient safety at risk may also meet this threshold – for example, where deliberately obstructive or aggressive behaviour towards colleagues prevents a patient receiving emergency care.

Case study: Isaac is admitted to accident and emergency with acute severe asthma. The doctor in training responsible for his care does not feel sufficiently experienced to manage his condition and asks an on-call senior colleague, consultant Mr London, to examine him. Mr London is very rude and aggressive towards the doctor in training and refuses to see the patient despite repeated requests. As a result of the delay, the patient’s health deteriorates and another consultant intervenes to make an immediate transfer to intensive care.

Proposed change: to guide panels they may consider more serious action where cases involve a failure to work collaboratively including bullying, sexual harassment or violence or risk to patient safety.

5 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Abuse of professional position

Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in *Good medical practice* (paragraph 53) and in our explanatory guidance *Maintaining a professional boundary between you and your patient* and *Ending your professional relationship with a patient*.

Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.* If a patient pursues a sexual or improper emotional relationship with their doctor, the doctor should treat them politely and considerately and try to re-establish a professional boundary. Doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them.

Personal relationships with former patients may also be inappropriate depending on the nature of the previous professional relationship, the length of time since it ended, the vulnerability of the patient and whether the doctor is caring for other members of the family.

Doctors are expected to be responsible and ensure their relationships with patients are contained within professional boundaries. Where a patient is vulnerable, there is an even greater onus on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of their illness, disability or frailty, or because of their current circumstances (such as bereavement or redundancy). Patients younger than 18 years should be considered vulnerable. If a doctor engages in an emotional or sexual relationship with a patient who is vulnerable, the risk to patient safety and public confidence in doctors is particularly significant.

A doctor engaging in predatory behaviour, motivated by the desire to establish an emotional or sexual relationship with a patient, may not constitute a criminal offence, but it does indicate a significant risk to patient safety and may significantly undermine public confidence in doctors. For example, where a doctor makes inappropriate use of a social networking site or uses personal contact details from medical records to approach a patient outside their doctor-patient relationship.

In cases where concerns do not constitute a criminal offence, it can be difficult for panels to be certain about the seriousness of concerns and to navigate the complex range of factors to decide on an appropriate action. For example, a doctor may argue that a sexual or emotional relationship with a patient was consensual in nature, or instigated by the patient. The sanctions guidance already provides guidance that panels may consider removing doctors from the medical register who have abused their professional position, but we want to provide greater clarification of the cases in which removing a doctor from the register would be an appropriate response. We also propose to update the section in the sanctions guidance relating to sexual misconduct in line with this approach.

* A definition of 'someone close to them' is provided in our explanatory guidance on maintaining a professional relationship between you and your patient, (paragraph 6), available at www.gmc-uk.org/guidance/ethical_guidance/21170.asp.

Case study: Following the death of her husband, Emma is referred by her GP for treatment from a consultant psychiatrist, Mr Edinburgh. After a few sessions of therapy, he invites her to a romantic dinner. She later finds out that he previously tried to establish a sexual relationship with three other recently bereaved patients.

Proposed changes: to guide panels to consider removing doctors from the medical register when abuse of their professional position involves predatory behaviour towards a patient, particularly where the patient is vulnerable.

6 Do you agree with this proposal?

☐

Yes

☐

No

Do you have any comments?

Discrimination against patients, colleagues and other people

Doctors must not discriminate against patients or colleagues by allowing their personal views to affect their professional relationships or the treatment they provide or arrange. This includes personal views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by law: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, and sex and sexual orientation.

Doctors may choose to opt out of providing a particular procedure because of their personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients. Doctors must not express their personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.

Discrimination is unacceptable in a modern society, undermines public confidence in doctors and is a serious risk to patient safety. This is consistent with our expectation that doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession. Doctors' duties are set out in *Good medical practice* about discrimination (paragraphs 54–59) and justifying patients' trust (paragraph 65).

The sanctions guidance already advises panels to consider removing a doctor from the medical register if they violate a patient's rights or exploit vulnerable people. We propose also to advise panels to consider removing a doctor from the medical register if they have discriminated against others.

Case study: A same-sex couple ask their doctor about fertility treatment on the recommendation of gay friends who successfully conceived via IVF at a local NHS clinic. Dr Wrexham makes offensive homophobic remarks.

7 Do you agree with this proposal?

☐

Yes

☐

No

Do you have any comments?

Proposed change: to guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics* in any circumstance, either within or outside their professional life.

* It is unlawful to discriminate against someone based on any 'protected characteristic' set out under the *Equality Act 2010*.

Doctors' lives outside medicine

The updated edition of *Good medical practice* includes that doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (paragraph 65). If a doctor's behaviour in their personal life undermines public trust in doctors, we may need to take action.

Case study: Dr Birmingham had been going through a difficult divorce for many months. After one session in court, he forced his way into his wife's home, causing severe bruising to her wrists. During the confrontation he also hit his seven-year-old son, fracturing his skull.

Proposed change: to guide panels to consider the factors which may lead to more serious action where the following issues arise in a doctor's personal life:

- misconduct involving violence or offences of a sexual nature
- concerns about their behaviour towards children or vulnerable adults
- concerns about probity (being honest and trustworthy and acting with integrity)
- misuse of alcohol or drugs leading to a criminal conviction or caution

- unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation
- any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings

The list is not exhaustive – if there are other specific issues that you think we should consider, please include them in the comment box below. We discuss aggravating and mitigating factors related to alcohol and drug misuse in the next question.

8 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Drug and alcohol misuse linked to misconduct or criminal offences

Misuse of alcohol and drugs in a doctor's personal life is one of the issues we suggest may undermine public confidence in doctors. When a doctor is unwell, including because of drug or alcohol addiction, they must take appropriate steps to make sure this does not affect patient safety. We may need to take action where a doctor's health has compromised patient safety and/or led to involvement in criminal activity. If we receive information that a doctor has been charged with, or received a conviction or caution, for a crime related to alcohol or drug misuse, we usually refer them for

a health assessment to see if they have an addiction that may pose a serious risk to patients.

We propose to add specific advice to the sanctions guidance to help panels assess the seriousness of concerns about a doctor's misuse of alcohol or drugs, inside or outside the workplace.

Case study: Dr Durham went to a nightclub with Dr Oxford, and they both took illegal drugs. The next day, Dr Oxford was off sick from work, but Dr Durham went to work while he was still under the influence of illegal drugs. Dr Durham stole morphine intended for a patient, which he self-administered in the staffroom before going into theatre.

Proposed change: to guide panels that they may consider specific factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs.

We take all issues relating to drug or alcohol misuse seriously. Some are more serious and have aggravating features and therefore would attract more serious outcomes. We believe panels should consider more serious action in cases involving the following factors:

- intoxication in the workplace or while on duty

- misuse of alcohol or drugs that has impacted on the doctor's clinical performance and caused serious harm to patients or put public safety at serious risk
- misuse of alcohol or drugs that has resulted in violence, bullying or misconduct of a sexual nature
- misuse of alcohol or drugs that led to a criminal conviction particularly where a custodial sentence was imposed.

This approach is consistent with our guidance on assessing the risk posed by doctors with health issues.*

9 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

* www.gmc-uk.org/Guidance_for_decision_makers_on_assessing_risk_in_health_cases.pdf_48690195.pdf.

Section 2: The role of apology and insight

This section looks at the role of apology and insight in our processes. We are reviewing this because doctors have a duty (*Good medical practice*, paragraph 55) to offer an apology when a patient is harmed or suffers distress as a result of a doctor's actions.

The Francis report recommended that introducing a professional duty of candour for health and social care professionals would encourage a culture of openness and honesty to be the norm.*

* The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
available at www.midstaffpublicinquiry.com/report.

In this section, we propose ways to strengthen our guidance for panels on apology and insight when dealing with concerns about doctors at MPTS hearings. We would also update our other guidance for decision makers to reflect these principles. There are six questions in this section.

The role of apology in our fitness to practise procedures

Good medical practice says doctors 'must be open and honest with patients when things go wrong and offer an apology when a patient under their care suffers harm or distress'.* However, we do not currently have a sanction that can require a doctor to apologise. If a patient wants an apology, we advise them to first contact the place where they received care; they can also use other routes, such as local mediation processes or civil proceedings. However, information that a doctor has apologised may be considered evidence of insight as part of our process for monitoring a doctor's progress with remediation.

We are considering whether panels should be able to require doctors to apologise where patients have been harmed. This would help us to hold doctors to account for their actions, for example where a serious clinical error has adversely affected a patient's life expectancy or quality of life.

If there is support for this in principle, we will do further work to develop proposals for how this might work in practice. Any proposals to change the range of sanctions available to panels will require further consultation prior to legislative change.

Issue to consider: should panels be able to require doctors to apologise where patients have been harmed.

10 Do you think panels should require a doctor to apologise where patients have been harmed?

☐ Yes

☐ No

Do you have any comments?

* General Medical Council (2013) *Good medical practice* (paragraph 55) available at www.gmc-uk.org/gmp.

Deciding whether a doctor has insight

In our current sanctions guidance, we define insight as where a doctor is able with hindsight to stand back and accept that they should have behaved differently, and take steps to address their failings. We believe panels should remove doctors from the medical register if they have a persistent lack of insight into the seriousness of their actions or the consequences. An apology may be evidence of insight, but a range of factors can influence whether, or how, a doctor apologises – such as fear of legal action and personal circumstances (eg ill health).

We propose to strengthen our guidance for panels on how to assess whether a doctor has insight, and the extent to which an apology is evidence of insight. In principle, we believe that where a patient has been harmed as a result of a doctor's actions or omissions, a doctor's failure to apologise is evidence that they lack insight.

This change would allow panels to hold doctors to account where they fail to apologise for harm caused to a patient, and increase consistency in our decision making when considering the role of insight.

11 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Case study: Dr Swansea failed to assess or examine vulnerable residents in a care home where he was responsible for providing GP services. Dr Swansea's sloppy attitude to performing clinical examinations caused the avoidable death of five elderly patients. For the following 12 months, he failed to be open and honest with bereaved relatives about what happened and refused to apologise. On the day before the hearing is due to start, Dr Swansea apologises for his actions but fails to tell the truth when giving evidence.

Proposed change: to introduce more detailed guidance on the factors that indicate a doctor has or lacks insight.

- A doctor is likely to have genuine insight if they: accept they should have behaved differently, consistently express insight,* take steps to remediate and apologise at an early stage before the hearing.
- A doctor is likely to lack insight if they: refuse to apologise or accept their mistakes, do not consistently express insight, or fail to tell the truth during the hearing.
- A doctor may also lack insight if they promise to remediate, but fail to take appropriate steps or only do so when prompted or immediately before or during the hearing.

* Expressing insight involves a demonstration of genuine reflection and remediation.

Stage of a doctor's UK medical career can affect insight

When a newly qualified graduate is first accepted onto the UK medical register and begins working as a doctor in the UK, they may well experience a steep learning curve as they take on new responsibilities. As a doctor's medical career progresses, we expect their understanding of the social and cultural context of their work, and appropriate standards, to improve.

Many doctors joining the medical register have previously worked, lived or were educated overseas, where different professional standards and social, ethnic or cultural norms may apply. In 2013, 37% of doctors on our medical register had gained their primary medical qualification outside the UK.* We expect these doctors to familiarise themselves with social and cultural norms where they work, although we recognise that experience of working as a doctor in the UK also plays a key role.

Case study: Dr Lisburn started surgical training in trauma and orthopaedics six weeks ago. He is very enthusiastic about his new role and uploads several radiographs of patients' fractures onto his Facebook page.

Proposed change: to guide panels they may consider the stage of a doctor's UK medical career as a mitigating factor, and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. However, in cases involving serious concerns about a doctor's performance or conduct (eg predatory behaviour to establish a relationship with a patient, or serious dishonesty), the stage of a doctor's medical career should not influence a panel's decision on what action to take.

12 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

* 37% (94,952) doctors on the medical register at 31 December 2013 gained their medical qualification outside the UK.

Assessing the value of testimonials

Sometimes doctors whose fitness to practise medicine has been found impaired submit testimonials from patients, colleagues and other people who know them. This may help panels to take a wider view of the extent to which doctors have reflected on and remediated the concerns, and what action if any is required. For example, a person who has recently supervised a doctor may be able to provide a useful perspective on the extent to which they have reflected on and remediated concerns in a clinical environment.

The testimonials are not always directly relevant to the concerns raised and there may be limited information about the context in which they were obtained. It is sometimes not clear whether the person providing the testimonial knew that the doctor intended to submit it as evidence in a hearing. Some doctors may also find it easier than others to seek testimonials depending on the length of their career and their access to social networks.

We are considering ways to improve how information from patients, colleagues and other people is used to inform decisions as to what action to take. In the short term, as part of this consultation, we are looking at the approach to assessing the value of testimonials by verifying their authenticity and making sure they are relevant. This reflects best practice in other tribunals.

Case study: Dr Reading persistently sexually harassed three female colleagues over a 12-month period. Each of the women rejected Dr Reading's advances, but this did not alter his behaviour. One female doctor was so intimidated that she was signed off work for three months due to stress. Dr Reading has provided around 30 testimonials from his neighbours detailing youth projects he has set up in the community. He has not provided any testimonials from colleagues or patients.

Verification checks on testimonials

Proposed change: to introduce a robust verification process to check the authenticity of testimonials before they are accepted as evidence in a hearing. This would involve checking the identity of anyone who has written a testimonial to eliminate the possibility of fraud or misrepresentation. We also propose to check that those who write testimonials are aware of the concerns about the doctor, what their testimonials will be used for, and that they are willing to come to the hearing to answer any questions if a panel asks them to do so. To allow sufficient time for checks to take place, doctors will have to submit their testimonials before the hearing starts.

Deciding whether testimonials are relevant

Proposed change: to introduce guidance for panels on the factors they may consider when deciding whether testimonials are relevant to their decision:

- whether the testimonial is relevant to the specific concerns about the doctor
- the extent to which the views expressed in the testimonial are supported by other available evidence
- how long the author has known the doctor
- how recently the author has had experience of the doctor's behaviour or work
- the relationship between the author and the doctor (eg a senior colleague)
- whether there is any evidence that the author has a conflict of interest in providing the testimonial (eg personal friendship).

13 If we introduce verification checks on testimonials, do you agree that we should continue to accept them as evidence?

☐ Yes

☐ No

Do you have any comments?

14 Do you agree that we should use the factors above to decide whether testimonials are relevant to the panel's decision?

☐ Yes

☐ No

Do you have any comments?

Feedback from responsible officers

In 2010, we introduced revalidation, which is a system of regular checks on every doctor practising in the UK to make sure they are competent and have kept their skills and knowledge up to date. Most doctors now have a responsible officer – a senior doctor who makes sure they are meeting our standards and monitors any fitness to practise concerns. In many cases, the doctor’s responsible officer is likely to be the medical director at their main workplace. We believe the doctor’s responsible officer should be more involved in the process for assessing the extent to which a doctor has reflected on and remediated the concerns at a hearing.

Case study: During our investigation, Dr Birmingham’s responsible officer is asked to provide a statement on the extent to which Dr Birmingham has shown insight and remediation in the workplace. The responsible officer confirms Dr Birmingham is complying with interim conditions on his registration and there have been no further complaints about his behaviour.

He also comments that Dr Birmingham has volunteered with the employee assistance programme at the hospital which supports staff who are struggling to cope at work.

Proposed change: to make sure we routinely request a statement from a doctor’s responsible officer* during our investigation for the panel to consider at a hearing. The statement should set out the extent to which the doctor has reflected on the matter before the panel, the extent to which they have shown insight and how far any issues about their performance or behaviour have been addressed. The panel may wish to consider the extent to which any evidence of insight in testimonials provided on the doctor’s behalf is supported by other available evidence, including the responsible officer’s statement.

We would also introduce guidance for panels to make sure doctors who do not have a responsible officer because they have given up their licence, or who are using alternative routes for revalidation, are not treated unfavourably.

15 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

* Some doctors without a responsible officer may have a suitable person as set out in *The Medical Profession (Responsible officer) Regulations 2010*. In those cases, we will obtain a statement from the suitable person.

Section 3: Changes to our guidance on suspension

We propose several changes to our guidance to help panels make consistent decisions about suspending doctors. There are four questions in this section.

Deciding the length of suspension

Panels can suspend doctors for up to 12 months. We propose to strengthen our guidance to make sure that the seriousness of the concerns is the primary factor when panels decide length of suspension. The box on page 38 sets out the aggravating factors that indicate the seriousness of concerns for different types of cases.

For example, where concerns are about a doctor's knowledge, skills and performance, the seriousness may be indicated by the extent of any significant departure from our expectations of doctors and the extent to which the behaviour was reckless. Whereas, in cases about a doctor's probity (being honest and trustworthy and acting with integrity), key factors may be the extent of any significant and/or sustained acts of dishonesty or misconduct and risk to patient safety and public confidence.

We believe panels' decisions should not be influenced by the personal consequences for the doctor (see question 1) or by the potential disruption to the health service. Where a panel has determined that the concerns about a doctor require that doctor be removed from practice, employers and healthcare commissioners should try to make arrangements to ensure adequate patient care is maintained.

The aggravating factors a panel considers when deciding the length of a doctor's suspension from the medical register

When panels set the length of a doctor's suspension from the medical register, they consider any aggravating factors which may indicate the seriousness of the concerns. The table below sets out examples of these under broad categories, depending on the nature of the case.

Knowledge, skills and performance

- The extent of the doctor's reckless behaviour.
- The extent to which the doctor departed from the principles of good medical practice.

Probity

- The extent of the doctor's significant or sustained acts of dishonesty or misconduct.
- The extent to which the doctor's actions risked patient safety or public confidence in doctors.

Compliance with GMC investigation

- Whether the doctor is reluctant to take remedial action and/or apologise.
- Whether the doctor fails to be open and honest with GMC and local investigations.

Relationships with patients

- The extent of the doctor's predatory behaviour.
- The impact that the doctor's actions had on vulnerable people and risk of harm

Working with colleagues

- Whether the doctor has shown a lack of responsibility toward clinical duties and patient care.
- The seriousness of a doctor's inappropriate behaviour

Teaching and supervision

- The extent to which the doctor failed to comply with requirements.
- Whether the doctors has shown a deliberate disregard for requirements.

Safety and quality

- The extent to which the doctor failed to address serious concerns over a period of time.

Case study: Sarah took her 18-month-old son to her GP surgery with bruising to his arms and back. She told Dr Hull that her son had fallen down the stairs and she just wanted him checked over. Although she noticed unusual bruising, not consistent with the explanation of the injuries, and a change in the child's behaviour, Dr Hull failed to refer the child for an urgent paediatric assessment or to notify other professionals involved in his care. Three months later the child was admitted to accident and emergency with a severe brain injury later found to be caused by being shaken aggressively by his father. The child died several days later in hospital. Dr Hull has expressed remorse for failing to consider the possibility of child abuse. She recognises the seriousness of her actions and has undertaken several courses to help her spot signs of child cruelty in the future.

Proposed change: to guide panels they may consider five key factors when deciding the length of suspension:

- the risk to patient safety
- the impact on public confidence in doctors
- the seriousness of the concerns, and any mitigating or aggravating factors (as set out on the opposite page)
- sending a message to the medical profession that standards must be upheld
- ensuring the doctor has adequate time to remediate.

Panels may also wish to consider the time all parties may need to prepare for a review hearing if one is needed.

16 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

Suspending doctors with health issues

If a doctor has a serious health condition which could affect patient safety they must seek medical advice and take appropriate steps to protect the public as set out in *Good medical practice* (paragraph 28). Where a doctor fails to do this and their fitness to practise is impaired solely on the basis of health, GMC decisions makers or panels will usually agree undertakings or impose conditions to protect patients. But, where this will not offer the level of public protection required, it may be necessary to suspend a doctor. We propose to clarify our guidance to panels on the factors to consider in these circumstances.

Proposed change: where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration.

17 Do you agree with this proposal?

☐

Yes

☐

No

Do you have any comments?

How can doctors keep their clinical skills up to date while they are suspended?

We expect suspended doctors to keep their clinical skills up to date to avoid any deterioration of their fitness to practise. If the original matter related to clinical concerns, they are also required to bring those skills up to a level where they will be allowed to practise again. The sanctions guidance says suspended doctors may do similar work to that of a final year medical student, provided they are supervised by a fully registered doctor. In such cases, they must explain to patients that they are suspended and the events that led up to it, and seek the patients' consent.

However, as the panel has decided that it is not appropriate for the doctor to work under restrictions, it may be that members of the public would expect that a suspended doctor should not have any direct contact with patients (eg, by treating patients under supervision) and that contact with patients should be confined to observation roles.

Case study: Dr Aberdeen was suspended from the medical register for six months after she repeatedly provided false information about her attendance on continuing professional development courses. Her specialist area of practice is general practice. To keep her clinical skills up to date during this period, she found a placement shadowing colleagues so that she could observe them conducting patient consultations.

Proposed change: to provide guidance that suspended doctors should keep their clinical skills up to date by working in ways that do not allow them to be able to play any part in interactions with patients. This would still enable them to observe and later reflect on clinical care such as observing clinics related to their area of practice and of course by engaging in continuing professional development.

18 Do you agree with this proposal?

☐ Yes

☐ No

Do you have any comments?

The influence of previous interim orders

Where there are very serious allegations against a doctor, a panel may decide to impose an interim order. This immediately stops or restricts a doctor's right to practise while we are investigating the concerns or the MPTS is holding a hearing in order to avoid unnecessary risk to patients or public confidence in doctors.

Interim orders are given on the basis of untested evidence as it emerges during our investigation or the hearing – ie before the facts are proved. By contrast, sanctions are given at the end of a hearing, once all the evidence has been heard and the facts found proved. Currently, panels do not usually consider the impact of previous interim orders when they are deciding on the sanction.

However, when it has been established that the doctor is no longer a risk to patients and the panel is considering suspension solely to uphold public confidence in doctors, it could be argued that panels should be able to take into account the time a doctor has been suspended under previous interim orders when they are deciding on the sanction. This is because the interim order itself may have helped

to maintain public confidence in doctors. The impact on the suspended doctor is the same whether it has been imposed as an interim order or following a full panel hearing. However, where a doctor remains a risk to patients and suspension is needed for patient safety, any previous interim orders should not influence the panel's decision.

There are arguments against changing the current approach. Different legal tests apply to interim orders and fitness to practise sanctions – the former deals with an assessment of risk to patients based on unproven allegations, while the latter deals with an assessment of risk based on facts. It may also be seen as unfair to treat suspension differently to conditions.

Case study: During a locum placement, Dr Newport was verbally aggressive to a number of patients and physically assaulted a colleague. He has been subject to an interim order of suspension for 18 months, and a fitness to practise panel has now found him impaired because he continues to present a risk to the public.

Issue to consider: whether panels should take account of previous interim suspension orders in a panel's sanction decision on suspension where action is solely to uphold public confidence in doctors.

19 Where a panel suspends a doctor solely to uphold public confidence in doctors, should any previous interim order influence the panel's decision?

☐ Yes

☐ No

Do you have any comments?

Section 4:

Giving patients a voice

We are exploring ways to enhance the role of patients in our fitness to practise procedures. We are already undertaking a pilot to involve patients and relatives who have complained about a doctor – this consists of a meeting with a member of GMC staff at the start and end of our processes. The aim is to ensure we fully understand the patient's concerns, to explain our role and procedures and to explain the outcome of the case following a decision.

In addition to this, we are considering the benefits of meetings between doctors and patients where a patient has been harmed as a result of a doctor's actions or omissions to enable them to tell the doctor how they feel about what happened and ask the doctor any questions. This would only apply where a meeting had not already taken place as part

of a local process and where the patient wishes to meet with the doctor.

If there is support for this in principle, we will do further work to develop how this could work in practice.

Case study: Tom's leg had to be amputated when a wound became infected due to Dr Colchester's failure to comply with basic hygiene guidelines. He meets with Dr Colchester to explain how this has affected him and to ask questions to help him understand what went wrong.

Issue to consider: the benefits of meetings between doctors and patients where a doctor's actions have seriously harmed a patient.

20 Do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed?

☐

Yes

☐

No

Do you have any comments?

Section 5: Changes to our powers to give warnings

This section looks at when we give warnings to doctors to make sure we identify and address gaps in our ability to take action and take a proportionate approach. There are four questions at the end of this section.

The role of warnings

We give warnings to doctors who have made a significant departure from the principles set out in *Good medical practice* and supporting explanatory guidance, but the concerns are not so serious that their fitness to practise medicine in the future is impaired. A warning sends a message to the doctor and the wider medical profession that standards must be maintained and misconduct must not be repeated. It does not affect a doctor's right to work in the UK.

We introduced warnings when we reformed our fitness to practise processes in 2004. They replaced reprimands for doctors' past failings because the new approach recognised the principle that fitness to practise relates to a doctor's current ability to practise medicine safely. The original intention was that warnings would help to escalate repeat low level concerns that involve a significant departure from our guidance, but there is currently no formal mechanism for this.

Warnings can be given at two stages of the fitness to practise process.

- The end of an investigation: two senior GMC staff (called case examiners) can give a warning if the concerns are significant, but not sufficiently serious to call the doctor's fitness to practise into question.
- The end of a hearing: a panel can give a warning if it finds some or all of the allegations proved, but decides this does not amount to impairment.

Case study: Dr Bristol received a conviction for driving while under the influence of alcohol on her way home from the pub. A health assessment confirms that she does not have any issues with addiction. A case examiner decides this does not meet the threshold for impaired fitness to practise and issues a warning.

Why should we change the current model?

Warnings allow us to respond to concerns that involve a significant breach of our standards which do not meet the threshold for impairment. But we are aware of several concerns about them.

Proportionality

One of the key principles of good regulation is proportionality.* Doctors and their representatives have raised concerns that employers do not always treat information about a warning proportionately as the least serious of our actions. We publish warnings on the online medical register and disclose to all enquirers for five years. In addition, we disclose warnings to employers indefinitely. Sanctions in more serious cases where the doctor's fitness to practise is impaired (suspension, conditions and undertakings) are published and disclosed to all enquirers indefinitely.† We are aware that the reaction of employers and insurers to warnings can have serious consequences for the affected doctors. In view of this, it may be worth considering whether warnings in their current form are a proportionate action for dealing with less serious concerns that involve a significant departure from *Good medical practice*.

* The Better Regulation Executive has identified five principles of good regulation: proportionate, consistent, targeted, transparent and accountable.

† For more information see our publication and disclosure policy for fitness to practise information at: www.gmc-uk.org/DC4380_Publication_and_disclosure_policy_36609763.pdf.

If we decide to retain warnings as a mechanism for dealing with significant departures from our guidance that do not amount to impairment, it may be useful to review our approach to the publication and disclosure of warnings. There have been some concerns about the length of time for which we currently publish and disclose warnings. We are interested in your views about how long we should publish and disclose warnings in the future.

It may also be useful to consider whether warnings could be used to escalate repeated departures from *Good medical practice*. This would enable faster, targeted action to protect patients where a pattern of low level concerns raises more serious issues. It would also help us to communicate that doctors must make sure they do not repeat behaviour that led to a warning.

Case study: In 2012, Dr Exeter examined a patient who had been diagnosed with an irregular heartbeat and had spent six days in an overseas hospital after she collapsed on holiday. Dr Exeter failed to refer the patient to a specialist on her return to the UK, and instead booked her for a blood test the following week. Before the patient was able to have the blood test, she collapsed at home and needed urgent treatment.

There was no evidence of a pattern of concerns and Dr Exeter exhibited insight into his failings in relation to that patient. The GMC decision makers decided that this was a significant departure from our guidance that did not amount to impairment and gave Dr Exeter a warning, which said that he should take greater care in assessing the risks associated with certain conditions and make sure he followed local referral procedures. His medical director has since referred Dr Exeter to the GMC again for failing to refer three patients to specialists in accordance with local referral procedures in the last three months.

Action to deal with misconduct

Warnings can only be issued in response to concerns that do not call into question the doctor's fitness to practise. However MPTS panels have suggested that it would be useful for them to be able to respond to misconduct where they decide the doctor's fitness to practise is impaired but more serious action seems disproportionate. In such cases, the lack of an appropriate alternative means the case can end with a finding of impairment but no action. Panels have suggested that a warning or a similar response would be useful to indicate unacceptable behaviour.

If we make this change, one option would be to stop giving warnings in cases where there is no finding of impairment. However this would mean that low level concerns that involve a significant departure from *Good medical practice* would result in no action and that could have an impact on the confidence of patients and reputation of the profession.

Another option would be to retain warnings to deal with unacceptable behaviour in cases with no impairment, while introducing new powers to give warnings in cases with impairment. It would be necessary to review the terms used to describe these two types of warnings to make sure they were seen to be different. This would have the advantage of providing a more precise system to separate behaviour above and below the threshold of impaired fitness to practise.

Any change to the threshold for issuing warnings will require legislative change supported by public consultation.

Case study: Dr Derby is convicted of causing death by careless driving. Her driving licence is suspended for 18 months and she is given a community order. This is an isolated incident and she has demonstrated significant insight through her voluntary work with a local road safety charity. Following legislative change, a panel would have the option to find the doctor's fitness to practise impaired and issue a warning.

Issue to consider: how effective and proportionate is our current warnings system, when should we be able to issue warnings, and should more serious action be taken where there are repeat low level concerns that involve a serious departure from *Good medical practice*?

21 Do you think warnings are an effective and proportionate means of dealing with low level concerns which involve a significant departure from *Good medical practice*?

☐

Yes

☐

No

Do you have any comments?

22 When do you think we should be able to give warnings?

☐

a Not in any circumstances.

☐

b Only to deal with low level concerns that involve a significant departure from *Good medical practice* where a doctor's fitness to practise is not impaired.

☐

c Only to deal with misconduct where a doctor's fitness to practise has been found impaired.

☐

d To deal with low level concerns and misconduct (see b and c) if different terms are used to describe them.

