

**FITNESS TO PRACTISE IN THE MEDICAL PROFESSION**

**A REPORT TO UNIVERSITIES UK AND THE COUNCIL OF HEADS OF MEDICAL  
SCHOOLS**

**EVERSHEDS**

**JULY 2001**

**EVERSHEDS  
SENATOR HOUSE  
85 QUEEN VICTORIA STREET  
LONDON  
EC4V 4JL  
020 7919 4500  
020 7919 4919 FAX**

**UNIVERSITIES UK/ COUNCIL OF HEADS OF MEDICAL SCHOOLS**

# FITNESS TO PRACTISE IN THE MEDICAL PROFESSION

## CONTENTS

Executive Summary	2
1. Introduction	6
2. The criteria for Fitness to Practise decision making structures	9
3. Proposals	16
4. Implementation	25
5. Support and Training	28
6. Conclusions	29
Annex 1 Specimen Fitness to Practise Procedure	30
Annex 2 Sources	36
Annex 3 European Convention on Human Rights, Article 6	39

## **Executive Summary**

### **Introduction**

1. The report considers fitness to practise issues from the viewpoint of higher education institutions in England and Wales in membership of both Universities UK and CHMS. Under the Medical Act (1983), they are responsible for the education and training of doctors up to full registration by the General Medical Council, i.e. for both the undergraduate and pre-registration house officer (PRHO) stages of education and training for the medical profession. Universities have a duty under the Act to ensure that those who graduate from undergraduate courses and complete their PRHO training are fit to practise.
2. The report recommends principles for the adoption by universities of fitness to practise procedures that are fair to individuals, reflecting legislative requirements, and that do not necessarily follow a uniform and rigid pattern across all institutions. Subject to consistency with the principles, the detailed procedures will be for determination by individual institutions taking account of their own statutory and regulatory systems.
3. Those universities that to date have not established fitness to practise arrangements are urged to do so as a matter of priority.

### **Criteria for fitness to practise structures**

4. Universities should ensure that the attention of applicants is drawn to disciplinary and other regulations that are relevant to fitness to practise before the individuals enter into contractual relationships with their providing institutions.
5. Fitness to practise rules and procedures must be consistent with the institution's general disciplinary and other regulations. The procedures in Annex 1 of this report are for guidance.
6. In the interests of actual and perceived fairness, representatives of students' bodies should be involved in discussions leading to the adoption of fitness to practise rules and procedures, both nationally and locally.
7. The Council of Heads of Medical Schools may wish to consider working with the GMC on empirical studies of the factors which contribute to fitness to practise problems, to enable warning signs to be identified within the medical student group. However, rehabilitation rather than regulatory sanctions may be more appropriate in dealing with problems when they arise.
8. The fitness to practise system adopted by universities must have clear and realistic objectives, reflected in appropriate terms of reference, adequate resources and the commitment of senior management to their implementation and monitoring.
9. Any fitness to practise procedure should be applied consistently. Comprehensive and accurate recording of decisions and reasons for them are crucial in ensuring consistency.

10. The system adopted by universities should fit with the wider structure of regulation in the NHS and the medical profession and with the quality assurance requirements set out in the QAA's codes of practice.

### **PRHO Status**

11. In so far as the fitness to practise procedures of the universities will apply to PRHOs, institutions will need to create a contractual relationship with PRHOs to parallel the contractual relationship with undergraduate students. It is suggested that in future PRHOs be required to register as postgraduates of the institutions responsible for their education and that the terms of this enrolment (e.g. obligations and amount of any fee) be considered carefully.

### **Proposals and recommendations**

#### **a) Substance**

12. CHMS should take the lead in encouraging the development as a matter of urgency of a common set of core rules of conduct for medical students, liaising as appropriate with the GMC. The rules and principles incorporated into the universities' contracts with students and the basic principles should be incorporated into the QAA benchmarks for academic standards in medicine. The rules should be kept under review.
13. The standards expected of PRHOs should be made clear to final year students before they take up their PRHO posts and should be incorporated into any future contracts between medical schools and PRHOs.
14. There will be a need for a non-judgmental approach on health issues which places substantial weight on the therapeutic needs of the student. The student health committee will need to consider the medical evidence against the current guidelines on these conditions which should prevent clinical work being undertaken. A specific health code for medical students should be adopted, building on guidance provided by the GMC.
15. In relation to disabilities account will need to be taken of:
  - the Disabilities Discrimination Act 1995; and
  - the Special Educational Needs and Disability Act 2001.

#### **(b) Process**

16. There are more advantages than disadvantages in having separate committees to consider cases of ill health and allegations of misconduct. Where concerns regarding a student include both conduct and health, parallel proceedings may be needed.

17. There should be clear separation in the disciplinary process of the investigation of allegations from the making of decisions regarding innocence or guilt. It is particularly important that the Head of the Institution plays no part in the proceedings except, perhaps as the final avenue of appeal, if it is not possible for some other person or body to undertake the appellate role.

### **(c) Investigation**

18. There should be a central point, (eg the Academic Registrar or equivalent), for receipt of allegations concerning fitness to practise or student health. Allegations should be in writing and signed. Anonymous allegations should not be considered.
19. The Academic Registrar, or equivalent, should inform the Dean of the Medical School or other senior academic responsible for the student's programme of studies. Where possible the matter should be resolved informally, but if that is not possible the case should be referred to a senior member of staff, who has had no previous involvement, for investigation and report in accordance with the formal procedure.
20. Those appointed to investigate allegations should be selected and trained in the institution's procedures. The investigator should always interview the student concerned and the maker of the allegation, and notes of the interviews should be taken. The investigator should be accompanied by another member of staff when interviewing the student.
21. If the investigator concludes that there is a serious issue of fitness to practise to be determined, this should be reported in writing to the Academic Registrar and the student informed of the next steps in the process.

### **(d) Adjudication**

22. The body responsible for adjudicating fitness to practise issues should be either:
  - (a) a very senior member of the medical staff of the institution; or
  - (b) a small committee, of perhaps three people.
23. For the purpose of this summary, a committee is taken to be the most likely model, one for health and one for conduct. Members of each committee could be drawn from the same panel of seven to eleven senior members of staff of the institution who should not have had any involvement or interest in the matter and should ideally not be current teachers of the student. At least one should be from a different department/school from that of the student. One might be from another institution, though that might be more appropriate at the appeal stage and if health issues are to be considered one member should have expertise in student health matters. The panel should be chaired by a senior member from another faculty. [Guidance on detailed procedures is set out in Annex 1].

### **(e) Appeals**

24. Where a student's studies are suspended or terminated as the result of a decision by a student health or conduct committee there should be a right to appeal to a fitness to practise appeals

committee. The committee should comprise of three people not involved previously in the matter and it should be chaired by a person of standing from outside the medical school and, if the institution's statutes and regulations allow, from outside the institution.

25. It would be helpful if the Universities Clinical Education Standards Board (see below) or, until this is established, the Council of Heads of Medical Schools, could establish and maintain a list of senior academics and medical and legal practitioners to serve as members and chairs of fitness to practise committees.

**(f) Monitoring/Review**

26. There should be regular review of the system for handling complaints and appeals as part of the institution's quality assurance process.
27. An overarching monitoring body comparable to that developed for the accountancy profession should be established by the universities. It might be called the Universities Clinical Education Standards Board. It should not consider individual cases, but should receive information about cases to ensure that:
- i) individuals who have had their studies terminated by one institution are not able to circumvent the system by obtaining a place at another medical school; and
  - ii) a consistent approach is taken by medical schools to similar issues. The Board should publish a report annually confirming the numbers of fitness to practise cases reported to it by medical schools and trends in the nature of the issues dealt with.

**Implementation**

28. The procedures proposed should be put in place for the academic year 2002/3 in view of the public interest in regulation of the medical. This would require applicants for entry in 2002 to have information about the fitness to practise requirements during the 2002 admissions cycle. However, it may not be possible for all institutions to make the necessary adjustments to their statutory and regulatory framework to fit with that timetable. In that event the aim should be for implementation with effect from the 2003/4 academic year.

August 2001

## Introduction

### **The need for Fitness to Practise decision making structures, policies and procedures**

- 1.1 This report considers the question of Fitness to Practise in the medical profession from the viewpoint of those higher education institutions in England and Wales in membership of Universities UK (UUK) and the Council of Heads of Medical Schools (CHMS), which are responsible for the training of doctors. The report does not therefore consider directly the content of the initial training of doctors and the assessment of that content. These are essentially matters of academic judgement as informed by reports, such as that of the Education Committee of the General Medical Council “Tomorrow’s Doctors: Recommendations on Undergraduate Medical Education” (1993). Nor does this report attempt to canvass the whole range of Fitness to Practise issues which may arise during the practising careers of doctors. These are matters for the General Medical Council rather than the providers of initial health training (although we would suggest that there be liaison between initial training providers and the GMC to ensure that appropriate relationships are established between decisions taken at the initial training stage and at stages of doctors’ careers).
- 1.2 This report does not consider the implications of these issues for the initial training of other health professionals. It is anticipated that these may form the subject of a later report. We are aware that a number of universities are already beginning to address these issues in the context of the training of other health professionals and that where these universities also train doctors they may well wish to develop consistent procedures for all the trainee health professionals concerned.
- 1.3 The need for Fitness to Practise arrangements at the initial stage of the training of doctors is put well in the Oxford University Code of Conduct for medical students as follows:

“Medical students have a relationship that is different to that which most junior members have with members of the public. Medical students work in clinical settings and their behaviour in these settings may affect the welfare of patients. Medical students must ensure that their behaviour both in and outside their day to day work is responsible and demonstrates that they would be fit to practise medicine.”
- 1.4 A further reason why medical schools have a particular responsibility to the public is that by granting the medical degree they give the student an automatic right to provisional registration with the GMC, allowing the student to proceed to the Pre-Registration House Officer (PRHO) year. We would also suggest that this public responsibility extends also to that year, since the university from which the student graduates is responsible under the Medical Act 1983 for ensuring that he or she is placed in a PRHO post which it has approved as providing the required experience, supervision and training. It must also certify to the GMC whether each PRHO has made the educational and clinical progress expected of a doctor at the end of basic medical education and is fit to be fully registered under section 10 of the Medical Act 1983. Although we shall be addressing in section 2.18 the question of the legal relationship between medical schools and PRHOs we consider almost all of the fitness to practise issues canvassed in this report apply equally to medical students and

PRHOs and the term “students” is used as shorthand to cover both groups. Where an issue applies only to students or PRHOs this is indicated.

