1. Do you agree with the government’s proposal that the mandatory reporting duty of FGM should apply to cases of ‘known’ abuse?

We are clear in our guidance Protecting children and young people: the responsibilities of all doctors* that FGM is a safeguarding issue, and that doctors must report concerns to an appropriate agency unless there are exceptional reasons for believing it would not be in the best interests of the child or young person to do so. But we sound caution about reports to the police being mandatory in all cases. The proposed duty leaves no scope for considering the best interests of the child or young person.

We strongly agree that the proposed duty should not apply to ‘suspected’ or ‘at risk’ cases of FGM. There is no clear evidence that mandatory reporting of ‘suspected’ or ‘at risk’ cases protects women and girls, and substantial evidence that such models can undermine effective safeguarding. We also have concerns that a mandatory duty to report all ‘suspected’ or ‘at risk’ cases of FGM would distort professional judgement. In addition we would highlight the potential for damage in trust in doctors. The obvious risk of a mandatory duty to report ‘suspected’ or ‘at risk’ cases of FGM is that vulnerable women and children will be discouraged from engaging with healthcare services.

We are also not aware of any evidence to suggest that the introduction of a mandatory duty to report ‘known’ FGM would be the right tool to resolve a highly complex issue. From our own evidence we know that doctors do not always know how to approach FGM, and that anxieties and uncertainties exist about how to broach the issue, what risk factors to look for (beyond nationality), where to go for advice, and what the care pathways are. We therefore welcome the launch of the FGM prevention programme and consider that education of professionals, public education, awareness raising and prevention activities should be the first priority. This programme of activities should be implemented and evaluated before there is any consideration of mandatory reporting.

* The guidance is on our website here: [http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp](http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp)
2. Do you agree with the government's definition of ‘known' abuse, as something which is visually confirmed and/ or disclosed by the victim?

As the consultation paper recognises, there are some forms of FGM that are very difficult for even expert clinicians to confirm following a physical examination. A study by Deborah Hodes et al (2014) found that of 15 girls examined with FGM, 10 girls were found to have a normal or near normal examination, highlighting that the physical signs of FGM may be subtle and difficult to detect without disclosure.* There is also significant variation in the knowledge and skills to identify FGM among the healthcare professionals to whom the proposed duty will apply. A disclosure by the victim may also be ambiguous, for example because the girl is embarrassed or using terminology that is unfamiliar to the doctor. We therefore think that further consideration needs to be given to what it means to “know” that FGM has taken place.

We would also not wish to see any duty framed in terms that required repeated intimate examinations of children or young women which serve no clinical purpose, and which may be harmful to the child or young person. In our child protection guidance we emphasise the importance of obtaining consent or other legal authorisation when carrying out examinations. We advise doctors that if a child or young person who is able to make the decision refuses consent to a child protection examination, they must respect this decision, even if it affects the quality of forensic evidence available.

We strongly welcome the reassurance in the consultation document that the introduction of any duty to report should not be interpreted as the creation of express or implied duties to examine girls or young women except where that is part of the delivery of healthcare. It would also be important that no express or implied expectation is created that patients will be examined without appropriate consent or another legal basis.

3. Do you agree with the government's proposal that the duty be limited to FGM in under 18s?

We strongly agree that the proposed duty should not apply to individuals over the age of 18.

Our guidance recognises the rights of individuals who have capacity to make decisions in their own interests (including decisions about when their confidential information is disclosed), unless there is a public interest in overriding the person's wishes, or the disclosure is required by law. As a general principle, if no one else is at risk of harm, our view is that decisions about how best to proceed when a woman is found to have been subject to FGM should be taken in partnership with the woman (Confidentiality†, para 51).

* D Hodes, A Armitage, A Dykes, ‘Female genital mutilation in London and the UNICEF report; a local perspective on worldwide statistics', Archives of Disease in Childhood 2014; 99. Available at: http://adc.bmj.com/content/99/Suppl_1/A73.1

† This guidance is on our website here: http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp
It may of course be proportionate and legitimate to disclose information about an individual without consent – either because it is likely to assist in the investigation or prosecution of a serious crime (Confidentiality, para 53), or because steps need to be taken to protect others (Confidentiality, para 55). But that decision should take into account the purpose of every disclosure, what it seeks to achieve, and the potential consequences for the woman. We do not consider it to be proportionate to routinely override a woman’s right to privacy and self-determination and consider that such an approach would damage the trust between clinicians and patients. It would also open questions about a whole range of criminal offences – for example serious sexual offences – where there is at present no mandatory requirement for clinicians to disclose confidential information to the police.