Do you have any comments?

23 If we continue to give warnings, do you agree that more serious action should be taken where there are repeat low level concerns that involve a significant departure from *Good medical practice*?

☐ Yes

☐ No

Do you have any comments?

24 How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired?

- ☐ **a** Publish warnings for **five years** and disclose to employers and responsible officers indefinitely.
- ☐ **b** Publish warnings for **one year** and disclose to employers and responsible officers for five years.
- ☐ **c** Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years. Indefinite disclosure to employers and responsible officers.

Do you have any comments?

Next steps

We will publish a report on the outcome of this consultation next year. The findings will be used to inform a new version of the indicative sanctions guidance and the future role of apologies and warnings in our procedures. We will also update our guidance for decision makers in line with these principles. Changes to legislation may be required to take some proposals forward.

About you

Finally, we'd appreciate it if you could give some information about yourself to help us analyse the consultation responses.

Your details

Name

Job title (if responding as an organisation)

Organisation (if responding as an organisation)

Address

Email

Contact telephone (optional)

Would you like to be contacted about our future consultations?

☐

Yes

☐

No

If you would like to know about upcoming GMC consultations, please let us know which of the areas of the GMC's work interest you:

☐

Education

☐

Standards and ethics

☐

Fitness to practise

☐

Registration

☐

Licensing and revalidation

Data protection

The information you supply will be stored and processed by the GMC in accordance with the *Data Protection Act 1998* and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

Responding as an individual

Are you are responding as an individual?

☐ Yes

☐ No

If yes, please complete the following questions. **If not, please complete the 'responding as an organisation' section on page 55.**

Which of the following categories best describes you?

☐ Doctor

☐ Medical educator (teaching, delivering or administering)

☐ Medical student

☐ Member of the public

☐ Other healthcare professional

☐ Other (please give details) _____

Doctors

For the purposes of analysis, it would be helpful for us to know a bit more about the doctors who respond to the consultation. If you are responding as an individual doctor, could you please tick the box below which most closely reflects your role?

☐ General practitioner

☐ Consultant

☐ Other hospital doctor

☐ Trainee doctor

☐ Medical director

☐ Other medical manager

☐ Staff and associate grade (SAS) doctor

☐ Sessional or locum doctor

☐ Medical student

☐ Other (please give details) _____

If you are a doctor, do you work

☐ Full-time

☐ Part-time

What is your country of residence?

☐ England

☐ Northern Ireland

☐ Scotland

☐ Wales

☐ Other – European Economic Area

☐ Other – rest of the world (please say where) _____

To help ensure that our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

What is your age?

☐ Under 25

☐ 25–34

☐ 35–44

☐ 45–54

☐ 55–64

☐ 65 or over

Are you:

☐ Female

☐ Male

Would you describe yourself as having a disability?

☐ Yes

☐ No

☐ Prefer not to say

The *Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

What is your ethnic group? (Please tick one)

White

- ☐ English, Welsh, Scottish, Northern Irish or British
- ☐ Irish ☐ Gypsy or Irish traveller
- ☐ Any other white background, please specify _____

Mixed or multiple ethnic groups

- ☐ White and black Caribbean ☐ White and black African ☐ White and Asian
- ☐ Any other mixed or multiple ethnic background, please specify _____

Asian or Asian British

- ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
- ☐ Any other Asian background, please specify _____

Black, African, Caribbean or black British

- ☐ Caribbean ☐ African
- ☐ Any other black, African or Caribbean background, please specify _____

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group, please specify _____

Responding as an organisation

Are you responding on behalf of an organisation?

☐ Yes

☐ No

If yes, please complete the following questions. **If not, please complete the 'responding as an individual' section on page 52.**

Which of the following categories best describes your organisation?

☐ Body representing doctors

☐ Body representing patients or public

☐ Government department

☐ Independent healthcare provider

☐ Medical school (undergraduate)

☐ Postgraduate medical institution

☐ NHS/HSC organisation

☐ Regulatory body

☐ Other (please give details) _____

In which country is your organisation based?

☐ UK wide

☐ England

☐ Scotland

☐ Northern Ireland

☐ Wales

☐ Other (European Economic Area)

☐ Other (rest of the world)

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0161 923 6602 to use the Text Relay service

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Published August 2014

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GMC/RHWDWCAD/0814

General
Medical
Council

**Consultation methodology, breakdown of responses and
analysis**

Introduction

From 22 August to 14 November 2014 we consulted on changes to our sanctions guidance and on the role of apologies and warnings.

The focus of the consultation was on the action we take when we believe a doctor may be putting the safety of patients, or public confidence in doctors, at risk.

This document sets out a summary of the responses to our consultation.

Background

Good medical practice sets out the standards expected of doctors. To make sure panel decisions are transparent, fair and consistent, we provide guidance to help panels decide what sanction is appropriate. This is called our *Indicative Sanctions Guidance for the Fitness to Practise Panel*. The indicative sanctions guidance sets out the issues panels should take into account when making a decision, including whether a doctor's actions have fallen below the standards we expect, any mitigating or aggravating factors, the current risk that the doctor poses, and whether we need to take action in the public interest.

Following an extensive consultation, we published an updated edition of *Good medical practice* and supporting explanatory guidance in March 2013, which came into effect in April 2013. This edition reflects what doctors and patients think are the important values and principles of good care.

Our consultation

Our consultation covered five different areas:

Changes to our sanctions guidance

To make sure it reflects society's values and expectations of doctors, which are set out in the updated edition of *Good medical practice* and supporting explanatory guidance, published in 2013.

The role of apology and insight

We reviewed this because doctors have a duty (*Good medical practice*, paragraph 55) to offer an apology when a patient is harmed or suffers distress as a result of a doctor's actions.

Changes to our guidance on suspension

To help panels make consistent decisions about suspending doctors

Giving patients a voice

We are exploring ways to enhance the role of patients in our fitness to practise procedures.

Changes to our power to give warnings

This section looks at when we give warnings to doctors to make sure we identify and address gaps in our ability to take actions and take a proportionate approach.

Our approach

We asked 24 questions about the proposed changes to our sanctions guidance and on the role of apologies and warnings. Respondents were asked whether they agreed or disagreed with each question. They were then asked to provide any additional comments. Appendix A sets out the 24 questions we asked, the breakdown of responses and a summary of the comments.

Respondents were able to reply to our consultation online using our e-consult website, by email or in writing. We provided a consultation response form for those who preferred to reply by email or by providing a handwritten response. We also published a Welsh language version of both the consultation document and response form.

Breakdown of responses

We received a total of 429 responses to our written questionnaire. The table below shows the breakdown of responses according to source. Most respondents responded by completing our e-consult survey, or by completing a response form which we uploaded to the e-consult site. We also received some broader comments on the consultation by email and letter. These comments were included in the free-text analysis, but not in the statistical analysis, as we could not clearly attribute a 'Yes' or 'No' response.

The written questionnaire was supported by the 'Fitness to practise panel decisions in action' microsite which gave the public the opportunity to tell us what action they thought should be taken in four scenarios, and the factors which influenced their decision. We received 1600 responses to the microsite, and a summary of the responses is included for relevant questions.

Source	Response number
Written questionnaire (e-consult)	427
Group responses from stakeholder events	36
Group responses from RLS events	63
Responses in other formats (emails, etc)	39
TOTAL	565

The table below provides a breakdown of the categories of respondent who completed our written questionnaire:

Category	Sub-category	Response number
Individuals	Doctors	284
	Members of the public	52
	Other individuals	21
	Unknown	3
Organisations	Bodies representing doctors	12
	Bodies representing patients/public	11
	Other organisations	44
TOTAL		427

Appendix C provides a list of organisations that responded to our consultation

Summary of findings

Changes to our sanctions guidance

The majority of our proposals on changes to our sanctions guidance received strong support from respondents, although the BMA, MDU, MDDUS and MPS had reservations, highlighting issues of fairness and proportionality. Responses to many of our proposals emphasised the need to allow panels discretion in their decisions; ensuring they could approach sanctions on a case by case basis.

Respondents, including the BMA, agreed in principle that panels should consider taking action where a doctor's fitness to practise medicine was found to be impaired unless there were exceptional circumstances. However, many commented on the need to give a clear, thoughtful definition of exceptional circumstances to ensure fairness.

The PSA agreed that a definition of exceptional circumstances would be helpful, but didn't support the definition proposed. They also stated that insight, remediation and mitigation were largely irrelevant in cases where impairment was found based on public interest.

Although there was strong support for our proposal to guide panels to take more serious action where cases involved a failure to work collaboratively (including bullying, sexual harassment or violence or risk to patient safety), there were serious concerns about the protection afforded to whistleblowers, and the impact this proposal might have on them. In addition, that bullying was difficult to define or assess and would be better dealt with at a local level.

There was overwhelming support for our proposal to guide panels to consider removing doctors from the medical register when abuse of their professional position involved predatory behaviour towards a patient, particularly where the patient is vulnerable. Respondents felt it was fair to expect the highest standards of professional behaviour from doctors and predatory behaviour was a breach of the trust placed in doctors by the public and their patients. However some respondents said that panels should recognise doctors may form genuine relationships with their patients, particularly in isolated locations, and that perhaps panels should be guided to consider evidence of coercion and recurrence of inappropriate behaviour.

Our proposal to guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics in any circumstance, either within or outside their professional life, received strong support from the majority of respondents, including the BMA. However, some respondents referred to a doctor's right to personal beliefs.

We outlined a number of specific factors in our consultation for panels to consider when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. There was strong support for this proposal from respondents, including the BMA, MDU, MDDUS and MPS. Many stated that the misuse of alcohol or drugs was a serious issue that impaired a doctor's ability to practise safely, putting patients at risk and undermining public confidence in the profession. Some respondents raised concern about the approach to these cases though, suggesting that these doctors would be better dealt with through treatment.

We proposed changes to guidance on panels' consideration of doctors' lives outside medicine, outlining six issues which may lead to more serious action. Although members of the public expressed clear support, opinion was split for doctors, and the proposal did not

receive support from the BMA, MDU, MDDUS or MPS. Concerns were raised about the potential infringement on a doctor's human rights, and the BMA requested further consultation on what type behaviour in a doctor's private life might be engaged under this proposal.

Opinion was divided on whether panels should be guided to consider taking action to maintain public confidence in doctors even when a doctor had remediated, if the concerns were so serious or persistent that failure to do so would impact on public confidence in doctors. Although members of the public and bodies representing patients or the public strongly supported the proposal, the majority of doctors, together with the BMA, MDU, MDDUS and MPS disagreed. The MPS stated that these cases would be rare, and that panels should be able to 'exercise their own judgment to determine the extent to which the matters complained of are capable of being remediated and the extent to which they have been remediated'.

Opinion was also divided on our proposal to guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence. As with the responses to our proposal to guide panels to take more serious action where cases involve a failure to work collaboratively, a large number of doctors were concerned about the lack of protection afforded to whistleblowers.

The role of insight and apology

There was no consensus of opinion as to whether or not panels should be able to require doctors to apologise where patients have been harmed. Although many respondents agreed that a doctor should apologise when something has gone wrong, they questioned the value of a forced apology, asserting that it would probably be meaningless. The PSA were 'doubtful an apology [would] hold much value for the recipient so long after the event and particularly when they [would] probably also know the doctor has been ordered to apologise'. Conversely, some respondents felt that by forcing doctors to apologise, panels may encourage others to give apologies freely, and at an earlier stage of the process.

Our proposal to introduce more detailed guidance on the factors that indicate a doctor has or lacks insight was met with strong support from the majority of stakeholder groups. The PSA supported the development of additional guidance in this area, however, it outlined slightly different factors it believed panels should consider. In particular, the PSA cautioned that limited weight should be attached to an apology, admission or engaging in proceedings as these actions may be taken in order to receive a more lenient outcome as opposed to showing genuine insight. A number of other respondents also made suggestions as to the factors which should be included in this guidance.

The BMA expressed concern that this proposal 'could lead to doctors being afraid to fight their cases because of a belief that any failure to apologise could lead to them being held to lack insight [and] could thereby undermine their right to a fair trial under Article 6 of the European Convention on Human Rights.'

Respondents felt that the proposal to advise panels to take action to maintain public confidence even where doctors have remediated conflicts with the proposal to guide panels that taking steps to remediate is an indication of genuine insight.

Respondents across all stakeholder groups gave strong support to our proposal to guide panels to consider the stage of a doctor's UK medical career as a mitigating factor, and whether they had gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. The BMA were wholly supportive of the proposal, whilst the MDU stated that the proposal should be expanded to include doctors who may be more senior, 'but have little experience in a particular field.' Respondents also agreed that it was important to consider this in relation to the nature of the breach.

The Patients Association raised concern that the cases which reach the sanction stage of a fitness to practise panel hearing would be sufficiently serious to render this proposal unworkable. They were concerned about the message the proposal might send to doctors and patients.

There was overwhelming support from all stakeholder groups with regard to our proposal to introduce verification checks on testimonials, and on the factors that should be used to determine whether testimonials are relevant to the panel's decision.

Although supportive of the use of verification checks, the BMA and MDDUS raised concern about the submission of testimonials before a hearing, the BMA stated that the GMC shouldn't restrict the evidence doctors could present in their defence.

There were mixed views on whether personal friendship presents a conflict of interest for testimonial authors, with many respondents commenting on the blurred boundary between work colleagues and friends. The BMA asserted that 'personal friendship and honesty/objectivity are not mutually exclusive.'

There was also strong support across stakeholder groups for routinely requesting a statement from a doctor's responsible officer (or suitable person) during our investigation for the panel to consider at a hearing. Participants at both the Responsible Officer Reference Group and the Key Stakeholder consultation events highlighted that this was a major part of a good appraisal process and part and parcel of a responsible officer's role.

Some concerns were raised regarding the impact this might have on responsible officers with large area teams. If the proposal is taken forward, we would work closely with responsible officers to ensure we fully understand, and take account of, these types of challenges.

Another concern amongst respondents in relation to this proposal relates to the objectivity of responsible officers, from the perspective of both patients and doctors.

Changes to our guidance on suspension

The proposals for changes to our guidance on suspension received strong support across all stakeholder groups, although concerns were raised by the BMA, MDU, MDDUS and MPS regarding the clarity of our proposed guidance for how doctors can keep their clinical skills up to date whilst they are suspended.

The majority of respondents supported our proposal to guide panels they may consider five key factors when deciding the length of suspension. However, a considerable number of respondents raised concern about the use of factor two (the impact on public confidence in

the profession), and factor four (sending a message to the medical profession that standards must be upheld). Some respondents questioned how objective the test of public confidence would be, and what evidence there was to indicate these decisions would support public confidence in doctors. The Royal College of Physicians raised concern that the use of factor four 'could be interpreted as making an example of an individual doctor and could be open to accusations of inequity or unfairness in application'.

We proposed that, where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration.. There was strong support for this proposal across all stakeholder groups, although there was discussion around the importance of supporting doctors in these cases, whilst ensuring patient safety isn't compromised.

Our proposal to provide guidance on how doctors can keep their clinical skills up to date while they were suspended received strong support from respondents, although there was some discussion around the need to provide support mechanisms to help doctors return to practice following a period of suspension.

The PSA considered that this might not be appropriate for all doctors, for example where a doctor has abused patients or acted dishonestly.

Of those who opposed this proposal, a large number raised concern that, without patient interaction, doctors would be unable to maintain their clinical skills.

There was support across all stakeholder groups for our proposal to guide panels to take account of previous interim suspension orders in panels' sanction decision on suspension where action was solely to uphold public confidence in doctors. The PSA however, did not consider that an interim suspension was a relevant consideration as it would have been imposed for a different reason/purpose than the substantive sanction.

Giving patients a voice

A large number of respondents across the majority of stakeholder groups agreed that there were benefits of meetings between doctors and patients where a doctor's actions have seriously harmed a patient. The BMA, although in agreement, noted the need for detailed work around the practicality of the proposal.

The PSA did not provide a view about whether or not they supported this proposal, but they did state that, if it is taken forward, their research around public views on alternatives to final fitness to practise hearings might be helpful.

Those respondents who opposed the proposal raised concern that these meetings would not be effective if mandatory and, if led by the GMC, there could be a perceived bias

Changes to our powers to give warnings

The majority of respondents considered warnings to be an effective and proportionate means of dealing with low level concerns that involve a significant departure from *Good medical practice*. Discussion centred around repeat concerns and remediation, when and how long warnings should be used, and an escalatory principle for warnings.

It was the majority view across all stakeholder groups that warnings should be used to deal with low level concerns (where a doctor's fitness to practise is not impaired) and misconduct (where a doctor's fitness to practise has been found impaired), if different terms are used to describe them.

The PSA supported the GMC having the power to issue warnings in cases where the doctor was found impaired, as well as where there isn't a finding of impairment as this mirrors the approach of other regulators. The PSA would like to see consistent terminology across the regulators.

There was consensus across all stakeholder groups that more serious action should be taken where low level concerns that involve a significant departure from *Good medical practice* are repeated.

The proposal to amend the publication and disclosure of warnings was welcomed by all stakeholder groups, with many highlighting the disproportionate impact of warnings as a result of the publication period. The majority of respondents agreed that the GMC should issue guidance to case examiners and MPTS panels on determining the length of publication on a case by case basis up to a maximum of five years, with indefinite disclosure to employers and responsible officers.

The PSA stated that the publication and disclosure of warnings should be based on the public interest.

Conclusions and next steps

Overall there was a very high level of support for our proposals. The vast majority of respondents agreed with most of the changes proposed to our sanctions guidance and on the role of apologies and warnings.

We will carefully consider the findings of the consultation, and our Council will decide which of the proposals we will take forward.

Throughout the consultation, a number of comments were made regarding fairness and proportionality. We captured these comments throughout our free-text analysis, drawing out any reference to equalities issues. These issues will feed in to an equality analysis which will help minimise any adverse impact on particular groups and will accompany the report to Council.

Appendix A: Proposal analysis

We received 427 responses to our written questionnaire. It was not compulsory to respond to every proposal, or to provide additional comments. We also received 39 responses in other formats, together with 99 feedback forms from our consultation events. The responses in other formats and information from feedback forms were not included in the statistical breakdown, but were included in the overall analysis of the comments.

In this appendix we have set out each proposal, followed by the statistical breakdown of responses and a summary of all of the themes that arose from the comments provided by respondents.

Changes to our sanctions guidance

Proposal 1: Where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	181	42%	107
No	235	55%	194
Blank	11	3%	6
TOTAL	427	100%	307

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	3	10	0	13
	Body representing patients or public	9	2	0	11
	Government department	0	0	0	0
	Independent healthcare provider	3	4	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	3	0	2	5
	NHS/HSC organisation	13	6	0	19
	Regulatory body	1	0	1	2
	Other	5	2	1	8
Individuals	Doctor	93	186	6	285
	Medical educator	1	5	0	6
	Medical student	0	0	0	0
	Member of the public	34	17	1	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	14	3	0	16
	Blank	0	1	0	1

Introduction

Opinion is divided on whether panels should be influenced by personal consequences of sanctions on doctors, with the majority (55%) opposed in principle and 42% in favour. There was support from 13 NHS/HSC organisations and 6 royal colleges. The BMA, MDU, MDDUS, MPS, and the majority of individual doctors (65%) opposed the approach. 53 members of the public responded with 66% in favour.

Comments opposed to our proposal

69 respondents raised concerns about the impact this proposal might have on doctors, with some commenting that penalties imposed will impact on the doctor's family/ children and consideration for personal circumstances must be given to ensure sanctions are proportionate.

The MDDUS commented that current guidance was sufficiently clear for panellists. Some respondents suggested that the proposal was harsh and not consistent with the process of law which routinely takes the defendant's personal circumstances into account. An individual doctor commented that 'whilst I strongly agree that patient safety is paramount I strongly believe that the GMC and regulatory bodies also have a duty of care to doctors and to provide support and care'.

Concerns were also raised that a 'one size fits all' approach should not be adopted as laws do not work that way to deliver justice. Some respondents also questioned whether the proposal was in breach of a doctor's rights under article 8 of the European Convention on Human Rights.

There was some discussion about the damage that can be done by malicious claims or genuine accidents caused by system failures, which may be blamed on an individual.

Comments in support of our proposal

The Royal College of Psychiatrists commented that it is important that GMC maintain clear standards, and that must be unaffected by public opinion from which the GMC's integrity, and thus public confidence, will ultimately be derived. 66% of members of the public were in favour of panels not being influenced by personal consequences of sanctions on doctors. One respondent commented that in all other professions, where one's performance or conduct is lacking, action will be taken and the medical profession should be no exception.

32% of individual doctors were in favour of this proposal, with 33 respondents commenting that patient safety or needs of the patient were the primary concern. One individual doctor stated that 'Patients need to be protected. This should take first priority. In busy secondary care the ability to closely supervise a doctor with warnings and conditions is next to impossible. Vulnerable patients need to be protected'.

11% of respondents agreed with the proposal but with reservations. A response from an individual doctor commented that the bar needs to be set at a level to ensure that this is not applied to 'minor' issues. One NHS/HSC organisation who supported the proposal went on to state that 'the need must be assessed on a case by case basis. If there have been no other concerns and the employing organisation is reassured this is an isolated incident...personal consequences for the doctor should be taken into account and a pragmatic outcome sought. Obviously this will depend on the severity of the issue.' The

Law Society of Scotland also agreed with the proposals, commenting that societal values and expectations of doctors should be taken into account. However, they stated that, whilst panels should take account of the public interest, they must also act proportionately. Furthermore, societal values would be maintained even if action isn't taken where a doctor has made a minor mistake that does not result in serious harm.

Another individual doctor stated that 'if a doctor has acted unprofessionally and broken the terms of *Good medical practice*, then this is incompatible with the medical profession. In all other public facing professions the same sanctions would apply with the same circumstances'.

Equalities Issues

Respondents commented that the proposals may result in doctors concealing illness. In addition, some highlighted that investigations have an impact on a doctor's mental health. Also, that the proposals don't appear to make allowance for doctors with physical or mental health illnesses. Some respondents raised concern that the proposals may impact on families and children, as sanctions against a doctor may impact on the doctor's livelihood.

Proposal 2: To guide panels to consider taking action where a doctor's fitness to practise medicine is found to be impaired unless there are exceptional circumstances. To define exceptional circumstances as those that are unusual, special or uncommon. For example, it is not unusual for doctors to express regret for their actions, so this is not an exceptional circumstance.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	267	63%	96
No	144	34%	110
Blank	16	4%	6
TOTAL	427	100%	212

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	7	6	0	13
	Body representing patients or public	8	3	0	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	4	0	1	5
	NHS/HSC organisation	17	2	0	19
	Regulatory body	1	0	1	2
	Other	7	1	0	8
Individuals	Doctor	163	112	10	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	34	15	3	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	12	3	1	16
	Blank	0	1	0	1

Introduction

There was strong support for taking action in cases unless there are exceptional circumstances, with the majority of respondents (63%) in favour and 34% opposed. The majority of NHS/HSC organisations supported the approach, together with 12 royal colleges. 57% of doctors agreed with the proposal, together with 65% of members of the public who provided a response were in favour. The Law Society of Scotland and Royal College of Surgeons of Edinburgh and Royal College of Psychiatrists were in favour whilst the BMA, MDU, MDDUS and the MPS opposed the proposal.

The PSA stated that 'It would be helpful to clarify the guidance on exceptional circumstances, however we cannot support the definition proposed.' They considered the definition in the proposal to be too broad and raised the importance of highlighting to the panels that they must 'fully and clearly explain what the exceptional circumstances are.'

Comments in support of our proposal

12 respondents fully agreed with this proposal. An individual doctor commented that 'If properly taught and guided practitioners know that the privileges registration gives them - not just legally but as trusted members of society - requires the standards of the conduct of their life to be worthy of that respect'.

The Royal College of Psychiatrists commented on the need to define what might constitute exceptional circumstances. In addition a doctor commented 'Unless there are very good definitions of 'exceptional' there is the chance of inconsistency in decisions by the Panel, so I say yes with reservations'. In total 27 commented on the importance of defining exceptional circumstances across all stakeholder groups, including those in favour and those opposed in principle. In addition some respondents stated that only very exceptional circumstances such as illness or stress should be accepted. A number of respondents have commented for the need to be proportionate when taking action and that more emphasis should be placed on helping the doctor remediate rather than punishing them.

28 respondents cautioned that action must be proportionate. A response from an individual doctor commented 'so long as it is clear that panels 'consider taking action' as part of the proposal, not that they automatically do so...i.e., it may depend on what the 'guidance' includes'. A response from an independent healthcare provider commented ' Agree but need to be clear on what 'guide' means - can panels deviate from 'guidance' if felt appropriate to do so ?' In addition a response from an NHS/HSC organisation commented 'Doctors now seem to have been 'coached' by their defence organisation to appear penitent and contrite at a hearing and to state that they wish to undergo remediation, even when they have shown no remorse right up to the hearing.'

Comments opposed to our proposal

The BMA stated 'although we agree in principle that panels should consider taking action unless there are exceptional circumstances, it would be difficult in practice to determine what are 'exceptional circumstances' and there would need to be a proper and sensitive explanation of what is meant by 'exceptional circumstances' that guided panels to take account of findings made and sanctions imposed elsewhere'. The MDDUS also opposed the proposal, and stated that it 'is draconian and takes no account of other factors which a rounded panel's consideration would take into account'.

One respondent expressed concern that the proposal would lead to over prescriptive guidance for panels and that each case should be addressed on an individual basis considering all of the circumstances. There was noticeable concern about the phrase 'taking action in all cases'. This was supported by 9 individual doctors and the Medical Protection Society who commented that panels should be able to use their own discretion.

A minority of individual doctors (39%) opposed this proposal. Some commented that the approach was too punitive and that there should be a greater focus on remediation, which would lead to an 'open' culture where doctors felt supported rather than punished. There was some concern that this proposal would lead to under reporting of issues.

Equalities Issues

No equalities issues were raised with regard to this proposal

Proposal 3: To guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	188	44%	86
No	222	52%	185
Blank	17	4%	8
TOTAL	427	100%	279

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	4	9	0	13
	Body representing patients or public	6	4	1	11
	Government department	0	0	0	0
	Independent healthcare provider	3	3	1	7
	Medical School (undergraduate)	1	0	1	2
	Postgraduate medical institution	3	1	1	5
	NHS/HSC organisation	14	5	0	19
	Regulatory body	2	0	0	2
	Other	3	4	1	8
Individuals	Doctor	106	170	9	285
	Medical educator	0	6	0	6
	Medical student	0	0	0	0
	Member of the public	35	14	3	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Unknown	11	5	0	16
Unknown	Blank	0	1	0	1

Microsite analysis: Dr Glasgow made very serious clinical errors over a period of time that harmed a number of patients. Should we still take action even though she has retrained?

Action category	Number of respondents 377
No action needs to be taken	3%
The doctor needs to be reminded that the behaviour is undesirable	19%
The doctor's practice should be restricted in some way	53%
The doctor should be removed from practice for a period of time	19%
This behaviour is incompatible with being a doctor	6%

Introduction

Opinion was divided on whether panels should be guided to consider taking action to maintain public confidence even when a doctor has remediated if concerns are so serious or persistent that public confidence could be damaged if action isn't taken. The BMA, MDU, MDDUS, the MPS and 52% of respondents were opposed in principle and 44% were in favour. Those opposed included the 60% of individual doctors and medical educators. The Law Society of Scotland and 8 royal colleges were in favour of the proposal. In addition NHS/HSC organisations were broadly supportive of this proposal with 14 in favour and 5 opposed. 67% of members of the public were in favour of the proposal.

Comments opposed to our proposal

Concern was raised by a number of respondents about the value of remediation, if a doctor having successfully retrained may under these proposals face further sanction based on past failings. The MDDUS commented that changing the guidance in this manner would, in their view, be unlawful. They stated that there 'is now a long line of case law which makes it clear that the role of a fitness to practise panel is not to punish doctors, but to assess current fitness to practise.' 40 respondents commented that successful, good quality remediation should be sufficient for obtaining public confidence in the profession. Some respondents questioned how public confidence would be assessed, and who by. The majority of individual doctors (60%) opposed this proposal, many commented that once a doctor has been successfully remediated they should be allowed to practise, and it is the GMC's function to strongly defend its decisions to accept that a doctor has adequately retrained and learnt from previous errors. In addition, some commented that the panels would need to consider the weight of evidence that remediation has been effective. In addition, it would be appropriate to fully explain why the remediation had been effective to ensure public confidence.

There was some discussion about the need for doctors to be treated fairly, and therefore this proposal should be considered on a case by case basis; a number of respondents strongly disagreed with what they perceived to be a blanket policy. Some respondents commented that the GMC's focus should be on protecting the public and remediation of doctors where necessary. They considered that all other issues ought to be dealt with by existing legal processes whether civil or criminal justice. A response from an individual doctor commented 'if the doctor has remediated then that is the end of the matter.' They stated that if this didn't happen it would be like double jeopardy.

Several respondents commented that the proposals were at risk of scapegoating doctors to satisfy the public and media's desire to see strong sanctions imposed on doctors. Furthermore, that this would create a heightened culture of fear where doctors would work even harder to hide mistakes and therefore not learn from them as they would do in an 'open culture'.

The Medical Protection Society commented that 'there will be a few serious cases in which it would be appropriate to take action to maintain public confidence in the profession even when a doctor has remediated. However, these cases should be rare and there should be exceptional circumstances involved otherwise applying sanctions in this way would only be serving a punitive function. Panels ought to be entrusted to consider the circumstances of the case, and exercise their own judgment to determine the extent to which the matters complained of are capable of being remediated and the extent to which they have been remediated'.

Comments in support of our proposal

The Royal Society of Psychiatrists were in favour of this proposal and commented 'Clearly there are circumstances where failings may be serious or persistent. However, there is potential for disciplining doctors for past misconduct...Whilst a single update to training may solve the current gap, if it is not accompanied by a system to identify future gaps and maintain skills, then it will not be effective in protecting patients'. 67% of members of the public were in favour of the proposal. One member of the public commented that 'confidence needs to be maintained in doctors' judgement. Where a doctor has past failings it gives question to their judgement, how would they prevent this happening again after retraining.'

