

Consultation report: Reforming our fitness to practise investigation and adjudication processes

Section 1: Introduction

From 25 March to 20 May 2015 we consulted on changes to the rules we follow when investigating complaints and making decisions at hearings about doctors (known as adjudication).

The focus of the consultation was to complete a reform programme to improve and modernise how we carry out investigations and adjudication. This builds on changes the UK Government made to the *Medical Act 1983* in March 2015.

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

Background

We started a reform programme in 2011 to clearly separate our investigation and adjudication functions. This was after the Government decided not to establish an independent adjudication body – the Office of Health Professions Adjudicator. As an alternative, we consulted on and received widespread support to establish the Medical Practitioners Tribunal Service (the MPTS). Within the same reform programme, we included other improvements to our investigation and adjudication processes.

In 2013, we consulted on and introduced improvements that did not require any changes to the *Medical Act 1983*. Between July and September 2014, the Department of Health (England) consulted on the remainder of the improvements that required change to primary legislation. Parliament approved the order making amendments to the *Medical Act 1983* in March this year. These included:

- revising the GMC's statutory objective
- the introduction of a new right of appeal for the GMC, in its capacity as a party to fitness to practise proceedings
- removing the exceptional circumstances element of the five year rule so that, once the change is implemented, the GMC will consider cases that are older than five years if it is in the public interest to do so.

Our consultation

Our consultation aimed to give a complete picture of all the changes we are making to our rules. This included those made to reflect amendments to the *Medical Act 1983*, in relation to which we did not ask a question.

It covered six different areas:

Formally separating our investigation and adjudication functions

We included the draft rules for establishing the MPTS as a statutory committee and issues relating to operational separation such as the separation of notice of allegation from the notice of hearing.

Streamlining and modernising our hearing process

We clarified our use of undertakings, proposed changes to rule 17, which sets out the process to be followed at a panel hearing, and the case manager's powers to adjourn hearings.

Making case management more effective

This included the circumstances in which a case management decision will not be binding and how we will award and assess the costs regime introduced through change to the *Medical Act 1983*.

Removing the need for parties to attend review hearings

This section referred to our revisions to reflect changes to the *Medical Act 1983* allowing for a chair or full panel to review an outcome agreed between the parties, after considering all the relevant evidence in writing. We did not ask a question in this section.

Making our investigation processes simpler and more effective

We proposed removing the requirement to tell employers about complaints against a doctor until we have determined whether it raises a question about their fitness to practise.

Improving compliance and making assessments more effective

This covered proposals to address a doctor's failure to comply with an investigation and increasing the flexibility of how we assess clinical performance.

The consultation document was supported by a range of annexes. Annex 1 showed how our existing rules will look if all the proposed changes are made. Annexes 2 – 4 set out the changes to our Fitness to Practise Rules, the revised Panel Rules and Legal Assessors' Rules and the new rules to govern the MPTS as a statutory committee.

We also asked whether any of our proposals might adversely affect people from groups with protected characteristics.

Methodology

We asked 19 questions about the proposed changes to our rules. Respondents were asked whether they agreed or disagreed with each question, and had the option of stating that they were not sure. They were then asked to provide any additional comments.

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

Section 2 of this report sets out a summary of responses received and Appendix A includes the detailed analysis of responses to each question.

Where respondents did not state whether they agreed, disagreed or were not sure about the proposal and made a comment, we have included these in the dataset and the analysis. Respondents who did not check any of the yes/no/not sure boxes and did not leave a comment do not appear in the dataset or analysis for the question concerned.

Out of scope comments

Respondents made a number of comments that were outside the scope of the consultation questions. Some related to changes that the Department of Health consulted on and have included in the Section 60 Order approved by Parliament in March this year. Others were comments that did not relate to the question asked. We have included a summary of these comments at Appendix B and will consider these as part of our ongoing review of our processes.

Equality and Diversity

Question 20 asked whether respondents thought the proposals would have an adverse impact on people from groups with protected characteristics. In addition, a small number of respondents made comments about protected characteristics in response to some of the specific proposals.