- 1.5 The justification for Fitness to Practise arrangements is therefore fundamentally that of protection of the public interest in safeguarding patient wellbeing. This interest has been vividly highlighted in the media by a number of serious cases of medical malpractice, such as the Harold Shipman case. It would be unrealistic to think that any Fitness to Practise regime could necessarily identify, perhaps many years in advance, individuals who might later in their careers exhibit criminal tendencies. Government is putting in place a range of other mechanisms, such as the proposed National Clinical Assessment Authority, annual appraisal of medical practitioners and stronger powers of health authorities to remove unsatisfactory family health practitioners from their lists. However, we suggest that providers of initial training of doctors would be failing in their duty to take reasonable care of patients if they were to ignore evidence of possible unfitness to practise on the part of their student members.
- 1.6 It can also be argued that universities have obligations to the students themselves to ensure that they do not proceed without careful examination of their fitness into a career for which they may not be suited, particularly given the considerable time, commitment and expense involved in the process of qualification.
- 1.7 Finally, unlike some other disciplines, such as law, which may be studied at university at least in part for purely academic purposes, the vast majority of medical students will undertake their courses in order to put their knowledge into practice and it does them no favours if they are encouraged in the belief that they may be able to do so when in reality they would be prevented from so doing by the relevant regulatory body. The GMC, as the statutory regulatory body for medicine, is unable under the Medical Act 1983 to decline to register a UK medical graduate who applies for registration. Thus, if graduates who seek registration have demonstrated health or conduct problems that call into question their fitness to practise, the only recourse for the GMC is to register them and then immediately refer them to the council’s fitness to practise committees”
- 1.8 Nevertheless, it is important to bear in mind that medical students also have rights. Exclusion from medical school is likely to mean, in the vast majority of cases, that the individuals concerned are unable to pursue their chosen career. In these circumstances, the university has a legal as well as a moral duty to treat the student fairly. The rules of English law requiring public bodies to make decisions in accordance with natural justice have been strengthened by the Human Rights Act 1998. The position of the UK Central Council for Nursing, Midwifery and Health Visiting in investigating and adjudicating on these issues is currently being challenged in the courts under Article 6 of the European Convention on Human Rights and in order to head off similar complaints by teachers the General Teaching Council for England is establishing separate investigating and adjudicating committees.

#### **Assumptions on which the report is based**

- 1.9 We are aware that there are those who would argue that the question of Fitness to Practise should be left to the GMC as the regulatory body and that it should be possible for a medical student to graduate “MB” or “ChB” without thereby automatically becoming eligible for provisional registration

with the GMC. However, this would require a change to the Medical Act 1983. We do not consider that there is any likelihood of such a change occurring in the foreseeable future. There are, in any event, arguments against such a change. It may be, however, that the question of the appropriate point at which regulation should start to bite is a matter which should be considered by the Universities' Clinical Education Standards Board (UCESB), which we propose should be established as part of the arrangements for monitoring Fitness to Practise issues.

- 1.10 We have also assumed that the Government's response to recent breakdowns of regulation of the health professions will, for the foreseeable future, be as set out above. If Government were minded to go further and, for example, to dismantle the existing arrangements for "self regulation" of the health professions, then these issues might need to be revisited. Such further major change seems unlikely in the foreseeable future.
- 1.11 Finally, we have assumed that universities' existing arrangements for handling students' complaints and appeals will remain in place for the immediate future. While we are aware that Government has indicated its desire, in principle, to establish new arrangements incorporating an independent external element, the shape of the proposed new arrangements is insufficiently clear at the time of writing for us to take them fully into account in this report.

### **Methodology used**

1.12 This report is based on scrutiny of the following main types of material:

- (a) current and forthcoming legislation;
- (b) consultation documents on modernising medical education;
- (c) existing arrangements for determining Fitness to Practise issues within UK universities;
- (d) arrangements in place or being developed for regulation of a number of other professions including accountancy, law and teaching;
- (e) comments on the report in draft from a number of medical schools, the CHMS Council, and the Universities UK Health Committee.

1.13 A full list of sources is contained at Annex 2. We wish in particular to acknowledge the value of the Accountancy Foundation's papers on independent regulation of the accountancy profession, from which we have drawn in considering the monitoring and review arrangements, and the Fitness to Practise procedures at the universities of Nottingham and Manchester; which have significantly informed the development of the specimen procedure at Annex 1.

## The criteria for Fitness to Practise decision making structures

- 2.1 We suggest that there are six main criteria against which any Fitness to Practise decision making arrangements should be judged, namely legality, actual and perceived fairness, effectiveness, consistency, efficiency and fit with the wider structure of regulation of the health professions and of universities.

### Consistency – introductory comment

- 2.2 Consistency might be regarded as being one aspect of fairness but we consider that it is so important that it should be discussed separately.
- 2.3 It might also be argued that risk management principles would suggest the undertaking of a cost/benefit analysis of fitness to practise issues. Indeed, we are aware of some teaching institutions which have adopted this approach and deliberately decided, for example, not to establish arrangements for investigating the significance of criminal convictions declared by applicants for their courses. However, whilst we accept that such an approach might conceivably be reasonable in relation to courses other than those concerned with health, we believe that the risks to the public which may arise where students display evidence of unfitness to practise are so serious that deciding not to establish Fitness to Practise arrangements is not a sensible option for medical schools. We appreciate that there are still a number of universities which have to date not established such arrangements but we would urge them to do so as a matter of priority.
- 2.4 This is not to say, however, that the arrangements for Fitness to Practise decision making should not be efficient and effective as well as lawful and fair. Moreover, in many cases, highly elaborate structures may be no fairer than simple ones, as well as being considerably more expensive to operate.

### Legality

- 2.5 The three main sources of law affecting Fitness to Practise arrangements are:
- 2.5.1 the common law of natural justice and fairness.** This requires those making decisions affecting people's rights to do so in an unbiased manner, giving the persons concerned a fair chance to express their views, and where powers used are based on statute, doing so reasonably and without fettering discretion or delegating the decision to a person lacking the power to do so. These rules are enforceable through applications for judicial review, but such applications will only lie against bodies which are considered by the courts to be sufficiently public in nature. The majority of post-1992 universities, being statutory higher education corporations, are susceptible to judicial review. Other post-1992 universities are probably so subject. Pre-1992 universities are only subject to judicial review if created by statute. Chartered universities are generally subject to the jurisdiction of their Visitor rather than the ordinary courts, the Visitor being entrusted by the founder with the

ultimate responsibility for enforcing the local law of the institution. The Visitor, however, is susceptible to judicial review if he/she exceeds jurisdiction or breaches natural justice.

**2.5.2 the Human Rights Act 1998.** The purpose of this Act was to make the main provisions of the European Convention on Human Rights (ECHR) enforceable in the English courts, so avoiding the necessity for claimants to bring actions in the European Court of Human Rights at Strasbourg. The extent to which the 1998 Act affects the legal position of higher education institutions is a matter of some uncertainty. For present purposes the following points should be noted:

- i) It is unclear whether there is a right to higher education within the broader right to education contained in Article 2 of the First Protocol to the European Convention on Human Rights. On the one hand, there are ECHR cases suggesting that the right applies primarily to elementary education (**X v UK** Application No. 5962/72, 2 DR 50 (1975)). On the other hand, some commentators suggest that in an advanced society such as that of the UK, which aims for an inclusive higher education system available to all those who may benefit from it, potential students should not be denied the benefit of higher education unless they are incapable of meeting appropriate academic criteria (**X v UK** No. 8844/80, 23 DR 228 (1980)) or are for some other objective reason unsuitable. This view may be particularly cogent in the area of professional health education, where a finding of unsuitability may effectively prevent that person following such a career for life. In the absence of definitive case law, we would suggest that universities in general, and medical schools in particular, should proceed as if Article 2 of the First Protocol were to apply to higher education, if only because this is more consistent with universities' mission than the opposite view. This guidance should not be construed as acceptance by UUK of the principle that Article 2 of the First Protocol does in fact apply, since this is an issue which would need to be determined by the English Courts.
- ii) In any event, acceptance of a place on a course of initial health training creates a binding contract between the student and the provider and it is likely that exclusion from such a course amounts to a "determination of a civil right" which will bring Article 6 of the Convention into play. Article 6 requires that such a decision should be made, normally in public, by an impartial and independent tribunal established by law. The text of Article 6 is set out in Annex 3. The complete text of the Article is set out, including the rights relating to criminal proceedings. This is because although fitness to practise procedures may on the face of it, appear to be civil proceedings, some of the protections of Article 6 paragraph 2 may apply where the allegations are of conduct which may also constitute a crime and where expulsion is a possible penalty.