One member of the public stated 'the first priority is to protect patients from harm', whilst an individual doctor stated it was important for guidance to clearly indicate that the sanction should be fair and proportionate, and based on the gravity of the harm caused.

37% of individual doctors were in favour of the proposal. One respondent commented that no matter the remediation, if the concerns remain serious or persistent, then patient safety could not be assured.

Several respondents agreed with the proposal but with caution, stating that a doctor's failings may be a by-product of the environment they work in, over which they may have little control. In addition a response from an individual doctor commented 'in relation to the 'raising concerns' statement- there have been issues of bullying/intimidation of whistle blowers so this would need to be taken into account. A duty we would normally act on may be very difficult to follow in these circumstances'.

Microsite summary

Microsite analysis: <u>Dr Glasgow</u> made very serious clinical errors over a period of time that harmed a number of patients. Should we still take action even though she has retrained?	
Action category	Number of respondents 377
No action needs to be taken	3%
The doctor needs to be reminded that the behaviour is undesirable	19%
The doctor's practice should be restricted in some way	53%
The doctor should be removed from practice for a period of time	19%
This behaviour is incompatible with being a doctor	6%

Overall there were 377 responses via the microsite, with the majority (292) from doctors and 37 from members of the public. 53% of respondents thought that the doctor's practice should be restricted in some way. The majority of respondents indicated that the most important factor when considering what action to take was the seriousness of the harm (58%), with a further 26% of respondents indicating that the length of time the doctor's performance was poor was an important consideration.

Equalities Issues

One respondent commented that consideration of a potential restriction of scope of work for disabled doctors must be given to comply with disability legislation. They didn't provide any further detail on what was required.

Proposal 4: To guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	198	46.37%	119
No	211	49.41%	171
Blank	18	4.22%	11
TOTAL	427	100%	301

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	4	7	2	13
	Body representing patients or public	8	2	1	11
	Government department	0	0	0	0
	Independent healthcare provider	5	2	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	4	1	0	5
	NHS/HSC organisation	15	4	0	19
	Regulatory body	2	0	0	2
	Other	5	2	1	8
Individuals	Doctor	109	167	8	284
	Medical educator	2	4	0	6
	Medical student	0	0	0	0
	Member of the public	33	14	5	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Other	9	6	1	16
Unknown	Unknown	0	1	0	1
	Blank	0	1	0	1

Microsite analysis: <u>Dr Belfast</u> didn't raise concerns about basic care	
Action category	Number of respondents 383
No action needs to be taken	11%
The doctor needs to be reminded that the behaviour is undesirable	67%
The doctor's practice should be restricted in some way	16%
The doctor should be removed from practice for a period of time	5%
This behaviour is incompatible with being a doctor	2%

Introduction

Opinion was divided on whether or not panels should take more serious action where doctors have failed to raise concerns, and where appropriate, whether doctors should be removed or suspended from the medical register to ensure public confidence. 46% of respondents were in favour of the proposal and 49% were opposed, with 5% failing to provide a response. Members of the public predominantly supported the proposal, with 63% in favour. BUPA and the majority of NHS/HSC organisations supported the approach, together with 10 royal colleges. The BMA, MDU and MPS opposed the proposal together with 59% of doctors.

Comments opposed to our proposal

The biggest concern expressed by respondents was in relation to the worries doctors may have around whistleblowing, and their lack of protection if they were to report concerns that they encounter in their daily practice. Many doctors responding to the proposal explicitly stated that the treatment of whistleblowers might mean this may not be realistic for doctors in practice. One doctor stated that 'until there is robust protection for whistleblowers, it would be wrong to impose such severe sanctions' if concerns are not reported, and another doctor remarked on the personal stress associated with whistleblowing. Some respondents raised concern that, due to whistleblowers not being treated with 'respect and dignity', this proposal was problematic. An attendee at one of our Regional Liaison Service events referred to the stigma associated with whistleblowing whilst maintaining the need to protect the public. The BMA stated that the GMC was not visible enough when a doctor may be subject to penalty for whistleblowing and 'that the proposal has not taken into account the implications on other areas of law, most particularly, the law relating to protected disclosures ('whistleblowing') and other employment rights, data protection and confidentiality'. The Royal College of Psychiatrists raised concerns that whistleblowing policies were not being implemented, although it is not clear whether this meant locally or more generally across the NHS.

Of those who opposed our proposal, several respondents highlighted that a lack of organisational support and proper procedure may have an impact in relation to concerns reported or underreported by doctors; mention was made of the 'ongoing culture of fear in the NHS'. The BMA stated that 'Doctors should not be held responsible for organisational or cultural failings or for the failings of professionals who are outside their managerial control'. This was echoed by those involved in an external engagement event, who emphasised the need for a doctor to know which 'routes to go down' when raising concerns, and the potential for the outcome to be influenced by the 'system'. The Family Doctors Association reiterated that systematic issues/failures in the NHS were concerning. One respondent highlighted that resources within the NHS, 'in terms of time, premises [and] staffing levels' were not widely and consistently available, making it difficult to manage concerns. There was some discussion about the hierarchical nature of a lot of organisations making reporting concerns extremely difficult, especially considering the disparity between places where there may be a 'bullying culture' compared with a 'corporate culture of openness'. One respondent from our external engagement event referred to the need to consider Trust escalation policies when looking at our proposal.

Nine respondents argued that our current system for handling the reporting of concerns was adequate, and didn't need to be changed. They stated that the duty to report concerns was included in *Good medical practice*, and 'punitive actions for [cases where concerns are not reported] are already available'. One response from a Panel Chair argued that maintaining

the status quo would be more desirable, stating that 'Panels are already enjoined to use the principle of proportionality in reaching decisions on a sanction'.

Respondents also highlighted that other regulators such as the NMC and the CQC should require healthcare professionals to report failings in the same way that the GMC's proposal requires doctors to proactively raise concerns. We note that the NMC have their 'Standard of Conduct' which sets out what is expected of nurses and midwives. Cross regulatory working was a point reiterated through our external engagement events in London.

The BMA raised concerns about whether doctors would be adequately protected within the remit of The Public Interest Disclosure Act 1998. Depending on who the doctor made the disclosure to, 'the effect of raising concerns with the GMC or otherwise than with the employer may lead to further legal exposure of the employer (NHS Trust) or individual (doctor or other) colleagues'.

Comments in support of our proposal

Two respondents identified the duty of candour as having an influence on doctors reporting concerns, with two responses highlighting that this would go some way to supporting our proposal, though acknowledging the duty would 'raise difficulties' when considered in the context of whistleblowing. It was also mentioned by one doctor that this duty may lead to a rise in vexatious complaints by one doctor against another. Three responses referred to a bullying culture within the managerial structure in an employment setting and asked that this be considered when taking action against a doctor's licence. They argued that failing to report concerns should not result in removal or suspension if there were 'mitigating circumstances, such as bullying from senior staff or management'.

One of the medical educators who responded to the consultation stated that our proposal would lead to a 'significant shift in thinking amongst medical professionals as doctors very rarely commit to raising concerns'. Thirteen qualitative responses in favour of our proposal made reference to whistleblowing concerns, arguing that protection should be afforded to those who do come forward and raised issues about the level of care provided to patients. An organisation responsible for representing doctors agreed in principle with our proposal, but pointed out that 'whistleblowing is a very difficult process and is fraught with fear and uncertainty'; a concern echoed by several other respondents to the question. Respondents argued that our proposal would require an attitudinal change in relation to the treatment of whistleblowers for it to be practical. One respondent at an engagement event said that an absolute duty to report would encourage doctors to do so, and that it would form part of a 'cultural change'.

The majority of the members of the public who responded were of the opinion that doctors should already be reporting concerns, and failing not to do so 'should be a crime'. One respondent stated that 'everybody is responsible for their actions collectively'. Likewise, another respondent stated 'for someone not to raise concerns about the performance of a colleague is tantamount to turning a blind eye' with another member of the public believing 'a physician who chooses to ignore negligent conduct should be as culpable as the perpetrator'. Doctors who responded also argued that our proposal would help with the problem of doctors 'closing ranks'. One respondent from at an engagement event also referred to the severity of the doctor in the employment setting and whether this would make a difference. Another doctor remarked 'maintaining public confidence should not be paramount, maintaining safety is'. Our external engagement events reiterated that 'public confidence should not be defined by the media response to a case'.

Suggestions to refine our proposal

Several respondents suggested that there should be specific guidance on the level of concern that would require a doctor to raise a concern, with one of our NHS respondents saying clear parameters have to be set when 'deciding the threshold for not raising concerns'. Some doctors suggested that the 'severity of the risk/urgency of action that is required' should be made explicit, otherwise as one NHS body stated 'difficulties will arise in the setting of minor or low-end concerns'. The PSA considered that the term 'to guide panels to consider more serious action' was not sufficiently clear, and revised guidance may be more beneficial. They also stated that this clarity should refer to whether this relates to reporting concerns about themselves as well as others, and the guidance should refer to the failures in the professional duty of candour.

One doctor argued there should be a 'no-blame method of raising concerns' and this might lead to an increase in the number of doctors willing to disclose issues to management, as well as a change in attitudes on the matter.

Microsite summary

The majority of respondents (68%) thought that Dr Belfast should be reminded that his behaviour is undesirable. The second most popular course of action was to restrict his practice in some way. Non-doctors were much more likely to choose a more serious course of action with 10% fewer choosing 'remind undesirable'. Almost all of the respondents who said that this behaviour was incompatible with being a doctor were not doctors themselves. The most important factor in making decisions was the fact that Dr. Belfast failed to take prompt action when he had concerns about basic care needs being met. Nearly 50% of people ranked this as their key consideration. The least important factor was that action was required to maintain public confidence, more than 80% of people ranked this 4th or not at all. Non-doctors thought that upholding public confidence was more important than doctors. 50% of doctors did not even select this as a factor affecting their decision. Doctors did however rank the fact that there was a significant risk to patient safety higher than non-doctors.

Equalities Issues

There were no specific equalities issues raised in relation to this proposal by any of the respondents.

Proposal 5: To guide panels they may consider more serious action where cases involve a failure to work collaboratively including bullying, sexual harassment or violence or risk to patient safety

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	335	78.45%	143
No	82	19.20%	66
Blank	10	2.34%	3
TOTAL	427	100%	212

Community people responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	8	4	1	13
	<i>Body representing patients or public</i>	9	2	0	11
	<i>Government department</i>	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	16	3	0	19
	Regulatory body	2	0	0	2
	Other	6	2	0	8
Individuals	Doctor	217	60	8	285
	Medical educator	6	0	0	6
	Medical student	0	0	0	0
	Member of the public	46	6	0	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Other	12	3	1	16
Unknown	Unknown	0	1	0	1
	Blank	0	1	0	1

Introduction

There was strong support for the proposal that panels should be able to consider more serious action where cases involve a failure to work collaboratively including bullying, sexual harassment or violence or risk to patient safety. Overall 78% of respondents were in favour, of the proposal to guide panels they may consider more serious action where cases involve a failure to work collaboratively, including 76% of doctors. Only 19% of respondents disagreed with the proposal. There was strong support from members of the public, with 88% in favour. Of the 19 healthcare professionals who provided a response to this consultation, 16 supported this proposal.

The MDDUS supported the proposal together with 13 royal colleges, however the BMA, MDU and MPS disagreed with it.

Comments in support of our proposal

Several doctors highlighted the need for effective, collaborative working in clinical settings to ensure patient safety remains a priority. Doctors agreed that accusations of bullying should be properly followed up, especially in the context of doctors who may have been subject to bullying as a result of being a whistleblower. One doctor stated 'there have been a number of high profile campaigns against whistleblowers'. Another doctor stated that often it was those who occupy the higher ranks within medical organisations who were 'more likely to be involved in bullying'. Of our external engagement events, the majority agreed with this proposal stating that collaborative working was important when considering the implications it can have for patient safety.

Two doctors and one medical educator were surprised that our proposal was not already in practice, acknowledging that 'failure of team-working can be a team and not an individual problem'. At one of our external events, Staffordshire GP appraisers reiterated that the 'key issue is patient safety', which was echoed by North Tees & Hartlepool NHS Foundation Trust. An individual doctor, who provided a response to our written questionnaire, explained that the 'biggest cause for team dysfunction' is workplace bullying. However, another individual doctor emphasised the need for panels to have 'very good objective grounds' for taking more serious action against doctors in GMC fitness to practise procedures. One member of the public argued that the law on harassment should cover the scenario put forward in our proposal, and that it would be right for us to amend our approach to reflect this.

Most members of the public strongly agreed with the proposal, with one member of the public stating 'there is no place for this type of behaviour anywhere in the practice of medicine', and another member of the public arguing that team failings impact on patient care: 'Bullying is not a victimless crime'. However, a representative of the BMA at one of our external engagement events remarked that 'there are two sides to any story', and that issues surrounding bullying should be dealt with at a local level and 'punished accordingly'.

Three doctors stated that 'bullying is hard to define', and that some doctors who receive adverse feedback about their practice might use that as grounds for a bullying claim, whereas another doctor may respond differently. Likewise, the BMA stated that defining bullying in itself is not a simple task, and 'one person's bully is another person's firm but fair manager'.

Another doctor stated that, whilst they supported the proposal, they believed that 'the GMC should not cross the boundaries of either HR procedures or criminal procedures', and 'it would only take one irritated junior, or an annoyed nurse to potentially ruin a doctor's career'. One of the respondents from the independent healthcare sector again questioned whether this proposal was within the remit of the GMC.

One doctor stated their reason for supporting the proposal was because of the NHS' deference in dealing with instances of bullying. However, an NHS/HSC organisation stated that 'stronger sanctions are not necessarily the answer to failure in collaborative working', and instead motivation of staff is better than 'punishment'.

Three doctors provided narrative of their own personal issues with the GMC in relation to bullying/victimisation experiences they had encountered in their own workplaces.

Two NHS/HSC organisations referred to the culture of senior management and individual trusts when considering how failures to work collaboratively should be dealt with. The stated that senior clinical leadership should be critiqued to a greater extent, and Trust HR policies should also be considered. A respondent on behalf of the police referred to a culture within the NHS that may 'blight' a junior doctor's career if not appropriately handled. Again, a postgraduate medical institute referred to a culture within the NHS that encourages blame and finds it difficult to accept criticism.

Comments opposed to our proposal

There was some discussion about how *Good medical practice* already has mechanisms to deal with doctors who may not cooperate with colleagues and choose to actively bully or harass those they work with, one respondent stated that 'further punitive advice is unnecessary and inappropriate'.

Others had concerns about the burden of proof and the standard applied when deciding whether a doctor's behaviour amounted to bullying or harassment. The BMA stated that 'Bullying, harassment and discrimination are not failures to work collaboratively – but matters which are inherently far more serious'. One doctor opposed to the proposal believed that where violence or harassment was proved in court, a heavier sanction would be warranted, but stated that 'bullying is an immensely subjective concept'. Another doctor stated that 'bullying claims are a common way of silencing whistleblowers', and the GMC should be alive to that reality when considering amending its guidance. One NHS/HSC organisation put forward the view that the GMC should only impose greater sanctions on a doctor where 'overwhelming evidence of unprofessional or criminal activity' has been proved by the police and Crown Prosecution Service.

Two doctors indicated that they felt the GMC were acting outside of their remit in attempting to introduce this proposal, stating that it 'goes completely against the Human Rights Act'. This was a view shared by the BMA, who had concerns that the 'diffuse requirement imposed by the GMC on doctors to 'work collaboratively' may also amount to an impermissible interference with the doctors rights to freedom of expression under Article 10 European Convention on Human Rights'.

Another individual doctor remarked that our proposal 'raises the prospect of scapegoating a practitioner for a systems failure', whilst another individual doctor believed the emphasis should instead be on the harm caused to the patient'.

As was the case with those in support of the proposal, one doctor suggested that bullying and harassment in the workplace should be 'dealt with by Employment Rules, not the GMC', believing that there were adequate statutory mechanisms to handle issues without GMC intervention. The BMA also added that the GMC were unlikely to have the expertise to guide the MPTS in considering the complexities of bullying and harassment claims as 'even in the specialist jurisdictions where discrimination claims are heard, the adjudication of discrimination claims is limited to the most experienced judges and Tribunals and even for them, only after receiving additional specialist training'.

Suggestions to refine our proposal

One doctor stated that, in order to strengthen our proposal, 'a confidential help line to help whistle blowers' would support those who are subject to bullying and harassment as a result of raising concerns about patient safety.

Another doctor in support of the proposal stated that the GMC should define what they meant by 'failure to work collaboratively' and another NHS organisation stated that clear definitions of 'unacceptable behaviour' would be required, otherwise the system may be open to abuse. The BMA response referred to the 'chilling effect' of silencing doctors' where a doctor may not wish to report concerns about a colleague in the event that they face accusations of failing to work collaboratively.

Another medical educator said that they believed the scenario was not clear in recognising whether the doctor was exhibiting bullying behaviour or to be accountable for bullying a patient. One member of the public put forward the suggestion that the GMC could impose a loss of status to a medical director where there were reasonable grounds to believe they were bullying or harassing their colleagues.

A Medical Practitioner Tribunal Service (MPTS) panellist suggested that the indicative sanctions guidance should make mention of abusive relationships through social media that may occur between members of staff.

One individual doctor suggested a revision to the wording in our initial proposal to read 'cases that involve a failure to work collaboratively including bullying, sexual harassment or violence and represent a persistent risk to patient safety'. The BMA in their response to this question, 'the wording of the proposal is unduly vague and diffuse', whilst the PSA stated in their response that they would like to see a clearer explanation of the language used in the proposal to guide panels as to when they may consider more serious action. The PSA asserted that 'to alleviate this uncertainty we would like to see the revised guidance carefully drafted so that it clearly states which issues the GMC considers are so serious that panels should generally treat them as fundamentally incompatible with continued registration (such that ordinarily only removal will satisfy the public interest in the case)'. The BMA also suggested the incorporation of guidance on bullying to be included within *Good medical practice*, 'the most appropriate way to proscribe bullying and those other forms of behaviour set out in the consultation paper is by including them specifically within GMP, supported by clear standards as to what falls within and outside the scope of those behaviours'.

Attendees at one of our external engagement events referred to the role of revalidation, and ensuring that collaborative working forms part of the multi-source feedback that doctors are expected to collect in support of their appraisals.

Equalities Issues

One respondent from a postgraduate medical institute suggested that sometimes there are cultural aspects to bullying and harassment for example where 'doctors...have done the majority of their training in a different culture' where they may be unfamiliar working in equal relationships with females 'and this can lead to tensions'.

Proposal 6: To guide panels to consider removing doctors from the medical register when abuse of their professional position involves predatory behaviour towards a patient, particularly where the patient is vulnerable.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	371	86.89%	132
No	45	10.54%	34
Blank	11	2.58%	6
TOTAL	427	100%	172

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	11	1	1	13
	Body representing patients or public	9	1	1	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	18	1	0	19
	Regulatory body	2	0	0	2
	Other	7	0	1	8
Individuals	Doctor	245	32	8	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	48	4	0	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Other	12	4	0	16
Unknown	Unknown	0	0	0	0
	Blank	0	1	0	1

Introduction

87% of respondents supported the proposal to guide panels to consider removing doctors from the medical register where they have behaved in a predatory manner towards patients, particularly those who are vulnerable. All NHS/HSC organisations, bar one, together with the MPS, 12 royal colleges, 86% of individual doctors and 92% of the public who responded were in favour of the proposal.

The BMA were also in favour of the proposal, noting that the case study provided a clear example of why the professional rule existed. However, they raised concerns that a sanction should only be imposed 'where there has really been abuse' and noted there 'would be difficulties involved in specifying the circumstances in which it can be said that this is the

case'. The RCGP also voiced concerns that the burden of proof had not been described in relation to this proposal.

The MDU and MDDUS did not support the proposal.

Comments in support of our proposals

35% of the respondents who supported and commented on the proposals said it was clear that any doctor engaging in predatory behaviour should be subject to the most serious sanctions, including removal from the register. Respondents felt it was fair to expect the highest standards of professional behaviour from their doctor and predatory behaviour was a breach of the trust placed in doctors by the public and their patients. One individual doctor said, 'Of course they should be removed. People in other roles involving vulnerable groups are readily dismissed from their jobs, why should doctors be any different?'.

Comments opposed to our proposals

Out of the 34 respondents who opposed and commented on the proposals, seven (together with 8 respondents who supported and two who neither supported nor opposed the proposal) said that panels can already consider erasure in relation to predatory behaviour. Seven respondents felt that there may be circumstances in which panels would consider erasure too harsh or inappropriate. The National Clinical Assessment Service commented, 'Patient safety is paramount. However safety may be maintained by lesser sanctions than removal'.

Four individual doctors felt that the proposal risked becoming a witch hunt, with one doctor commenting that the proposals were vindictive in tone. Three doctors felt that the panels should be free from GMC influence when making decisions.

Suggestions to refine our proposals

38 respondents who commented (34 in favour and 4 opposed to the proposals) said that a common sense approach should be taken to what may be a complex situation. They argued that instances should be dealt with on a case by case basis, recognising that doctors may form genuine relationships with their patients, particularly in isolated locations where there were limited opportunities to socialise outside the community the doctor served. Other factors respondents felt should be considered included the severity of harm caused, recurrence of the doctor's behaviour, patient consent and evidence of coercion. Respondents taking part in three of our consultation events agreed with this approach, commenting that the case study was too extreme and a more nuanced approach should be encouraged.

17 respondents (including two who were neither in favour nor opposed to the proposal) felt that clear definitions of relevant terms including 'vulnerable', 'predatory' and 'abuse' were key. Three respondents (a member of the public, an individual doctor and a responsible officer) thought that all patients should be treated as vulnerable. Diverse Cymru proposed a nuanced definition of vulnerability recognising a variety of factors including a lack of understanding of what was going on, and personal circumstances such as bereavement, mental health issues and a history of abuse or neglect. It was suggested that abuse should not be limited to sexual abuse but also include emotional and financial abuse. Respondents at one of our consultation events thought the use of 'predatory' was unhelpful and alternative terminology should be used.

17 respondents highlighted the importance of a robust process in investigating and ensuring that the accusations were supported by evidence. The Royal College of Anaesthetists commented that this would sometimes be difficult to do where there were only the testimonies of the doctor and patient and no other objective evidence to assess. Some comments reflected the position of the Royal College of GPs and also referred to the standard of proof. They thought, given the doctor faced being removed from the register, the criminal standard of proof (beyond reasonable doubt) should apply.

Five respondents called for the guidance provided to panels to be clearer regarding when it would be appropriate to erase a doctor, with one respondent commenting that prescriptive guidance would leave no room for equivocation. However, this is in contrast to the general comment made in relation to the consultation as a whole by the Medical Protection Society that, 'as a principle, panels should take all evidence into account in their decision making, decide how much weight to give the various factors and make an appropriate decision based on their judgement and experience' rather than be fettered by prescriptive guidance.

The Law Society of Scotland, in partial agreement with the proposal, suggested distinguishing between behaviour which was predatory and that which was inappropriate.

Equalities Issues

Three respondents highlighted the need for support for vulnerable witnesses with one suggesting the use of video links and pre hearing evidence similar to the procedures used in cases involving children.

Three respondents referred to the vulnerability of doctors, including one who referred to situations where a doctor may have a mental illness. This respondent suggested, 'the only time [the proposal] ... may need to be reconsidered may be the probably rare times where a doctor has a mental illness eg hypomania and the behaviour is linked with this. Then proper psychiatric care AND the proven capacity of the doctor to engage with this properly could well be a mitigating circumstance over time'. They continued, 'Where the health of the doctor however cannot be guaranteed then there should be a means found of protecting the public.'

Proposal 7: To guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics in any circumstance, either within or outside their professional life.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	260	60.89%	103
No	143	33.49%	111
Blank	24	5.62%	13
TOTAL	427	100%	227

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	5	6	2	13
	Body representing patients or public	9	2	0	11
	Government department	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	12	7	0	19
	Regulatory body	2	0	0	2
	Other	6	1	1	8
Individuals	Doctor	159	110	16	285
	Medical educator	3	2	1	6
	Medical student	0	0	0	0
	Member of the public	39	9	4	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Other	11	5	0	16
Unknown	Unknown	0	0	0	0
	Blank	1	0	0	1

Microsite summary: <u>Dr Wrexham</u> discriminated against homosexual patients	
Action category	Number of respondents: 368
No action needs to be taken	2%
The doctor needs to be reminded that the behaviour is undesirable	53%
The doctor's practice should be restricted in some way	27%
The doctor should be removed from practice for a period of time	10%
This behaviour is incompatible with being a doctor	8%

Introduction

61% of respondents supported the proposal to guide panels to consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics in any circumstance, either within or outside their professional life. The BMA supported the proposal together with 56% of doctors, 75% of members of the public and 12 royal colleges.

The MDU, MDDUS and MPS did not agree with the proposal.

Comments in support of the proposal

16 respondents referred to the importance of considering discrimination and ensuring those with protected characteristics were sufficiently protected. One member of the public stated that 'racism, sexism, homophobia etc may be enshrined in legislation, but other vulnerable groups remain unprotected', for example the elderly. One doctor remarked that consideration should be given to doctors who are subject to discrimination within the workplace from other colleagues. Another individual doctor suggested that doctors should be permitted to express personal beliefs, for example in line with religious beliefs, even if these relate to protected characteristics, so long as this does not impact on their professionalism within the workplace.

A large number of respondents felt that this proposal was already covered within *Good medical practice*, with one member of the public stating that 'doctors are employed to do a job, they are not there to make judgments'. Another doctor respondent remarked 'all discrimination must not be tolerated in medicine'.

One medical educator emphasised the need to ensure that discrimination is proven, and not just a vexatious complaint, with clear definitions of what constitutes discrimination being available. Another NHS/HSC organisation supported this standpoint, stating that 'clear definition of levels of unacceptable behaviour will need to be explicit'. Many of the doctors in support of this proposal agreed with this.

The Gay and Lesbian Association for Doctors and Dentists highlighted the importance of our proposal as many doctors who are LGBT have experienced homophobia either from colleagues or from patients. They stated that it is important that they feel 'empowered' to complain.

Of those who responded positively to our proposal, a large number referred to the doctors' beliefs being a central consideration when panels are considering whether to consider more serious action. One individual doctor highlighted that doctors should be able to express 'their personal views so long as it does not impair the treatment their patients receive'. Other respondents from NHS organisations highlighted the need for equality and diversity training, suggesting that it become part of an appraisal process to ensure all doctors have awareness in conjunction with the emphasis already contained within *Good medical practice*. Staffordshire GP Appraisers referred to the fact that doctors should have freedom of speech, but where appropriate, remedial action would be preferable to imposing sanctions. York Healthwatch emphasised the need for proportionality, and stated that doctors should be able to express themselves and that their comments should not to be taken out of context.

Comments opposed to our proposal

Of the 143 respondents who opposed this proposal, over a third commented on the boundary between a doctor's personal and professional life. One doctor stated they agreed with the proposal, but 'only pertaining to the professional life', whilst another doctor believed our proposal had a 'catch-all' nature. Three NHS/HSC organisations who responded agreed that it was not appropriate for a doctor's personal beliefs to be subject to scrutiny, providing the concerns did not impact on their professional duties. Some respondents argued that the GMC was attempting to act outside of their regulatory remit, stating that the central concern should be the doctor's professional life, and not their personal beliefs. A panellist remarked that if this proposal were to go forward, 'extensive guidance' should be created to determine the severity of the sanction against the level of discrimination present within a given case. The PSA likewise asserted that the GMC needed to more clearly explain what the phrase 'to guide panels they may consider more serious action [if]')' meant in practical terms

A response from a police force argued that current legislation and guidelines already cover instances such as the one given in our proposal, whilst one doctor stated that the GMC should not become the 'thought police'. Other individual respondents argued that existing legislation provides the necessary framework for handling discrimination of those with protected characteristics. One individual argued that panels can 'cope unguided', whilst a doctor highlighted that remediation in instances of discrimination was available through Disability Tribunals, and 'the GMC have no role in enforcing this law'.

Some respondents made the point, that irrespective of protected characteristics, a doctor should treat all patients well, and one doctor stated that 'protected characteristics should not mean people are entitled to a different level of justice'. Two responses from individual doctors made mention of 'political correctness', and questioned if in some cases it was the sensitivity of the patient that was problematic instead of the conduct of a doctor. The BMA supported the notion that a doctor's 'conscientious objection to a particular treatment provided that he or she had made the appropriate referral to a colleague should be respected'.

Proportionate action against a doctor who has acted in some way discriminatorily was referred to in a high number of responses. Concern was raised about why merely taking action as opposed to 'serious action' was insufficient. One doctor emphasised the need for panels to approach such issues on a 'case by case basis'. One individual doctor stated that removal from the register in instances as described in the scenario would be 'too harsh'. An NHS/HSC organisation believed the sanction applied to a doctor should be guided based on the impact on the patient.

The majority of those who did not support our proposal or considered it to be disproportionate were individual doctors. One doctor respondent remarked it would be a mechanism 'open to potential abuse'. Though, the BMA were firm in their response, asserting, 'We note the need for unequivocal evidence of discrimination before more serious action is taken.'

Suggestions to refine our proposal

Those who attended our stakeholder events referred to the language used in the proposal, and stated that rather than the panel having discretion ie 'may consider more serious action', it should read 'should consider more serious action'.