We have reported comments about health, including reference to self harm and suicide, but not stress, as within the protected characteristic of disability. We also included comments about unrepresented doctors as some of these doctors are from groups with protected characteristics.

Percentages

Percentages shown have been rounded up or down and, in some instances, the totals do not equal 100.

Breakdown of responses

We received 109 responses to our questionnaire: 71 were completed on our e-consult website; and 38 sent or emailed the consultation form to us for uploading to the e-consult site. The latter included an email response we received with comments in relation to one question only.

The table below provides a breakdown of the types of respondents. Appendix C provides a list of organisations that responded to our consultation.

Organisations	
Body representing doctors	10
Government department	1
Independent healthcare provider	1
Postgraduate medical institution	5

NHS/HSC organisation	2
Regulatory body	3
Other	2
Total organisations	24
Individuals	
Doctor	76
Medical educator (teaching, delivering or administrating)	3
Member of the public	1
Responsible Officer	1
Other	3
Total individuals	84
Unknown	
Blank	1
Total unknown	1
Overall total	109

Summary of findings

Formally separating our investigation and adjudication functions

The majority of respondents were in favour of the proposals saying they were logical given the operational separation of the GMC's investigation and adjudication functions. Respondents also welcomed the increased transparency provided by publishing criteria for the appointment of legally qualified chairs, provisions about these chairs giving legal advice and separating out the notice allegation and hearing.

The minority of respondents who disagreed with the proposals raised concerns about the hearing process being a quasi-judicial process, wanting more professional involvement. Respondents also made suggestions for refining our proposals, including comments on the legal drafting which we will consider when developing the recommendations in response to the consultation outcome.

Streamlining and modernising our hearing process

The majority of respondents supported all our proposals for streamlining our process, in particular identifying a doctor at a hearing before any preliminary legal argument, clarifying responsibilities for recording hearings and the use of terminology, such as use of the term 'witness', and adjourning hearings that are part heard.

Comments from the minority of respondents who did not agree referred to delay in the process and the detrimental impact this has on doctors, particularly those who are unwell. Specific suggestions were also made in relation to the drafting of the rules and we will consider these when developing our recommendations.

Making case management more effective

The majority of respondents agreed with panels reconsidering a case management decision if in the interests of justice to do so. Many of the comments we received focussed powers of our panels in primary legislation or elsewhere in our rules but not currently under review or part of this consultation. For this reason we have not included these here but will reflect on them as part of our ongoing review of our processes.

39 respondents agreed with the proposal for awarding and assessing costs. 25 respondents were against the proposal and 16 were not sure. Suggestions were made in relation to the draft rules which we will consider when developing our recommendations.

Making our investigation processes simpler and more effective

The large majority of respondents welcomed the proposal to remove the requirement to inform a doctor's employer about provisional enquiries. Many of those in favour welcomed the change as avoiding reputational damage and reducing stress for doctors. Those opposed were concerned that not telling employers could put patients at risk.

Improving compliance and making assessments more effective

The large majority of respondents were in favour of the proposal for a new type of non-compliance hearing commenting that it was the duty of doctors to comply with an investigation. Those against thought the measures were draconian.

Appendix A: Proposal analysis

We received 109 responses to our consultation in total. It was not compulsory to respond to every proposal, or to provide additional comments and we have identified how many responses we received to each proposal in the introduction to the analysis of each question.

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

Formally separating our investigation and adjudication functions

Question 1 – We have drafted new rules for the MPTS committee. Do you agree with the arrangements for the MPTS committee as set out in these rules?

Responses:

Option	Response number	Percentage%	Number of comments
Yes	63	59	12
No	20	19	10
Not sure	18	17	7
Comment only	5	5	5
TOTAL	106	100	34

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	8	1	0	1	10
	Government department	0	0	0	1	1
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	3	1	1	0	5

	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	0	1	0	2	3
	Other	2	0	0	0	2
Individuals	Doctor	42	16	14	1	73
	Medical educator	2	1	0	0	3
	Member of the public	0	0	1	0	1
	Responsible Officer	0	0	1	0	1
	Other	3	0	0	0	3
Unknown	Blank	0	0	1	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 106 answered this question. 63 of these respondents (59%) supported the proposed rules required to establish the MPTS committee, including the BMA, the MDU, the MDDUS and more than half of the individual doctors who responded. 20 (19%) were opposed, including the PSA, the MPS and the Royal College of Psychiatrists. 18 (17%) were unsure about the proposal. Five respondents, including the Chief Nursing Officer's Directorate of the Scottish Government, did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