- iii) While many of the provisions of Article 6 (such as the requirement of impartiality and, to some extent, the duty to give reasons for a decision) are similar to the UK requirements of natural justice and fairness, others (such as the general requirement that the “trial” be in public) are not to be found in pre-existing UK law. In particular, the Convention requirement that the decision maker’s response should be based on a legitimate social aim and go no further than is necessary in pursuit of that aim (the requirement of “proportionality”) requires those considering Fitness to Practise issues carefully to weigh up the risk of harm to the public and the damage to the student which will result from disciplinary measures.
- iv) It is a matter of considerable uncertainty whether Article 6 needs to be complied with throughout the whole of the process of determining civil rights. It seems likely that so long as the ultimate decision is made by a body which is so compliant the decision will be valid (unless the contract with the student is clearly intended to give two Article 6 compliant procedures, i.e. initial determination and an appeal). It is also unclear how extensive an appeal or review process has to be to “cure” an earlier defect in process. We would suggest that the more streamlined and informal the earlier stages of the procedure the more steps should be taken to provide an Article 6 compliant final appeal process. Conversely, if it were desired to restrict the final appeal process to one essentially of review on limited grounds, then we would suggest that the earlier stages should comply with the main tenets of Article 6. We have taken the latter approach in drafting the specimen procedure in Annex 1.
- v) Finally, the requirement under Article 6 that the decision maker be “independent” will raise difficult issues for some universities if this is interpreted to mean that the ultimate appeal should be to a person or body independent of the providing institution. It will be necessary to check whether the constitution of the medical school, or of the university of which most medical schools are part, allows them to delegate such decisions to a person or body outside the institution. However, such problems should be resolved if and when mechanisms for the independent adjudication of complaints and appeals are made possible by changes to current governance arrangements, as proposed by Government.

**2.5.3 contract and institutional disciplinary rules.** As indicated in 2.5.2(ii) above, students (although not, currently, PRHOs, although we propose in section 2.18 that this should be changed) are in a contractual relationship with their providing institutions. The nature of the contract is often somewhat uncertain given the general lack within universities of a single document containing all the terms of the contract. Terms may be drawn from the university’s offer of a place, its prospectus, material provided at any open day or interview, and material on the institution’s web site. Students will normally be asked to confirm, in accepting the offer of a place, that they agree to be bound by the institution’s

disciplinary and other regulations. On occasions universities have not made sufficient efforts to draw such regulations to the attention of applicants. It is particularly important that those disciplinary and other regulations, which are relevant to the decision relating to Fitness to Practise, are drawn to the applicant's attention in the prospectus and the web site, i.e. before the contract is made. Further, the rules need to be both reasonable under the Unfair Contract Terms Act 1977 and fair under the Unfair Terms in Consumer Contracts Regulations 1999. The basic test of reasonableness and fairness is whether the term puts the institution at a significant advantage given the considerably stronger position of the university compared with that of the student, who is unlikely to be able to secure more favourable terms by choosing a course elsewhere. However, procedures which are designed to protect the public interest, rather than that of the institution, should not run into difficulty under the 1977 Act and the 1999 Regulations.

- 2.6 Finally, it should be emphasised that the Fitness to Practise rules and procedures must be consistent with the institution's general disciplinary and other regulations. Accordingly, the specimen Fitness to Practise procedure set out in Annex I is to be regarded as a specimen for guidance and not a model to be applied slavishly without adaptation to the institution's individual needs. In particular the question of whether the Fitness to Practise procedure should rely on the institution's general appeal procedure or contain its own appeal provisions is considered in paragraphs 3.25-3.32.
- 2.7 In practice, because the different regulations and procedures are developed at different points in time, there may be overlaps and gaps between the various regulatory regimes. For example, the Fitness to Practise rules and procedures could overlap with the institution's general regulations, disciplinary regulations, rules on equal opportunities and harassment. In relation to fitness issues arising from health problems there also need to be considered the institution's disability statement under the Disability Discrimination Act 1995 and, in due course, the procedures which will be required to ensure compliance with the Special Educational Needs and Disability Act 2001.

### **Actual and perceived fairness**

- 2.8 It is suggested that this is an additional criterion to that of the common law of natural justice and fairness, since lay perceptions of fairness may be more extensive than those required by the courts. For example, there may be an expectation that reasons should be given, even where the law would not require this (for example, on refusal to admit a student for a Fitness to Practise reason: see **R v. University College, London ex parte Idriss**, [1999] Ed. C.R.462 confirming that there was no duty to provide reasons for refusing to admit a medical student; contrast the obligation on the GMC to provide reasons in misconduct cases: **Selvanathan v GMC** The Times October 26, 2000 (Privy Council). It is suggested that the most effective way of dealing with this aspect is, first, to involve students' representatives in discussions leading to the adoption of Fitness to Practise rules and procedures (both nationally and locally with the institution's students' union) and, secondly, that the sector should not adopt a restrictive approach to the interpretation of the Human Rights Act 1998 and associated legislation (even if, for the time being at any rate, such an approach is taken by some members of the judiciary: see Lord Woolf's remarks in **Daniels v Walker** (2000) All ER D 608.)

## **Effectiveness**

- 2.9 It is important that government, health service regulators and the sector appreciate what Fitness to Practise rules and procedures can and cannot do. There is a dearth of empirical evidence as to the factors which contribute to Fitness to Practise problems within the professions generally, and not just in relation to the medical profession. For the future, it is suggested that the Council of Heads of Medical Schools (CHMS) may wish to consider working with the GMC on empirical studies which might enable warning signs to be identified within the medical student group. It is possible that the Shipman Inquiry in its final phase may wish to explore this area in considering what should be done to prevent similar cases happening in the future.
- 2.10 However, research undertaken in British Columbia on similar issues relating to lawyers points to most Fitness to Practise problems arising, not as a result of dishonesty and other character failings, but through a combination of personal circumstances (such as financial difficulty, dependency on alcohol and other drugs), and likely to show themselves only after five to ten years of post-qualification practice. There is anecdotal evidence to suggest that in some cases of doctors coming before the GMC, medical schools were aware of problems, but believed they would be resolved during the PRHO year.
- 2.11 This suggests that there may be substantial difficulties in identifying those individuals at risk at the student stage and, conversely, that where such problems arise within the student cohort, rehabilitation rather than regulatory sanctions may be more appropriate. Clearly, there will be some individual students who are found to have committed such serious acts of misconduct or are subject to such serious health problems that it would not be safe for them to be allowed to have contact with patients. For them, the effectiveness of the Fitness to Practise procedure will be measured by the extent to which such persons are removed from contact with patients. However, care should be taken before any wider aims for the Fitness to Practise system are adopted. There may be pressures on institutions to seek to reassure the public, anxious as a result of recent scandals within the medical profession, by applying the system harshly. However, the public may not appreciate the impracticability of identifying a future Harold Shipman, and that the vast majority of medical students do not need to be deterred from such criminal behaviour by the threat of expulsion from medical school.
- 2.12 To conclude this section, the Fitness to Practise system must have clear and realistic objectives, reflected in appropriate terms of reference, adequate resources and the commitment from the senior management of institutions to ensure that they are properly implemented and monitored.

## **Consistency**

- 2.13 Any Fitness to Practise procedure should be applied consistently, both as a matter of basic fairness, and also to ensure that, insofar as the system has a deterrent role, a clear message is sent to students as to what is expected of them. A failure to apply a procedure consistently may lead to an application for judicial review on the grounds of unreasonableness and unfairness. The key to ensuring consistency is comprehensive and accurate recording of decisions and reasons for them, and ensuring that those responsible for decisions are made aware of previous decisions in similar cases. Basic records of decisions and reasons for them will need to be kept indefinitely, even after

the limitation period for any challenge has expired. Consistency should also operate not only within the same institution over time, but also between institutions. For this reason, amongst others, it is suggested that there should be a sharing of information (on an anonymous basis) between institutions and with the GMC. The national review body which we propose in section 3.34 will have a key role to play here.

2.14 However, consistency should not be confused with uniformity. Fitness to Practise committees will need to apply policies rather than rigid rules. The Administrative Court will be likely to consider that a policy which is followed without exception is likely to be a rule, however it may be described within the institution, and may be prepared to grant judicial review of a decision if it feels that the facts of a particular case have not been properly taken into account. It must always be open for individual students to seek to distinguish their case from those earlier cases which the Fitness to Practise committee may be being asked to follow. Distinctions will be easier to find in the early days of Fitness to Practise committees, and become more difficult to demonstrate as a pattern of detailed decisions becomes established.

2.15 Finally, it should be noted that consistency is the harder to attain the greater the number of individuals and bodies dealing with Fitness to Practise issues. For this (and other) reasons, the possibility of Fitness to Practise decisions being taken by appropriate individuals, rather than committees, calls for consideration. For example, The Law Society in the mid-1990s moved from a committee-based system to using individual senior practitioners (where possible with judicial experience) to determine Fitness to Practise cases. An appeal to a very senior adjudicator was provided, and the most serious cases, where public confidence in the profession as a whole would be called into question (such as convictions for murder, rape and other serious assaults) were reserved for a committee of very senior Council members. The system appears to have increased the consistency of decision-making and not to have led to any general concerns with regard to fairness. On the other hand, some institutions may feel more comfortable with decisions being taken by small groups rather than by individuals, particularly in the early years of the scheme while precedents are still being set and the case load may not be prohibitively heavy.

### **Fit with wider regulatory structures**

2.16 It is vital that the system adopted by the sector fits properly with the wider structure of regulation within the Health Service, and in particular the structures adopted by the GMC in the light of the Shipman case and the procedures being put in place in relation to general practitioners under the Health and Social Care Act 2001. The procedures proposed in the Act for removal of general practitioners from health authority lists are designed to balance practitioners' rights to follow their profession with the public interest in safe and efficient medicine. They may therefore provide the practitioner with more protection than the medical student can expect.