Microsite summary:

Members of the public and non-doctors suggest stronger action than doctors. 14.5% of non-doctors stated that the actions were incompatible with being a doctor, compared to 8.5% of doctors. Around 50% of respondents thought that Dr. Wrexham should be reminded her behaviour was undesirable, this was slightly higher for Doctors and lower for non-doctors. The next most popular course of action to be taken was to restrict Dr. Wrexham's practice in some way, which 28% of respondents chose. Approximately 10% said she should be removed from practice for a period of time. 55% of the group thought that the fact Dr. Wrexham allowed her personal views to affect her treatment was the most important factor. The least important factor was maintaining public confidence, around 76% ranked this either 4th or not at all. Causing distress to and intimidating patients were both seen as important factors.

Equalities Issues

Equalities issues were raised throughout given the context of this proposal.

Proposal 8: To guide panels to consider the factors which may lead to more serious action where the following issues arise in a doctor's personal life:

- misconduct involving violence or offences of a sexual nature
- concerns about their behaviour towards children or vulnerable adults
- concerns about probity (being honest and trustworthy and acting with integrity)
- misuse of alcohol or drugs leading to a criminal conviction or caution
- unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation
- any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	239	55.97%	116
No	172	40.28%	151
Blank	16	3.75%	7
TOTAL	427	100%	274

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	6	7	0	13
	Body representing patients or public	9	2	0	11
	Government department	0	0	0	0
	Independent healthcare provider	4	3	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	4	1	0	5
	NHS/HSC organisation	15	4	0	19
	Regulatory body	2	0	0	2
	Other	6	1	1	8
Individuals	Doctor	139	134	12	285
	Medical educator	4	2	0	6
	Medical student	0	0	0	0
	Member of the public	38	11	3	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Other	10	6	0	16
Unknown	Unknown	0	0	0	0
	Blank	0	1	0	1

Introduction

Of the 427 responses received to our written questionnaire, 56% supported guiding panels to take more serious action against a doctor where events have occurred in their personal life which may adversely impact them in a professional manner. Members of the public expressed clear support, with 73% favourable to our proposal, along with 10 royal colleges. 49% of individual doctors agreed with our proposal.

The proposal did not receive support from the BMA, MDU, MDDUS, or MPS.

Comments in support of the proposal

Of the 239 respondents who supported our proposal, a large proportion believed that more serious action against a doctor in such instances would be warranted. The BMA did not believe the scenario was helpful as the criminal conduct of the doctor would mean they would be brought to the attention of the GMC in any case. One NHS organisation explained that the pressures of a domestic situation are 'unlikely to apply in a work situation', and it is the place for the courts and legal system to determine guilt and punishment. One doctor acknowledged that 'doctors don't get an entirely private life' and that scrutiny should be expected due to the nature of the role doctors hold. Another doctor supported the proposal, provided that the panel was able to 'consider' the factors instead of being directed to take certain action without the exercise of discretion. Comments were also made by those who agreed with this proposal about providing adequate support to doctors who may be facing difficult personal or health problems. A small number of responses referred to exceptional circumstances and how they can often affect matters more acutely, highlighting that the GMC response to such instances should reflect this reality.

Of the doctors who supported the proposal, there was a consensus that a doctor occupies a unique position, and that 'honesty and probity are extremely serious issues' which should be appropriately addressed.

Some respondents suggested that the 'any other behaviour that may undermine public confidence in doctors' statement in our proposal was far too broad and may lead to abuse. This was affirmed at an engagement event, with one attendee stating the example given was an extreme one, and that other examples may not be as clear. One of the postgraduate medical institutes believed this category to be a 'grey area', with another doctor referring to it as a 'catch-all' category and it being open to interpretation. Another individual doctor stated that the GMC should not 'pander to the tabloid press'.

Several respondents referred to the importance of upholding public confidence and ensuring that public safety was the paramount consideration. The majority of NHS/HSC organisations supported our proposal; one stated that sanctions applied to a doctor 'should be appropriate to the nature and level of the offence', distinguishing between fraud cases which may not impact on patient safety but would impact on confidence in the profession. Members of the public referred to the importance of 'personal integrity [being] paramount in the profession'. One doctor stated that 'being a doctor in the medical profession [as] an absolute privilege' and this meant that their actions would be subject to scrutiny and action should be taken where appropriate to uphold public confidence.

Comments opposed to our proposal

The majority of respondents opposed to our proposal disagreed with the interference its introduction would have with the private lives of doctors. A large number of respondents opposing this proposal were doctors. One individual doctor cited that 'a doctor's life is just that, personal', whilst another doctor stated 'When I am a work, I am a doctor. When I am not, I am not'. Of those doctors who responded negatively to the proposal, the overwhelming opinion was that the GMC would be surpassing its role if were to consider a doctor's private life and whether action is justified in certain circumstances. One independent healthcare provider believed the standard being applied here was of such 'perfection' that many would fail to meet an acceptable threshold in accordance with the GMC's purported proposal. There was an appreciation in the responses against our proposal that in instances of criminal conviction, it would be proportionate for action to be taken against a doctor's registration.

The BMA expressed concerns about the potential infringement on a doctor's human rights, stating that 'the proposal could lead panels to take more serious action against doctors on the basis of relatively minor issues in their personal lives that have no relationship to the health and safety of the public and could thereby undermine their right to respect for their private life under Article 8 of the European Convention on Human Rights'. They argued that the GMC should set out 'with specificity' what private behaviour was deemed appropriate so there can be full consultation with doctors, representative organisations and other stakeholders so doctors were aware of the standards they should adhere to. Furthermore that guidance as to how such matters would be determined and what sanctions could be imposed, so that those who engage in the proscribed behaviour fully understand the consequences.'

Many respondents believed the wording of our proposal lacked sufficient clarity, and with its broad remit, would have the potential to be misused. One member of the public stated that they thought the proposal was 'too strict' and did not take account of the fact that doctors just like the general public are fallible. One individual doctor argued that the 'any other behaviour' category gives the GMC a 'carte blanche' to handle cases according to its own interests. The BMA stated that 'it is not appropriate in a regulatory context for a catch all to be used of 'any other behaviour which may undermine public confidence...', in respect of such a diffuse expression, particularly where the GMC has not provided any guidance as to what may undermine public confidence'. Of the NHS/HSC organisations that responded to this question, there was also a concern that the final category was too broad and could undermine public confidence. There was however a consensus that when issues of criminality arose, these should come within the remit of the proposal. Three respondents believed the inclusion of civil proceedings to be disproportionate.

Concerns were raised by doctors and members of the public about the proportionality of our proposal; one doctor remarked that the list contained 'minor issues mixed in with terrible crimes'. One member of the public stated they believed this particular proposal needed to be treated with 'maturity and care', with the focus being on whether what has occurred outside of work impacts on a doctor's practice. One NHS/HSC organisation gave the example of a doctor who was in a dispute with their landlord about the payment of their rent, and how this would not warrant GMC intervention. The PSA referred to the need for more clarity in our proposal, and stated that they believed 'The seriousness of the issues listed in question 8 [are] not conditional upon the issues arising in the doctor's personal life'.

Three respondents remarked that there should be more assistance in situations such as those mentioned in our proposal, as there is 'not much help out there for doctors'.

Peterborough Healthwatch questioned whether the burden of proof should change when considering civil and criminal matters respectively when considering whether harsher sanctions should be imposed.

Equalities Issues

One attendee at one an engagement event stated that if the actions of a doctor were as a result of some form of substance abuse issue, this should be appropriately considered by the panel. This was a view reiterated by Spire Alexandra Hospital who said that a doctor's problems should be considered as this will eventually impact on patient safety, and an assessment of their mental health and wellbeing should be considered. Healthwatch Dorset stated that 'doctors should always declare if they have HIV or [they are] hepatitis positive so regulations can be incorporated to reduce the risk to others'.

Proposal 9: To guide panels that they may consider specific factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. We take all issues relating to drug or alcohol misuse seriously. Some are more serious and have aggravating features and therefore would attract more serious outcomes. We believe panels should consider more serious action in cases involving the following factors:

- intoxication in the workplace or while on duty
- misuse of alcohol or drugs that has impacted on the doctor's clinical performance and caused serious harm to patients or put public safety at serious risk
- misuse of alcohol or drugs that has resulted in violence, bullying or misconduct of a sexual nature
- misuse of alcohol or drugs that led to a criminal conviction particularly where a custodial sentence was imposed.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	339	79%	120
No	72	17%	59
Blank	16	4%	5
TOTAL	427	100%	184

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	10	3	0	13
	Body representing patients or public	11	0	0	11
	Government department	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	19	0	0	19
	Regulatory body	1	0	1	2
	Other	6	1	1	8
Individuals	Doctor	220	54	11	285
	Medical educator	4	2	0	6
	Medical student	0	0	0	0
	Member of the public	42	8	2	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	12	3	1	16
	Blank	1	0	0	1

Introduction

79% of respondents agreed with our proposal to add specific advice to the guidance to help panels assess the seriousness of concerns about a doctor's misuse of alcohol or drugs. All the NHS/HSC organisations who responded were in favour of this change, together with the BMA, the MDDUS, 12 royal colleges, 77% of individual doctors and 81% of members of the public who responded. Those opposed to the change included the MDU, the MPS and the Royal College of Psychiatrists.

Five respondents did not provide a yes or no answer. These respondents included the Nursing and Midwifery Council and the Law Society of Scotland, both of which partially agreed. The former felt that the factors listed should lead to a more serious action but that there were other factors that should be taken into account, such as the nature and frequency of drug or alcohol misuse. The Law Society of Scotland noted, in line with their response to question 7, that panels should be able to consider action where cases involved substance misuse however, this should be set within a clinical context.

In line with some of the respondents below, the BMA noted that, as in the case study, where a doctor took drugs and took time off work sick as result, their situation should be addressed through management of a health problem.

Comments in support of our proposals

39 respondents supported the proposal because the misuse of alcohol or drugs was a serious issue that impaired a doctor's ability to practise safely, putting patients at risk and undermining public confidence in the profession. Comparisons were made to other work settings in which the use of drugs and/or alcohol was banned.

Some respondents felt that serious action should be taken where the substance misuse directly impacted on a doctor's fitness to practise and others (including both those in favour (23) and those against(4)) highlighted the need to consider the circumstances of each case. In particular, some queried how convictions for drink driving or drunk and disorderly offences would be treated. Where these were one off offences or out of character, it was suggested that the panel should take this into account as a mitigating factor. Other mitigating factors suggested included evidence of insight and treatment being undertaken. The Royal College of GPs thought the fact that a conviction may be significantly in the past should also be taken into account.

Five respondents were in favour of the proposal as long as the misuse was evidenced and two felt that the criminal standard of proof would be appropriate. Others commented that clear definitions of relevant terms such as 'intoxicated' would be required.

Comments opposed to our proposals

10 respondents opposed to the proposal felt that the changes were unnecessary, disagreeing in principle with further GMC guidance for panels or that the guidance already provided was sufficient. Two respondents opposed the change on the basis that it did not go far enough, preferring instead an absolute prohibition on substance misuse with a sanction of removing the doctor from the register if repeatedly breached. In contrast, some opposing the proposal felt it was too punitive and called for a proportionate approach reflecting the circumstances of the case (see above). One doctor commented that doctors sometimes found themselves subject to GMC procedures even when they had been abstinent for a prolonged period.

Eight respondents, made up of individual doctors, a member of the public and one organisation representing doctors, had concerns about the specific factors listed in the proposal, in particular regarding criminal convictions. They felt that this was a matter for the criminal courts, with one doctor commenting that this effectively amounted to double jeopardy. Concerns were raised that the factors conflated separate issues of health and misconduct.

Doctors with underlying health issues

32 doctors, an organisation representing doctors and patients, and one member of the public, raised concern that alcohol and drug misuse might represent a health concern. Some felt that the doctor may be suffering from an underlying health condition or addiction that would be better dealt with through treatment. In addition, the proposed approach may be perceived as punitive and result in doctors being reluctant to admit to and address these health issues. Eight respondents (five in favour and three against) suggested that the panel should make provision for treatment as part of the sanction. Three respondents felt the GMC should establish a separate procedure for doctors who are unwell.

Suggestions to refine our proposals

Respondents suggested addressing the wider cultural issues linked to alcohol misuse through compulsory testing for drugs and alcohol within workplaces, though they recognised that this may be expensive.

Others suggested refinements to the guidance itself, including additional factors, such as: persistent misuse; persistent absence from work and repeated lateness; dishonestly acquiring controlled drugs; and misuse of prescribed medication.

Respondents attending one of our consultation events agreed that use of the past tense in factors 2 and 3 was mistaken. 'It is too late if a doctor has caused serious harm to a patient through misuse of alcohol or drugs' the respondent said and continued, 'There should be a zero-tolerance policy towards any alcohol or drug consumption by doctors'. The same respondent also suggested lowering the alcohol blood limit for doctors to below the level required for driving a car.

Equalities Issues

As referred to above, concerns were raised in relation to the doctors misusing drugs or alcohol who may have an underlying mental health issue and some proposed a completely separate GMC procedure for doctors who are unwell.

The role of apology and insight

Proposal 10: Do you think panels should require a doctor to apologise where patients have been harmed?

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	185	43.33%	119
No	224	52.46%	197
Blank	18	4.22%	14
TOTAL	427	100.00%	330

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	4	9	0	13
	Body representing patients or public	7	2	2	11
	Government department	0	0	0	0
	Independent healthcare provider	6	0	1	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	1	4	0	5
	NHS/HSC organisation	8	11	0	19
	Regulatory body	0	2	0	2
	Other	4	3	1	8
Individuals	Doctor	114	161	10	285
	Medical educator	1	5	0	6
	Medical student	0	0	0	0
	Member of the public	32	16	4	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Other	5	11	0	16
Unknown	Unknown	0	0	0	0
	Blank	1	0	0	1
Total		185	224	18	427

Introduction

Opinion was divided on whether panels should require doctors to apologise if their actions or omissions have caused a patient harm, with a majority of those responding to the written questionnaire (53%) opposed in principle and 43% in favour. The Independent Doctors Federation supported this approach along with 62% of members of the public. Those opposed include 11 of 19 NHS organisations, the majority of individual doctors, the patient representative body Action against Medical Accidents (AvMA), eight royal colleges, the BMA, and the MDU, MDDUS and MPS.

Feedback from the consultation events held followed a similar pattern with opinion very much divided on the merits of this proposal. At the Regional Liaison Service events, of the

21 groups (ranging from 3 to 13 people) who discussed this proposal, 10 were opposed to it and 10 were in favour, with one not providing a definite answer. At the Key Stakeholder events, five groups discussed this proposal, of whom only one expressed a firm opinion which was in opposition to the proposal.

Respondents opposed to the proposal

Although the MDU confirmed that it believed doctors 'should apologise when something has gone wrong, even if patients have not been harmed', it questioned the value of a forced apology, asserting that it would be meaningless. This opinion was shared by the MDDUS and MPS. The BMA was also of the view that 'a forced apology is a devalued apology', furthermore that forced apologies could also devalue apologies freely given. The PSA were 'doubtful an apology will hold much value for the recipient so long after the event and particularly when they will probably also know the doctor has been ordered to apologise.'

Concerns about the value and sincerity of a 'forced' apology were expressed in a total of 140 comments across all stakeholder groups, including those in favour and those opposed in principle. This was also a theme coming out of the consultation events, with one group describing an apology as an insult if it is not real, and another commenting that 'extracting an unwilling apology is of no value but an apology freely given is very healing.' One regulatory body stated that:

'A meaningful apology is often the first step to repairing a damaged relationship and it can help to restore dignity and trust. It says that both sides share values about appropriate behaviour towards each other and that the offending side has regrets they do not behave in lines with those values...[an] MPTS panel cannot force medical staff to make a meaningful apology although we believe panels should recommend this.'

The majority of individual doctors (58%) opposed this proposal, many citing caution that an apology provided in response to a regulatory requirement is unlikely to be perceived as genuine by patients. 'If a doctor is truly sorry, they will apologise. If they are not, then a forced apology is meaningless,' commented one doctor. These views were shared by a responsible officer (RO) who said: 'Doctors should be required to acknowledge the facts as proven. An emotional response to the facts cannot be commanded.'

Some respondents suggested that apologies should be seen in the broader context of a doctor's insight, with three doctors stating that it should be considered on a case by case basis. One member of the public said: 'An apology should be spontaneous and not influenced by the panel. Where a doctor is allowed to apologise of their own will [they] may now have insight into the conduct which caused harm.' One individual doctor suggested that a refusal to apologise should be sanctioned, but requiring a doctor to apologise is ineffective. A group at one of the consultation events commented that if an apology came as a result of a sanction, and therefore a long time after the event, it was 'almost not an apology'. Another group thought that requiring a doctor to apologise was not part of the remit of the GMC.

There was some discussion around the need to consider instances where a doctor has been advised by their employer, or legal representative, not to apologise. One doctor stated that the GMC would need to investigate whether or not the doctor was prevented from apologising.

Concerns were also raised about the practicalities of implementing or enforcing a panel requirement to apologise. Participants at the consultation events commented that it needed to be part of a properly managed process and raised questions about what constitutes an apology; how and where it would be given, bearing in mind the potential for emotions to be high; and whether there is a role for mediation.

Comments in support of the proposal

32 members of the public were in favour of panels requiring doctors to apologise. One respondent commented on the need to 'remove the institutionalised stigma against apologising.' This was also raised at the consultation events where groups commented that there was no legal bar to a doctor apologising but that [legal representatives] could be very defensive and should instead be educating doctors to apologise early. Another patient harmed by a doctor's actions commented that 'an apology offered early on could have helped me put into perspective what has happened to me and stopped the very strong emotions I suffer from.' Some respondents suggested that an apology is only effective if supported by an accurate account of what went wrong, and provided in a format which is acceptable to the harmed patient.

A large minority of individual doctors (40%) were in favour. Respondents commented that 'often this is all the patient wants,' and 'it can only help patient recovery.' This view was also put forward at the consultation events. One group commented that an apology may mean something to the patient even if imposed, and that at least then the patient takes away something from the hearing. There was also a view that making a doctor apologise could help maintain or increase public confidence. One health care professional suggested that doctors should also be required to apologise where their conduct caused harm to other members of staff. An individual doctor proposed that a requirement to apologise might be a suitable alternative to replace the current system of warnings.

Several individual doctor respondents who expressed support in principle held concerns about tokenism and commented that the effectiveness of this measure is dependent on complainant or patient perception that the apology is 'genuine'. These views were shared by some members of the public and by participants at the consultation events, with one group commenting that an apology was meaningless unless the doctor had insight. However, the view was also expressed that the sanction of imposing an apology may in itself help to build insight.

Suggestions to refine the proposal

Some respondents commented that an apology should not in of itself be treated as an admission of guilt. This is consistent with the Compensation Act 2006. One respondent suggested that an apology be provided after legal proceedings are concluded to avoid impacting on compensation claims. This view was echoed by a group at a consultation event who thought that the outcome of an investigation should be complete before an apology is required. There was some discussion about the need to apply a legal definition of harm, one member of the public proposing that patients should determine if harm is caused. One group at a consultation event suggested that a statement from the patient about the harm caused could be put before the panel. Comments at these events also highlighted that apologies did not have to be admissions of guilt but could be expressions of regret for the outcome the patient has had.

A collaborative approach was suggested by NHS England, which proposed giving consideration to whether any organisations involved in providing care should issue a joint apology with the doctor. This approach is supported by several individual doctors who commented that harm to patients may be caused by both individual failings and system failures and it may be unfair to direct an individual doctor to apologise without recognition of this.

A number of alternatives were suggested by individual respondents. One member of the public suggested that better information sharing throughout the investigation and adjudication process would be more effective in improving patient experience. There was some discussion around the idea that an additional 'reciprocal gesture' may be necessary to restore confidence. A doctor suggested that 'clearer guidance on saying sorry should be provided to doctors.' A group at a consultation event thought that it was preferable to put measures in place to prevent future harm rather than force an apology. Another group asked whether there was any research, for example within the criminal sphere, on what people's experience is of receiving a forced apology. Finally, it was proposed that any change in approach should be reviewed and monitored to ensure effectiveness.

Equalities issues

One individual doctor working in the independent sector raised concerns about cultural differences and attitudes towards giving an apology and the potential impact on protected groups. Participants at the consultation events commented that culture impacts on people's perception of complaints, and one group suggested that doctors from different cultural backgrounds need to be supported to understand the context of apology in UK culture.

Proposal 11: To introduce more detailed guidance on the factors that indicate a doctor has or lacks insight.

- A doctor is likely to have genuine insight if they: accept they should have behaved differently, consistently express insight,* take steps to remediate and apologise at an early stage before the hearing.
- A doctor is likely to lack insight if they: refuse to apologise or accept their mistakes, do not consistently express insight, or fail to tell the truth during the hearing.
- A doctor may also lack insight if they promise to remediate, but fail to take appropriate steps or only do so when prompted or immediately before or during the hearing.

* Expressing insight involves a demonstration of genuine reflection and remediation.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	304	71.19%	129
No	103	24.12%	84
Blank	20	4.68%	14
TOTAL	427	100%	227

Community people responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	7	4	2	13
	Body representing patients or public	9	2	0	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	3	1	1	5
	NHS/HSC organisation	17	2	0	19
	Regulatory body	2	0	0	2
	Other	6	1	1	8
Individuals	Doctor	192	80	13	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	40	9	3	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Other	13	3	0	16
Unknown	Unknown	0	0	0	0
	Blank	1	0	0	1

Microsite summary: <u>Dr Bath</u> didn't apologise when he failed to spot cancer symptoms	
Action category	Number of respondents
	453
No action needs to be taken	1%
The doctor needs to be reminded that the behaviour is undesirable	8%
The doctor's practice should be restricted in some way	67%
The doctor should be removed from practice for a period of time	18%
This behaviour is incompatible with being a doctor	5%

Introduction

The majority of respondents to the written questionnaire (71%) were in favour of this proposal, including 67% of individual doctors and 77% of members of the public. All independent sector organisations responding to the consultation supported this proposal, together with 17 NHS/HSC organisations and 9 royal colleges. The PSA were also supportive.

The MDU and MDDUS agreed in part with the proposal but expressed serious concerns around the fairness of some of the factors suggested. The BMA and MPS were opposed to the proposal.

The views expressed at the consultation events were also largely in favour of the proposal. 22 groups at the Regional Liaison Service events discussed this proposal, of whom 17 were in favour and five did not express an opinion. The members of the 17 groups in favour were practically unanimous in their views. At the Key Stakeholder events, four groups discussed this proposal of whom one was in favour; one was in favour to an extent; and two did not express an opinion.

Comments in support of the proposal

There was strong support for this proposal across all major stakeholder groups, including the majority of individual doctors and members of the public. Some respondents commented on the importance of insight in reducing the continuing risk of harm to others. NHS Sheffield commented that 'insight is one of the most important factors that a panel should take into account.' One respondent said 'insight is the most critical part of maintaining safe practice.' Others felt doctors' reluctance to demonstrate insight may be linked to cultural issues within the healthcare system.

The PSA welcomed the proposal but stated that the guidance could be improved further if:

'it explained that insight means accepting what you did was wrong, understanding why what you did was wrong (rather than just an understanding that hypothetically it might be wrong) and how you would avoid it happening again in future (as opposed to a recognition that you need to take steps to avoid it happening again in future).'

In general, there was a broad consensus within this group in favour of the proposed guidance for panellists on establishing insight. One respondent proposed applying a simpler, alternative test: 'whether a normal person having committed such an action would have

behaved in the same way following it.' Two respondents stated that panels would need clear guidance on insight, whilst others noted that panels should exercise discretion when applying guidance on insight on a case-by-case basis. The Medical Womens Federation and Royal College of Surgeons of England stressed the importance of early recognition, apology and remediation. One doctor raised a concern that attempts at remediation can sometimes be hindered by influences out of a doctor's control.

There was some discussion about the role of apology in determining insight. Several respondents said greater weight should be placed on apologies which are not provided in response to a regulatory requirement. One respondent commented that proposals for panels to require doctors to apologise may undermine the effectiveness of an apology as a measure of genuine insight. Six respondents expressed concerns about the potential impact on doctors who do not show insight or apologise where findings against them are later disproved.

The connection between apology and insight was also discussed by several groups at the consultation events. Groups highlighted that an apology did not always demonstrate insight, as it could just be the result of being advised to apologise, and that it is important for a clinician to demonstrate empathy and understanding. Another said that a doctor can say all the right things but this does not mean they have good clinical care. One group commented that a lack of remorse or a refusal to apologise should lead to a greater sanction being imposed.

Three doctors highlighted that the doctor may be not have apologised because they are 'innocent'. This guidance would only be applied to doctors where the facts have been found proved and their fitness to practise found to be impaired.

Comments opposed to the proposal

24% of respondents opposed this proposal. Of the 80 individual doctors not in favour, 8 commented on the subjectivity of insight and the difficulty of establishing a fair and objective approach. This was also raised by one group at a consultation event. One individual doctor working in medical education suggested this is a complex issue, as some doctors with good insight fail to demonstrate this due to fear for their future career. The BMA expressed concern that this proposal 'could lead to doctors being afraid to fight their cases because of a belief that any failure to apologise could lead to them being held to lack insight [and] could thereby undermine their right to a fair trial under Article 6 of the European Convention on Human Rights.'

Others commented that doctors should not be expected to express apology or insight without the support of their medical defence organisation. Participants at the consultation events commented that there may be reasons why doctors do not apologise early, perhaps because they do not know all the details of the case at that point or because their employer tells them not to. The BMA opined that expressing insight and taking steps to apologise at a later stage, or even at the hearing, could indicate a '...journey from a lack of self-awareness...and demonstration of genuine learning.'

Concerns were raised about the relationship between new guidance on determining if doctors have insight and proposals to take action on a doctor's registration to uphold public confidence in the most serious cases even where a doctor has demonstrated insight and remediation. These concerns were shared by the MDDUS. On the other hand one individual

doctor felt guidance on insight to be unnecessary as unsafe doctors should be removed from the medical register.

The MPS stated that panels should be given discretion to determine on a case by case basis whether the doctor has gained insight. It considers that a 'checklist of what does and does not amount to insight is simplistic and could result in unfairness.'

Suggestions to refine the proposal

Respondents made several suggestions to refine this proposal, described below under the following themes: insight before a hearing, evidence of insight, repeat behaviour, and format of apologies.

Insight before a hearing

There was some discussion about the significance which should be attached to the timing of a doctor's demonstration of insight. One GP partnership felt that where doctors only take steps to remediate immediately before or during a hearing, this should be acceptable evidence of insight as some people need prompting to take action. An individual doctor commented that where doctors are working in an isolated environment without the benefit of peer feedback, the investigation and adjudication process may play a vital role in developing insight.

Evidence of insight

Several respondents felt that evaluating a doctor's level of insight is a specialist task which requires specific skills and knowledge. Four doctors suggested that psychiatrists are best placed to provide a report on whether a doctor has insight. Two respondents proposed that panels should receive training on personality traits and behaviours in order to equip them to evaluate insight appropriately. The medical director for NHS England suggested there may be a role for appraisal documentation in establishing evidence of a doctor's insight.

Repeat behaviour

Some respondents suggested that cases involving repeat behaviour should be treated differently. One individual doctor commented that evidence of insight should be treated with greater caution in cases involving repeated and intentional breaches of GMP over a period of time. Two respondents suggested that further thought should be given to tackling repeat unacceptable behaviour following an apology.

Format of apologies

There were also some comments in relation to the format of apologies. One respondent proposed that apologies should take the form of a personal letter to the patient, and compensation provided. It was also suggested that caution should be applied where a written apology is drafted by legal representatives. A separate consultation is being held on the Duty of Candour and explanatory guidance for doctors on how and when to give an apology.

Other suggestions from the consultation events

One of the groups at a Key Stakeholder event expressed agreement with points 1 and 3 of the consultation proposal, but were more equivocal about point 2. This seemed to be partly because of the view that there may be good reason why doctors have not apologised, and also because the preference of a panel for a patient's version of events does not necessarily mean that the doctor is lying. Another group made the suggestion that point 1 in the consultation paper should be extended to include at the end 'and that the doctor's actions are consistent with his apology'. One group suggested that the phrase 'is likely to' in the consultation proposal should be replaced with 'may'.

Microsite summary

For this question, a case study – of a doctor who had provided substandard care and failed to apologise or agree to retrain until faced with a panel hearing – was made available on a microsite as an alternative means of gathering views. 410 responses were received, 324 of which (79%) were from doctors and 32 (8%) from members of the public. The remaining responses were thinly spread across other categories such as medical educators and other health professionals.

The majority of respondents thought that the doctor's practice should be restricted in some way (66%), with removal from practice for a period the second most popular sanction (19%). In making their decision, the majority of respondents (57%) ranked seriousness of harm to the patient as the most important factor.

While seriousness of harm to patients was at the forefront of people's decision making in this case, the fact that the doctor did not agree to retrain until faced with a panel hearing also figured highly, with half of respondents putting this factor in the top two. This suggests that people do consider it important that a doctor demonstrates insight by recognising the need for remediation where something has gone wrong. Greater importance was placed in the microsite responses on this factor than on the timing of the doctor's apology which, particularly when coupled with the favoured sanction of imposing restrictions on future practice, suggests that respondents' prime concern is on reducing the risk of the doctor causing similar harm in the future.

Equalities issues

Five respondents commented that a lack of insight may indicate that a doctor has an underlying health problem, with one doctor highlighting that insight can sometimes be deficient in individuals with mental health issues. One respondent suggested that an ability to demonstrate insight may be linked to the protected characteristic of age. One individual doctor raised concerns that foreign medical graduates may be unfairly disadvantaged if they are unable to articulate complex ideas or emotions due to insufficient knowledge of English. As with consultation question 10, participants at the consultation events thought that cultural background had an impact on people's perception of complaints and approach to apologies.

Proposal 12: To guide panels they may consider the stage of a doctor's UK medical career as a mitigating factor, and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. However, in cases involving serious concerns about a doctor's performance or conduct (eg predatory behaviour to establish a relationship with a patient, or serious dishonesty), the stage of a doctor's medical career should not influence a panel's decision on what action to take.