General comments

A small number of respondents made general comments in response. One respondent thought that establishing the MPTS as a statutory committee, therefore requiring Parliamentary approval for any future changes, would make the reform process very slow. The BMA felt that if the MPTS were to fulfil an entirely judicial role and the GMC could appeal its decisions, consideration should be given to funding it from a Government grant.

Comments in support of our proposal

Those in favour of the proposal said it was logical, pragmatic and appropriate. The clear benefits to operational separation were an increase in public confidence, fairness and objectivity.

Comments opposed to our proposal

Respondents opposed to our proposals commented on committee membership, criteria for disqualification and the change in terminology.

Seven respondents commented either that the committee had too many lay members or that there should be a medical majority. Two opposed (and one in favour) suggested that there should be a GP member, and another suggested the membership include a GP, a specialist, a legal member and two lay members. One respondent thought it was not necessary to have committee members who are legally qualified. One respondent thought (mistakenly) that the proposal would result in an increase in committee members and that this would result in an increase in costs.

The PSA disagreed with the proposal on the basis that the rules did not exclude current and former GMC employees from the MPTS committee.

In relation to the disqualification criteria, respondents made a range of comments about the criteria for disqualification of doctors from MPTS committee membership including opposing disqualification on the grounds of:

- a history of administrative or voluntary erasure (two respondents)
- conditions on their practice (two respondents)
- interim conditions on their practice (one respondent)
- being barred by the Disclosure and Barring Service, undertakings or being subject to an investigation and membership would undermine public confidence in the profession (one respondent).

Comment only responses

The Chief Nursing Officer's Directorate of the Scottish Government said that the MPTS should be responsible for appointing both the MPTS Chair and Deputy Chair.

Suggestions to refine our proposal

One respondent in favour suggested the rules should make clear who would have a casting vote where the committee was sitting with 4 members and votes were equally split.

One respondent suggested that committee members be trained so they could treat doctors in the process in the same way that doctors were trained to meet the needs of patients.

Impact on groups with protected characteristics

One respondent commented that the changes proposed would not address issues of subconscious racial bias in panel decisions.

Question 2 – We propose making provision in the rules for the MPTS to be responsible for setting and publishing the criteria for appointing panellists and panel chairs. Do you agree?

Responses:

Option	Response number	Percentage %	Number of comments
Yes	65	65	17
No	12	12	6
Not sure	19	19	13
Comment only	4	4	4
TOTAL	100	100	40

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	7	1	1	1	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	4	0	1	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	44	10	13	2	69
	Medical educator	1	0	1	0	2
	Member of the public	0	0	1	0	1
	Responsible Officer	0	0	1	0	1
	Other	1	1	1	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents, 100 responded to this question. 65 of these respondents (65%) were in favour of the proposal to allow the MPTS to be responsible for setting and publishing the criteria for appointing panellist and panel chairs. There was support from a number of organisations including the MDDUS, the MDU and the NMC. Three respondents did not say whether they were in support, opposed or unsure but made comments.

The BMA opposed the proposal, sharing concerns, also raised by two doctors in their responses to this question and another doctor in their response to question 3, that hearing concerns about doctors will become a quasi-judicial process lacking professional input.

Comments in support of our proposal

Those in favour of the proposal said that full transparency in the appointment of panellists and panel chairs would improve trust and public confidence in the hearing process. Two respondents also noted that the legal experience and knowledge of legally qualified chairs was important for the process and would ensure fairness for doctors.

Four respondents in favour of the proposals felt that it was important for a panellist to have the appropriate skills and knowledge for each case. Less time would be required at the hearing to explain complex medical and legal issues. Two respondents (one in favour of and one who was not sure about the proposal) said respect, empathy and conscientiousness were concepts necessary for judging fitness to practise issues.