It is important to remember, however, that children and young people also have confidentiality rights. Without the trust that confidentiality brings, children and young people might not seek medical care and advice, or they might not tell clinicians all the facts needed to provide good care. There is no clear bright line between childhood and adulthood. While under-18s do have a different status to adults in law, at 16 it is legally presumed that young people have the ability to make decisions about their own care. Discussions about the treatment and care of a 17 year old may be indistinguishable from those relating to an adult.

To give a more concrete example, if an adult woman discloses to a health professional that she has been raped, there is no automatic referral to the police or any other agency. Our advice to doctors in such situations is that all decisions should be taken in partnership with the woman, and should focus on supporting and empowering the patient to make decisions about disclosure of information about her. In the case of a 17 year old woman disclosing the same crime, there may be strong grounds for sharing that information with an appropriate agency (see our guidance 0-18 years: guidance for all doctors, paragraph 49), but it is not automatic. The views of the young person are relevant to that consideration of the benefits and harms that might arise from the disclosure. There may be circumstances in which the potential harm to the child or young person of reporting FGM could outweigh the public interest in reporting the crime. Potential harmful consequences for the child or young person should not be ignored.

We therefore consider that there should be some discretion over the timing of any disclosure, to allow time for any negative impacts for the child or young person to be mitigated. It is difficult to place a time limit on this, as it will be case specific. For example, in the case of a pregnant young woman a clinician may consider the risk of her opting out of care to be significant for the whole of her pregnancy, and not just for the first month.

We also consider that there should be scope for clinicians to decide not to report FGM if they believe that to do so would cause serious harm to the mental or physical health of the child or young person. This would not be a decision that we would expect doctors to take in isolation. We would expect the doctor to take appropriate advice (for example from a named or designated professional) and to make a record of the reasons for the decision, and any advice taken.

Such a ‘reasonable excuse’ should be allowed for on the face of the legislation, rather than considered as a mitigating factor when considering a possible sanction for failure to
report. Otherwise clinicians may feel driven to act against what they feel are the best interests of a child or young person.

4. **Do you agree with the government’s proposal that the duty should be placed on health care professionals, teachers and social care professionals?**

We have no views on what other professional groups should be covered by any duty.

5. **Do you have views on any necessary differentiation between different professional groups on whether the duty should cover disclosure and/or visual identification?**

No comment.

6. **How do you think mandatory reporting of FGM should apply in the early years sector?**

No comment.

7. **Do you agree with the government’s proposal that all reports should be made to the police?**

We do not agree that healthcare professionals should be required to make reports direct to the police. GMC guidance, and the statutory guidance in *Working Together*, emphasises the importance of professionals and agencies working together to meet the multiple needs of someone affected by FGM. In our view, the primary focus of doctors should always be on the needs of the patient. While there may be a public interest in criminal prosecution, doctors should not lose sight of the fact that a child or young person is at the centre of the discussions, and that their best interests should be the focus of attention.

We therefore consider that FGM should be dealt with as part of existing child protection structures, policies and procedures. Relationships between health providers and the police are likely to vary across the country but protocols and procedures should be well-established for referring child safeguarding concerns to social care teams.

We note that the Metropolitan Police’s current Standard Operating Procedures for investigating FGM start with a referral to the local child social care team.* We also note that the Royal College of Midwives proposed in evidence to the Home Affairs Select Committee’s Inquiry into FGM that the local Safeguarding Children’s Board, as a multi-agency hub, should coordinate the whole response to a child or young person who has been the victim of FGM.

We consider that this is a suggestion that should be explored further. It has the advantage of avoiding the duplication and confusion that can be caused by the existence of multiple

referral routes. It also ensures that referral to social care is not delayed, and that all agencies (including the police) can formulate a coordinated plan to support the child or young person and her family during what is likely to be a highly stressful experience. This approach also potentially provides a ‘hub’ for recording referrals to the police which could help to reduce the likelihood of multiple referrals.

8. **Do you agree that reports should be made at the point of initial disclosure/identification?**

See our response to the next question.

9. **If an individual is in contact with multiple organisations, should they be reported once, once from within a sector, or repeatedly throughout life?**

It is important to keep in mind that it is not the individual victim of FGM who is being reported to the police, but the alleged crime.

If the main policy objective underlying the proposed mandatory duty is to increase successful prosecutions of perpetrators of FGM, then it is difficult to see what the benefit of multiple referrals will be, assuming that a single referral will be sufficient for the police to assess the evidence and make a charging decision. It seems to us nugatory (and potentially damaging) for the same individual to be put through this process multiple times.

As such, we would consider it to be disproportionate for the same individual to be referred to the police by multiple organisations, or throughout their lifetime. In the specific context of healthcare such an approach could be disastrous for the trust of entire communities in healthcare professionals.
Responses to questions for PART B

10. By what mechanism do you think sanctions should be placed upon individuals who fail to report FGM under the new duty?