2.17 It is also crucial that the procedures are consistent with the wider quality assurance requirement applying to universities and set out in the QAA Code of Practice. The section of the code which is most apposite relates to student placements. This stresses that, prior to a placement, the institution must ensure that students are made aware of their responsibilities towards the placement provider and its customers, clients, patients and employees, the need to ensure adequate preparation for and support in the placement, including health considerations and legal and ethical considerations,

such as confidentiality; and the need for proper monitoring of the placement. The code is, of course, primarily written from the viewpoint of ensuring a good quality learning experience for the student, rather than the protection of the public. Other sections of the code which are of some relevance are those on recruitment and admissions, complaints and appeals (particularly in relation to the former, the code being restricted to academic appeals); and disability. It should also be noted that the QAA's expectations in relation to Fitness to Practise in the medical profession have also had an effect in relation to the benchmark standards considered in section 3.3 below. However, the Chief Executive of QAA is well-known for his espousal of the view that Fitness to Practise should be a matter for the regulatory body, rather than the university, and it would seem unlikely that QAA's regulatory role will be extended in this area.

- 2.18 We have indicated in the introduction that the fitness to practise procedures we are proposing should apply equally to both students and PRHOs. A further possible complication is that once appointed to and on taking up their PRHO posts, these new doctors are no longer students or members of the university from which they graduated. We do not believe that this prevents the medical school having both the power and the duty to recommend (or not) to the GMC that they be fully registered, since this power derives from section 10 of the Medical Act 1983 and not from any contract between the medical school and the PRHO. However, there may well be educational advantages in integrating the PRHO year more closely with the undergraduate period of training. In so far as the university may wish to tie their Fitness to Practise procedures into their other regulations, which are based on contract, they will need to create such a contractual relationship with PRHOs. We therefore suggest that PRHOs be required in future to register with their medical schools as postgraduate members of the institution. The terms of this enrolment would need to be considered carefully so that it is clear precisely what obligations universities have for the placement of their graduates in (for example, in relation to selection of PRHO posts) and for their supervision in posts, and the amount of any fee which the university would wish to charge the PRHO (or employing NHS trust), in respect of services provided by the University.

## Proposals

### Substance

- 3.1 It is, perhaps, inevitable that, insofar as the sector has considered Fitness to Practise issues, more attention has been given to matters of process and less to matters of substance. This may be because of the relative simplicity of devising committee structures and procedures and the much greater difficulty in obtaining agreement as to the substantive codes of conduct, and criteria relating to health, which such structures will have to apply. Agreement in these areas is likely to be all the more difficult to secure within universities, which properly attach great importance to inclusiveness, academic freedom and diversities of view and expression, within the law. Many academics, including those within the medical profession, may feel that a greater liberality is appropriate when considering the conduct of those who have not yet professionally qualified, compared with the same conduct committed by a registered practitioner, given the more limited knowledge of the former and institutions' academic and pastoral responsibilities to them.
- 3.2 Accordingly, it is not suggested that Fitness to Practise structures should simply adopt the rules and ethical expectations applicable to registered medical practitioners. However, it is suggested that the process of professional formation within the medical (and other) professions should include a process whereby the intending medical practitioner comes to understand and accept the basic principles of medical ethics and applies those basic rules, which are vital for the protection of patients with whom they come into contact. These basic rules and principles should be made known to medical students before they come into contact with patients. Indeed, for them to be legally binding on the students as a matter of contract, they will need to be available to students at the start of their courses.
- 3.3 The means by which the rules and principles will become incorporated into the institution's contracts with students are likely to vary. The most basic principles are likely, in the future, to be incorporated into the QAA benchmarks for medicine, currently under development. Once finalised, it is likely that such benchmark standards will become implied terms within the contracts that all medical students have with their institutions. However, institutions may well wish to go into greater detail with regard to the conduct expected of medical students than can be prescribed for all medical students via the benchmark standards. In any event, rules of conduct should be established as a matter of urgency in order to ensure that institutions are in a position to make objective judgements on Fitness to Practise issues before the benchmark standards are finalised. It is suggested that CHMS should take the lead in encouraging the development of a common set of core rules of conduct for medical students, liaising as appropriate with the GMC to ensure a proper relationship between such rules and the GMC's requirements of practitioners. (The GMC's existing guidelines in relation to medical students do not address conduct issues in any detail.) Such rules will need to be kept under review, for example in the light of the development of the QAA benchmark standards. In the future, the national Fitness to Practise monitoring body we propose could take on this task.
- 3.4 The GMC's report 'New Doctors' referred to the need to ensure that programmes are co-ordinated so that the overall curriculum is adaptable to innovation and change. The standards to be expected of PRHOs will need to be made clear also. Progress on this has been made by the joint CHMS/COPMeD group on the Transition from Medical Student to Doctor. These standards should

be made known to all medical graduates before taking up PRHO posts so that they are known to be the standards appertaining to the decision to recommend full registration. If PRHOs in future are required to register with their medical schools they will also be incorporated in PRHOs' contracts with their medical schools.

- 3.5 With regard to those issues of health rather than conduct which should prevent a medical student undertaking clinical work, we consider a different approach should be taken. While patient care should be paramount, there will be a need for a non-judgmental approach which places substantial weight on the therapeutic needs of the student. The implications for the Fitness to Practise decision-making process are discussed in paragraphs 3.16-3.24. The student health committee (which is recommended there) will need to consider the medical evidence against the current guidelines on those conditions which should prevent clinical work being undertaken. For reasons of convenience and accessibility to staff and medical students, it is suggested that a specific health code for medical students should be adopted, building on the guidance already provided by the GMC. However, it is likely that the code can be essentially the same as the core principles of conduct applying to registered medical practitioners. It would be advisable to give special attention to those conditions to which students may be most at risk, such as dependency on alcohol and other drugs, sexually communicated diseases, and mental illness.
- 3.6 It will also be necessary to distinguish between temporary conditions and those which may last 12 months or more and amount to disabilities to which the Disabilities Discrimination Act 1995 applies, or at least will apply in relation to education once the Special Educational Needs and Disability Act 2001 is in force. Issues such as the duty to make reasonable adjustments to enable disabled students to study medicine should normally be addressed before the student starts a medical course, but the adequacy of the arrangements provided should be monitored and the needs of those who become disabled during the course must be properly addressed.

### **Process**

- 3.7 The stages of the decision making process will be considered in detail below. However, it is important in our view to ensure a proper separation of functions at two levels. At the horizontal level we feel that, although the issue is a finely balanced one, there are more advantages than disadvantages in having separate committees to consider allegations of ill health and allegations of misconduct. The standard of proof may be higher in conduct than in health cases; in cases solely of alleged misconduct there will be no need for medical evidence or to have a committee member able to evaluate it. There may be a stigma in appearing before a conduct committee which may not attach, at least to the same extent, to a health committee. There may also be a justification in postponing any reference to a health committee while a student with, say, an alcohol dependency problem, receives treatment, provided patient safety is not compromised. The GMC of course has followed the pattern of having two separate committees. This is an issue on which institutions may agree to differ.
- 3.8 In any event, where concerns regarding a student include both conduct and health, parallel proceedings may be needed, although each committee should be informed of the outcome reached by the other and, wherever possible, proceedings should be co-ordinated so that decisions on the two aspects are made as close together in time as possible.

- 3.9 It has been suggested to us that it would be preferable that where a case involves not only health and conduct issues but also issues of poor academic progress then one committee should be able to deal with the whole matter. Where that poor progress is manifested by, say, poor attendance, then it may comprise misconduct and be liable to be dealt with under that head. Where the student fails assessments then it is likely that the relevant Assessment Board will wish to keep responsibility for the imposition of academic sanctions, subject to receiving evidence of mitigating circumstances. It may therefore not be possible to have all aspects of the matter dealt with in one forum. However, where this is the case it is essential that the Academic Registrar or equivalent officer ensures that the case is dealt with by all the relevant bodies.
- 3.10 The other level of separation is vertical. We are aware of a number of long established institutions where those involved in the disciplinary process are involved in both investigating allegations and making decisions regarding innocence or guilt; in some cases also acting as informal mediators. We consider that such confusion of roles is likely to be in breach of the requirement, under both the rules of natural justice and Article 6 of the ECHR, not only to be unbiased but also to be seen to be so. We think it only a matter of time before students raise these issues in court proceedings and would recommend that institutions amend existing rules to ensure that those involved at one stage of the process are not involved in later stages. Given their overarching managerial responsibilities within the institution, it is particularly important that the Head of the Institution plays no part in the proceedings except, perhaps, as the final avenue of appeal, so as to be able to undertake that appellate role (if it is not possible for some other person or body to do so).

### **Investigation**

- 3.11 There should be a central point for the receipt of allegations that a medical student is suffering from a health condition, or has conducted him/herself in such a way, such that his/her Fitness to Practise is called into question. That point might be, for example, the Academic Registrar of the medical school (or an equivalent officer) and for convenience this will be assumed in the discussion that follows. The allegation should be in writing and signed by the maker. Anonymous allegations should not be considered. However, it may be possible for the maker of the allegation to request confidentiality as to his/her identity in exceptional circumstances (for example where the person concerned reasonably fears that the student will harass or bully him/her). Even in such exceptional cases it will be necessary to inform the student of the nature of the allegations and in broad terms the nature of the evidence so the student can respond to the allegations.
- 3.12 Issues relating to fitness to practise may also be identified by Examination Boards. To assist monitoring, such allegations should also be channelled via the Academic Registrar.
- 3.13 The Academic Registrar or an equivalent officer should first inform the Dean of the Medical School or other senior academic responsible for the student's programme of studies or for the PRHO's training, and inquire whether any attempt has been made to resolve the matter informally. Where it has not the Academic Registrar should allow the Dean a maximum of 5 working days in which to do so. Where informal resolution has not succeeded, the Academic Registrar will refer the matter to a senior member of staff who has had no involvement in the matter for investigation and report within the period stated in the procedure. The period (which should run from the date on which the student or PRHO is informed that the matter is to be investigated formally,) should normally be relatively

brief, with the possibility of extension by the Academic Registrar in complex or serious cases such as those where the police are conducting investigations. Those appointed to investigate such allegations should be carefully selected; in a large medical school it may be feasible to identify a small number of senior staff who may be asked to undertake this role from time to time and they can be provided with training in the institution's procedures (see below). The investigating member of staff should always interview the student concerned and the maker of the allegation, and notes of the interviews should be taken. It will be essential for the investigator to be accompanied by another member of staff when interviewing the student and this should also happen wherever the investigator has to question potential witnesses whose replies may be to their detriment. While the institution will not be able to compel the student or any other student or staff member to answer the investigator's questions, it can by appropriate wording in the student contractual documentation ensure that the investigator can access the institution's academic records on the student, and, where relevant, the institution's computer and CCTV systems.