Two respondents said the criteria should be published.

Comments opposed to our proposals

Three respondents who opposed the proposal said that the MPTS alone should decide the criteria (so, in fact, appear to agree with the proposal). Two suggested that the GMC should also be involved and one said an independent body should decide the criteria.

Two doctors responded that they would like to see the criteria in order to comment. One responsible officer asked how the criteria is going to be decided.

Impact on groups with protected characteristics

Two respondents raised concerns about the impact of fitness to practise hearings on doctors. One respondent raised a specific concern that legally qualified chairs may be more pointed in how they express themselves and that, 'given the suicide rate amongst practitioners under investigation, it is vital that the MPTS's committee behaviour is always exemplary'.

Question 3 – We propose that where legally qualified chairs advise the panel on a question of law they will do so either in the presence of the parties or, where the parties are not present, they will include their advice in their decision. Do you agree?

Responses:

Option	Response number	Percentage%	Number of comments
Yes	77	79	14
No	13	14	10
Not sure	5	5	3
Comment only	2	2	2
TOTAL	97	100	30

Responses by category of respondent:

		Yes	No	Not sure	Blank	TOTAL
Organisations	Body representing doctors	7	2	0	1	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	4	1	0	0	5
	NHS/HSC organisation	1	0	1	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	53	9	4	0	66
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	2	1	0	0	3

Unknown	Blank	1	0	0	0	1
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Introduction

Out of the 109 respondents, 97 responded to this question. 77 (79%) of these respondents were in favour of our proposal for legally qualified chairs giving legal advice to the panel, including the NMC, the MDDUS, the MDU, various Royal Colleges, the Independent Doctors Federation, and 53 of the 66 individual doctors who responded. Those opposed included the Law Society of Scotland, the Royal College of Psychiatrists and the Medical Protection Society.

Two respondents did not say whether they were in support, opposed or unsure but made comments.

Comments in support of our proposal

Eight respondents who commented agreed with the proposal with three saying it would lead to greater openness and was good practice. Two respondents commented that chairs would require appropriate skills and training, with another saying that a specialist legal opinion should always be sought where necessary.

Comments opposed to our proposals

Two respondents who disagreed, one doctor and one panellist, thought a legally qualified chair should not give legal advice at all. The Medical Protection Society said that there should be a legal assessor in each hearing and an individual doctor said the legal assessor role was very important for unrepresented doctors and in assisting the flow of the case. The same respondent also said the independence of the panel would be lost as the level of interaction required between the legally qualified chair and the parties would lead to questions being asked about the chair's independence.

Three respondents opposed to our proposals (and one in favour) said that the legally qualified chair should not give any legal advice to the panel in private. The MDU (who were in favour of the proposal) commented that where a legal assessor is not appointed, the current provision for legal assessors repeating advice given to the panel in camera to every party should apply to legally qualified chairs. The BMA were concerned that in hearings without a legal assessor the repetition of advice to all parties would be lost.

The Law Society of Scotland thought any advice given, whether in the presence of the parties or in camera, should be set out in writing and one respondent thought the determination including advice given in camera should also include the reasons for the advice.

Four respondents opposed to the proposal (and two in favour) said there should be an opportunity for parties to challenge legal advice given by the legally qualified chair. Without this, Radcliffes Le Brasseur (a law firm representing doctors) the hearing would be 'fundamentally unfair'.

Suggestions to refine proposal

The Royal College of Physicians, Edinburgh, commented that it should be made clear to parties that the lay chair includes a legally qualified chair.

One respondent noted that rule 6 should be amended to cover the situation where the registrant is not present at the time the advice is given but arrives after deliberation begins, and where the advice precedes the Tribunal beginning to deliberate. They suggested that this advice should be included in the written decision. We consider the current drafting provides for this scenario.

Question 4 – We propose that the MPTS should send the notice of hearing and the GMC should send the notice of allegation. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	82	85	16
No	6	6	6
Not Sure	5	5	2
Comment only	3	3	3
TOTAL	96	99	27

Response by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	10	0	0	0	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	3	1	1	0	5
	NHS/HSC organisation	2	0	0	0	2

	Regulatory body	1	0	0	2	3
	Other	2	0	0	0	2
Individuals	Doctor	56	5	3	1	65
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	2	0	1	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 96 answered this question. 82 (85%) of these respondents supported our proposal that the MPTS send the notice of hearing and the GMC send the notice of allegation with only 6 (6%) of respondents opposed and 5 (5%) who were not sure.

