Reviewing how we deal with concerns about doctors

What did our consultation into sanctions and the role of apologies and warnings show us?

About our consultation

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

The consultation focused on the action we take when we believe a doctor may be putting the safety of patients, or public confidence in doctors, at risk. This document summarises the responses to our consultation (a full report is also available here).

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

This consultation was commissioned by the Council of the General Medical Council (GMC), which has overall responsibility for the sanctions guidance. His Honour David Pearl, Chair of the Medical Practitioners Tribunal Service (MPTS), chaired the sanctions guidance project board.

Background

Our guidance Good medical practice sets the standards we expect doctors to meet. To make sure the decisions that fitness to practise panels make are transparent, fair and consistent, we give them guidance to help them decide what sanction is appropriate. This guidance is called our Indicative Sanctions Guidance for the Fitness to Practise Panel.

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

Following an extensive consultation, we published an updated edition of Good medical practice and supporting explanatory guidance in March 2013, which came into effect in April 2013. This edition reflects what doctors and patients think are the important values and principles of good care.
What did our consultation explore?
We asked respondents about five different areas.

- **Changes to our sanctions guidance**
  We want to make sure our guidance reflects society’s values and expectations of doctors, which are set out in the updated edition of Good medical practice and supporting explanatory guidance, published in 2013.

- **The role of insight and apology**
  We reviewed this because doctors have a duty (Good medical practice, paragraph 55) to apologise when a patient is harmed or suffers distress as a result of a doctor’s actions. Following the recommendations in the Francis report, we wanted to seek views on our proposals to strengthen our guidance for panels on apology and insight.

- **Changes to our guidance on suspension**
  We asked respondents about this because we want to help fitness to practise panels to make consistent decisions about suspending doctors.

- **Giving patients a voice**
  We’re exploring ways to enhance the role of patients in our fitness to practise procedures. We wanted respondents to give us their ideas on how best to do this.

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

How did we run the consultation?
We asked 24 questions about the proposed changes to our sanctions guidance and about the role of apologies and warnings. Respondents were asked whether they agreed or disagreed with each question. We also asked them if they wanted to make a comment on each question. Annex A of the full consultation report sets out the 24 questions we asked, the breakdown of responses and a summary of the comments.

How did people respond to the consultation?
Respondents could reply to our written consultation online, by email or in writing. People could also give us their thoughts at events we ran.

We received 427 responses to our written questionnaire. The table below shows the breakdown of responses according to source. Most respondents responded online survey, but we also received some broader comments on the consultation by email and letter. These comments were included in the free-text analysis, but not in the statistical analysis, as we could not clearly attribute a yes or no response.

<table>
<thead>
<tr>
<th>Source</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written questionnaire (online)</td>
<td>427</td>
</tr>
<tr>
<td>Group responses from stakeholder events</td>
<td>36</td>
</tr>
<tr>
<td>Group responses from Regional Liaison Service events</td>
<td>63</td>
</tr>
<tr>
<td>Responses in other formats (emails, etc)</td>
<td>39</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>565</strong></td>
</tr>
</tbody>
</table>

The written questionnaire was supported by an area of our website called Fitness to practise panel decisions in action. It let respondents tell us what action they thought should be taken in four scenarios and the factors that influenced their decision.

We received 1,600 responses through Fitness to practise panel decisions in action – a summary of the responses is included for relevant questions in the full report.
Reviewing how we deal with concerns about doctors. What did our consultation into sanctions and the role of apologies and warnings show us?

The table below shows the categories of respondents who completed our written questionnaire.

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-category</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individuals</strong></td>
<td>Doctors</td>
<td>284</td>
</tr>
<tr>
<td></td>
<td>Members of the public</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Other individuals</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td><strong>Organisations</strong></td>
<td>Organisations representing doctors</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Organisations representing patients or the public</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Other organisations</td>
<td>44</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>427</td>
</tr>
</tbody>
</table>

Organisations that responded to our consultation are listed in Annex C of the full consultation report.

**Responses to our consultation**

**Changes to our sanctions guidance**

There was broad support for changes to our sanctions guidance

The majority of our proposals on changes to our sanctions guidance received strong support from respondents. However, the British Medical Association (BMA), the Medical Defence Union (MDU), the Medical and Dental Defence Union of Scotland (MDDUS) and the Medical Protection Society (MPS) had reservations, highlighting issues of fairness and proportionality.

Responses to many of our proposals emphasised the need to let panels exercise discretion in making their decisions – making sure they could approach sanctions on a case by case basis.

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

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

**Could collaboration proposals affect whistleblowers?**

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

**Taking action against predatory behaviour, discrimination and misuse of drugs**

There was overwhelming support for our proposal to guide panels to consider removing doctors from the medical register when abuse of their professional position involved predatory behaviour towards a patient, particularly where the patient is vulnerable.

Respondents felt it was fair to expect the highest standards of professional behaviour from doctors and predatory behaviour was a breach of the trust placed on them by the public and their patients. However, some respondents said that panels should recognise that doctors may form genuine relationships with their patients – particularly in isolated locations – and that perhaps panels should be guided to consider evidence of coercion and recurrence of inappropriate behaviour.
One of our proposals is to guide panels that they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics – either in professional or personal circumstances. This received strong support from the majority of respondents, including the BMA. However, some respondents referred to a doctor’s right to personal beliefs.