- 3.14 Access to sensitive personal data such as records of criminal convictions, ethnic origin, and student health and counselling service records, will however, normally be barred to the investigator, both under the Data Protection Act 1998, Article 8 of the ECHR. The professional ethics of doctors is another factor. There will be exceptional circumstances where the prevention of crime or of serious harm to the student or others will allow such information to be disclosed to the investigator but the investigator seeking such access should seek the advice of the institution's lawyers before proceeding. In health cases, however, while the investigator may not be able to access the student's records it should be open to them to ask the student to undergo a medical examination for the purpose of establishing the student's fitness to continue with clinical work, and for the investigator to refer the matter to the adjudicating body (with a view to the student's clinical studies being suspended) if the student refuses to undergo such examination.
- 3.15 If the investigator concludes that there is a serious issue of Fitness to Practise to be determined then this should be reported to the Academic Registrar or equivalent officer in writing, for the matter to be determined in accordance with the next stage of the procedure. The Academic Registrar should speedily inform the student in writing of the outcome of the investigation and of the next steps in the process (where relevant). If the Academic Registrar considers that the nature of the allegations is such that the student's studies should be suspended pending the meeting of the committee Dean or other senior academic with power under the institution's regulations to suspend students.

### **Adjudication**

- 3.16 It is suggested that the body responsible for adjudicating Fitness to Practise issues should be **either** a very senior member of the medical staff of the institution – preferably with no current teaching responsibilities – **or** a small committee. It is anticipated that medical schools establishing a fitness to practise procedure will prefer the committee model to that of the individual adjudicator and accordingly the committee model will be followed. It is considered that in order to avoid the stigma of referrals to a body which deals with matters of conduct there should be two parallel committees with different names according to whether health or conduct is an issue. However, there is no reason why members of the committees should not be drawn from the same panel. Committees would comprise three people drawn from a panel of seven to eleven people being largely senior

members of staff of the institution. Ideally no members of the group should be current teachers of the student, although this may be impracticable in smaller medical schools, but in any event no member must have had any involvement or interest in the matters to be considered by the committee. At least one member should come from a different department from that of the student. It is for consideration whether the panel should provide, if the institution's constitution allows, for one member to come from outside the institution to bring experience from a fitness to practice committee in another institution, and to help ensure consistency of decision making (although this external membership might be held over to the appeal committee stage – see paragraphs 3.25-3.32) The panel will need to include at least one person with specialist expertise in matters relating to student health, who should always sit when a health issue falls to be considered.

- 3.17 It should also be considered whether there should be a student representative on the panel, perhaps a sabbatical students' union officer. Some university disciplinary committees include student members, but other institutions feel that given the importance of the issues and the short time which students could serve on the committees it is not appropriate for such committees to have student members. A possible compromise is for the committees to include, wherever possible, a relatively recently fully qualified doctor. The panel should be chaired by a senior academic from another Faculty.
- 3.18 The detailed procedures to be adopted by the health and conduct committees are set out in Annex 1. However, the main features which call for comment are set out below.
- 3.19 The committees will be served by a secretary who is not a member but will be present during the hearing. If the committee retires to consider its decision, in order to avoid any suggestion of improper influence the secretary will only attend on members of the committee during their deliberations if the student or PRHO agrees or if specifically requested by the committee in order to give advice on procedural matters.
- 3.20 Prior to the meeting of the committee the secretary will ensure that the student is provided with copies of all documents circulated to members of the committee and is aware of the procedures to be followed.
- 3.21 We have considered whether the provisions of Article 6 ECHR mean that the committees should meet in public. We consider a workable compromise between the interests of the student/PRHO, staff and patients is likely to be as follows. The committees will meet in private, unless either the student or any member of staff identified in the material to be considered by the committee requests in writing, with reasons, for the committee to meet in public. It is expected that the student will not normally wish to do so. The Chair of the committee may in any event decide that a hearing should be in private where he/she considers that the interests of the student, PRHO, or the patient require this. This is likely to be the case with health committees, as is the practice of the GMC Health Committee.
- 3.22 The Medical School's case will be presented by the Dean or a senior academic nominated by him/her. The student may be accompanied at the hearing by a friend, a relative, a student union representative or, where suspension or termination of the student's studies is being considered, by a lawyer. The name and status of the student's representative should be notified to the committee

in good time before the hearing. If the student decides to be represented by a lawyer this must be at the student's own expense, save that in wholly exceptional cases where the committee Chair believes that it is essential for the student to be represented to enable justice to be seen to be done, the medical school should retain the discretion to fund such representation. We consider that if provision is made as suggested in paragraph 5.1 for the training of student advisers who will be available to represent students it should not be necessary for students normally to be legally represented. However, we consider it would be unwise for institutions to prevent such representation, at least where suspension or exclusion is a possible outcome, and at the appeal stage. By the same token it will normally be unnecessary for any staff involved in the matters in dispute, or the committee itself, to be legally represented, but the procedure should not preclude this.

- 3.23 Each party will have the opportunity to question the other and their witnesses, if any and members of the committee will also be able to question the parties and their witnesses.
- 3.24 The committee will make a decision after retiring to deliberate if necessary. It will communicate its decision in writing to the student as soon as possible and in any event within two working days of the decision being reached. The outcome of the hearing (suspension, termination of studies etc) will be published but reasons for it will be regarded as confidential between the medical school, the student and the regulatory bodies (the GMC and the proposed Universities Clinical Education Standards Board (UCESB) see paragraph 3.34.)

## Appeals

- 3.25 While there is no general obligation, either in the domestic law of natural justice and fairness or under Article 6 of the ECHR, requiring the Medical School to provide an appeal from decisions of the student health and conduct committees, we would advise that it is desirable to provide such a right. This is simply because if there is a procedural error at an earlier stage of the process there would be no mechanism for correcting it apart from court proceedings or, if the institution has a Visitor, an application to the Visitor. Whether or not the Visitor system complies with Article 6 is a matter of considerable debate. Judicial review, where available, may not necessarily cure earlier procedural defects: contrast **Kingsley v UK**, ECHR Application No. 35605/97 where judicial review did not cure the defect with **Johns and McLellan v Bracknell Forest DC** 21 December 2000, Administrative Court where the High Court held that judicial review meant that Article 6 had been complied with. We therefore recommend that where a student's studies are suspended or terminated as the result of a decision by a student health or conduct committee there should be a right to appeal to a fitness to practise appeals committee.
- 3.26 We have considered whether the appeals committee should be the institution's existing appeals committee or should be one established specifically to deal with fitness to practise appeals. We consider that on balance despite the convenience of integrating fitness to practise issues into existing structures a bespoke committee would be preferable in order to ensure that appropriate personnel and procedures are used. The appeals committee should comprise three people who have not been in any way involved previously in the matter. They should be drawn from a panel including (in a health case) at least one person with expertise in student health matters, a senior member of academic staff from outside the medical school, where the institution's constitution

allows, a senior medical practitioner from outside the institution, and, if the institution feels it is appropriate, a medical student. The appeals committee should be chaired by a person of standing from outside the medical school, and if the institution's constitution allows, from outside the institution. It would be helpful if the UCESB, or until this is established, the Council of Heads of Medical Schools, could establish and maintain a list of senior academics and practitioners working in the medical and legal fields who would be available to serve as members and Chairs of fitness to practise committees.

- 3.27 It is suggested that if the recommendations for procedure at the initial committee stage described above are followed it will be sufficient for the grounds for an appeal to be limited to the following:
- (a) there is new evidence which could not have reasonably been brought to the attention of the health or conduct committee; and/or
  - (b) procedural irregularity; and/or
  - (c) the decision of the health or conduct committee was manifestly unreasonable.
- 3.28 The committee should not uphold an appeal on grounds (a) or (b) unless it is satisfied that the health or conduct committee might reasonably have been expected to have come to a different conclusion if it had been aware of the evidence or if there had been no such procedural irregularity. The appeals committee should, however, apply this "proviso" with great care since it is dangerous to assume that procedural failings will have no difference on the outcome of a case.
- 3.29 If the limited appeal process described above is adopted it would be appropriate for the appeal committee when allowing an appeal to remit the case back to a (differently constituted) fitness to practise committee to reconsider the case, rather than determining it itself. However, if a more informal procedure for the initial committees is adopted, then the appeal process should be by way of a complete rehearing of the case, rather than simply reviewing the reasonableness or otherwise of the view formed by the health and conduct or conduct committee. The appeals committee should then have all the powers of the health and conduct committees and should not normally send the case back to the health or conduct committee for reconsideration.
- 3.30 Where the student wishes to put forward new evidence and this wish is granted by the appeal committee the procedure to be followed in the appeal will be essentially as for that followed by the health and conduct committees. Where no new evidence is to be given the procedure will be limited to the parties making statements of their cases and responding to questions from the other party and the committee.
- 3.31 It is likely that in practice this appeal provision will be as far as the medical school will be able to go in the direction of an independent appeal mechanism as stipulated by Article 6 of the ECHR. Medical schools of chartered universities could indeed delegate the holding of an appeal to an external body. However, in relation to medical students (though not PRHOs who are not formally at present members of the university) such an external body's findings would still be subject to the jurisdiction of their university's Visitor. Those institutions lacking a Visitor will be susceptible to actions for judicial review or breach of contract. It would be possible for medical schools to establish a system of informal review of appeals committee decisions, The reviewer might, for example, be a

recently retired senior medical academic from a different medical school. Indeed a number of medical schools could appoint a small number of such persons to consider such applications for review, on a regional basis. The outcome of such review could at present only be a recommendation that the health or conduct committee look again at a particular case and this recommendation could not be binding on the medical school concerned.