56 out of 65 of the doctors who responded agreed, together with eight bodies representing doctors, including the BMA.

Three respondents did not say whether they were in support, opposed or unsure but made comments.

Comments in support of our proposals

Five respondents who commented supported separation of the notices, with one who said this was important for transparency. One respondent said it was key for the doctor to receive the notice of allegation first and another that this should be received as early as possible to make sure the process was fair.

One respondent in favour of the proposal also suggested the notice be drafted in plain English removing reference to various statutes and that the GMC and MPTS be fined if they miss the deadlines for serving notices.

Another who agreed suggested that the GMC provide administrative support in order to save costs.

Comments opposed to our proposal

Four respondents who commented said there would be duplication as a result of the proposal and cause stress for the doctor. Similarly, one respondent in favour said that the process should be as simple as possible and minimise points of contact.

Two respondents said the notice of allegations should be sent by the GMC and then again, by the MPTS, with the notice of hearing.

One respondent highlighted the importance of timeliness, giving an example of delay by the GMC in informing a doctor of the deadline for submission of evidence.

Comments from those who were unsure

One respondent who was unsure about the proposal said that the change should also apply to interim order hearings.

The response from the Royal College of Anaesthetists was split between the clinical members who agreed with the separation of function and the lay members who thought one statutory body should be responsible for serving the notices.

Impact on groups with protected characteristics

One respondent who agreed with the proposal said the GMC process appears punitive, with adverse impacts on a doctor's health, including risk of suicide.

Question 5 – Do you agree that we should change our rules to reflect our current practice of giving doctors at least 28 days' notice of all matters relating to the hearing (including time and venue)?

Responses:

Option	Response number	Percentage	Number of comments
Yes	80	83	26
No	7	7	4
Not sure	7	7	6
Comment only	2	2	2
TOTAL	96	99	38

Response by category of respondent:

		Yes	No	Not sure	Blank	TOTAL
Organisations	Body representing doctors	9	0	0	1	10

	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	5	0	0	0	5
	NHS/HSC organisation	1	1	0	0	2
	Regulatory body	2	0	0	1	3
	Other	1	0	1	0	2
Individuals	Doctor	55	5	5	0	65
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	1	1	1	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 96 responded to this question. 80 (83%) of these respondents supported changing our rules to give doctors at least 28 days' notice of all matters relating to a hearing, including 55 out of 65 of the individual doctors who responded. The BMA, the MDDUS, the Nursing and Midwifery Council and the Law Society of Scotland were among those organisations in support. Only 7 (7%) of respondents opposed the proposal with 7 (7%) unsure.

Two respondents did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

Comments in support of our proposal

Out of those respondents in favour who commented on the proposal, four respondents said the current provision in the rules of no less than seven day's notice of the precise time and venue of the hearing was too short. Three said 28 days should be the minimum, whilst one respondent thought 28 days was excessive if the hearing was subsequently rescheduled to a later date. One said notice should be given as soon as the date was known (if earlier than 28 days before the hearing).

Three respondents thought the notice period should be brought in line with the six week notice period required of doctors when requesting a leave of absence. This would avoid experts and the doctor concerned being unable to attend the hearing.

Four agreed with our proposal on the basis that the change would allow the doctor more time to prepare for the hearing.

The NMC pointed out that the proposal mirrored their own rules which provided for a 28 day notice period.

Comments opposed to our proposal

Three respondents (including one in favour) suggested longer notice periods of 8 weeks and under 3 months.

Comments from those who were unsure

One respondent thought the proposal defeated the aim of speeding up adjudication and two thought doctors should be able to consent to a shorter notice period and a faster process.

The Faculty of Public Health noted that a longer notice period would give a doctor longer to prepare but a short notice period allowed for quick listings if hearings were cancelled.