We outlined a number of specific factors in our consultation for panels to consider when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs. There was strong support for this proposal from respondents, including the BMA, MDU, MDDUS and MPS.

Many stated that the misuse of alcohol or drugs was a serious issue that impaired a doctor’s ability to practise safely, putting patients at risk and undermining public confidence in the profession. Some respondents raised concerns about the approach to these cases, suggesting that these doctors would be better dealt with through treatment.

Should panels consider doctors’ personal lives and instances of remediation?

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

Concerns were raised about the potential infringement on a doctor’s human rights, and the BMA requested further consultation on what type of behaviour in a doctor’s private life might be engaged under this proposal.

Opinion was divided on whether panels should be guided to consider taking action to maintain public confidence in doctors even when a doctor had remediated, if the concerns were so serious or persistent that failure to do so would impact on public confidence in doctors. Although members of the public and bodies representing patients or the public strongly supported the proposal, the majority of doctors, together with the BMA, MDU, MDDUS and MPS, disagreed.

The MPS stated that these cases would be rare, and that panels should be able to ‘exercise their own judgment to determine the extent to which the matters complained of are capable of being remediated and the extent to which they have been remediated’.

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

The role of insight and apology

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

Guidance on whether a doctor has insight

Our proposal to introduce more-detailed guidance on the factors that indicate a doctor has or lacks insight was met with strong support from the
Reviewing how we deal with concerns about doctors. What did our consultation into sanctions and the role of apologies and warnings show us?

majority of respondent groups. The PSA supported the development of additional guidance in this area, but outlined slightly different factors it believed panels should consider.

In particular, the PSA cautioned that limited weight should be given to an apology, admission or engagement in proceedings, as a doctor could take these actions in order to receive a more lenient outcome, rather than showing genuine insight. A number of other respondents also made suggestions as to the factors which should be included in this guidance.

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

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

Should the stage of a doctor’s career be taken into account?

Respondents across all groups gave strong support to our proposal to guide panels to consider the stage of a doctor’s UK medical career as a mitigating factor, and whether they had gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience.

The BMA were wholly supportive of the proposal, whilst the MDU stated that the proposal should be expanded to include doctors who may be more senior, ‘but have little experience in a particular field.’ Respondents also agreed that it was important to consider this in relation to the nature of the breach.

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

Checking testimonials

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

Although supportive of the use of verification checks, the BMA and MDDUS raised concerns about the submission of testimonials before a hearing, and the BMA said that we shouldn’t restrict the evidence doctors could present in their defence.

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

Statements from responsible officers

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

Some concerns were raised regarding the impact this might have on responsible officers with large area teams. If the proposal is taken forward, we would work closely with responsible officers to make sure we fully understand, and take account of, these types of challenges.
Another concern amongst respondents in relation to this proposal was about the objectivity of responsible officers, from the perspective of patients and doctors.

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

**Five key factors to consider**
The majority of respondents supported our proposal to guide panels that they may consider five key factors when deciding the length of suspension. However, a considerable number of respondents raised concerns about the use of factor two (the impact on public confidence in the profession), and factor four (sending a message to the medical profession that standards must be upheld).

Some respondents questioned how objective the test of public confidence would be, and what evidence there was to indicate these decisions would support public confidence in doctors. The Royal College of Physicians raised concern that the use of factor four ‘could be interpreted as making an example of an individual doctor and could be open to accusations of inequity or unfairness in application’.

**Concerns about a doctor’s health**
Where concerns are solely about a doctor’s health, we proposed to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration. There was strong support for this proposal, although there was discussion around the importance of supporting doctors in these cases, while making sure patient safety isn’t compromised.

**Keeping clinical skills up to date**
Our proposal to provide guidance on how doctors can keep their clinical skills up to date while they were suspended received strong support from respondents, although there was some discussion around the need to provide support mechanisms to help doctors return to practice following a period of suspension. The PSA considered that this might not be appropriate for all doctors, for example where a doctor has abused patients or acted dishonestly. Of those who opposed this proposal, a large number raised concerns that, without patient interaction, doctors would be unable to maintain their clinical skills.

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

**Giving patients a voice**
We asked respondents if they thought there are benefits to doctors and patients meeting where a patient has been seriously harmed. A large number of respondents agreed that these meetings would be beneficial. Although the BMA agreed, it noted the need for detailed work around the practicality of the proposal.

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

Those respondents who opposed the proposal raised concern that these meetings would not be effective if mandatory and, if led by the GMC, there could be a perceived bias.
Changes to our powers to give warnings

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

Most respondents also agreed that warnings should be used to deal with low level concerns (where a doctor’s fitness to practise is not impaired) and misconduct (where a doctor’s fitness to practise has been found impaired), if different terms are used to describe them.

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

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

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

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

What next?
Throughout the consultation, respondents made a number of comments about fairness and proportionality. We captured these comments through our free-text analysis, drawing out any reference to equalities issues. These issues will feed into an equality analysis which will help minimise any adverse impact on particular groups.

Our new sanctions guidance will be presented to Council for approval on 23 April 2015, and we will publish the new guidance in August 2015.