- 3.32 Medical schools which commented on this report in draft felt such non-binding review would only add a further layer of complexity and that it was better to involve external members in the original decision where possible. However, if the Government brings forward legislation to enable universities to establish a final mechanism for dealing with complaints and appeals which is truly independent of the university, then students (and PRHOs if steps are taken to register them as members of the university) will be able to access that procedure. The Government's intentions are at the time of writing unclear. UUK has recently published a consultation paper seeking views on a system of review which would (assuming the Visitors' jurisdiction was not abolished) be similar to that outlined above, except that institutions might agree that they would accept the Independent Reviewer's advice save in the most exceptional circumstances. As the consultation period will not expire until mid-October 2001 it is impossible at the time of writing to speculate on the outcome of the consultation.

### **Monitoring/Review**

- 3.33 The possibility of further review at the level of the individual case has been considered above. Further monitoring and review at a systemic level should in our view take place for two reasons. First, it is a requirement of the QAA Code of Practice that systems for handling complaints and academic appeals should be subject to regular review as part of the institution's quality assurance process. We are sure that medical schools will in any event wish to note trends in the number and types of fitness to practise issues which are emerging and the way in which they are dealt with by the health, conduct and appeals committees. Such review should be undertaken by the head of the medical school or other senior medical academic entrusted with quality assurance matters.
- 3.34 In addition, we consider that it is vital that the general lessons learned from the operation of the Fitness to Practise system should be disseminated in order that similar issues are addressed in a similar way at different medical schools. We propose that to achieve this there should be established an overarching monitoring body, the Universities Clinical Standards Review Board (UCESB), comparable to that being developed for the accountancy profession by the Accountancy Foundation, as part of the new system of non-statutory, independent regulation of the accountancy profession now being implemented. The Accountancy Review Board is comprised entirely of persons not involved in any other part of the system of regulation of the accountancy profession. Its role is to oversee the development of standards of ethics, auditing practices and the handling of investigation and discipline in individual cases. It is intended to be a major driver of change in the improvement and development of the framework of regulation of the accountancy profession. We see the UCESB as having a similar role in relation to Fitness to Practise issues arising within medical education. However, we do not envisage that such a board would have a role to play in reconsidering individual cases. The board should (subject to the comments below regarding data sharing) receive information on individual cases only for the purposes of ensuring that (i) individuals who have had their medical studies terminated by one institution are not able to circumvent the

system by obtaining a place at another medical school and (ii) a consistent approach is taken by different medical schools to similar issues.

- 3.35 We believe that such a board could be established fairly quickly using the good offices of CHMS and GMC. It would be necessary to identify persons with experience of professional education (largely of professional education outside medicine, although persons with previous experience of medical education not currently involved in it should be involved, as a minority of members.) Other board members should have experience of complaints handling, human resources and representation of patients and consumer interests generally.
- 3.36 The board should publish a report annually confirming the numbers of Fitness to Practise cases reported to it by medical schools and trends in the nature of the issues dealt with and medical schools' responses to such issues. In addition the board may wish to undertake further investigation and report on matters of topical concern. These reports should feed through into the updating and development of guidelines on medical student health and conduct and on the development of QAA benchmarks.

### **Alternative Forms of Dispute Resolution**

- 3.37 Following the changes to the Civil Procedure Rules in relation to the civil courts it is now common for dispute procedures to contain arrangements for informal methods of dispute resolution in the hope that disputes can be settled quickly and cheaply by informal means. Fitness to practise issues are of course not conventional disputes and it may be argued that where investigation shows that there is at least a prima facie case for the student to answer then the formal procedure outlined above should be followed. There are certainly dangers of unfairness occurring where a decision-maker, with the best interests of the student at heart, seeks to move out of the adjudicative role by conducting informal discussions with the student. However, there may be occasions where such discussions could uncover the underlying problem which might otherwise remain hidden for much or perhaps all of the formal proceedings. There may also be situations where the student's alleged behaviour is only part of a wider problem, which may include deficiencies in teaching or inappropriate behaviour by other students or staff.
- 3.38 It is most likely that any such informal resolution will be achieved at the outset before any reference to the fitness to practise committees. However, we feel there may be cases where later in the procedure it appears to the Chair of the committee or to the Academic Registrar or equivalent officer that informal resolution might be more appropriate. We have therefore provided for such a further attempt at informal resolution in the specimen procedure in Annex 1.
- 3.39 Where the matter is resolved informally the health and conduct committees will not need to consider it further, but otherwise the ordinary fitness to practise procedure will continue; the deliberations of the informal procedure will not be disclosed to the committees or the Academic Registrar except in those wholly exceptional circumstances where disclosure by a counsellor would be appropriate.

## Implementation Timetable

- 4.1 It is proposed that the fitness to practise procedures which we have suggested should be put in place for the academic year 2002/3. This is to ensure that applicants for courses in medicine can be made aware of medical schools' expectations in relation to student health and conduct, through prospectuses and course guides; to give medical schools time to adjust the principles of what we propose to the specific requirements of their institutions; to secure the passage of the necessary changes to university statutes and (where needed) Privy Council approval (see below); and to ensure that appropriate training and support arrangements are in place (see below). To achieve this end point we envisage the following milestones will need to be passed:-
- (a) UUK receives this report and discusses it with GMC (September/October 2001)
  - (b) Discussion with the Privy Council Office on the principles of the proposals (November/December 2001)
  - (c) Guidance on the procedures to be made available for the information of those intending to apply for places on medical courses starting in October 2002 (February 2002)
  - (d) Institutions agree proposals to amend their statutes (March/April 2002)
  - (e) Institutions amend their statutes (timing dependent upon procedures in university statutes, ideally by July 2002).
- 4.2 It will be noted that this timetable is very tight and any significant slippage would result in implementation being delayed until the 2003/04 academic year. We consider that this would be against the public interest and would be likely to subject medical schools to public criticism. While medical schools may well have their prospectuses printed before details of the fitness to practise arrangements are finalised there should be no difficulty in bringing the main features of the Scheme and the expectations to be made of students to the attention of applicants, through careers services, UCAS and medical school's web sites.

### Mechanisms

- 4.3 We believe that it is very much in the interest of medical schools for these matters to be dealt with through institutions' existing legislative arrangements, rather than being imposed by government through primary legislation. The only respect in which institutions will need wider legislative changes is with regard to independent external review of complaints and appeals, as discussed in section 3.25-3.32. The Government has promised to make the necessary legislative provision to allow for introduction of such independent review, although this may be through the creation of a student Ombudsman and the demise of the Visitor. The timetable for the introduction of such public legislation is not yet known and the proposals in this report therefore do not depend on such legislation.

## **Is Privy Council approval needed?**

- 4.4 Under some university statutes amendments to disciplinary procedures will require approval by the Privy Council. As a number of institutions will require to amend their statutes it is important that preliminary discussions with the Privy Council Office on the nature of the changes that will be required should take place as soon as these principles have been agreed between CHMS, UUK and GMC.

## **Student Contracts**

- 4.5 Under basic contract law principles the disciplinary procedures and other regulations affecting students incorporated in institutions' agreements with them when they accepted places on their courses will be those applicable to them throughout their studies. It is the case that some educational institutions seek to incorporate in their contracts with students a provision whereby students are subject to the institutions' regulations, as amended from time to time. However, any such clause must be read subject to the provisions of the Unfair Contract Terms Act 1977 and Unfair Terms in Consumer Contracts Regulations 1999. A court is likely to hold that any alteration to the institutions' regulations which are adverse to the interests of the student so as to be unfair or unreasonable are in breach of the Act and all the regulations.
- 4.6 Whilst in procedural terms the proposals contained in this report are likely to be in a student's best interest, it is possible that the production or revision of codes of conduct and guidelines on student health may result in a stricter regime being applied to students on medical courses than has been the case in the past, at least in some institutions. It is therefore considered that the codes of conduct, health guidelines and procedural arrangements proposed in this report should not be applied retrospectively but only with regard to those students joining medical courses from the 2002/2003 academic year, provided that the timetable referred to above is complied with. Institutions which already have codes of conduct and procedures in place but which wish to revise them to bring them into line with those suggested in this report may feel able to bring the changes into force sooner, provided the changes are and are seen to be in the interests of students, for example by increasing the transparency of the arrangements. It will be important that prospectuses, offer letters and other documentation setting out the institutions contractual arrangements with the student make appropriate reference to the universities' regulations, policies and procedures, including the fitness to practise procedures. Otherwise a student will be able to claim that the arrangements are not properly incorporated into the contract and are not binding on them.

## **Data Protection Issues**

- 4.7 Information relating to alleged misconduct or health problems relating to medical students will be likely to be sensitive personal data under the Data Protection Act 1998. Accordingly, explicit consent of the student is required for the institution to hold or otherwise process such data. In addition to use by the institution within the fitness to practise process consideration also needs to be given to (a) retention of information after the fitness to practise procedures are completed and (b) transfer of all or part of such data, once the processes are complete, to outside bodies.
- 4.8 In relation to (a) the Data Protection Act requires that institutions should only hold such data as long as is necessary. Where a decision under the fitness to practise procedure has been taken leading

to the student's suspension or exclusion from a course it is proposed that the data generated under the procedure should be retained by the school for a period of at least six years, this being the applicable period of limitation in contract or tort. There is a case for the information being held for a longer period, but from the point of view of patient protection it will probably be sufficient if at least the basic findings of fact and the penalty imposed are held on the database which we propose should be maintained by the UCESB.