The consultation document suggests that the GMC does not have specific professional regulation relating to the reporting of FGM. This fails to recognise, however, that as FGM falls within the context of child abuse, doctors are obliged to follow our guidance on protecting children and young people. Any serious or persistent failure to follow GMC guidance will put a doctor’s registration at risk.

The GMC can take action against a doctor’s registration in the public interest where it appears that a doctor’s fitness to practise may be impaired by poor skills or performance, ill health, misconduct or a criminal conviction. The purpose of any action we take is to protect the public by helping to make sure doctors on our register provide safe care and to uphold public confidence in doctors. It is not our role to punish or discipline doctors.

When a serious concern is raised about a doctor’s behaviour, health or performance, we investigate to see if the doctor is putting the safety of patients, or the public’s confidence in doctors, at risk. We collect and review evidence, such as witness statements and reports from experts in clinical matters. We also consider any mitigating or aggravating factors, the current risk that the doctor poses, and whether taking action is in the public interest – for example, to protect patients, maintain public confidence in doctors and to uphold proper standards of conduct and behaviour.

Following the investigation we may issue advice or a warning to the doctor, or we may agree with the doctor that he or she will restrict their practice, retrain or work under supervision.

In some cases, we will refer the case to the Medical Practitioners’ Tribunal Service (MPTS) for a hearing. When action is needed to protect the public or to maintain public confidence in doctors, an MPTS panel can suspend a doctor’s right to work, or restrict their practice – for example by requiring them to work under supervision, or undergo further training. If necessary, a panel can also suspend or restrict a doctor’s right to work while the investigation is conducted. In a few very serious cases, a doctor may be removed from the medical register.

If a doctor was referred to us with an allegation that he or she had breached a legal duty to report FGM, we would investigate the case as set out above and would need to establish evidence that the doctor failed to report FGM as required by the duty. For example, if a doctor claimed not to have noticed anything was wrong it would be necessary to establish what the doctor would have been likely to see at the material time (given that the presentation of FGM can change as the child matures), and what the doctor ought to have been able to recognise (given the wide variation in clinicians’ knowledge and ability to detect FGM).

It is also important to note that our role is to determine whether or not the doctor’s fitness to practise is impaired to a degree justifying action on the doctor’s registration. The
sanctions mentioned in the consultation document – such as requiring periods of re-training or supervised practice, suspension, or removal from practice – would only be available to us if the doctor’s fitness to practise was found to be impaired.

As such, automatic referral to the GMC for alleged failure to report FGM may not result in the outcome the Government seeks, although we have no objection in principle to such referrals being made.

In terms of referral to the DBS, while this would ensure a consistent approach whether or not the individual is a regulated professional, it is important that any measures taken are proportionate. The threshold for barring a doctor for failure to report FGM should be consistent with failure to report other similar forms of abuse and should be based on evidence that the doctor poses a risk of harm to vulnerable groups. Furthermore, if the DBS considered that a doctor presented such a significant risk to vulnerable patients that he or she should be placed on the ‘barred list’ then questions will also be raised about the doctor’s fitness to practice, and the doctor should be referred to the GMC.

11. What level of sanction do you think should be placed upon individuals who fail to report FGM upon the new duty?

This is difficult to answer as it is entirely dependent on the circumstances of the failure to report.

As set out in our response to question 10 the sanctions mentioned in the consultation document – such as requiring periods of re-training or supervised practice, suspension, or removal from practice – would be available to us if the doctor’s fitness to practise was found to be impaired. Otherwise the only action available to the GMC under current powers would be to issue a warning. A warning will be appropriate if the concerns indicate a significant departure from the standards set out in the GMC’s guidance, *Good medical practice*, or if there is a significant cause for concern following an assessment of the doctor’s performance, that does not amount to impaired fitness to practise.
Responses to questions for PART C

12. Do you agree that all persons exercising public functions in relation to tackling FGM should be under a duty to have regard to the statutory guidance?

We have no objection to guidance for professionals on FGM being put on a statutory basis, but it should be considered as part of the existing statutory guidance Working Together. It is also not clear what the consequences of it applying to “all persons exercising public functions in relation to tackling FGM” would be.

We also do not think that the status of the existing guidelines should simply be changed. Our view is that the guidelines need to provide substantially more detail on a range of matters, including how to identify girls and women at risk of FGM, how to identify FGM once it has happened, what training and support is available, and the care pathways and support services for women and girls who have undergone FGM.

The guidelines should also provide detailed guidance for professionals on how to comply with any mandatory duty that is introduced. Statutory guidelines (if developed) should therefore be subject to separate consultation.

13. Are there substantive amendments which could be made to the guidelines, which would help to prevent FGM and protect and support victims?

No comment