One asked for clarification of 'all matters' where reference, in the consultation document, is made to giving notice of all matters relating to the hearing.

Suggestions to refine proposal

One respondent who was unsure suggested giving a range of dates and then 7 days before the hearing giving a firm date for the hearing.

Another suggested a cut-off point by when the notice of the date of hearing must be given.

Radcliffes Le Brasseur (a law firm) suggested retaining the current provision to serve the notice of allegation as soon as reasonably practicable after referral.

The MDU made two suggestions:

- to retain the current provision in rule 15(4) that allows the Registrar to give a shorter period of notice where it is reasonable in the public interest and additionally where it is in the exceptional circumstances of the case. In their response to question 4, the MPS made a similar suggestion including giving a shorter notice period where the practitioner consents.
- To allow for only the MPTS to decide whether shorter notice should be given in the public interest (rule 15(2)).

Question 6 – We propose to remove the rule that provides that the MPTS should tell the GMC when an interim order is due to expire. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	64	69	12
No	9	10	6
Not Sure	18	19	9
Comment only	2	2	2
TOTAL	93	100	29

Response by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	10	0	0	0	10
	Government department	0	0	0	1	1
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	3	0	2	0	5
	NHS/HSC organisation	1	1	0	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	41	7	14	0	62
	Medical educator	0	0	1	0	1
	Member of the public	0	1	0	0	1

	Responsible Officer	1	0	0	0	1
	Other	2	0	1	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 93 responded to this question. 64 (69%) of these respondents supported removing the rule that provides that the MPTS should tell the GMC when an interim order is due to expire. 41 out of 62 doctors who responded agreed together with the BMA, the MDDUS, the MDU, the Medical Protection Society, and the Royal Colleges of Radiologists and of Physicians and Surgeons of Glasgow among others.

18 (19%) were unsure with only 9 (10%) opposed. Two respondents, including the Chief Nursing Officer's Directorate of the Scottish Government, did not say whether they were in support, opposed or unsure but made comments.

Comments in support of our proposal

Three respondents who commented agreed that this proposal was reasonable. Two respondents thought it was for the GMC to monitor the expiry of an interim order, with one also noting that it confirmed the independence of the MPTS.

One respondent who agreed said they did not understand the proposal and there should be clarity for all parties concerned over the expiry of an interim order.

Two respondents, including the PSA, agreed provided the process still worked well.

Comments from those who were unsure about the proposal

Two respondents said the change would make no difference, one calling it cosmetic and the other a virtual measure that would not achieve separation.

Comments opposed to our proposal

One respondent disagreed on the basis that the MPTS and GMC should be in continual communication with each other.

Six respondents (three opposed and three who were unsure) said there was a risk that an interim order would lapse by accident and a reminder from the MPTS of the expiry would be sensible. Another respondent referred to the rule as a safeguard against an order lapsing.

Comment only responses

The Chief Nursing Officer's Directorate of the Scottish Government said the GMC needs to be informed of the decisions of the panel irrespective of when undertakings might expire.

Suggestions to refine proposal

The Royal College of Physicians, Edinburgh suggested that as the original order was made by the MPTS, they should retain responsibility for reviewing it every 6 months and requesting any proposed extension.

Question 7 – We propose clarifying the circumstances in which we can refer a doctor with panel undertakings for a review where the doctor does not agree to changes we want to make to their undertakings. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	72	81	11
No	4	4	2
Not Sure	11	12	1
Comment only	2	2	2
TOTAL	89	99	16

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	10	0	0	0	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1

	Postgraduate medical institution	5	0	0	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	1	0	0	2	3
	Other	2	0	0	0	2
Individuals	Doctor	44	4	10	0	58
	Medical educator	2	0	0	0	0
	Member of the public	0	0	1	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 89 answered this question. 72 (81%) of these respondents agreed with clarifying the circumstances in which we can refer a doctor with panel undertakings for a review. These included 44 of the individual doctors who responded and various organisations, including various defence organisations (the MDDUS, the MDU and the MPS), and doctor's representative bodies (the BMA and the Independent Doctors Federation).