- 4.9 Conversely, where under the fitness to practise procedure a student is allowed to continue his or her studies we propose that a Health and Conduct Committee should normally direct that the data should be destroyed, either immediately or after a stipulated period of time which should be as short as is necessary to ensure that any residual concerns which the Committee may have are addressed. Medical schools should be, in any event, reviewing their policies for the holding of personal data in the light of forthcoming extension of the Data Protection Act to personal data held in non-structured record systems, when the Freedom of Information Act 2000 comes into effect.
- 4.10 In relation to (b) it will be vital to ensure that where information is retained within the medical school and, even more importantly, when it is transferred to the UCESB, access to such data is tightly restricted and controlled. Furthermore, while there will be exceptional situations where a transfer of such data will be permitted under the Data Protection Act in order to protect students and/or patients, explicit consent to the holding and processing of such data should be obtained from students, at the point when they accept offers of places on courses. Indeed, applicants should be asked to declare when applying for a medical school any matters relevant to their fitness to practice and appreciate that they are under a continuing responsibility throughout their studies to draw such matters to the school's attention.

## **Support and Training**

### **Students**

- 5.1 It is suggested that fitness to practise criteria and procedures should not be seen narrowly in a penal or disciplinary light but as an important part of the arrangements for ensuring the well being of all members of the school and its patients. It is considered that this change of culture and the acceptability of the new arrangements will be greatly increased if representatives of the medical student body are involved in the discussions leading to the acceptance of the arrangements, both nationally and within institutions. The purpose of the arrangements should be made clear to students as part of their induction into their courses; and ideally students should have some role within the procedures, for example, as Committee or Appeal Committee members. It will also be important to ensure the effectiveness of this educational process that those who represent and support students on a sabbatical or permanent professional basis receive suitable training on the operation of the fitness to practise procedures.

### **Committee Members**

- 5.2 It is vital that those who will be responsible for administering the procedures, including the Academic Registrar or equivalent, Committee members and those providing support services to them, are all made familiar with the aims and operational methods of the different parts of the processes. Such training will need to be provided before the procedures become operational. It is likely that such training will need to be more extensive where there has been no fitness to practise procedure within the medical school; in those schools where a procedure has already been operating the training can concentrate on the changes necessary to bring the procedure into line with the principles set out in this report. It is also important that Committee members receive appropriate recognition of the importance and difficulty of their task from the medical school and information (we suggest provided by the UCESB) on the way in which similar procedures are being operated in other medical schools. In the early years of operation of the Scheme it might be helpful if the UCESB were to hold annual or biennial conferences for fitness to practise Committee members where current issues and trends could be discussed.

## **Conclusions**

- 6.1 The proposals in this report are not put forward as the only possible model, rather they aim to encapsulate a set of principles which meet the criteria set out in section 2 and which must be met if public confidence in this aspect of medical education is to be maintained. It will be important for universities to reach a consensus on the acceptability of these principles and agree to commit themselves to the urgent task of implementing these principles within their own institutional structures. We believe that there is sufficient time, provided the necessary debate is not protracted, for all medical schools to have appropriate procedures in place for those students starting their courses in autumn 2002. We recommend that all medical schools should do so, using the offices of CHMS and UUK to liaise with the parallel work being undertaken by GMC in relation to registered practitioners.
  
- 6.2 Finally, we believe that, if these principles are properly explained, they will be seen by students and their representatives to be in their best interests as well as in the interest of patients. The procedures should therefore be a valuable contribution to the process of professional formation within the medical profession, balancing the diversity so rightly valued by universities with proper concern for patient care.

# **Annex 1**

## **Specimen Fitness to Practise Procedures**

### **Introduction**

The attached procedures are based on procedures put into effect at the Universities of Nottingham and Manchester. The agreement of these universities to their use in this way is gratefully acknowledged.

### **Committee Structure and Terms of Reference**

The procedures relate to students on any course leading to a professional medical qualification and also to Pre-registration House Officers (PRHOs);

There is a Fitness to Practise Panel supported by a Secretary. It consists of 5 to 11 persons consisting of a majority of senior members of staff of the Institution but with the addition of a person from outside the institution where the institution's rules allow and, if thought appropriate, a student representative. In each instance of referral the Secretary convenes a Committee of three members. If possible, *no* members of the Committee should be current teachers of the student in question. The Committee will be known as the Health Committee or the Conduct Committee, depending on the cause of the alleged unfitness to practise. Its composition will also be affected by this since a Health Committee shall include a person with experience of dealing with student health issues. It will be chaired by a Dean of a Faculty other than that of the student or PRHO appointed by the University.

Students may be referred to either Committee by the Academic Registrar who will act on concerns expressed to him/her in writing that for reasons of misconduct and/or ill health the medical student or PRHO is or maybe unfit to practise medicine under appropriate supervision;

Where the decision of the Committee requires the suspension or cessation of the student's studies, the extension of or refusal of certification of the PRHO's pre-registration year, it may be the subject of an appeal. Appeals are heard by the Fitness to Practise Appeals Committee. (This may be the institution's existing student appeals committee where suitable membership can be achieved, otherwise a dedicated committee for hearing fitness to practise medicine cases will need to be established.) The Fitness to Practise Appeals Committee comprises three people not in any way previously involved in the matter, drawn from a panel including at least one person with expertise in student health matters, a senior academic from outside the medical school, (where the institution's constitution allows) a senior academic or medical practitioner from outside the institution and (where the institution considers it appropriate) a student representative.

## **Fitness to Practise Procedural Rules**

### **1. Initiation of the Procedure**

1.1 Any concerns that a student enrolled on a course leading directly to a professional qualification which gives the right to practise medicine or a Pre-Registration House Officer (PRHO) may have acted in such a way or may suffer from a health problem which may render that student or PRHO a person not fit to be admitted to and practise medicine should be disclosed to the Academic Registrar in writing. The person making such disclosure must identify themselves to the Academic Registrar. The Academic Registrar will not consider any disclosures which are raised anonymously. In exceptional circumstances the Registrar may permit the discloser's identity to remain confidential provided that this is consistent with the rules of natural justice.

1.2 In this procedure the term "student" includes both medical students and Pre-Registration House Officers unless there is specific indication to the contrary.

### **2. Investigations**

2.1 On receipt of a written disclosure as set out at paragraph 1 above, the Academic Registrar shall promptly, and in any event within 5 working days, ascertain from the Dean of the student's faculty or from the senior member of staff responsible for the training of the PRHO whether an attempt has been made to resolve the matter informally, and if it has not the Academic Registrar will ask the Dean to seek to do so and inform him/her of the outcome within 5 working days.

2.2 Having ascertained that the matter cannot be resolved informally, the Academic Registrar shall promptly, and in any event within 5 working days refer the matter to another member of staff for investigation and shall notify the student/PRHO of

- a. the details of the allegations against him/her; and
- b. the identity of the investigating officer; and
- c. of any suspension from his/her clinical course or limitations or conditions placed upon the continuance of his/her studies or supervised practice during the period of the investigation.

2.3 The investigating officer may request the Head of School and/or members of staff connected with the case to provide written comments on the student's conduct and/or health, explaining why there is concern as to the student's fitness to practise. Factual information about the student's professional progress on the course and any other relevant documentation should also be provided.

2.4 The investigating officer shall interview relevant individuals including the student himself/herself. At such interviews the investigating officer shall be accompanied by an assistant who shall prepare a written note of the interview.

2.5 The student may be required to attend the University's Occupational Health Service in order that a report can be made on his or her fitness to practise on medical grounds.

2.6 Save in exceptional circumstances, the investigating officer shall, no later than 15 working days after the referral by the Academic Registrar in accordance with 2.1 above, make a written report of the results of the investigation to the Academic Registrar detailing all evidence obtained during its course of the Committee.

### **3. Referral to Health/Conduct Committee**

3.1 Promptly on receipt of the report from the investigating officer, and in any event within 5 working days, the Academic Registrar shall notify:

a) the student in writing of:

- (i) the outcome of the investigation;
- (ii) whether the matter is to be referred to the [Health/Conduct] Committee together with full details of the procedures to be adopted; and
- (iii) the imposition cessation continuance or alteration (as the case may be) of any suspension or conditions/limitations placed on the student's studies.

b) the Secretary to the Fitness to Practise Panel (subject to 3.2) of the need to convene a [Health/Conduct] Committee and will send him/her a copy of the investigating officer's report.

3.2 If the student consents to the matter being referred to mediation, the Registrar shall make the appropriate referral within 5 working days of receipt of the student's consent. If no response has been received from the student within 10 working days of the date of postage of the notification to the student referral to in paragraph 3.1a) above the Registrar shall be entitled to request the convening of the [Health/Conduct Committee] as set out in 3.1.b) above.

3.3 In the event that the Secretary to the Fitness to Practise Panel is notified that a [Health/Conduct] Committee should be convened, the Secretary will notify the student of the identity of the Committee members and the date of the proposed meeting of the Committee and make available to him/her, all of the evidence detailed in the investigating officer's report.

3.4 The student shall be allowed at least 15 working days in which to prepare his/her case. All information on which the student intends to rely must be made available to the members of the [Health/Conduct] Committee at least 5 working days before the date set for the meeting of the Committee.

#### **4. Attendance at the Meeting**

4.1 The student will be required to attend the meeting of the Committee in person. If the student fails to attend without reasonable explanation, the Committee will consider the case in the student's absence. The Chair will have discretion as to what constitutes a 'reasonable explanation'.

4.2 Members of the University who may have information relevant to the case may be required by the Chair to attend the meeting to give evidence.