Community People response			
Option	Response number	Percentage	Number of comments
Yes	337	78.92%	95
No	74	17.33%	46
Blank	16	3.75%	6
TOTAL	427	100%	147

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	11	1	1	13
	Body representing patients or public	9	2	0	11
	Government department	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	3	0	2	5
	NHS/HSC organisation	18	1	0	19
	Regulatory body	2	0	0	2
	Other	7	1	0	8
Individuals	Doctor	224	51	10	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	40	10	2	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Other	10	5	1	16
Unknown	Unknown	0	0	0	0
	Blank	0	1	0	1

Introduction

79% of respondents were in favour of this proposal, including 79% of individual doctors and 77% of members of the public. The BMA, MDU and MDDUS supported the proposal, along with 10 royal colleges. There was a broad consensus in favour among NHS/HSC organisations and independent healthcare providers, with 24 of 26 in favour. This proposal was considered by only two groups at the Key Stakeholders consultation events, both of whom were in favour of it. The MPS were opposed to the proposal.

Comments in support of the proposal

There was very strong support for this proposal across all stakeholder groups. Both individual doctors and members of the public commented that medical students or trainee doctors who 'make blunders' or 'minor indiscretions' should be given a second chance and provided with an opportunity to learn from their mistakes. One individual doctor commented that 'professional maturity comes with experience and knowledge.' Participants at a consultation event thought that junior doctors should be held less responsible but should be required to address the issues that have arisen, and others commented that overseas doctors new to UK practice should be offered some leniency.

The BMA were wholly supportive of the proposal stating that 'a new doctor who is ingenuous and has no malevolent intent should be treated in a way proportionate to the stage of his or her career.' The MDDUS also supported the proposal but raised concern about the relationship between new guidance on considering the stage of a doctor's UK medical career and proposals to take action on a doctor's registration to uphold public confidence in the most serious cases even where a doctor has demonstrated insight and remediation.

The MDU stated that the proposal should be expanded to include doctors who may be more senior, 'but have little experience in a particular field'.

11 respondents highlighted the importance of considering the nature of the breach under this proposal, with some suggesting that panels would need to be supported by detailed guidance on where the 'goal posts' were.

Comments opposed to the proposal

19% of respondents were opposed to this proposal. Two respondents commented that our core guidance for doctors, Good Medical Practice, applies to all doctors regardless of the stage of their medical career. One independent healthcare provider suggested that where doctors have a lengthy, unblemished medical career this should be treated as a mitigating factor.

The Patients Association argued that:

'the majority of cases which progress beyond the initial stages of the GMC's Fitness to Practise procedures are likely to be potentially serious. The standards of medical practice that patients should expect should be that of a reasonably competent medical practitioner, regardless of the experience of the doctor...it could have serious consequences for patients if there was any suggestion that poor practice may be acceptable because the doctor is inexperienced. While this is obviously not the intention of the proposal, there is a danger that it could be interpreted in this way.'

The MPS were 'not clear why any change [was] necessary'. They were concerned about the 'arbitrary' nature of the distinction between serious concerns and other types of concerns.

9 respondents who responded that they were not in favour of this proposal made additional comments which indicated they were in favour and had perhaps misunderstood the question.

Suggestions to refine the proposal

Six respondents felt that the stage of a doctor's UK medical career is relevant in performance cases but not conduct issues. One MPTS panellist suggested that guidance will need to be carefully worded to ensure serious misconduct issues are not trivialised due to a doctor's inexperience or culture. One respondent commented: 'A doctor should know at what is right or wrong [at every] stage of [their] career, and the choices [they] make are a reflection on character.' This view was supported by 24 trainee doctors participating in a consultation event in Northern Ireland. Other participants at the consultation events emphasised that there needed to be a balance between the severity of the issue and the stage of the UK career, with one group commenting that while the stage of the career may be relevant to the question of insight, there are some professional care issues that apply to all.

One individual doctor suggested that whilst inexperience may be a mitigating factor in cases involving trainee doctors, such issues may be an early indicator of repeat behaviour which should be subject to monitoring. One NHS organisation suggested that in addition to considering the stage of a doctor's UK medical career, panels should also consider whether a doctor has previously been provided with relevant advice. Staffordshire and Stoke on Trent Partnership NHS Trust suggested that panels may wish to take advice on the social and cultural background of a doctor in making their decision. One group at a consultation event thought that less serious competency issues should be dealt with locally for newly qualified doctors rather than by the GMC through sanctions.

Equalities issues

There was some discussion about the provision of additional support to enable overseas doctors and new graduates to familiarise themselves with UK health systems. Suggestions include formal mentoring during the early stages of their UK medical career, and requiring doctors to pass an examination on Good Medical Practice before they are allowed to practice in the UK. NHS England also commented there may be a need to signpost the standards expected of doctors during the application process for a licence to practise medicine. One doctor commented that it may be unfair to solely consider a doctor's stage of their medical career in the UK as a mitigating factor as this could lead to inequity where doctors have extensive experience working in other countries. This respondent suggested that it may be more appropriate to consider a doctor's stage of medical career anywhere in the world as relevant to insight. Alternatively, one respondent suggested that clinical experience and awareness of social norms and culture are issues which should be dealt with separately.

It was also suggested that steps need to be taken to avoid discriminating against doctors whose personal beliefs, culture or religion prevented them from conforming to social norms within the UK such as alcohol consumption. To mitigate this risk, one respondent suggested the guidance should be amended to state that: 'overseas doctors should familiarise themselves with and conform with social and cultural norms, where it is in the interests of patients or in the wider public interest for them to do so.'

A range of other comments were made about the impact on equalities groups. One doctor perceived that this proposal may help to 'reduce indirect discrimination against overseas graduates.' Another doctor commented that within particular specialities and hospitals culture may be the underlying cause of discrimination on the basis of gender or speciality. One respondent expressed concern about whether this proposal complies with the Equality Act.

Proposal 13: If we introduce verification checks on testimonials, do you agree that we should continue to accept them as evidence?

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	372	87.12%	137
No	46	10.77%	34
Blank	9	2.11%	3
TOTAL	427	100%	174

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	8	3	2	13
	Body representing patients or public	11	0	0	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	17	2	0	19
	Regulatory body	2	0	0	2
	Other	7	1	0	8
Individuals	Doctor	251	27	7	285
	Medical educator	6	0	0	6
	Medical student	0	0	0	0
	Member of the public	43	9	0	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Other	13	3	0	16
Unknown	Unknown	0	0	0	0
	Blank	0	1	0	1

Introduction

87% of respondents supported this proposal. There was a broad consensus in favour among organisations who responded to the consultation, including NHS England, Lincolnshire Local Medical Committee, the Independent Doctors Forum and 6 independent sector providers, 14 NHS organisations and Avon & Somerset Constabulary. The BMA, MDDUS and 13 royal colleges agreed with the proposal, along with 88% of individual doctors and 83% of members of the public. This proposal was discussed by only two groups at the Key Stakeholder consultation events. One was in favour and one only in part. The MPS did not support the proposal.

Comments in support of the proposal

A strong majority of individual doctors were in favour of this proposal, with many responses emphasising the value of testimonials in delivering an adjudication process which is fair to

doctors. One respondent commented: 'it is vitally important that doctors are able to provide evidence of normal good practice/standing with colleagues, to deny them this is simply wrong.' Testimonials were seen by some respondents as useful in providing a picture of previous performance and establishing if concerns related to a single episode or pattern of behaviour.

Respondents expressed particular support for proposals to ensure testimonial authors are aware of the concerns about the doctor and the purpose their information will be used for, although one group at an external engagement event highlighted the need to provide a reminder of the guidance on raising concerns. One NHS organisation, Lancashire Care, commented: 'This is a very good idea, in my experience doctors who write testimonials can be completely in the dark about the behaviour of the doctor whom they are supporting.'

Some of those in favour of continuing to use testimonials felt it was inappropriate not to accept testimonials solely because authors are unwilling to provide oral evidence. Seven individual doctors and one member of the public expressed concerns that the prospect of giving evidence to a hearing may intimidate potential authors, particularly patients, adversely impact on willingness to provide a written testimonial and present logistical difficulties for those unable to make time to attend a hearing for example due to ill-health or work commitments.

Although supportive of the use of testimonials, the MDDUS stated that submission of testimonials before the hearing might be problematic. This was an issue raised by the MPS also. The BMA highlighted that 'as a matter of equity there should be no restriction on the evidence doctors can adduce in their defence.'

There was also strong support for the introduction of verification checks, with 11 respondents expressing surprise that this did not currently form part of the process. This was also strongly supported by a group at a consultation event who commented that there had to be a structure and a process that ensures verification.

One regulator suggested that the GMC (or a professional body) should collect the testimonials to ensure independence and so that those giving the testimonial don't have to submit it to the doctor under investigation.

Comments opposed to the proposal

11% of respondents were not in favour of this proposal, including 9% of individual doctors. Seven respondents were opposed in principle to the use of testimonials, citing that decisions about a doctor's fitness to practise medicine should be based purely on facts. One doctor expressed concern about the fairness of panels placing limits on the evidence which a doctor may submit to a hearing.

There were also concerns that disclosure of charges to potential testimonial authors may unfairly influence their willingness to make a supportive statement. One respondent suggested this was analogous to the criminal justice system, where previous offences are not disclosed to a jury. One respondent stated that the GMC has the relevant legislative powers to compel witnesses to provide oral evidence.

One of the groups at a Key Stakeholder consultation event thought that testimonials should continue to be accepted with or without verification, and that it was a matter for the panel to determine how much weight to place on them. They questioned if there might be

practical difficulties for interim orders panels for which there would be a limited time to obtain verification. They wanted to know how much of a problem the current lack of verification was and whether the proposal was actually necessary.

Although they supported the use of testimonials as evidence in hearings, the MPS argued that where 'the GMC has reason to suspect that a testimonial has been obtained or relied upon dishonestly, then it could investigate this as a separate matter.' Furthermore, that it is for panels to assess the authenticity of testimonial evidence and how much weight to attach to it, if any.

Suggestions to refine the proposal

There were concerns about the extent to which testimonials self-selected and collected by a doctor can be relied upon. Several respondents suggested that a pro-forma should be developed to enable testimonials to be provided in a consistent and clearly structured format, with clear questions and responses supported by evidence. Participants at a national consultation event including ROs discussed the suitability of appraisal reports and feedback gathered as part of the revalidation process as a more systematic, objective source of this type of information.

The MDU did not consider that verification checks were necessary as defence teams ensure those providing testimonials are aware of the concerns about the doctor, supplying the testimonial invitation letter to the panel. They also raised concern that this proposal might 'inhibit some people whose testimonials may be helpful [and] could considerably disadvantage the defence of doctors.'

Alternative suggestions to reduce the possibility of fraud or misrepresentation include disclosure of letters seeking testimonials, seeking testimonials from a selection of individuals within a doctor's personal and professional life, and empowering the panel to seek additional testimonials from other relevant professionals. It was also proposed that the GMC should play a role in collecting testimonials from persons identified by the doctor to ensure appropriate verification checks take place. Information about those who had refused to provide a testimonial when requested by a doctor was perceived by some stakeholders as a significant gap in the process.

One doctor suggested the GMC should pay costs for locum cover if doctors providing testimonials are asked to provide oral evidence at a hearing. Some respondents also commented on the need for any verification process to be fast and efficient. A number of participants proposed that a similar process should apply to complainants and evidence provided as part of the investigation. NHS England proposed that doctors should be warned that provision of incorrect testimonial information may place their registration at risk.

Equality issues

One respondent suggested that cultural bias may dissuade some people from submitting a testimonial if concerns about the doctor's fitness to practise medicine are disclosed. Two individual doctors expressed concerns about fairness on the basis that testimonials reflect a doctor's social status rather than clinical ability and integrity.

Proposal 14: Do you agree that we should use the factors below to decide whether testimonials are relevant to the panel's decision?

- Whether the testimonial is relevant to the specific concerns about the doctor
- The extent to which the views expressed in the testimonial are supported by other available evidence
- How long the author has known the doctor
- How recently the author has had experience of the doctor's behaviour or work
- The relationship between the author and the doctor (eg a senior colleague)
- Whether there is any evidence that the author has a conflict of interest in providing the testimonial (eg personal friendship)

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	342	80.09%	104
No	61	14.29%	39
Blank	24	5.62%	7
TOTAL	427	100%	150

Community People responses by category of respondents					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	9	2	2	13
	<i>Body representing patients or public</i>	11	0	0	11
	<i>Government department</i>	0	0	0	0
	Independent healthcare provider	6	0	1	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	4	1	0	5
	NHS/HSC organisation	18	1	0	19
	Regulatory body	2	0	0	2
	Other	8	0	0	8
Individuals	Doctor	221	48	16	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	43	6	3	52
	Healthcare professional or staff (not dr)	0	0	0	0
Unknown	Unknown	12	3	1	16
	Blank	1	0	0	1

Introduction

80% of respondents supported this proposal, including 77% of individual doctors and 83% of members of the public. The BMA, MDU, MDDUS and 13 royal colleges were in favour of the proposal. 18 of 19 NHS/HSC organisations who provided a response agreed with the proposal, along with 6 out of 7 independent healthcare providers. Only one group discussed

this in detail at the Key Stakeholder consultation events and they were supportive. The MPS however, opposed the proposal.

Comments in support of the proposal

The majority of responses across all stakeholder groups were in favour of this proposal. One individual doctor commented: 'A doctor may be a shining example in some area of their life but if this is not related to the area of concern it really has no relevance in protecting patients and maintaining public confidence. Several respondents commented that the proposed relevancy criteria appeared to be consistent with the approach taken in criminal courts, employment and financial references.

One respondent commented that personal testimonials should not influence the outcome necessary to protect the public. Some respondents suggested that testimonials should be obtained on a standard pro-forma with questions relating to the relevancy criteria and space to comment and provide any evidence to support opinion on the doctor's capability or conduct.

A Health and Social Care Board commented on the need to take steps to develop guidance on seeking patient testimonials to ensure they do not fear being treated differently or loss of service.

Comments opposed to the proposal

14% of respondents opposed this proposal. Three respondents, all individual doctors, suggested that testimonials should not be accepted as evidence because it is difficult to evaluate relevancy, and the focus should be on facts, experience and qualifications rather than opinion. Several respondents suggested that panels should be given the discretion to determine the degree of relevancy, but not to exclude specific testimonial evidence being heard. One member of the public expressed concern that the relevancy criteria lacked detail, and excluded testimonials in support of the doctor and patient views.

One individual doctor queried the relevancy of how long the testimonial author has known the doctor.

One individual doctor who stated they did not agree with the relevancy criteria appeared to have misunderstood the proposal as their comments indicated support.

Suggestions to refine the proposal

Participants at a consultation event raised the question of situations where testimonials were missing, for example if they were not provided from a doctor's current workplace. They also suggested that there could be a limit on the number that could be reasonably considered and that in some situations, testimonials should be gathered on behalf of the doctor in the interests of natural justice.

Conflict of interest

There were mixed views on whether personal friendship presents a conflict of interest for testimonial authors, with many respondents commenting on the blurred boundary between work colleagues and friends. One respondent felt that personal knowledge of the doctor should be a prerequisite for testimonial authors. Some respondents suggested it may be

appropriate to accept testimonials from friends provided there was a declaration of interest. One organisation stated that sometimes 'those who have worked alongside a colleague for many years are best placed to provide a testimonial, despite the fact that their professional relationship has grown into mutual friendship over that time.' The BMA supported this view, and stated that 'personal friendship and honesty/objectivity are not mutually exclusive.' The MDDUS was also in agreement, and the MDU stated that it was for the panel to bear in mind the relationship, and whether or not there was a conflict of interest.

Some respondents suggested testimonials from friends may be permitted, but greater weight should be placed on testimonial from those in a professional capacity. Conversely, 4 respondents felt that submission of testimonials as personal friends to be inappropriate as this may lead to bias or exchange of favours.

A response from BUPA UK suggested that consideration of conflict of interest issues involving testimonials should include kin relationships between the author and doctor.

Equality issues

No comments were made about the impact on equalities groups.

Proposal 15: To make sure we routinely request a statement from a doctor's responsible officer* during our investigation for the panel to consider at a hearing. The statement should set out the extent to which the doctor has reflected on the matter before the panel, the extent to which they have shown insight and how far any issues about their performance or behaviour have been addressed. The panel may wish to consider the extent to which any evidence of insight in testimonials provided on the doctor's behalf is supported by other available evidence, including the responsible officer's statement. We would also introduce guidance for panels to make sure doctors who do not have a responsible officer because they have given up their licence, or who are using alternative routes for revalidation, are not treated unfavourably.

* Some doctors without a responsible officer may have a suitable person as set out in The Medical Profession (Responsible officer) Regulations 2010. In those cases, we will obtain a statement from the suitable person.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	316	74.00%	101
No	92	21.55%	69
Blank	19	4.45%	10
TOTAL	427	100%	180

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	10	2	1	13
	Body representing patients or public	9	2	0	11
	Government department	0	0	0	0
	Independent healthcare provider	6	0	1	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	17	2	0	19
	Regulatory body	1	0	1	2
	Other	7	1	0	8
Individuals	Doctor	200	72	13	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	42	8	2	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Other	11	4	1	16
Unknown	Unknown	0	0	0	0
	Blank	0	1	0	1

Introduction

The majority of respondents to the written questionnaire (74%) were in favour of this proposal, including 70% of individual doctors and 81% of members of the public. 6 independent sector organisations responding to the consultation supported this proposal, together with 17 NHS/HSC organisations and 12 royal colleges. The MDU and MDDUS agreed with the proposal however the BMA and MPS were opposed.

This proposal was discussed by two groups at the Key Stakeholders consultation events, of whom one agreed with the proposal and the other did not say. It was also discussed at the Responsible Officer Reference Group; one group was in agreement and the other two did not provide a definitive response. Their comments suggested that opinion was divided on whether the proposal was workable or not.

Comments in support of the proposal

74% of respondents were in favour of this proposal, including 14 NHS/HSC organisations and the majority of individual doctors and members of the public. NHS Shetland commented: 'This is a key element in understanding the degree to which the doctor's behaviour is likely to present ongoing patient safety issues.' This view was shared by the independent healthcare organisation Spire Healthcare, which argued 'considerable weight' should be given to information provided by an RO. Participants at both the Responsible Officer Reference Group and the Key Stakeholder consultation events highlighted that this is a major part of a good appraisal process and part and parcel of what ROs do anyway.

Many respondents commented on the practical implementation challenges this may present for ROs in different contexts across the NHS and independent sector. It was suggested that acute trust ROs may be better placed to provide information than NHS England ROs. It was suggested that requests would need to be clearly signposted in large area teams where one RO may cover over 3000 GPs.

Two independent health organisations identified issues for doctors working in their sector. Bupa UK commented that responsible officers are likely to lack direct personal contact where doctors practise solely in the independent sector. The RO for a locum agency raised concerns about the ease of obtaining relevant information for doctors working across several places of employment who may lack adequate engagement with appraisal and designated bodies. Three respondents suggested that where an RO lacks direct personal contact with the doctor, a statement should be sought from their line-manager. Similar issues were raised at a Responsible Officer Reference Group where one group commented that not every designated body employs its doctors and the only person who has contact is the appraiser. However, it was pointed out that an appraiser could be contacted directly to look at these issues.

Three of those in support of this proposal, including two ROs, identified the need for clear guidance on the information which should be included in the statement and how to seek third party information where appropriate. This view was shared by ROs at a Key Stakeholder Event. They commented on the need to provide clear, fact-based statements supported by evidence such as appraisal information. One respondent commented on the need to monitor RO workloads.

42 members of the public supported this proposal. Of those, 2 made comments which indicated they did not understand the role of the RO.

Comments opposed to the proposal

71 individual doctors opposed this proposal, of whom 9 expressed doubts about whether ROs have sufficient personal knowledge of the doctors involved to comment on the extent of their insight. This view was shared by the MPS. One individual doctor commented that the role of the RO has only recently been introduced, and it may be too soon to roll-out additional responsibilities effectively. Several other respondents commented on the impact of increasing the scope of the RO's duties within their statutory role. One group at a Responsible Officer Reference Group wondered about the time between the event under investigation and the provision of the statement being too short for an RO to develop knowledge of a doctor's insight. They considered an assessment of insight was more valuable after a long period of remediation. They also suggested that an RO could not be in a position to know if demonstration of insight about a particular issue is even necessary until findings of fact had been made.

Four members of the public opposed this proposal, of whom two perceived that ROs could not be trusted to act objectively in providing statements as they would be part of the medical profession. This view was supported by the BMA and MPS. Two individual doctors expressed concern about the extent to which ROs are able to express an objective opinion independent of the GMC. The need for patients to be assured of the neutrality of ROs was also raised at a Key Stakeholder consultation event.

During a Key Stakeholder Event, one participant raised concerns that routinely requesting a statement from an RO will detract from a panel's ability to make inferences from gaps in testimonial provision. A number of respondents appeared to be unclear about the difference between an RO statement and a testimonial. One group at a consultation event also highlighted that trainees have two ROs – medical and deanery – so there was the potential for conflicting views.

Several respondents within this group also raised concerns about conflict of interest, as discussed below.

The MDDUS stated that 'introducing a requirement that the responsible officer should engage in every proceeding is going to increase costs and cause delay, often to no good purpose. It should not be necessary in all cases.' The MDU stated that it should only be introduced at stage 2 of the hearing (when the panel considers any impairment).

Suggestions to refine the proposal

14 respondents commented on potential conflict of interest issues, including 7 doctors who supported, and 5 doctors who opposed this proposal. Concerns were raised that the RO may be the source of a referral to the GMC; motivated to protect the reputation of their organisation, engaged in ongoing internal capability and disciplinary proceedings, or a personal friend or colleague of the doctor concerned. Suggestions to mitigate the risk of perceived bias include allowing the doctor to comment on any views expressed by the RO, and seeking information via 360 appraisal systems. At a Responsible Officer Reference Group it was suggested that, to address potential conflict of interest issues, it might be possible to use an RO from outside of the organisation, although it was acknowledged that this might prove too onerous for them.

Several respondents also commented on the need to ensure that any new steps within the investigation process did not impact on the timeliness of concluding cases. One individual doctor suggested seeking an additional statement from the doctor's previous RO.

Concern was raised at Key Stakeholder Event that this proposal would require non expert ROs to make judgements which could potentially be open to legal challenge. Participants questioned what legal support ROs would have, and what training would be provided in putting together a statement ahead of appearing at a hearing. One group also commented that remediation was much easier to evidence than insight. They highlighted that there may be areas on which an RO would not be able to comment or would have no evidence available, and suggested that it should be possible for an RO to comment 'don't know' and for this to be seen as neutral. It was suggested that the proposal should be piloted.

Equality issues

One individual doctor raised concerns that this proposal may adversely impact on doctors sharing the protected characteristics of race and disability, but did not explain how.

Changes to our guidance on suspension

Proposal 16: To guide panels they may consider five key factors when deciding the length of suspension:

- the risk to patient safety
- the impact on public confidence in doctors
- the seriousness of the concerns, and any mitigating or aggravating factors
- sending a message to the medical profession that standards must be upheld
- ensuring the doctor has adequate time to remediate.

Panels may also wish to consider the time all parties may need to prepare for a review hearing if one is needed.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	288	67.45%	91
No	120	28.10%	101
Blank	19	4.45%	9
TOTAL	427	100%	201

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	8	5	0	13
	<i>Body representing patients or public</i>	10	1	0	11
	<i>Government department</i>	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	1	1	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	17	2	0	19
	Regulatory body	1	0	1	2
	Other	8	0	0	8
Individuals	Doctor	170	98	17	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	44	7	1	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	12	4	0	16
	Blank	1	0	0	1

Introduction

The majority of respondents (67%) were in favour of this proposal, including 60% of doctors and 85% of members of the public who responded to the consultation. The BMA, MDU and 13 Royal colleges supported the approach, although the MDDUS and MPS raised

concerns about the panel taking account of public confidence or the need to send a message to the profession.

Comments in support of the proposal

Whilst the majority of respondents supported the proposal to guide panels to key factors when deciding the length of suspension (288), 118 respondents went on to comment on possible amendments and/or additions to those factors.

80 respondents raised concerns about the fourth factor in the proposal, sending a message to the medical profession that standards must be upheld, including five royal colleges. The Royal College of Physicians stated that 'There is a chance that 'sending a message to the medical profession that standards must be maintained' could be interpreted as making an example of an individual doctor and could be open to accusations of inequity or unfairness in application', whilst the Royal College of Pathologists opined that 'It risks being perceived as a form of punishment and may be over-used in particularly prominent, well-publicised cases'. One doctor commented that 'The profession generally does not need to be reminded that standards must be upheld. Some respondents were concerned that this is a punitive approach, and not within the GMC's remit. The Royal College of Surgeons stated that 'in the case of protecting public confidence or sending a message to the profession, suspension should only be applied when the breach of GMC standards is very serious or persistent.'

47 respondents disagreed with the inclusion of the second factor in the proposal, 'the impact on public confidence in doctors'. One NHS/HSC organisation stated that 'Public confidence in doctors would be best served by a fair process which properly deals with poorly performing doctors. If this is done successfully there should be no reason to add further penalties just in order to demonstrate to the public that the GMC is taking a firm line.'

Five respondents suggested additional factors they felt should be considered: admission of the failure and remorse; the physical or emotional harm caused; and consideration of any period of interim suspension. One organisation opined that sanctions should '...differentiate between moral failures, clinical errors and procedural errors in that descending order of seriousness.'

6 respondents who supported the proposal considered that the factors should be prioritised, with 3 respondents stating that factor one, 'the risk to patient safety', should be the primary consideration.

Two respondents commented that factor 4, 'sending a message to the medical profession that standards must be upheld', would only be possible if decisions were disseminated better.

A small number of respondents questioned the purpose of a suspension, and raised concerns about the doctor's ability to remediate during a period of suspension. Five respondents raised the need for the GMC to support the wellbeing of doctors during this process, and one doctor highlighted the need for the GMC to act proportionately.

A member of the public suggested a variation in the wording of factor five, but this appears to be on the basis of a misunderstanding of the range of cases this would be applied to.

Comments opposed to the proposals

120 respondents (28%) opposed this proposal, with 101 respondents providing additional comments. Although they disagreed with the use of all factors, 20 respondents supported guiding panels to consider the risk to patient safety when deciding the length of suspension, 16 respondents agreed that the seriousness of the concerns and any mitigating or aggravating factors were relevant, and 14 respondents favoured including 'ensuring the doctor has adequate time to remediate' in the list of factors provided to panels. 1 member of the public indicated that each case was individual and should be judged as such.

58 respondents, including 48 doctors, raised concerns about the use of factor four, sending a message to the medical profession that standards must be upheld, in guidance to panels on determining length of suspension. One doctor stated that it '...sounds heavy handed and punitive...', whilst another doctor asserted that 'Sending a message is grossly unfair to the individual...'. In addition to the concerns raised about the use of factor four in guidance to panels on the length of suspension, 35 respondents disagreed with the use of factor two, the impact on public confidence in doctors. The majority of comments suggested that public confidence in the profession was irrelevant to the length of suspension, with one doctor asking 'What evidence is there the public want this or would be reassured by this'. Another doctor asked 'what measurements / guidelines are there for assessing the impact on public confidence. This criterion could lack objectivity.'

The Medical and Dental Defence Union of Scotland (MDDUS) agreed that panels should be provided with guidance on determining the length of suspension, however, they stated that factor two (the impact on public confidence), factor four (sending a message to the profession) were inappropriate. They also raised concern that factor five (ensuring the doctor has time to remediate), signifies a punishment rather than fairness, particularly given that under proposal three, remediation may not be taken into account. The MDDUS suggested that personal consequences for the doctor should be an additional consideration when determining length of suspension.

There was some discussion at one of our stakeholder events around the need to test a doctor following a period of suspension to ensure they are fit to return to practise.

Two doctors raised concerns about the impact of the proposal on the health and wellbeing of doctors, 'particularly mental health consequences', whilst three respondents stated that suspension should be used much less, and only in the most serious of cases.

The Sick Doctors Trust were concerned that this proposal 'implies (maybe inadvertently) that a period of suspension represents a punishment where duration (like a prison sentence) is proportionate to the [crime]...Such a concept would not be appropriate in cases where the impairment is a consequence of illness and where suspension should surely be linked to an estimate (assuming some sort of recovery) of when the doctor might be well enough to return to work.'

One doctor stated that 'The Indicative Sanctions Guidance is not a sentencing guideline...' and that '...the duration of suspension should depend not on the seriousness but on how long it takes to develop and demonstrate the necessary insight and remediation are complete (or almost complete)...'. An individual stated that they had '...significant reservations about suspending doctors for single incidents (except in extreme cases) when there is no increased risk of recurrence and the doctor has true insight'. The purpose of suspension was questioned at one of our stakeholder events; some attendees considered

that it wasn't an appropriate course of action in any circumstance, whilst others considered that suspension is appropriate where a doctor with a health condition fails to adhere to conditions or undertaking.

Equalities Issues

One doctor who disagreed with our proposal stated that 'Suicide and mental health issues amongst doctors is increasing annually and if we have any hope of retaining doctors then we must care for their welfare and we would any patient.'

Proposal 17: Where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	337	78.92%	97
No	75	17.56%	47
Blank	15	3.51%	5
TOTAL	427	100%	149

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	12	0	1	13
	Body representing patients or public	10	1	0	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	19	0	0	19
	Regulatory body	2	0	0	2
	Other	7	0	1	8
Individuals	Doctor	214	59	12	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	41	10	1	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	13	3	0	16
	Blank	0	1	0	1

Introduction

The majority of respondents (79%) supported our proposal to guide panels, where concerns are solely about a doctor's health, to consider suspending them if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration. All independent sector and NHS/HSC organisations responding to the consultation supported the proposal along with 75% of doctors and 79% members of the public. Support was also received from the BMA, MDU, MDDUS, MPS and 11 Royal Colleges.