4 (4)% of respondents were against the proposal and 11 (12%) were unsure. Two respondents did not say whether they were in support, opposed or unsure but made comments, including the PSA.

Comments in support of our proposal

Four of the respondents who agreed with the proposal said that this would strengthen the process and allow for a change in the doctor's circumstances. One felt it would also allow for doctors who are cooperative to demonstrate their insight.

Two respondents said that any changes to panel undertakings would have to be endorsed by the panel.

One respondent in favour agreed with the PSA, who said that the circumstances for referral should be clarified. The PSA also commented that it was unclear whether the panel undertakings being referred to would be those under the existing process or under the process once the new rules are agreed and in force.

Comments opposed to our proposals

Two respondents (both doctors) were concerned that this change would introduce 'double jeopardy' and felt it would be more appropriate for the GMC to appeal a decision if it was not content with the undertakings agreed.

Suggestions to refine proposal

One respondent who opposed the proposal suggested that referrals should only be made where there had been a change in circumstances or on the basis of new evidence.

Question 8 – We propose making clear that a doctor with undertakings whose language skills either deteriorate or otherwise give rise to further concerns can be referred to a panel. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	72	81	11
No	6	7	2
Not Sure	9	10	4
Comment only	2	2	2
TOTAL	89	100	19

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	8	1	1	0	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	5	0	0	0	5

	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	1	0	0	2	3
	Other	2	0	0	0	2
Individuals	Doctor	45	5	8	0	58
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 89 responded to this question. 72 (81%) of these respondents were in favour of the proposal to make clear that doctors with undertakings whose language skills either deteriorate or otherwise give rise to further concerns can be referred to a panel. These respondents included 45 out of the 58 doctors who responded and a number of organisations, including various Royal Colleges, medical defence organisations (the MDDUS, the MDU and the MPS) and the Independent Doctors Federation.

6 (7)% of respondents were against the proposal and 9 (10%) were unsure. Two respondents did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

Comments in support of our proposal

Two respondents, the Royal College of Anaesthetists and the Faculty of Public Health, said that an adequate knowledge of English language was fundamental to patient safety and the failure to communicate effectively compromises medical care.

The MDU noted that the introduction of knowledge of English as a category of impairment was relatively recent and, though they agreed in principle, they had no experience of how this may operate in practice.

Comments opposed to our proposals

Three respondents (including one who was in favour) noted that the criteria for referral including who would make the referral decision and the basis on which the decision would be made must be transparent.

Two respondents, one of whom was unsure, asked how deterioration in English language would be evidenced.

Comments from those who were unsure

An individual doctor who was not sure about the proposal wanted to know the reason behind the change.

Suggestions to refine proposal

BLM (a law firm specialising in risk and insurance) suggested that, where there were further concerns caused by language difficulties, they should be treated as a new referral and investigated.

Impact on groups with protected characteristics

The BMA commented that criteria, including the evidence required to show deterioration, was necessary to mitigate against the risk of discrimination on the grounds of race and disability.

Question 9 – We propose giving our hearings a more logical order, identifying a doctor at a hearing before hearing any legal argument. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	65	76	14
No	5	6	1
Not Sure	15	17	5
Comment only	1	1	1
TOTAL	86	100	21

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	9	1	0	0	10

	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	4	0	1	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	1	0	1	1	3
	Other	2	0	0	0	2
Individuals	Doctor	40	4	11	0	55
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	0	0	1	0	1
	Other	2	0	1	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents who responded to the consultation, 86 responded to this question. 65 (76%) of these respondents supported identifying the doctor before hearing any preliminary legal argument. 40 out of 55 doctors who responded were in favour as well as various organisations, including the BMA, the Medical Protection Society, the MDDUS, and the MDU. 15 (17%) were unsure and 5 (6%) were opposed.

One respondent did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

Comments in support of our proposal

Six respondents said that this proposal was logical or straightforward and three respondents agreed it would streamline our process.

Two respondents asked questions: would the complainant also be identified?; and was there more to the change than naming the doctor?

Comments from those who were unsure

Two respondents who were unsure asked for the rationale behind the change, with one also saying it seemed sensible.

Another said the change would make no difference, not saving time and naming doctors who would already be known to the press.