4.3 At the discretion of the Chair, the Committee may also call upon other persons (whether or not a current member of the University) to provide advice on specific aspects of the case in writing or in person.

4.4 The University's case will be presented by the Head of School or his or her nominee.

4.5 The student may choose to be accompanied by a friend, relative, student union representative or, where suspension or termination of the student's studies is being considered, by a lawyer (collectively referred to in these Rules as 'the friend').

4.6 The meeting will be held in public unless the student wishes it to be held in private or the Chair considers that this is in the best interests of the student or a patient.

#### **5. Procedure for the conduct of the Meeting**

This section is a guide to the conduct of the meeting itself. The Chair has discretion to vary these arrangements as she/he thinks fit. In particular the Chair may at any stage of the meeting seek the consent of the student to the matter being referred to a person appointed by the Academic Registrar if she/he considers that the matter may most effectively be resolved informally.

5.1 Prior to the meeting the Secretary to the Committee will ensure the student has copies of all documents circulated to members of the Committee and is aware of the proceedings to be followed.

5.2 The student, the friend (if attending) and members of staff required to attend under section 4.2 will then join the meeting.

5.3 The Chair will introduce by name and explain the functions of the members of the Committee, the staff, and any others present.

5.4 The Chair will explain the powers of the Committee.

5.5 The Chair will invite the Head of School (or nominee) to make an opening statement and then invite the Committee to ask questions. Other staff attending will be offered the same opportunity to make a statement and may be asked questions.

5.6 The Chair will invite the student or the friend to make a statement. The Chair will explain that the Committee will wish to hear directly from the student in his/her own words.

5.7 Members of the Committee will be invited to question the student.

5.8 The Chair will invite any other person(s) called upon by the Chair to attend the meeting (as referred to in Section 4.3), to make a brief statement, and will then invite the Committee to ask questions.

5.9 At each stage the Chair has discretion to allow reciprocal questioning by the various parties.

5.10 Once the Chair is satisfied that the Committee has completed their questioning and the student and staff have had a full opportunity to convey information to the Committee, both the students and members of staff will withdraw.

5.11 The Committee will then discuss the case.

5.12 If for any reason the Committee requires further clarification of any aspect of the case from either student or staff members they must be all invited back into the meeting while the questioning takes place. When the Chair so determines, they will then leave the meeting again.

5.13 The Committee will make its decision.

5.14 The decision, and any findings of fact, will be communicated to the student and the other parties as soon as possible, and will in any event be communicated to the student in writing by recorded delivery, within two working days of the decision being reached.

## **6. Powers of the Fitness to Practise Committee**

6.1 The Committee may, following consideration of the case:

in the case of an undergraduate student:

- permit the student to continue with the course;
- permit the student to continue with the course under close supervision;
- suspend the studies of the student for a specified time;
- require the student to re-sit a specified part or parts of the course;
- require any other action considered appropriate by the Committee to enable the student's successful completion of the remainder of the course;
- recommend that the student's studies on a course leading to a professional qualification be terminated but permit registration for an alternative academic qualification;
- recommend that the student's course be terminated and that the student be required to withdraw from the University.

In the case of a Pre-registration House Officer:

- confirm the recommendation that the pre-registration period be extended or certification be refused;
- refer the case back to the Faculty Pre-Registration Committee and require that the case be reconsidered in the light of its findings.

6.2 Where it proves impossible to continue to offer the course because the student is deemed incapable on non-academic grounds (such as health) of completing it and will not therefore be fit for practice, the student's registration will be suspended and every reasonable effort will be made to offer an appropriate alternative course of study.

6.3 Where a student is allowed to continue with the course, or when the studies have been temporarily suspended, he or she may be required to meet with the Committee on further occasions in order that progress can be monitored.

## **7. Appeals**

7.1 In the event that the [Health/Conduct] Committee has decided that the student should be suspended or expelled from his/her course, the student may appeal to the Fitness to Practise Appeals Committee if any of the following grounds apply:

7.1.1 there is new evidence available which could not reasonably have been brought to the attention of the [Health/Conduct] Committee; or

7.1.2 there has been a procedural irregularity; or

7.1.3 the decision of the [Health/Conduct] Committee was manifestly unreasonable.

7.2 The procedure adopted by the [Fitness to Practise Appeals Committee] shall be either in accordance with the University's existing student appeal procedures set out in [cross refer to University Calendar/Handbook] or shall follow the procedure set out in section 5 save that after the Chair has explained the powers of the Appeal Committee the Chair will ask the student whether he/she wishes to put forward new evidence not available to the original committee, and if so, the reasons why such evidence was not provided to the [Health/Conduct] Committee. If the student wishes to do so the procedure will continue as set out in section 5. If the student wishes to rely only on the grounds set out in sections 7.1.1. or 7.1.2 the Chair will invite the student to make an opening statement in accordance with section 5.6 before inviting the Head of School to make an opening statement in accordance with section 5.5. The procedure will then continue as set out in section 5.

7.3 If the Student Courses Appeals Committee allows the appeal it will:

7.3.1 remit the case to a differently constituted Health/Conduct Committee for reconsideration;

7.3.2 consider whether the student's studies should be suspended pending the reconsideration by the Health/Conduct Committee.

## **Annex 2**

### **Sources**

#### **Legislation**

Data Protection Act 1998

Disability Discrimination Act 1995

General Teaching Council for England (Disciplinary Functions) Regulations SI 2001/1268 and Disciplinary Rules of Procedure made thereunder

Health and Social Care Bill 2001

Medical Act 1983

Medical Act 1983 (Amendment) Order 2000 SI 2000/1803

Special Educational Needs and Disability Act 2001

#### **Reports**

Accountancy Foundation, Independent Regulation of the Accountancy Profession, A Brief Outline of the New System, December 2000

Tomorrow's Doctors: recommendations on undergraduate medical education, GMC, December 1983

Student Health and Conduct, a report and advice, GMC, 1995

The New Doctor: recommendations on general clinical training, GMC, 1997

Association of Heads of University Administration, response to UUK consultation on the Pre-Registration House Officer Year, December 2000

CVCP Medical Committee and GMC Education Committee, Student Health and Conduct: Final Report, April 1998

Council of Heads of Medical Schools/Conference of Postgraduate Medical Deans of the UK: The Transition from Medical Student to Doctor, March 2000

CHMS Working Group on Fitness to Practise, Graduation and Registration: Background Paper and meeting notes, January 2001

General Medical Council: Tomorrow's Doctors: Recommendations on Undergraduate Medical Education, December 1993

GMC Revalidation of Doctors in Training Group, notes of meeting on PRHOs, fitness to practise and registration, January 2000

Tomorrow's Doctors: recommendations on undergraduate medical education, December 1993

Universities UK, Consultation Paper on Independent Review of Student Complaints, July 2001

### **Books**

Harris, D.J., Boyle, M.O., Warbrick, C., Law of the European Convention on Human Rights, Butterworths, 1995

Mason, J.A., McCall Smith, R.A., Law and Medical Ethics, 3<sup>rd</sup> edition, Butterworths, 1991

Powers, M., Harris, N., Clinical Negligence, 3<sup>rd</sup> edition, Butterworths, 2000

### **Articles**

Baty, Phil, Visitors survive disputes reform, Times Higher Education Supplement 6 July 2001, p.8

GTC Focus, Times Education Supplement 15 December 2000

Pittilo, Mike: Trust me, I'm a physician's asst, Times Higher Education Supplement, 2 March 2001, p.18

Glasgow Herald, Matron in Rights Test on Discipline, Herald 20 December 2000, p.10

Sanders, Claire, Moves to get the NHS fighting fit, Times Higher Education Supplement, 8 June 2001, pp.6-7; New arm for surgery training, Times Higher Education Supplement 6 July 2001, p.17; Carry on training, doctor, Times Higher Education Supplement 6 July 2001, p.26

Utley, Alison, Dismissed medical student demands damages, Times Higher Education Supplement 29 June 2001, p.9

Various authors, The Bristol Heart Inquiry, The Independent 19 July 2001. pp3-4

### **Existing Medical School procedures**

University of Bristol, 2001 (draft)

University of Dundee: Fitness to Practise Issues and the Requirement for a Fitness to Practise Medicine Committee, December 1999

University of Manchester, Faculty of Medicine, Dentistry and Nursing, Procedure for a Committee on Fitness to Practise, undated

University of Nottingham, Faculty of Medicine and Health Sciences, Fitness for Practice Procedures, 1999

Oxford University, Medical Sciences Board: Procedures for dealing with questions of Fitness to Practise amongst Medical Students, undated

Oxford University, Medical Sciences Board, Code of Conduct for Medical Students, undated

Royal Free and University College Medical School, Procedure for the Assessment of the Fitness to Practise Medicine, undated

### **Comments on draft report**

Prof. S. Bailey, Department of Law, University of Nottingham

Council of CHMS

Prof. Peter Hill, University of Newcastle Medical School

Prof. R. Stout, Queen's University, Belfast

Working Party on regulations, St George's Hospital Medical School

Universities UK Health Committee

### **Personal communications**

Personal communications with Sue Eccleston, Post Admission Training Manager, The Law Society, Anna Preston, General Teaching Council for England, Nigel Woodian, Teacher Training Agency, Andrew Skidmore, CCETSW, Prof. Neil Gold, University of Windsor Ontario School of Law

### **Web Sites**

Department of Health

General Medical Council

General Teaching Council for England

## **Annex 3**

### **European Convention on Human Rights**

#### **Article 6**

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and impartial public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgment shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interest of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3. Everyone charged with a criminal offence has the following minimum rights:

(a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;

(b) to have adequate time and facilities for the preparation of his defence;

(c) to defend himself in person or through legal assistance of his own choosing, or if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

(d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

to have the free assistance of an interpreter if he cannot understand or speak the language used in court.