Comments in support of the proposal

29 respondents provided strong support to the proposals, including five royal colleges and The Patients Association. The Sick Doctors Trust asserted that "We would not wish to see a

scenario in which an impaired doctor lacks insight, so putting patients at risk." And where a doctor refuses undertakings but is so unwell that they are potentially impaired, "suspension (perhaps for a year in the first place) is appropriate to protect the public, and allow more intervention on the doctor." There was some discussion from a number of respondents around the importance of patient safety. One member of the public stated that "If there are any questions over a doctor's health affecting his/her fitness to practice there must be strict rules in place to protect [the] level of patient care and safety". There was also support for this proposal during discussion at one of our stakeholder events.

There was some discussion about the need to support doctors with health concerns and the need for a balanced approach from panels. One independent healthcare provider stated that "...clearly where the doctor lacks insight or attempts to evade or subvert conditions/restrictions etc this needs to be dealt with...However...regard must be given, in some way, for the care of that doctor and appropriate support mechanisms must be in place to ensure that 'duty of care' is not disregarded altogether."

Six respondents, including five doctors and one NHS/HSC organisation highlighted the importance of obtaining independent medical/occupational health opinion about the doctor. Another NHS/HSC organisation stated that an individual doctor might not have insight into their condition or its impact on patients and suggested that 'A system for others to report confidentially their concerns to an impartial local assessor such as an occupational health doctor for proper assessment might be valuable'. The Royal College of Psychiatrists stated that "Occupational health services have a role to play here and there must be common sense and proportionality".

Two respondents, including a doctor and an independent healthcare provider, raised the importance of allowing this to be at the panel's discretion, and "...not to direct the panel to act in one way or another."

Comments opposed to the proposal

75 respondents (18%) disagreed with this proposal. Three doctors were concerned that our proposal was "too vague", and stated that it needed "more clarification". Another doctor stated that what is required to protect patients is subjective and can be interpreted in different ways.

Three respondents suggested that these matters should be dealt with locally, with one indicating that the GMC could "...consider an independent health assessment as being appropriate and then act on that in terms of restricting registration."

There was some discussion around the need to support doctors. One doctor who opposed our proposal stated that "...it must be considered extremely serious if a doctor fails to comply with restrictions on their registration and therefore suspension would be appropriate." However, they considered that this proposal might encourage too many panels to suspend doctors in instances where other sanctions would be more appropriate. Another doctor highlighted the impact this can have on doctors and said it should only be used in "extreme cases".

Healthwatch Enfield argued that "The GMC should work with Doctors with health issues and encourage them to take appropriate steps to adapt their work accordingly instead of suspending the individual."

Two respondents raised concerns about the independence of panels. One doctor considered that the current approach provided public protection, but appeared to misunderstand the proposal. A law firm considered that the standards set out in *Good medical practice* were sufficient to mitigate any risks, this appears to be based on a misunderstanding of the purpose of the indicative sanctions guidance.

Equalities Issues

Four respondents opposed to this proposal considered that it would be discriminatory against doctors with health concerns. One member of the public stated that "it needs to be clear how this fits with the disability discrimination act" and cautioned that it "may actually prevent doctors coming forward for help."

Proposal 18: To provide guidance that suspended doctors should keep their clinical skills up to date by working in ways that do not allow them to be able to play any part in interactions with patients. This would still enable them to observe and later reflect on clinical care such as observing clinics related to their area of practice and of course by engaging in continuing professional development.

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	307	71.90%	117
No	98	22.95%	83
Blank	22	5.15%	11
TOTAL	427	100%	211

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	7	4	2	13
	Body representing patients or public	7	3	1	11
	Government department	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	16	3	0	19
	Regulatory body	1	0	1	2
	Other	7	1	0	8
Individuals	Doctor	194	74	17	285
	Medical educator	4	2	0	6
	Medical student	0	0	0	0
	Member of the public	47	4	1	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	10	6	0	16
	Blank	1	0	0	1

Introduction

The majority of respondents (72%) supported our proposal to provide guidance that suspended doctors should keep their clinical skills up to date by working in ways that do not allow them to be able to play any part in interactions with patients. 68% of doctors agreed with the proposal, together with 90% members of the public, 16 of the 19 NHS/HSC organisations who responded and 13 royal colleges. However, the BMA stated that the wording of the proposal was unclear, and the MDU, MDDUS and MPS raised concerns about the impact on the doctor, stating that the current guidance was clear and provided the appropriate safeguards.

Comments in support of the proposal

A number of respondents in support of this proposal indicated that it is an extremely important guiding principle, one doctor stated that "This is an excellent idea, it is a very supportive and open way to offer remediation to doctors."

Although supportive of our proposals, there was some discussion around the practicalities of implementing it in the workplace. Several doctors suggested that additional support mechanisms would need to be made available to the suspended doctor. One doctor stated that "deaneries or ROs need [some way] to set up an educational scheme for suspended doctors - that helps them remediate/stay in touch with medicine", whilst another considered that "the GMC should take some initiative in identifying such placements and making them available." Three royal colleges highlighted the difficulties doctors might face in getting the support from healthcare providers.

One doctor highlighted the GP Induction and Refresher Scheme as a good example of a support mechanism that can help doctors return to practise after a break. This idea was supported by a member of the public and another doctor who raised the importance of assessing a doctor's performance and knowledge before allowing them to return to unrestricted practice. Other respondents suggested that detailed guidance should be provided to doctors if this proposal was taken forward.

One doctor argued that it shouldn't be compulsory for employers to provide these opportunities, and another stated that robust monitoring mechanisms would need to be in place.

An equality charity, who agreed with the proposal, also agreed that "patients would expect that a doctor who is suspended has no direct contact with patient, regardless of any conditions and supervision imposed on that contact. We feel that continuing to allow doctors to have any direct contact with patients undermines public confidence in the medical system and is incompatible with the seriousness of both the concern and the sanction of suspension."

The Sick Doctors Trust highlighted the importance of "a statement from GMC/MPTS to encourage/enable colleagues to provide such opportunity to doctors who find themselves in need of them."

Two royal colleges stated that the GMC should consider guiding doctors to make use of "accredited simulation [activities]".

Healthwatch Enfield cautioned that "The length of suspension and likelihood of revalidation needs to be taken into account to ensure that individuals do not receive costly training if they are unlikely to return to work."

Discussion at one of our stakeholder events focused on the areas of work which would be appropriate for a suspended doctor. It was generally felt that CPD was appropriate, but that other forms of work may be difficult. Some attendees felt that a combination of sanctions might be helpful; for example a short period of suspension followed by a period of conditions to transition the doctor back into practice.

There was some discussion around patient interaction. One member of the public underlined the importance of informing patients that the doctor's registration is suspended, giving them

the opportunity to say no to allowing the doctor to observe. One NHS/HSC organisation stated that "It will not maintain practical clinical skills and patients may not be happy that a suspended doctor is observing their care."

One doctor stated that "with current training techniques it is possible to maintain practical skills without needing to practice on patients while [suspended] as well as being able to maintain [non-physical] skills from observation and reflection."

Insight was discussed by two doctors in support of our proposals. One stated that undertaking this type of activity would indicate insight, but another suggested that proposal would only be appropriate for doctors who had already shown insight.

Comments opposed to the proposal

Of those respondents who opposed this proposal (23%), just over a quarter raised concerns that without patient interaction, doctors would be unable to maintain their clinical skills. One doctor stated that "There is no alternative to practising to maintain skills". 8 doctors and 1 NHS/HSC organisation suggested that a better option would be to allow the doctor to work under supervision as some interaction with patients would be necessary. However, two doctors indicated that even working under supervision would have its limitations "...since attitudes to patients could not be assessed" and "often the problem may lie precisely in how the doctor has interacted with patients."

Two individuals highlighted the conflict between the purpose of suspension and this proposal. One stated that "If a doctor is suspended [s/]he is not entitled to practise. If s/he can work albeit in a limited capacity then conditions would be more appropriate."

21 respondents, including 14 doctors, an independent healthcare provider and a member of the public, raised issues around the practicalities of implementing this proposal. One doctor stated that "Whilst the concept of maintaining skills is good the practicalities for the suspended [doctor] of organising clinical attachments is unrealistic to achieve." One individual argued that "...this would undermine public confidence in the GMC processes for remediation..." and stated that "The GMC would do well to liaise with the respective Medical Colleges on this to work out an appropriate general strategy for each specialty." One body representing doctors raised concern that the GMC should consider whether or not this would amount to erasure in practice, which would be wholly disproportionate.

Three respondents, including two doctors, argued that the forcing a doctor to explain to patients that they are suspended and the events that led up to it, and to seek the patient's consent would be "unfair and humiliating." One individual stated that patients would be unlikely to agree to this interaction, further that "If the doctor has been deemed fit to function as a final year medical student, then he/she should be allowed to do so without having to explain the suspension and the events that led up to it to every single patient."

Although the Medical Protection Society (MPS) agreed that a suspended doctor should not be able to treat a patient, it argued that the proposal required further clarification, particularly in relation to the level of interaction with a patient. The MPS stated that if the doctor was unable to speak to or touch the patient, it would have a detrimental effect on their ability to remediate, particularly in relation to communication skills, history taking and examination technique.

Some respondents raised concerns about the use of suspension within the GMC's procedures, with one doctor stating that "Suspension during investigation should not be so long that skills are lost."

The Nursing and Midwifery Council stated that the proposal needed further development to mitigate any risk to patient safety or public confidence. It cautioned that "even simply observing might not be appropriate in some instances."

Equalities Issues

No equalities issues were raised within the comments attributed to this proposal.

Proposal 19: Where a panel suspends a doctor solely to uphold public confidence in doctors, should any previous interim order influence the panel's decision?

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	256	59.95%	96
No	143	33.49%	82
Blank	28	6.56%	13
TOTAL	427	100%	191

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	11	2	0	13
	Body representing patients or public	7	3	1	11
	Government department	0	0	0	0
	Independent healthcare provider	6	1	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	3	1	1	5
	NHS/HSC organisation	13	6	0	19
	Regulatory body	1	0	1	2
	Other	6	1	1	8
Individuals	Doctor	159	106	20	285
	Medical educator	2	4	0	6
	Medical student	0	0	0	0
	Member of the public	36	12	4	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	10	6	0	16
	Blank	0	1	0	1

Introduction

The majority of respondents (60%) supported our proposal to guide panels to take account of previous interim suspension orders in their sanction decision on suspension where action is solely to uphold public confidence in doctors. Support was given by the BMA, MDU, MDDUS, MPS and 11 royal colleges. 56% of doctors supported the proposal together with 69% of members of the public and 13 out of the 19 NHS/HSC organisations who provided a response. The PSA did not support this proposal, they did not consider that the interim suspension was a relevant consideration when determining the length of the substantive sanction.

Comments in support of the proposal

Respondents in favour of this proposal who provided additional comments expressed strong support for the direction taken by the GMC. One individual opined, "...changing the rules on

this need have no impact on public opinion nor undermine the sanction imposed by the panel", whilst a doctor stated "...all that needs to happen is that the 'order'/'decision' recognises the time already spent in its decision statement..."

The Medical Protection Society stated that, as the substantive suspension would be directed based on the same reasons as the interim suspension, where this was solely to uphold public confidence it would be fair and proportionate to take account of the period of interim suspension. The Patients Association stated that "there may be exceptional circumstances in which the previous suspension is not relevant...however, at the very least it needs to be considered by the panel."

11 respondents, including nine doctors and one royal college, highlighted the parallels with the 'time served on remand' principle in criminal law. This was supported by comments made during Regional Liaison Service events. Three doctors indicated that, in order to mitigate any risk to public confidence, panels should make their decisions clear, with one doctor stated that panels should "...make clear the seriousness with which they view the behaviour...the length of suspension they consider appropriate to satisfy public confidence and then apply a calculation taking into account any IOP suspension (but not IOP conditions where the doctor has continued to work)."

Although supportive of this proposal, two respondents highlighted that the previous interim order may not always be relevant to the decision the panel is making on substantive sanction.

There was some discussion around the importance of considering repeat behaviour when determining what risks a doctor poses. The Royal College of Anaesthetists stated that "The more the panel know of a doctor's background the better for proper consideration and for patient safety. Repeated failings are significant and may indicate a pattern or a trend in failing which would be lost in considering only an isolated case."

Five doctors stated that taking action to protect public confidence, in the absence of patient safety issues, should only be done in the most serious of cases. The Care Inspectorate highlighted that "Suspensions to solely uphold public confidence might be helpful where there are issues with probity and possible concurrent criminal investigation ongoing." The Sick Doctors Trust raised concerns around how panels might objectively assess public confidence.

The MDU agreed with the aim of the proposal, but were concerned that fitness to practise panels might consider that, as an interim suspension was imposed, a substantive suspension would be the appropriate sanction.

One doctor suggested that this proposal should be expanded to consider "...redress for an interim order that turns out to be unnecessary or was more severe than the eventual sanction." This is not within the remit of our consultation.

There was some discussion at one of our stakeholder events around the need for panels to clearly outline what the full sanction would have been, and the allowance that has been taken for the period of interim suspension already undertaken. One attendee felt that, if the doctor denied the allegations found proved, the interim period of suspension should not be taken into account.

Comments opposed to the proposal

33% of respondents disagreed with this proposal, including 56% of doctors. 26 of these respondents argued that suspension should not be imposed solely to uphold public confidence in doctors based on fairness to the doctor. There was some discussion around considering this on a case by case basis.

Although they indicated that they disagreed with this proposal, subsequent comments by 19 respondents in this group indicate that this was based on a misunderstanding of the proposal. Many of the respondents appeared to think that the previous period of interim order would be used against the doctor in proceedings, and before the panel had reached a decision on impairment.

A further three respondents, including a doctor, medical educator and NHS/HSC organisation raised concerns about the doctor being 'tried or punished twice'. Again, this appears to be based on a misunderstanding of the proposal, as it looks to reduce the substantive suspension in cases where it is being directed for public confidence only, based on the period of suspension already 'served' under an interim order.

One doctor indicated that this proposal is too narrow, and should perhaps encompass doctors who have been under "unachievable" IOP conditions, and have therefore been unable to work, even though not formally suspended.

Two respondents queried the legality of this proposal.

One member of the public argued that we should only take into account previous interim suspensions in cases where the substantive order was based on a concern for patient safety as opposed to public confidence.

One NHS/HSC organisation argued that doctors are often paid during interim suspensions, whereas under a substantive sanction they would not be. They were concerned that "If interim suspensions are taken into consideration, there is the potential that the period of interim suspension will exceed the sanction and the doctor can return to work immediately and will not have suffered any loss of income." Another individual stated that, as the doctor can appeal an IOP decision, the substantive sanction should not take account of any interim suspension.

Equalities Issues

There were no equalities issues raised by the comments attributed to this proposal

Giving patients a voice

Proposal 20: Do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed?

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	327	77%	191
No	72	17%	45
Blank	28	7%	17
TOTAL	427	100%	253

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	6	5	2	13
	Body representing patients or public	10	0	1	11
	Government department	0	0	0	0
	Independent healthcare provider	5	1	1	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	4	0	1	5
	NHS/HSC organisation	18	0	1	19
	Regulatory body	1	0	1	2
	Other	5	2	1	8
Individuals	Doctor	223	49	13	285
	Medical educator	2	3	1	6
	Medical student	0	0	0	0
	Member of the public	40	7	5	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	10	5	1	16
	Blank	1	0	0	1

Introduction

A large majority of respondents (77%) agreed that there were benefits to doctors and patients meeting where a patient has been seriously harmed. All of the NHS/HSC organisations which responded, bar one, supported the proposal, along with 10 royal colleges. A large majority of individual doctors who responded were in favour (78%) with only 17% of these respondents opposing the proposal. Members of the public were split in similar proportions with 77% in favour and 13% against the proposal.

The BMA agreed with the proposal noting the need for detailed work around the practicality of the proposal. The Restorative Justice Council also welcomed the proposal highlighting evidence from the criminal justice system that 'restorative conferences can lower the incidence of post-traumatic stress symptoms'. In line with many comments, they proposed,

that to be effective, the meetings should be facilitated by a trained restorative practitioner who would conduct a risk assessment and prepare participants before the meetings. The RCGP also supported the proposals on the basis that they be voluntary for both parties. The NMC agreed in part with the proposals, acknowledging there may be benefits, but being uncertain as to how the meetings would fit within our fitness to practise procedures.

The MDU and MPS were not supportive of the proposal.

Comments in support of the proposal

The potential benefits of a meeting between a doctor and patient where a patient had been seriously harmed were highlighted by 40 respondents in favour of the proposal. 'Having a meeting might well have helped to put everything into perspective' said one member of the public.

Many said the meetings would allow both sides the opportunity to explain and communicate their views, allow the doctor to give an apology, and provide therapeutic benefits for both parties. Five respondents mentioned similarities with the restorative justice approach (referred to above), with one individual doctor also referring to: 'the evidence ... indicat[ing] this benefits the recovery of the victim and helps the person who was responsible for the harm to reflect in more depth the results of their actions'.

16 respondents (15 in support and one neither in favour nor against), and respondents attending one of our Key Stakeholder Events, felt this should be the patient's choice, with some respondents commenting that, if requested by the patient, the meeting should be obligatory for the doctor.

Comments opposed to the proposal

Those opposed to our proposals felt that a meeting would not be effective if mandatory and could potentially make the situation worse. Nine respondents (six of whom were individual doctors) felt there was a risk the meeting would be confrontational and that either party may find it difficult to articulate their views effectively. Two defence organisations, four doctors and one member of the public felt that the meeting should not be led by the GMC, because of perceived bias or that the meeting would conflict with the GMC's statutory objective of protecting the public. Six respondents felt that, if led by the GMC, the meeting would be too late in the process to be constructive.

Two respondents felt that the meetings would provide an opportunity to shift the blame for systems failures on to individual doctors. One doctor commented that it would not be fair to make a scapegoat out of individuals.

Five respondents noted the potential barrier posed by related litigation. The Royal College of Pathologists said, '[a]s a general principle, this is probably unwise. In most cases, there will be civil litigation, either proposed, on-going or completed. It is unlikely that legal representatives would be in favour of such meetings'.

Suggestions to refine the proposal

22 respondents in favour of the proposal and 10 against said this proposal would not be appropriate in all situations and should be applied on a case by case basis. 'There needs to

be care that this applies only to cases where real and obvious harm has occurred, and not to alleged psychological harm, serial complainants, vexatious complainants etc.' said one doctor.

18 respondents felt the meetings could only go ahead with the consent of the parties and 28 respondents commented that the meetings would require skilful facilitation in order to be effective. In addition to supervision, there would be need to be other safeguards in place, for example, using a safe environment, providing support to both parties, follow an agreed agenda and keeping a record of the meeting. Respondents at one of our consultation events, felt that patients would benefit from being signposted to advocacy support services.

The Sick Doctors Trust requested sight of the results of our pilot of meetings with doctors and meetings with patients before reaching a conclusion in relation to this proposal.

Equalities Issues

14 respondents (three of whom supported the proposal, two who were unsure and nine who were opposed) commented on the potential for the meeting to be damaging to the doctor, adding to the trauma they already feel in relation to the incident. 'Additionally, there could be a health aspect to the doctor's actions and he/she could not be expected to discuss these issues with a patient or relatives', commented a panellist respondent.

One of the general comments made by The Royal College of Physicians in their response applies particularly to this question. They noted the importance of reflecting in the guidance cultural differences in communication. They said, '... many doctors will have trained in overseas health systems with very different approaches to this'.

Changes to our powers to give warnings

Proposal 21: Do you think warnings are an effective and proportionate means of dealing with low level concerns which involve a significant departure from Good medical practice?

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	325	75.93%	107
No	74	17.29%	51
Blank	29	6.78%	13
TOTAL	428	100%	171

Community People responses by category of respondent					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	9	2	2	13
	Body representing patients or public	9	0	2	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	4	0	1	5
	NHS/HSC organisation	15	3	1	19
	Regulatory body	2	1	1	2
	Other	6	5	2	8
Individuals	Doctor	221	48	16	285
	Medical educator	5	1	0	6
	Medical student	0	0	0	0
	Member of the public	37	12	3	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
Unknown	Unknown	9	6	1	16
	Blank	0	1	0	1

Introduction

The majority of respondents (76%) considered that warnings were an effective and proportionate means of dealing with low level concerns which involve a significant departure from *Good medical practice*. This included the majority of doctors who responded (75%) and 37 out of the 52 members of the public. The BMA and MDDUS supported our proposal along with 10 royal colleges. The MDU did not agree with the proposal, and the MPS stated that "Whether warnings are an effective and proportionate mechanism varies from case to case."

Comments in support of the proposal

Proportionality and impact of warnings

32 respondents, while agreeing with a system of warnings, emphasised the need for proportionality. Ten respondents (seven doctors, two members of the public and an NHS organisation) made it clear that they believed warnings were an effective sanction because they carried an impact with one doctor commenting that ‘any type of sanction, even an investigation with the GMC is salutary and provides a strong incentive to reflect and improve’. Several respondents made clear they agreed with a system of warnings because they believed it important that some action was taken, with one individual commenting ‘as with any deviation to procedures in any business, warnings should follow if a person is not performing as they should be’.

In the context of proportionality, several respondents, including the British Medical Association, the British Medical Association of Northern Ireland, the Medical and Dental Defence Union of Scotland, and the Royal College of Physicians of Edinburgh proposed that there should be a graded system whereby low level concerns could give rise to letters of advice, with more formal warnings for more serious issues. The MDDUS suggested that ‘those letters of advice can certainly be recorded and can be used as a proper measure of escalation should there be repetition of a persistent and potentially dangerous nature’. An individual doctor made a similar suggestion that ‘low level concerns could receive a letter from the GMC indicating concern, discloseable only to an employer’, while another doctor commented that low level concerns should be dealt with by local processes as ‘the very fact that the GMC is involved implies that a level of seriousness has been reached’. The Law Society of Scotland, while unsure about the framing of the question and therefore not expressing a yes or no answer, also thought that low level concerns should initially be addressed locally and escalated if there were further shortcomings.

In general terms, participants at external engagement events were in favour of a system of warnings. However, there was strong support for greater flexibility and proportionality, with a wide range of options and different sorts of warnings for clinical and misconduct issues, and different lengths of publication depending on the gravity of the issue. One group suggested a points system, as with driving licences, and also the possibility of attending awareness courses rather than receiving a warning, again similar to driving offences. A points system was also suggested by a group at an RLS consultation event. One group at a Key Stakeholders Event commented that warnings had become more serious sanctions than intended, because of the publication period. A group of responsible officers commented that there was a need for more use of ‘closed with advice’, which would not be a public sanction but was useful to ROs to help them ‘concentrate a doctor’s mind’.

Both the MDDUS and an Equalities Charity, Diverse Cymru, thought that more was needed in terms of communication with employers and the wider public to ensure that they do not see warnings imposed for low level concerns as more serious than they actually are.

Repeat concerns and remediation

Although perhaps more relevant to proposal 23, 16 respondents (nine doctors, five members of the public, one NHS organisation, one regulatory body) emphasised that stronger action than just another warning would be necessary in cases where there were repeat concerns. The NHS organisation commented ‘in general, the issue of a GMC warning is likely to be effective in the majority of cases. However where there are repetitive

concerns, and there is evidence that the RMP [doctor] has not altered their behaviour as a consequence of repeated warnings, then more serious action may be warranted'. Six respondents, five doctors and a local Healthwatch body, also highlighted a need to link warnings with remediation with one commenting 'warnings need 'teeth' - the warning needs to come with recommendations for remedial (probably educational) activity, which should be reviewed before the warning is lifted'. Another thought that the warning 'must offer a way to gain the skills to comply with good medical practice' while a third commented that the issues arising should be discussed at a doctor's performance review the frequency of which should be increased to every six months. A Healthwatch body commented that 'reflection and insight is just as important for those receiving warnings as for those being suspended'. This view was also expressed by a group at a Responsible Officer Reference Group. Attendees stated that the doctor must demonstrate insight and remediation ready for appraisal to ensure that concerns have been addressed.

When and for how long should warnings be used

Four respondents (two doctors, one member of the public and one NHS organisation) raised questions over the case study used in the consultation paper, as they were unsure that the example of careless driving, which may have been as a result of a momentary lapse of concentration common to all, raised any issues relating to impaired fitness to practise or required any action by the GMC. One commented that warnings should be used for 'when events have happened which have a direct effect on a patient, rather than when a doctor has been involved in criminal proceedings which are unlikely to have a direct consequence on patient care'. A further three respondents, although answering yes to the overall consultation question, questioned the effectiveness of warnings generally, with one doctor commenting that 'all significant probity issues should be considered for greater sanctions as a routine, as warnings are seen as ineffective by the public and profession'.

Although perhaps more relevant to question 24, six respondents, four doctors, the MDDUS and the Royal College of Physicians Edinburgh, commented on the length of time warnings should remain in place. It was thought that there should be flexibility for panels to impose warnings for different periods of time depending on the circumstances with a definite expiry date both for publication and disclosure to employers. One doctor pointed out that disclosure of warnings for five years on the public website was quite a strong sanction compared to less than five years' conditional registration and suspension. The Royal College of Radiologists said that they agreed with a system of warnings, but thought that they 'should only remain on record for a limited period, such as three years'.

Other comments

One individual doctor thought that a requirement to apologise would be a better description of the sanction than a warning. Three respondents commented that they could see no reason to make any change to the current system. Conversely others had concerns about the effectiveness of the current system, with two, a member of the public and a doctor believing it was too heavy handed and encouraged complaints or pushed a doctor into accepting a warning in order to end the process; and one, a member of the public, expressing the view that the scope for appeal to the Investigation Committee prevented many warnings being issued that should be. The Professional Standards Authority emphasised the need for consistency between regulators in order for the public and employers 'to understand the regulatory process and have confidence in its outcomes'. In this regard, they commented that the terminology used should 'as far as possible match that used by other regulators for equivalent types of warnings'.

Comments opposed to the proposal

Where comments were made by respondents who did not agree with the statement set out in consultation question 21, they were largely divided between those who disagreed because they thought warnings had too serious an impact for the doctor where fitness to practise had not been impaired and were therefore inappropriate, and those who considered warnings were not a sufficiently stringent sanction.

Proportionality

Twenty respondents, including fourteen doctors and two organisations representing doctors, raised issues of proportionality. One doctor commented that warnings 'poorly discriminate and yet have a devastating effect on a doctor's career. There is nothing positive in addressing the issue concerned regarding re-training etc and nothing that considers the rest of that doctor's life-long commitment to medicine'. Another commented that 'anyone with even a warning on their record will find it very difficult to get employment. In the example given, the careless driving has no relationship to clinical performance'. This latter point – that the offence used in the case study was not relevant to patient care and did not warrant any action by the GMC – was made by five other respondents as well, one of whom felt that police cautions except for matters relating to children, vulnerable adults and patient safety should be ignored. A further respondent commented that 'warnings should only be given for things that directly affect patient care'. This view was echoed in the Regional Liaison Service consultation events where eight out of the eleven groups were opposed to a system of warnings, several of them because they disagreed that the case study presented issues with which the GMC should be involved as it did not affect medical practice. One further RLS consultation group commented that they did not understand the system of warnings, and another, while saying they supported their use, asked what evidence there was that they were effective.

Some of the comments made by those who disagreed with a system of warnings echoed issues raised by those who agreed, in relation to the length of time the warning remains discloseable, and the way in which warnings are perceived by employers and the public as more serious than they are intended to be. For example, the Medical Defence Union (MDU) commented that in many cases warnings

'have had an adverse effect on doctors' careers that is disproportionate to their purpose. This is in part because many employers, contracting bodies and other organisations providing medical services do not understand the intended impact of warnings and assume they are an indication of serious concerns, which they are not. Problems also arise because of the duration of warnings, which are public for 5 years, and in perpetuity for employers/potential employers. The fact that warnings are public for so long is, we believe, one of the factors that has contributed to their being treated by some, including employers, contracting bodies and independent healthcare providers, as a far more serious sanction than was ever intended'.

Ineffective sanction

Twelve respondents, including four doctors, three members of the public and NHS England, considered warnings to be insufficiently stringent or were not sure what they achieved. One NHS organisation commented that 'warnings are available to see - but don't instruct the

doctor to do anything in remediation' and a doctor commented 'if there is significant departure from GMP then a warning is inadequate'.

Other comments

One doctor thought that all cases should be heard in confidence, while another did not think it was always necessary to inform the doctor's line manager of a warning because of the potential for them to abuse their power. Another doctor considered the GMP guidelines to be ambiguous to some extent.

Comments from those who neither agreed nor disagreed

One individual doctor, who neither agreed nor disagreed with the proposal, commented that while warnings could be an effective sanction, they were 'often disproportionate in terms of their effect on the doctor'. Another doctor commented that they were unsure about warnings as a sanction because some allegations could be malicious and the support systems for doctors in these situations did not always exist. 'The reach of the GMC cannot be allowed to extend into personal and private lives' was the view of another doctor, who did not think there should be warnings unless there was impairment. The Royal College of Anaesthetists expressed uncertainty as to the relevance of the case study as it was unrelated to work, and also asked about what constituted low level concerns and what a serious departure would be in each speciality. Both the Medical Protection Society and a law firm representing doctors, highlighted that warnings could sometimes be effective, with the former commenting that this meant their effect is not consistent and 'there is a problem with their overall use'. The Nursing and Midwifery Council considered there was a need for clear criteria in this area. The Health and Social Care Board questioned the efficacy of warnings for clinical complaints, saying that they had examples of where a patient or family had complained of less than good care, but these had resulted in no further action. Finally, an individual doctor commented that he believed the consultation to be 'draconian and pre-determined'.

Equalities Issues

Two doctors highlighted the potential impact that a warning, or indeed any interaction with the GMC, could have on a doctor's mental health.

Proposal 22: When do you think we should be able to give warnings?

- a. Not in any circumstances.
- b. Only to deal with low level concerns that involve a significant departure from Good medical practice where a doctor's fitness to practise is not impaired.
- c. Only to deal with misconduct where a doctor's fitness to practise has been found impaired.
- d. To deal with low level concerns and misconduct (see b and c) if different terms are used to describe them.

Community People responses			
Option	Response number	Percentage	Number of comments
A	26	5.50%	11
B	138	29.18%	23
C	88	18.60%	24
D	188	39.75%	50
Blank	33	6.98%	12
TOTAL	473	100%	120

Community People responses by category of respondent							
		A	B	C	D	Blank	TOTAL
Organisations	Body representing doctors	1	5	0	7	1	14
	Body representing patients or public	0	3	1	6	1	11
	Government department	0	0	0	0	0	0
	Independent healthcare provider	0	3	0	4	0	7
	Medical School (undergraduate)	0	1	0	1	0	2
	Postgraduate medical institution	0	2	0	4	1	7
	NHS/HSC organisation	0	6	3	12	1	22
	Regulatory body	0	1	0	1	0	2
	Other	0	1	1	5	2	9
Individuals	Doctor	16	90	73	113	22	314
	Medical educator	1	3	1	3	0	8
	Medical student	0	0	0	0	0	0
	Member of the public	6	18	6	25	3	58
	Healthcare professional or staff (not dr)	0	0	0	0	0	0
	Responsible Officer	0	0	0	0	0	0
	Other	2	5	0	0	2	9
Unknown	Unknown	0	0	1	6	0	1
	Blank	0	0	0	0	0	1
TOTAL		26	138	88	187	33	472

Introduction

Question 22 set out four options for when the GMC should be able to give warnings to doctors. Of these, the option with the strongest support from respondents (40%) was option D – that warnings should be used to deal with both low level concerns and misconduct if different terms are used to describe them. Option B – that they should be used only to deal with low level concerns without impaired fitness to practise – had the next strongest support at 29%. Using warnings only to deal with misconduct where a doctor's fitness to practise has been found impaired was supported by 19% of respondents. Finally 6% of respondents selected option A, which was that warnings should not be used in any circumstances.

The order of preference selected by doctors followed the same overall pattern with option D receiving the strongest support at 36%. 29% selected option B and 23% option C. 25 of the 58 members of the public who responded to this question selected option D, and 18 selected option B. Seven of the 14 bodies representing doctors who responded selected option D, and five selected option B. Six of the eleven bodies representing patients or members of the public selected option D and 3, option B.

The BMA, PSA, MPS and 8 royal colleges favoured option D. The MDDUS supported option C, whilst the MDU stated that warnings should not be used.

Although the options were mutually exclusive, several respondents did tick more than one response, which means that the total number of options selected is higher by 45 counts than the number of people who responded to this overall question.

Comments for option D

Of those respondents who selected option D, ten made comments which reflected the need for the process to be judicious, with scope for discretion and the use of common sense, together with a need to ensure adequate proof and the opportunity for the recipient to challenge the decision. One respondent could not see the relevance of the case study, commenting that warnings should only be used for situations where there were issues of patient safety. The same point was raised by a group at a responsible officer reference group who supported option D. Another emphasised the importance of taking the warning into account where there were further breaches of good practice. One highlighted that warnings did not take into account remedial activity, so questioned whether, if the doctor's fitness to practise was impaired, this should be specified in conditions. Two respondents thought there was scope to make more use of responsible officers and employers to take action at a local level and monitor the situation. A group at a responsible officer reference group also raised this issue, commenting that there was a role for ROs to agree an action plan with the doctor concerned and discuss with the GMC. There was some suggestion that this could be used as an alternative to a warning.

The length of time the warning remained in place was raised by five respondents, with one commenting that their agreement to this proposal was connected with question 24, where they thought that the length of publication should be decided on a case by case basis to a maximum of five years. Another respondent suggested that there should be a two tier system on publication whereby initial warnings were not published, with doctors being advised that any future warning would be.

Several of the comments made simply expressed general agreement with option D, but one, a former panel member of the Investigation Committee commented that he found warnings

a blunt instrument and that while change was needed it had to be carefully considered. An individual doctor suggested an addition to the proposal stating 'I am in favour of an enhanced warning being available after a finding of impaired fitness to practise. However, it is a logical paradox and may undermine confidence to find that a doctor's fitness to practise is currently impaired and then not to impose a sanction that restricts practice. What is needed, therefore, is a 'declaration of previously impaired fitness to practise'. This should be used when past behaviour has crossed the threshold for impairment to be found but, due to subsequent insight and remediation and a low likelihood of repetition, the doctor is by the time of the hearing fit to practise again'. A group at a key stakeholder event supported option D but thought there should be consideration given to introducing two levels of advice and warnings.

Eight respondents commented on the wording of the proposal with most emphasising the importance of distinguishing between the two types of warning, although one respondent doctor commented that he was not sure why there was a need to distinguish between the two. One suggested that 'perhaps the GMC could issue 'professional guidance statements' and the MPTS issue 'professional warnings' '. A responsible officer, raised a similar point, commenting that 'there is confusion in doctors between advice and warning', adding that a warning was something that should be formally accepted and failure to comply with it should lead to further action. The Medical Protection Society said that 'there would need to be different terms to refer to the different types of warning in order to clearly mark their different functions. It considered that misconduct warnings could be referred to as 'warnings' whilst low level concern warnings could be referred to as 'advice' '. They also expressed the view that warnings for low level concerns 'should be kept confidential between the GMC, the doctor and the doctors' responsible officer'. The need for publicity where there was no finding of impairment was also a question raised by a group at a Regional Liaison Service consultation event who supported option D. The Professional Standards Authority commented that 'careful consideration would need to be given to the terminology applied to these different warning powers so that patients, the public and employers can easily distinguish between them'.

Comments for option B

Six respondents who selected option B commented that this was because they considered more serious issues involving impairment required a greater sanction. The Care Inspectorate commented 'we are not convinced a significant departure from Good Medical Practice can be addressed by a warning even if the doctor's practise is not impaired. This could undermine the status of GMP'. An individual doctor commented 'if fitness to practise is impaired then there needs to be some measure to indicate that the issues have been resolved. A warning is only then appropriate for misconduct'. A further respondent stated that 'panels need a certain amount of discretion to make sanctions appropriate'.

One doctor emphasised that 'if a warning has been given and there is another departure from *Good medical practice*, this should be taken much more seriously'. In a similar vein, a member of the public responding thought that initial warnings should not be published but that doctors should be advised that future ones would be. On the subject of publicising these matters however, a medical educator asked how the GMC proposed to warn the public about dangerous doctors. One individual doctor was concerned that some doctors in difficult fields may receive a lot of attention through social media sites which might lead to more complaints against them. They therefore considered that 'there needs to be a mechanism of appeal that is transparent, fair and efficient to the doctor'.

A doctor who had selected option B had also ticked option C and commented that it was 'unnecessary to draw a distinction between warnings issued where fitness to practise is not impaired and where fitness to practise is impaired but where more serious action seems disproportionate'. Another doctor selected option B but said that if the GMC was issuing a warning, as opposed to matters being dealt with at local level, it should by definition be about something serious. One group at a Regional Liaison Services event selected option B, but at the same time highlighted that a warning had a high impact on a doctor who was found not to have impairment. Finally, one doctor considered the current system struck the right balance, and another individual respondent who did not select an option also commented that the current system should be retained.

Comments for option C

Eight respondents who selected option C (the MDDUS, a Care Commissioning Group, five doctors and a member of the public) commented that they considered warnings were appropriate only where fitness to practise was impaired or where the matter related directly to patient care. One doctor for example commented that 'the GMC should police those medical aspects of a doctor's life and confine itself to that', and the member of the public thought 'it is disproportionate and unfair to record a warning on a practitioner's record where there has been an isolated clinical error with no impairment'. Two further respondents, both doctors, chose this option because they believed low level concerns should be dealt with at a local level, and two others suggested that there should be the prospect of escalation if there were repeat concerns, with one commenting 'there should be a mechanism for recording a single episode of misconduct so that it does not have serious adverse effects on an individual - given the ways these are handled in practice by employers and insurers'. A similar view was expressed by another doctor who thought that option C should apply to warnings that are made public, but that 'non-public warnings are appropriate for low level concerns'.

Seven of the eleven groups at the Regional Liaison Service consultation events who discussed this question selected option C. One commented that the GMC should confine itself to issues affecting fitness to practise, and another highlighted that the impact of warnings was serious and longlasting.

The Royal College of Psychiatrists considered that warnings should only be given 'following a hearing where the evidence has been appropriately examined' and an individual doctor responding commented that the impact of warnings could be huge and could ruin a doctor's career, while some doctors who have 'clearly done something bad' but are just required to retrain experience no impact on their careers at all. Another doctor commented that he considered warnings appropriate if there had been 'a proven act of dishonesty/misconduct'.

One individual respondent commented on 'a lack of clarity about what constitutes misconduct, serious misconduct and impaired fitness to practice.....it would be useful to get rid of this confusion and doing so might make it possible to have two levels of decision - misconduct requiring a warning of some sort and impairment requiring action on registration'.

Comments for option A

Three of the respondents who selected option A did so because they did not consider warnings an effective sanction, with one member of the public commenting that 'the only circumstances in which warnings should be given are to deal with low-level concerns about

minor departures from Good medical practice.....Warnings are never sufficient if a doctor's fitness to practise is impaired'. However, three others selected this option because they considered warnings to have a disproportionate impact on doctors, with the Medical Defence Union commenting 'we strongly believe that warnings should be abolished because of their unintentional but disproportionately punitive effect in several cases over the years in which they have existed'. They suggested an alternative approach whereby 'the GMC should introduce a 'letter of advice' to be issued at the investigation stage (when there has been no finding of fact), and then a different type of letter that would be issued after an FTP finding on fact and decision on impairment.'

Comments from those who did not select any of the four options

NHS England were not sure whether warnings were properly understood by the public or the medical profession as, 'very often the case will close with no warning and a statement that the evidence does not meet the threshold.....even when the doctor's actions raise substantial concerns'. A member of the public responding believed they should only be used for low level concerns where there was an insignificant departure from *Good medical practice* and not where a doctor's fitness to practise has been impaired because 'the GMCs function is to protect patients and to maintain public confidence and to be seen to be doing so'. The Royal College of Physicians wanted to see clearer definitions of what constitutes impairment.

A law firm urged the GMC to consider 'a pre-hearing approach of some similarity to that adopted by the GDC, for example, closing cases with no action, with advice, with an unpublished warning, or with a published warning at the Rule 7 stage'. An individual doctor did not select an option because he thought it should all be done on a case by case basis, and another considered that the list of options demonstrated 'the underlying problem which is confusion between punishment and safety'.

Equalities Issues

An individual doctor emphasised the need for warnings to be applied consistently and 'not just for doctors who have fallen out with individual patients or line managers'. Furthermore that there might be a disproportionate impact on doctors sharing protected characteristics.

Proposal 23: If we continue to give warnings, do you agree that more serious action should be taken where there are repeat low level concerns that involve a significant departure from Good medical practice?

Community People responses			
Option	Response number	Percentage	Number of comments
Yes	316	74.00%	95
No	80	18.74%	32
Blank	31	7.26%	7
TOTAL	427	100%	134

Community People responses by category of respondents					
		Yes	No	Blank	TOTAL
Organisations	Body representing doctors	11	2	0	13
	Body representing patients or public	10	0	1	11
	Government department	0	0	0	0
	Independent healthcare provider	7	0	0	7
	Medical School (undergraduate)	2	0	0	2
	Postgraduate medical institution	5	0	0	5
	NHS/HSC organisation	17	1	1	19
	Regulatory body	2	0	0	2
	Other	6	1	1	8
Individuals	Doctor	200	64	21	285
	Medical educator	4	2	0	6
	Medical student	0	0	0	0
	Member of the public	40	7	5	52
	Healthcare professional or staff (not dr)	0	0	0	0
	Responsible Officer	0	0	0	0
	Other	12	2	2	16
Unknown	Unknown	0	1	0	1
	Blank	0	1	0	1

Introduction

The majority of respondents (74%) agreed with this proposal. 70% of doctors supported the proposal along with 77% of members of the public. 11 out of the 13 bodies representing doctors, including the BMA, MDU and MDDUS also agreed with the proposal, as did ten out of the eleven bodies representing patients or the public. The majority of the groups attending the consultation events who discussed this proposal were in favour of it. The MPS did not support the proposal, stating that 'in general, unless the concerns are related this should not lead to further action and each concern should be considered on its own merits. If the doctor has disregarded the terms of a previous warning in his subsequent conduct then it would be appropriate to consider more serious action than would otherwise have been the case.'

Comments in support of the proposal

Many of the comments made by those who answered yes to this question were general comments of support for the proposal, largely because, in the words of one doctor 'repeated offences raise possibility of a pattern of poor performance over time - which is immediately more serious than a one off departure from *Good medical practice*'. Some respondents in agreement commented that they believed this was in any event what the GMC already did. Two respondents referred specifically to their support for a graded system of advice/warnings/sanctions, which they saw this proposal as a component of.

There was a division of opinion from respondents who made specific comments. Some respondents considered that further concerns after a warning had been issued should immediately trigger further action. However, others believed there was a need to consider issues on a case by case basis, taking into account whether or not it was a repeat issue which required escalation, or if it was different conduct where another warning would be an appropriate and proportionate response. In the former category, the Royal College of Anaesthetists commented 'a warning does not only act as a caution to the medical professional concerned, it is also a marker for the issuing regulatory body that this individual is otherwise safe to practice without restriction. Should a further incident occur while the warning is in place, the regulator is obliged to consider immediately the need for some further restriction while the professional's conduct and/or competence is being investigated'. In the latter category, an independent healthcare provider commented 'there needs to be discretion depending upon the nature of the concerns. An automatic trigger into more serious action without consideration of the content does not seem sensible'. Comments relating to the need for proportionality were made by 15 of the respondents. An NHS/HSC organisation commented for example, that 'there should be a careful definition of 'repeat' which safeguards patients and is fair and proportionate to practitioners'. The need for specific guidance on what would lead to more serious action and greater clarity as to what constitutes a significant departure from *Good medical practice* was mentioned by a further five respondents. Two respondents, an individual doctor and a member of the public, thought that this proposal should only apply to medical and not private issues.

Six respondents made comments to the effect that a warning needed to have a deterrent effect, with one doctor highlighting that the proposal at consultation question 23 'would be the point of a warning. It puts down a marker to say 'do anything like this again and the trouble will be worse'. On a connected theme, the importance of the doctor showing insight and steps to remediate was raised by 16 respondents, with the Patients' Association commenting for example that 'either the doctor has been unwilling to learn from the previous warning or is incapable of learning from it - either way, the implications for patients are serious and more robust action should be taken'. A group at a Regional Liaison Service event also highlighted the importance of doctors taking steps to remediate.

Finally, the Royal College of Physicians and an independent healthcare provider emphasised the importance of the GMC having in place good systems of monitoring.

Comments opposed to the proposal

Of those who answered no to this question and commented on the proposal, the most common reason given, by eleven respondents, was the need to consider each situation individually and make decisions on a case by case basis. A member of the public commented for example, 'if a doctor works in a risky speciality such as GP or A&E, where they see a high volume of patients and make difficult clinical decisions all the time, they are more likely to

receive complaints. I think each complaint should be taken on its own merit'. The MPS thought that 'unless the concerns are related this should not lead to further action and each concern should be considered on its own merits. If the doctor has disregarded the terms of a previous warning in his subsequent conduct then it would be appropriate to consider more serious action than would otherwise have been the case. Mechanisms at employer level would also be more appropriate to deal with these circumstances'.

The need for more local or employer involvement in these situations was raised by a further four respondents, all doctors, with two commenting that this was an issue best dealt with through appraisal. (The question of how appraisal fitted in was also raised by a group at a Regional Liaison Service consultation event who agreed with the proposal.) One considered that arrangements should be put in place for mentoring the doctor concerned with more serious action taken only if this failed. The fourth did not think the GMC should be involved unless there was 'good evidence of risk to patients' and also expressed concern about the guidelines by which doctors were being judged by those who have often not had to comply with them themselves. Concerns about the validity or appropriateness of the guidelines with which doctors are expected to comply, including *Good medical practice*, local protocols and NICE guidelines, were also raised by a further three respondents, with one doctor commenting 'some of the departures from local protocols are made because the protocols are themselves incorrect'.

Two of the respondents, a doctor and a member of the public, considered warnings an ineffective sanction because there were not sufficient safeguards to ensure health and social care systems were working as they should, and because the perspective of, and impact on, the patient was not properly considered. Two others, however, seemed to consider warnings inappropriate because either a doctor is impaired, in which case action should be taken, or they are not, so it shouldn't. One further respondent thought that action should only be taken for serious issues and not minor breaches.

The importance of proportionality was emphasised by three respondents, including the Royal College of Psychiatrists, who commented 'there is a risk that doctors will be required to meet a very high threshold of behaviour all of the time and this is not a realistic or proportionate expectation'. A group at a Regional Liaison Service event thought that the proposal was not proportionate in relation to the case study of Dr Exeter set out in the consultation because the doctor had shown insight and it presented too imposing a standard. Two further respondents raised the need for proper proof, with one doctor commenting 'the term 'concerns' is insufficient in my view. I do not accept that 'concerns' (which may not have been independently established and/or proven by way of an actual criminal conviction or a finding of some sort), should be included in any panel guidance'.

Other comments

Two respondents, the Law Society of Scotland and an individual doctor, thought that the matter should be considered on a case by case basis. Another individual respondent thought that more serious action should apply 'only if the repeated incidents are of a similar nature'. This view was shared by a group attending a Key Stakeholder consultation event, who considered a 'principal of escalation' appropriate if it was a related issue, and by one attending a Regional Liaison Service event. The former group also held a general perception that if a warning had already been given, a panel might be more likely to be able to establish impairment.

Equalities Issues

One of the groups at a Regional Liaison Service made a comment that the proposal seemed a bit like a 'witch hunt' and was so hard for young doctors.

Several respondents, both in favour and opposed to the proposal, made comments reflecting the need to ensure a fair and objective system whereby complaints against doctors are properly evidenced and proven before any action is taken.

Proposal 24: How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired?

- a. Publish warnings for five years and disclose to employers and responsible officers indefinitely.
- b. Publish warnings for one year and disclose to employers and responsible officers for five years.
- c. Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years. Indefinite disclosure to employers and responsible officers.

Community People responses			
Option	Response number	Percentage	Number of comments
A	36	8.33%	11
B	155	35.88%	36
C	173	40.05%	54
Blank	68	15.74%	44
TOTAL	432	100%	145

Community People responses by category of respondents						
		A	B	C	Blank	TOTAL
Organisations	Body representing doctors	1	2	8	2	13
	Body representing patients or public	3	3	3	2	11
	Government department	0	0	0	0	0
	Independent healthcare provider	0	0	6	1	7
	Medical School (undergraduate)	1	0	1	0	2
	Postgraduate medical institution	2	1	2	0	5
	NHS/HSC organisation	4	1	12	2	19
	Regulatory body	0	0	1	1	2
	Other	0	2	4	2	8
Individuals	Doctor	13	124	110	42	285
	Medical educator	0	3	3	0	6
	Medical student	0	0	0	0	0
	Member of the public	10	14	18	10	52
	Healthcare professional or staff (not dr)	0	0	0	0	0
	Responsible Officer	0	0	0	0	0
	Other	0	0	0	5	5
Unknown	Unknown	2	4	5	0	11
	Blank	0	1	0	0	1

Introduction

The majority of respondents (40%) believed that when considering warnings and their publication and disclosure, the preferable option would be to issue guidance to case examiners and MPTS panels. The BMA supported the preference of the majority, with the PSA advocating the need for regulators to work on 'harmonising sanctions powers and

terminology' to allow for 'greater consistency' and to ensure public confidence. They stated that this would then provide them with the discretion to determine the length of publication on a case by case basis, up to a maximum of 5 years, with indefinite disclosure to employers and responsible officers. The second preference (36%) was that we publish warnings for one year, and disclose to employers and responsible officers for five years. Eight percent of respondents opted to support the publication of warnings for five years, with the right to disclose to employers and responsible officers indefinitely. Doctors were among the highest number of respondents to this question, with 288 answering our proposal, the majority of whom backed the option to publish warnings for one year (43%), closely followed by 38% who believed that guidance should be issued to Panels and case examiners. Bodies representing patients and the public did not prefer any of the three options, with an even split across all three proposed actions.

Comments for option C

Of the 40% who supported 'option C', predominantly doctors were in favour of Panels and Case Examiners maintaining an element of discretion when deciding how long disclosures should be made to the public and to employers/responsible officers. One medical director of a NHS organisation referred to the need for a 'statute of limitations' when it came to disclosing warnings, and that it should expire and no longer need to be disclosed to employers. One doctor who supported this proposal instead argued that there should be a right of appeal against the publication of a warning where guidance has not been strictly followed by the Panel or Case Examiners. One NHS organisation referred to the fact that the retention of warnings should coincide with a doctor's revalidation cycle. A representative from an independent healthcare organisation referred to the need to clearly track a doctor's progress to ensure they remain on track with any remediation required of them. Again there was reference made to the 'arbitrary' five-year timeframe by this organisation. The Royal College of Psychiatrists stated that it was unfair to publish details of a warning if the doctor's fitness to practise was not impaired. The Royal College of Physicians in Edinburgh instead referred to the possibility of having warnings for different lengths of time instead of a standard five-year timeframe.

At our consultation events, the majority of participants favoured option C. One participant referred to whether we should instead have minimum periods for publication (6 months) up to a maximum of 5 years. Another participant referred to the fact that with a finding of 'no impairment', we still issue a warning and this approach lacks proportionality, but there would be value in explaining the seriousness of the outcome and providing context when they are published externally. Responsible officers highlighted the fact that a warning could affect a doctor's employment and indemnity insurance obligations, and that the five year period seems arbitrary. Again, there was suggestion that it would be preferable to tie a warning and its lapse from publication to a doctor's revalidation cycle. There was also a general feeling that the GMC should be clearer in explaining to doctors what they have to disclose and to whom in relation to warnings. Responsible officers acknowledged their role in monitoring doctors who were subject to warnings, and that it was important to maintain a close relationship with the GMC in addressing any concerns that may arise. One respondent at one of our regional events referred to whether the terminology of a 'warning' could be revisited.

Comments for option A

Of those in support of option A, one doctor remarked that 'it is employers (or potential employers) rather than the public that tend to overreact to warnings', despite there being an

acknowledgement that employers and responsible officers should have that awareness to be able to respond to future behaviour. One doctor likened a doctor's professional history to that of taking a patient history, and questioned whether the '5 year' lapse of publication was arbitrary, as any warning would always have some relevance. The Royal College of Physicians recommended that warnings are published for five years and disclosed to employers and responsible officers indefinitely.

One respondent in support of the proposal to publish warnings for one year, and disclose to employers and responsible officers for five years was wary, stating 'not all employers are like the NHS', and he had known an employer to use a complaint as a basis for dismissal. A doctor referred to whether it could feasibly be in the doctor's best interests to disclose information to employers and responsible officers indefinitely, and instead, 'it should be decided on a case by case basis' when considering whether to make a disclosure. One of the postgraduate medical organisations asserted that 'indefinite disclosure is too draconian' and so long as the doctor does not have any additional actions against their licence, this should be sufficient. A member of the public suggested that remediation might be more beneficial than scrutinising doctors and publicising their inadequacies. A member of the public referred to the fact that after seven years, a conviction is spent, and that it would seem disproportionate to publicise warnings indefinitely in this context. The Patients Association asserted that it would be more appropriate to publish warnings for a year as the option of 'c' left too much subjectivity to the GMC.

Equalities Issues

No specific equalities issues were raised under this proposal

Appendix B: Events and meetings

During the consultation period we held engagement events across the country to capture feedback from a wide range of groups, and to encourage individual and organisational responses to our consultation questionnaire.

We captured views and comments expressed at the events in feedback forms. These were analysed alongside the other responses received during the consultation period, and have been included in this report.

National stakeholder events

We held five national stakeholder events (London, Edinburgh, Manchester, Belfast and Cardiff), introduced by His Honour Judge David Pearl.

We reached around 120 people through these events, including those representing patients and doctors.

Regional Liaison Service meetings

The Regional Liaison Service organised 16 events across the country obtaining the views of around 225 people.

The meetings were attended by a wide range of stakeholders, including groups representing people with protected characteristics, such as The Gay and Lesbian Association of Doctors and Dentists (GLADD) and The British Association of Physicians of Indian Origin (BAPIO).

Responsible Officer Reference Group meetings

We held discussions on the consultation at the Responsible Officer Reference Group meetings in both Manchester and London, engaging with around 42 responsible officers.

Appendix C: Organisations that responded to the consultation

Academy of Medical Royal Colleges
Addictions Facult, Royal College of Psychiatrists
Avon and Somerset Constabulary
AvMA
BLM
Board of Community Health Council in Wales
Brighton & Sussex Medical School
British Medical Association Northern Ireland
British Orthopaedic Association
Brough and South Cave Medical Practice
Bupa UK
Care Inspectorate
Christian Medical Fellowship
Christian Medical Fellowship
City Hospitals Sunderland NHSFT
Clatterbridge Cancer Centre
Derbyshire Local Medical Committee
Diverse Cymru
Epsom & St Helier Universtiy Hospitals NHS Trust
Eric Moore Partnership, Warrington
Faculty of Pain Medicine of the Royal College of Anaesthetists
FICM, Royal College of Anaesthetists
Garswood Surgery
General Healthcare Group (BMI Healthcare)
Greater Preston CCG
Health and Social Care Board
Healthwatch Enfield
Healthwatch Peterborough
HEE north west london
Independent Doctors Federation
Kent and Medway Area Team
Lancashire Care
Lay Advisors Group of the Royal College of Surgeons of Edinburgh
Lincolnshire LMC
Liverpool Local Medical Committee
Maidstone & Tunbridge Wells NHS Trust
MDDUS
MDU
Medacs Doctors
Medical Women's Federation
Medteam Healthcare Ltd
National Clinical Assessment Service (an operating division of the NHS Litigation Authority)
NHS England
NHS England West Yorkshire

NHS Shetland
Nursing and Midwifery Council
Peterborough and Stamford NHS Foundation Trust
Picker Institute Europe
Plymouth University
Professional Standards Authority
RadcliffesLeBrasseur
Royal College of Anaesthetists
Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Sick Doctors Trust
Solent medical Services
Spire Healthcare
Staffordshire and Stoke on Trent Partnership NHS Trust
Thames Valley Area Team, NHS England
The Law Society of Scotland
The Medical Protection Society
The Patients Association
The Royal College of Anaesthetists
The Royal College Of Psychiatrists
The Royal College of Radiologists
UHBFT

Consultation audit report

General Medical Council

Regulating doctors
Ensuring good medical practice

Audit of Consultation

**Consultation on changes
to GMC's sanctions
guidance and on the role
of apologies and warnings**

Draft Final Report

11th December 2014



Social Research Centre

Independence Integrity Excellence

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ACKNOWLEDGEMENT

The Social Research Centre wishes to thank the
personnel from the General Medical Council's
Fitness to Practice Directorate for all their
Help and support during our conduct of this audit.

DISCLAIMER

This report has been prepared for and only for the General Medical Council (GMC) in accordance with the terms of reference specified to Social Research Centre's (SRC) in July 2014 and for no other purpose.

The opinions expressed by the participants in this consultation are strictly those of the person who gave them and not SRC.

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1. EXECUTIVE SUMMARY

1.1 BACKGROUND TO THE AUDIT

This report is an independent audit, prepared by the Social Research Centre (SRC) (www.srcentre.co.uk) of the consultation data submitted and gathered in relation to the General Medical Council's (GMC) consultation on, "[Changes to our sanctions guidance and on the role of apologies and warnings](#)" (August to November 2014).

1.2 TERMS OF REFERENCE

This audit was commissioned to provide¹:

- *Reassurance, to both internal and external audiences, about the reliability of the consultation report as an accurate summary of the consultation responses; and,*
- *An objective confirmation that GMC has identified all of the key themes raised by respondents.*

1.3 WHAT WE DID

SRC agreed the priority data sets for examination with GMC and agreed a sampling and audit approach that, within the budgetary and time constraints set for this exercise, enabled us to test the extent to which the data, findings, conclusions, recommendations generated by SRC concurred with those generated by the GMC Analysis Team in terms of completeness, accuracy and substance.

1.4 WHAT WE FOUND

SRC's audit of the data found that:

- ☒ There were very high levels of completeness and accuracy throughout the data sets examined with virtually all of the substantive points included; and,
- ☒ In so far as SRC can judge² virtually all of the substantive points from the quantitative and qualitative analysis have been identified and considered appropriately in the GMC Analysis Team's reports.

Please Note: As the audit proceeded, we brought GMC's attention to a small number of differences in our analysis vs GMC's. We would stress that these points were not material. Notwithstanding this, GMC did respond to these and SRC is satisfied that these points have now been reflected in GMC's consultation report.

Whilst not part of our formal terms of reference, we have, for the purposes of continuous improvement, provided GMC with a short list of general points upon which GMC may wish to reflect regarding the analysis of data in future consultations. At the time of writing, we were given to understand that GMC has committed to sharing these points with other colleagues involved in consultation exercises.

¹ Source: GMC's Audit Brief to SRC – September 2014.

² i.e. Based on an examination of the available data alone (and no other considerations)

2. INTRODUCTION AND BACKGROUND³

2.1 BACKGROUND TO THE CONSULTATION

2.1.1 Role of the General Medical Council

The General Medical Council (GMC) registers and licenses doctors to practise medicine in the UK.

2.1.2 Background to the Consultation

Good medical practice sets out the standards expected of doctors. To make sure panel decisions are transparent, fair and consistent, the GMC provides guidance to help panels decide what sanction is appropriate. This is called the Indicative Sanctions Guidance for the Fitness to Practise Panel. The indicative sanctions guidance sets out the issues panels should take into account when making a decision, including whether a doctor's actions have fallen below the standards the GMC expects, any mitigating or aggravating factors, the current risk that the doctor poses, and whether action is needed in the public interest.

Following an extensive consultation, the GMC published an updated edition of Good medical practice and supporting explanatory guidance in March 2013, which came into effect in April 2013. This edition reflects what doctors and patients think are the important values and principles of good care.

In summary, doctors must be competent, and keep their skills and knowledge up to date, to practise safely. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately including if they or a colleague fall ill and their performance or conduct suffers. They must also reflect on their practice, including any errors that affect patient safety and care, making use of the outcome of audits, patient and colleague feedback and lessons learnt through other patient safety and monitoring systems to improve the quality of care.

If the GMC receives a complaint about a doctor, it may need to investigate the concerns and take prompt action if it believes the doctor is putting the safety of patients, or public confidence in doctors, at risk. GMC can issue a warning, agree undertakings with the doctor that limit the type of work they can do or refer the case to an MPTS panel for a hearing.

The MPTS was established in 2012 to separate the GMC role in investigating concerns about doctors from the adjudication of cases, including holding hearings. At a hearing, a fitness to practise panel will review the evidence to decide whether the doctor's fitness to practise is impaired. If it is, the panel will decide the appropriate action to take – it can take no action, agree undertakings with the doctor, impose conditions, or suspend or remove the doctor from the medical register. To make sure panel decisions are transparent, fair and consistent, GMC provides guidance to help

³ The description of the background to, the operation of, the responses from and the analysis of the consultation process was provided by GMC.

panels decide what sanction is appropriate. This is called Indicative Sanctions Guidance for the Fitness to Practice Panel.

GMC proposes a range of changes to its sanctions guidance to make sure it reflects society's values and expectations of doctors, which are set out in the updated edition of Good medical practice and supporting explanatory guidance, published in 2013. In particular, these changes will better guide panels on the types of concern where it may be appropriate to permanently remove a doctor's registration.

GMC is also reviewing the role of apology and insight in its processes. This is being reviewed because doctors have a duty to offer an apology when a patient is harmed or suffers distress as a result of a doctor's actions. The Francis report recommended that introducing a professional duty of candor for health and social care professionals would encourage a culture of openness and honesty to be the norm.

2.2 THE CONSULTATION PROCESS

2.2.1 Launch

The consultation was launched on Friday 22 August 2014 and ran until Friday 14 November 2014.

2.2.2 Publicising the Consultation

A range of methods were used to publicise the consultation and ensure a range of audiences were aware of it:

- The consultation document "A public consultation on changes to our sanctions guidance and on the role of apologies and warnings" was published in hard copy and was prominent on the GMC website;
- An interactive ('Fitness to practise panel decision in action') microsite was created to support the consultation. This included a range of scenarios representing the behaviour of fictional doctors;
- an online GMC News article was emailed to all doctors who were signed up to receive GMC News to invite their response (over 10,000 opened the webpage);
- Over 400 relevant organisations, including charities, organisations representing doctors, medical defence unions, regulators, European medical organisations, EU institutions and stakeholders from the four UK countries were emailed to notify them of the consultation's launch and to invite responses;
- A Welsh language version of the consultation document was published; and,
- A series of consultation events were held with key stakeholders at which the fictional scenarios and other consultation material were presented.

2.2.3 Consultation Questions

In summary, the GMC asked 24 questions in the main consultation document (Detail below). Respondents were asked to answer yes or no to each question to indicate whether they agreed or disagreed with each question. Respondents were asked to provide further comments and reasons if they so wished. All questions were optional.

Specifically, the 24 questions outlined proposed changes to the sanctions guidance and the roles of apologies and warnings, as follows:

- **Proposal 1:** Where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor;
- **Proposal 2:** Where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor;
- **Proposal 3:** To guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors;
- **Proposal 4:** To guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence;
- **Proposal 5:** To guide panels they may consider more serious action where cases involve a failure to work collaboratively including bullying, sexual harassment or violence or risk to patient safety;
- **Proposal 6:** To guide panels to consider removing doctors from the medical register when abuse of their professional position involves predatory behaviour towards a patient, particularly where the patient is vulnerable;
- **Proposal 7:** To guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics in any circumstance, either within or outside their professional life;
- **Proposal 8:** To guide panels to consider the factors which may lead to more serious action where the following issues arise in a doctor's personal life:
 - misconduct involving violence or offences of a sexual nature;
 - concerns about their behaviour towards children or vulnerable adults;
 - concerns about probity (being honest and trustworthy and acting with integrity);
 - misuse of alcohol or drugs leading to a criminal conviction or caution;

- unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation;
 - any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings.
- **Proposal 9:** To guide panels that they may consider specific factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. We take all issues relating to drug or alcohol misuse seriously. Some are more serious and have aggravating features and therefore would attract more serious outcomes. We believe panels should consider more serious action in cases involving the following factors:
- intoxication in the workplace or while on duty;
 - misuse of alcohol or drugs that has impacted on the doctor's clinical performance and caused serious harm to patients or put public safety at serious risk;
 - misuse of alcohol or drugs that has resulted in violence, bullying or misconduct of a sexual nature;
 - misuse of alcohol or drugs that led to a criminal conviction particularly where a custodial sentence was imposed.
- **Proposal 10:** Do you think panels should require a doctor to apologise where patients have been harmed?
- **Proposal 11:** To introduce more detailed guidance on the factors that indicate a doctor has or lacks insight.
- A doctor is likely to have genuine insight if they: accept they should have behaved differently, consistently express insight,* take steps to remediate and apologise at an early stage before the hearing;
 - A doctor is likely to lack insight if they: refuse to apologise or accept their mistakes, do not consistently express insight, or fail to tell the truth during the hearing;
 - A doctor may also lack insight if they promise to remediate, but fail to take appropriate steps or only do so when prompted or immediately before or during the hearing.

** Expressing insight involves a demonstration of genuine reflection and remediation.*

- **Proposal 12:** To guide panels they may consider the stage of a doctor's UK medical career as a mitigating factor, and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. However, in cases involving serious concerns about a doctor's performance or conduct (e.g. predatory behaviour to establish a relationship with a patient, or serious dishonesty), the stage of a doctor's medical career should not influence a panel's decision on what action to take.
- **Proposal 13:** If we introduce verification checks on testimonials, do you agree that we should continue to accept them as evidence?

- **Proposal 14:** Do you agree that we should use the factors below to decide whether testimonials are relevant to the panel's decision?
 - Whether the testimonial is relevant to the specific concerns about the doctor;
 - The extent to which the views expressed in the testimonial are supported by other available evidence;
 - How long the author has known the doctor;
 - How recently the author has had experience of the doctor's behaviour or work;
 - The relationship between the author and the doctor (e.g. a senior colleague);
 - Whether there is any evidence that the author has a conflict of interest in providing the testimonial (e.g. personal friendship).
- **Proposal 15:** To make sure we routinely request a statement from a doctor's responsible officer* during our investigation for the panel to consider at a hearing. The statement should set out the extent to which the doctor has reflected on the matter before the panel, the extent to which they have shown insight and how far any issues about their performance or behaviour have been addressed. The panel may wish to consider the extent to which any evidence of insight in testimonials provided on the doctor's behalf is supported by other available evidence, including the responsible officer's statement. We would also introduce guidance for panels to make sure doctors who do not have a responsible officer because they have given up their licence, or who are using alternative routes for revalidation, are not treated unfavourably.

** Some doctors without a responsible officer may have a suitable person as set out in The Medical Profession (Responsible officer) Regulations 2010. In those cases, we will obtain a statement from the suitable person.*

- **Proposal 16:** To guide panels they may consider five key factors when deciding the length of suspension:
 - the risk to patient safety;
 - the impact on public confidence in doctors;
 - the seriousness of the concerns, and any mitigating or aggravating factors;
 - sending a message to the medical profession that standards must be upheld; and,
 - ensuring the doctor has adequate time to remediate.

Panels may also wish to consider the time all parties may need to prepare for a review hearing if one is needed.

- **Proposal 17:** Where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration.
- **Proposal 18:** To provide guidance that suspended doctors should keep their clinical skills up to date by working in ways that do not allow them to be able to play any part in interactions with patients. This would still enable them to observe and later

reflect on clinical care such as observing clinics related to their area of practice and of course by engaging in continuing professional development.

- **Proposal 19:** Where a panel suspends a doctor solely to uphold public confidence in doctors, should any previous interim order influence the panel's decision?
- **Proposal 20:** Do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed?
- **Proposal 21:** Do you think warnings are an effective and proportionate means of dealing with low level concerns which involve a significant departure from Good medical practice?
- **Proposal 22:** When do you think we should be able to give warnings?
 - a. Not in any circumstances;
 - b. Only to deal with low level concerns that involve a significant departure from good medical practice where a doctor's fitness to practise is not impaired;
 - c. Only to deal with misconduct where a doctor's fitness to practise has been found impaired;
 - d. To deal with low level concerns and misconduct (see b and c) if different terms are used to describe them.
- **Proposal 23:** If we continue to give warnings, do you agree that more serious action should be taken where there are repeat low level concerns that involve a significant departure from good medical practice?
- **Proposal 24:** How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired?
 - a. Publish warnings for five years and disclose to employers and responsible officers indefinitely;
 - b. Publish warnings for one year and disclose to employers and responsible officers for five years;
 - c. Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years; or
 - d. Indefinite disclosure to employers and responsible officers.

2.2.4 Submitting Responses

A range of methods was used to gather views on the proposals:

- **Structured responses (E-consult):** The vast majority of the responses were submitted via GMC's e-consult web site. (Data Set 1).
- **Unstructured written responses** - Some respondents did not complete the consultation questionnaire but instead sent a variety of comments to GMC via email or letters. These responses were entered into a separate log and analysed

and reported on along with the free text comments in the e-consult site and on the response forms. (Data Set 2).

- **Meetings** – During the consultation period, GMC staff met with key stakeholders / bodies representing doctors. These meetings were facilitated/hosted by the GMC. Comments were noted as a formal response to the consultation in the form of event feedback forms. However, GMC encouraged attendees to respond to the consultation separately as individuals or on behalf of an organisation. (Data Set 3).
- **Microsite responses** – Respondents could view an interactive microsite created to support the consultation and make a response online. However, the scenarios on the micro site (and hence the corresponding responses from the respondents) only covered questions 3, 4, 7 and 11. (Data Set 4).

2.2.5 Analysis of the Consultation Responses and Next Steps

All data collected throughout the consultation process was collated and analysed by GMC between October and December 2014. The GMC Analysis report contains a summary of the consultation responses – what respondents said. They do not discuss whether the GMC will make any changes to their sanctions guidance based on the consultation responses. The GMC will consider the responses, as summarised by the consultation report, and use that information to decide whether any changes to their sanctions guidance are necessary. Any changes identified will be agreed by the GMC's Senior Management Team, and approval will be sought from the GMC's Council in the form of a paper to the Strategy and Policy Board and to Council with recommendations.

2.3 TERMS OF REFERENCE FOR THE AUDIT

The terms of reference of the SRC audit specified that:

- The **purpose** of the audit was twofold to provide⁴:
 - **Reassurance**, to both internal and external audiences, about the reliability of the consultation report as an accurate summary of the consultation responses; and,
 - An **objective confirmation** that GMC has identified all of the key themes raised by respondents by considering whether the analysis reports the team produced reflected a **fair and reasonable interpretation** of the consultation data.
- The **scope** of the audit was to evaluate the following:

⁴ Source: GMC's Audit Brief to SRC – January 2014.

- **Preparation of data for analysis** (including the transfer of unstructured responses into the structured questionnaire and the accuracy of replicating responses onto the database); and,
- **Interpretation of results** (qualitative and quantitative data).

Consequently, the crucial test within this audit was the extent to which the data, findings, conclusions, which SRC generated, concurred with those of the GMC Analysis Team in terms of completeness, accuracy and substance.

2.4 SCALE OF THE AUDIT

GMC commissioned SRC to invest a small number days on the design and conduct of this audit of the consultation responses including this report on its findings.

3. WHAT WE DID

3.1 OVERVIEW

This section details how each phase of the audit was conducted.

3.2 A PRINCIPLES-BASED APPROACH

Our conduct of the audit was founded on the following six principles:

<input checked="" type="checkbox"/> RISK	Assessing where the greatest risks lay in terms of any potential for the data to be altered or misinterpreted in any way, and then and focusing attention specifically on the higher risk areas.
<input checked="" type="checkbox"/> SALIENCE	Allowing the shape and emphasis within our audit to be informed by an understanding of the aspects of the consultation which were perceived to have special strategic significance for GMC.
<input checked="" type="checkbox"/> ACCURACY	Designing and deploying specific measures to check the extent to which the response has been correctly assigned to the appropriate section of the consultation in accordance with the analysis instructions.
<input checked="" type="checkbox"/> COMPLETENESS	Designing and deploying specific approaches to test the extent to which all information submitted had been included in the analysis.
<input checked="" type="checkbox"/> SUBSTANCE	Confirming, to the fullest possible extent, within the time and budgetary constraints of this exercise, that all material issues had been identified and considered.
<input checked="" type="checkbox"/> SAMPLING	Judicious sampling of key data sets to perform the above tests and checks.

3.3 INITIAL RISK ASSESSMENT & SPECIFIC AUDIT MEASURES DEPLOYED

3.3.1 Initial Risk Assessment & Audit Approach Agreed

Given the scale and complexity of the data that had been collected, and the limited time and budgetary constraints available for the audit exercise, GMC and SRC mutually agreed that a sampling approach was the only feasible way forward.

At SRC's initial discussion with the GMC Analysis Team on 6th August 2014, combined with a series of subsequent meetings and conference calls, resulted in the following data being identified and the risks associated with being agreed. As the descriptions below explain, this collaborative assessment of risk directed SRC in terms of where to invest its efforts across the audit exercise.

Each data set was risk assessed in turn and an appropriate audit approach agreed as follows:

Structured responses

Data Set 1: E-consult responses: The vast majority of the structured responses to the consultation were submitted via GMC's e-consult web site.

Risk Assessment: Our assessment found that overwhelming majority of this data set was **LOW RISK** i.e. the specific manner in which data was captured (closed on-line system) intrinsically protected the completeness and accuracy of the data such that the possibility of corruption / inaccuracy was very low or negligible.

Audit Approach: Whilst one option would have been for SRC to simply choose a number of questions at random to analyse in details, we rejected this (GMC agreed) on the basis that such an approach might not select areas for examination that the GMC Analysis Team considered to be the most pertinent and / or valuable in the context of an audit. Hence, an important opportunity to provide assurance and potentially rigour would have been missed. Consequently, in order to ensure that SRC's audit work would be invested in examining aspects that the GMC Analysis Team considered the most valuable, we invited the Team to specify four areas that they considered to be especially salient in the consultation overall. Whilst several areas were potential candidates, the following four questions were finally selected **Questions 1, 3, 10 and 24 only**. These questions were selected because they were deemed, by GMC, to be **key** in terms of shaping the future policy on sanctions. Since the e-consult data was the primary data set of the consultation, **SRC checked the responses to all questions for arithmetic accuracy**. It was also agreed that SRC would audit a sample (5%) of the qualitative feedback to each of these questions since qualitative responses are inherently, more complex and consequently vulnerable to a degree of interpretation).

Data Set 2: Unstructured written responses – Thirty nine respondents did not complete the consultation questionnaire but instead sent a variety of comments to GMC via email or letters. These responses were entered manually by GMC personnel and became part of the same database as in the e-consult data.

Risk Assessment: Again, we classified this data as **MEDIUM RISK** since there was a possibility that data could be transferred incompletely or inaccurately from the free format reply to the e-consult database.

Audit Approach: Hence, whilst SRC audited a 10% sample (n= 4) of the unstructured responses to confirm the completeness and accuracy of data transfer to the e-consult database.

Data Set 3: Meetings – During the consultation period, GMC staff met with key stakeholders / bodies representing doctors. In total 23 meetings were held. These meetings were facilitated/hosted by the GMC. Comments were noted as a formal response to the consultation in the form of event feedback forms. However, GMC encouraged attendees to respond to the consultation separately as individuals or on behalf of an organisation. SRC selected 3 of these meetings at random for evaluation within the audit.

Risk Assessment: Our assessment found that this data set was **MEDIUM RISK** since the completeness and accuracy of the data could be affected by a number of factors including instructions given/observed by individual facilitators, the conditions prevailing at specific meetings (i.e. how much time was actually available to record information) and the consistency with which key points are recorded.

Audit Approach: Whilst SRC is aware that the manner in which the data is captured is a risk factor in itself. SRC cannot therefore assure completeness and accuracy beyond the notes taken by GMC personnel. Consequently, within the confines of this audit, the only meaningful cross check that SRC could, and did, perform was to select a sample of feedback from a number (n=3) of meeting sessions, selected at random and checked the extent to which the information had been entered onto GMC's Events database.

Data set 4: Microsite responses – Respondents could view an interactive microsite created to support the consultation and make a responses online. However, the scenarios on the micro site (and hence the corresponding responses from the respondents), were confined to questions 3, 4, 7 and 11.

Risk Assessment: Our assessment found that overwhelming majority of this data set was **LOW RISK** i.e. the specific manner in which data was captured (i.e. a closed on-line system) intrinsically protected the completeness and accuracy of the data such that the possibility of corruption / inaccuracy was very low or negligible.

Audit Approach: Since this data was a support to the consultation (i.e. and not the primary data set), and since the completeness and accuracy of the data was highly likely to be able to be relied upon given the 'closed' nature of the data capture mechanism, SRC agreed with GMC that it would compare the completeness and accuracy of the GMC's transfer of the microsite summary data (i.e. all four scenarios) from the raw data tables into the final GMC's analysis report.

3.3.2 Audit – Analysis & Comparison

Step 1: Analysis - Working in this way (as described above), enabled SRC to take a sample of data from each of the data collection processes and independently analyse it to assess the extent to which our findings, conclusions and recommendations (both quantitatively and qualitatively) concurred with the analysis performed by GMC. Crucially, we produced our analysis by:

- working directly with the primary data as far as possible (and with summaries in only a small number of cases); and,

- without reference to the GMC Analysis Team's own workings.

Step 2: Comparison - When SRC had completed its own independent analysis and interpretation, we then compared this with the GMC's Team's own analysis. The findings from our comparison are summarised in Section 4⁵).

NOTE: The reader should note that whilst it was feasible and appropriate to compare the quantitative data from a strictly arithmetic perspective, qualitative data, by its very nature requires a different approach. Within the time and budgetary constraints available for this audit, SRC's approach to analysing the qualitative data was to compare on 'substance' and 'reasonableness'. This involved:

- o Identifying the distinctive points⁶ emerging from selected segments of questionnaire data analysis (e.g. analysis of comments of those who said 'Yes'; those who 'said 'No' in relation to question 1, 3, 10 and 24);
- o Checking that the key issues identified in the other data sets sampled had been reflected appropriately in GMC's overall analysis; and,
- o Comparing all of this with the GMC Analysis Team's own work to ascertain if there were any material differences between our findings and theirs.

NOTE: The reader should note that SRC is entirely open about the fact that its capacity to interpret the data and make recommendations based on it is heavily constrained. We did not, nor were we expected to, possess the level of specialist and contextual knowledge of the GMC Analysis Team. Consequently, our interpretation of the material is based only on a broad comparison of the distinctive points emerging from the data available for analysis and not on wider contextual knowledge or understanding of the full authority of and constraints upon GMC, legislatively, financially or otherwise.

Given both of these factors, SRC's approach to auditing the GMC Team's Analysis was to create a summary of our own of all of the distinctive points that had emerged. We then compared this with the points made by the GMC Analysis Team in the various sections of its report.

⁵ Note: All relevant working papers have been provided to GMC.

⁶ Given the budgetary and time constraints on this exercise, SRC determined that this was the only feasible approach to take. More detailed analysis by 'themes' and 'mentions' and / or detailed coding and quantification of the qualitative responses was not achievable within the limited specified for this exercise and indeed any such comparison would have involved pre-agreement with GMC on what the specific themes were (i.e. so as coding frames could be set up).

4. WHAT WE FOUND

4.1 OVERVIEW

This section itemises the key findings, conclusions that ensued from SRC's examination of the data.

- ✓ Overall, the audit had found that the GMC Analysis Team's approach to analysis and interpretation was highly thorough;
- ✓ There were very high levels of completeness and accuracy throughout the data sets examined with all substantive points included; and,
- ✓ In so far as SRC can judge, the correct interpretation has been applied to all of the points raised.

The Sections below summarise the key findings and conclusions that ensued from SRC's examination of the data. The findings show the virtually complete levels of completeness and accuracy regarding data entry.

4.2 ARITHMETIC CHECKS

4.2.1 Sample

SRC carried out an arithmetic check on all (1 to 24) of the responses on the e-consult database to check that the numbers of responses and the classification of them (by organisation/ individual and by 'yes / no') matched GMC's analysis.

4.2.2 Audit Analysis & Results

In almost all instances the results matched. **See Appendix A for further details.** The tables (in Appendix A) show the checks and differences highlighted in yellow. The main difference related to a miscount on the number of doctors (GMC had 284 and SRC calculated 285). This was a result of a problem with merged cells in the excel spreadsheet that GMC forwarded to SRC. GMC has since provided SRC with the correct values for both cells.

In addition, SRC also reviewed the GMC's main analysis report which we have checked against the tables. Again the differences / inconsistencies were marked in yellow. This was emailed to GMC on 11th Dec 2014, and again, we have been assured by GMC that this has been corrected.

- ✓ **100% - The tables in Appendix A evidence the near perfect arithmetic match between the number and classification of responses computed by the GMC Team compared with SRC. Moreover, SRC has been assured that GMC has since rectified the difference.**

☒ Overall, the points identified by the GMC Analysis Team were, substantively the same points as those identified independently by SRC.

The E-consult data was the most comprehensive set of data pertaining to the consultation and hence, SRC paid particular attention to this. A total of 432 responses were received in the consultation, not all of which contained responses in comments boxes. In order to create a data set that was manageable within the time and budget constraints of the audit, the following process was adopted:

- The GMC analysis team specified four questions in which there were lower levels of agreement with the GMC proposals. These were:
 - Question 1: Proposed change: where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor. Do you agree with this proposal?
 - Question 3: Proposed change: to guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors. Do you agree with this proposal?
 - Question 10: Issue to consider: should panels require doctors to apologise where patients have been harmed? Do you think panels should require a doctor to apologise where patients have been harmed?
 - Question 24: How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired? a - Publish warnings for five years and disclose to employers and responsible officers indefinitely. b - Publish warnings for one year and disclose to employers and responsible officers for five years. c - Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years. Indefinite disclosure to employers and responsible officers?
- With a potential 432 responses to the "yes", "no" categories and the multiple choice options in question 24, it was agreed to select a 5% sample of responses for audit analysis. A random start and fixed interval method was used to select responses. Where the first selection contained no comment the next available response was substituted. The process resulted in the following being selected for audit:
 - Question 1 – Yes n=22
 - Question 1 – No n=22

- Question 3 – Yes n=22
- Question 3 – No n=22
- Question 10 – Yes n=22
- Question 10 – No n=22
- Question 24 – Yes to (a) n=4
- Question 24 – Yes to (b) n=13
- Question 24 – Yes to (c) n=18

4.4.2 Audit Analysis & Results

We took each of the qualitative responses to the questions, above, and we compared SRC's analysis of the themes with those identified in the analysis performed by GMC.

SRC found that:

☒ **All of the issues SRC identified had been noted by GMC's Analysis Team and, consequently, featured in the GMC's consultation report.**

For the record, a summary of SRC's analysis is shown below.⁷ We have not included themes where there are 2 citings or fewer. Also, please note that the number of citings is typically greater than the number of qualitative responses overall because each qualitative comment typically cited more than one theme.

Question 1 Proposed change: where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor. Do you agree with this proposal?

Q1 Those answering yes. Theme	Number of citings	Noted by GMC Analysis team?
Patient safety and trust is paramount	12	✓
People should be accountable	3	✓

Q1 Those answering NO. Theme	Number of citings	Noted by GMC Analysis team?
The impact on the doctor and, where appropriate, their family, should be taken into account e.g. as in court sentencing	16	✓
This change may be unlawful	5	✓
Punishments must be fair, equitable, balanced and proportionate	5	✓
Protecting patients is paramount, so sanctions are necessary	5	✓

⁷ Note: All relevant working papers re SRC's analysis have been passed on to GMC.

Question 3 Proposed change: to guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors. Do you agree with this proposal?

Q3 Those answering YES.	Number of citings	Noted by GMC Analysis team?
Theme		
General agreement with proposal	12	✓
Need flexibility case by case depending on the circumstances	6	✓
Sometimes remediation is not enough and further sanctions like this are needed	5	✓
Place more emphasis on retraining and skill development	4	✓
Remediation should be taken into account, going further is too much punishment	3	✓

Q3 Those answering NO.	Number of citings	Noted by GMC Analysis team?
Theme		
Remediation or retraining should be enough	11	✓
Disagree with emphasis on public confidence, how it would be defined or how it would be increased or maintained by this proposal	9	✓
Unfairly heavy handed, too loaded against doctors	8	✓
Need more flexibility case by case	4	✓

Question 10 Issue to consider: should panels require doctors to apologise where patients have been harmed? Do you think panels should require a doctor to apologise where patients have been harmed?

Q10 Those answering YES. Theme	Number of citings	Noted by GMC Analysis team?
Yes, apology is important	11	✓
Harm would have to be clearly identified. Apology should only be required if doctor clearly found guilty of causing harm.	5	✓
Apology does not have to be, and should be taken as, an admission of guilt	4	✓

Q10 Those answering NO. Theme	Number of citings	Noted by GMC Analysis team?
"Forced" apologies are meaningless	15	✓
Do not agree, but failure to apologise should be taken into account when determining sanctions	4	✓
Proposal is too harsh, punitive, circumstances should be taken into account	4	✓
Apology should be suggested or should be the choice of the doctor but not made a requirement	3	✓
Danger that an apology would be taken as an admission of guilt	3	✓

Question 24 How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired? a - Publish warnings for five years and disclose to employers and responsible officers indefinitely. b - Publish warnings for one year and disclose to employers and responsible officers for five years. c - Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years. Indefinite disclosure to employers and responsible officers?

Q24 YES to (a). Theme	Number of citings	Noted by GMC Analysis team?
Public has a right to know, Should be widely published, Important information for patients	3	✓

Q24 YES to (b). Theme	Number of citings	Noted by GMC Analysis team?
Indefinite disclosure too punitive	5	✓

Q24 YES to (c). Theme	Number of citings	Noted by GMC Analysis team?
Need more flexibility/ individual approach than these options provide and a decision on a case by case basis	9	✓
Take into account the impact that this has on a doctor's career	3	✓
The decision to disclose or not disclose should be made by the Panel on a case by case basis.	3	✓

4.5 AUDIT DATA SET 2: UNSTRUCTURED RESPONSES

4.5.1 Sample

We initially checked the quality of the data entry by checking the completeness and accuracy of a 10% sample (n=4) of the unstructured responses. These were the responses submitted by:

- The Medical and Dental Defence Union of Scotland (MDDUS);
- Lay Advisers Group of the Royal College of Surgeons in Edinburgh;
- Royal College of psychiatrists; and,
- Medical protection Society.

4.5.2 Audit Analysis & Results⁸

SRC found two not material matters:

- a small number of general comments – 4 sentences - were not included in one of the entries;
- a 'No' response had not been included in relation to question 10 in one of the entries (albeit this had been noted in the comments section pertaining to this question).

☒ These were brought to the attention of GMC Analysis Team immediately and SRC is now satisfied (See email from GMC 10th Dec 2014) that the GMC Analysis Team has made the appropriate corrections in full.

4.6 QUALITATIVE ANALYSIS OF SAMPLE OF MICRO SITE RESPONSES

4.6.1 Sampling of Microsite Responses

SRC reviewed all of the raw data in the microsite data file (all four case studies) and compared this with the summary generated by GMC.

4.6.2 Audit Analysis & Results⁹

SRC found that (in three out of the four case studies) the number of microsite responses shown in the GMC Analysis report was 4 to 5 more than were present on the microsite file examined by SRC. These arithmetic differences did not affect any of the trends.

⁸ Note: The working papers pertaining to this aspect of the audit are hardcopy only and have been passed on to GMC.

⁹ Note: The e-copy and hard copy working papers pertaining to this aspect of the audit have been passed on to GMC.

☒ Notwithstanding this, these differences were brought to the attention of GMC Analysis Team immediately and SRC is now satisfied (See further email from GMC 10th Dec 2014) that the GMC Analysis Team has made the appropriate corrections in full.

4.7 QUALITATIVE ANALYSIS OF EVENTS DATA RESPONSES

4.7.1 Sampling of Events

SRC selected three of the events at random, namely:

- Key stakeholder event-KS0013 - Palace hotel, Manchester, 30th of September 2014
- Health Watch event, London, RLA0016, 30th October 2014; and,
- The RO reference group, RO0008 29th October 2014, GMC Manchester.

We then compared the extent to which the handwritten meetings data was completely and accurately transferred onto the events database.

4.7.2 Audit Analysis & Results¹⁰

SRC found that the data on the handwritten pdfs regarding the key stakeholder event-KS0013 - Palace hotel, Manchester, 30th of September 2014 and the Health Watch event in London (30-Oct-14, RLA0016) matched the GMC Events database fully. However, the handwritten notes in the PDF above from the RO reference group (RO0008 29th of October 2014, GMC Manchester), did not match the comments on the events database based on the data we had received from GMC.

☒ This was brought to the attention of GMC Analysis Team immediately and SRC is now satisfied (See further emails from GMC on 11th & 12th Dec 2014) that the GMC Analysis Team has made the appropriate corrections in full.

¹⁰ Note: The e-copy and hard copy working papers pertaining to this aspect of the audit have been passed on to GMC.