Comments opposed to our proposals

Three respondents (including one in favour and one who was unsure) questioned the legal implications of what appeared to be the formal opening of the hearing. Currently, the registrant can apply for a stay of proceedings and if successful, is entitled to say they had not appeared before their regulator. This entitlement would be lost if the proposed change is implemented.

Suggestions to refine proposal

The MPS response suggests the Rules should acknowledge the instances that exist where pre-hearing publicity does not currently identify the registrant. They suggested the new rules should enable anonymity to be maintained prior to the commencement of a hearing.

Question 10– We propose allowing both parties to make submissions on the facts before the panel decides which facts are true. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	80	92	9
No	3	3	1
Not Sure	3	3	0
Comment only	1	1	1
TOTAL	87	99	10

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	10	0	0	0	10

	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	5	0	0	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	50	3	3	0	56
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents to the consultation, 87 answered this question. 80 (92%) of these supported allowing both parties to make submissions on the facts before the panel decides which are true. 50 out of 56 doctors who responded were in favour as well as various organisations including the BMA, the MDDUS, the MDU, the Royal College of Physicians of Edinburgh, and the Royal College of Physicians and Surgeons of Glasgow.

3 (3%) of respondents opposed the proposal and 3 (3%) were unsure. One respondent did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

Comments in support of our proposal

One respondent thought the proposal fair and another logical. Three respondents commented that this change will allow the doctor the opportunity to test the case against them. Three said it would assist the panel in understanding complex issues.

The Royal College of Anaesthetists said this brought our process in line with similar processes.

Three in favour (and one against the change) said this already happens at hearings with submissions at both the misconduct and impairment stage of the hearing.

Comments opposed to our proposals

One respondent noted that facts are subjective.

Question 11 – We propose removing the need to refer to transcripts of previous hearings in review and restoration hearings unless this is necessary. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	54	63	8
No	16	19	10
Not Sure	15	17	5
Comment only	1	1	1
TOTAL	86	100	24

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	7	2	0	1	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	3	0	2	0	5
	NHS/HSC organisation	1	1	0	0	2
	Regulatory body	2	1	0	0	3

	Other	2	0	0	0	2
Individuals	Doctor	33	9	13	0	55
	Medical educator	1	1	0	0	2
	Member of the public	0	1	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	2	1	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents to the consultation, 86 answered this question. 54 (63%) of these were in favour of removing the need to refer to transcripts of previous hearings in review and restoration hearings unless necessary. The majority of individual doctors supported the approach, with 33 out of the 55 who responded in favour. The BMA, the MDDUS, the British Orthopaedic Association, the Scottish Medical and Scientific Advisory Committee, the Royal College of Anaesthetists and the Royal College of Physicians and Surgeons of Glasgow supported the proposals.

16 (19%) opposed the proposal and 15 (17%) were unsure. One respondent did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

Comments in support of our proposal

Five respondents (including one who was unsure) commented that this was an appropriate step or that the proposals would streamline the process.

Four respondents said that the transcript should still be available when required.

One respondent noted that there may be legal argument about what is 'necessary'.

Comments opposed to our proposals

Five respondents said a transcript was needed to have a thorough hearing. This would allow the panel to consider all the facts, uncover any irregularities and appreciate any nuance. One respondent who was unsure said the transcripts allowed for a panel 'audit' of the evidence at each stage of the process.

Three respondents (including one who was unsure) said the panel should have the right to access transcripts as well as the parties and one suggested the panel should be able to consider them where relevant. Two respondents suggested that reference to the transcripts should be unnecessary only where both parties agreed to this.

Five respondents (including three who were unsure and the MPS who did not say whether they supported or opposed the proposal) thought there should be guidance about what was considered necessary and who decides on what is necessary.

The MPS also set out a number of reasons why a transcript was important:

- there may be matters relevant to the hearing that are not included in the panel determination
- the panel hearing the review or restoration may not have heard evidence from the previous hearing
- the transcript would include oral evidence given by the practitioner at the previous hearing which may assist the panel on review or restoration to assess whether the doctor has shown insight.

They added that requesting the transcript during a hearing may waste time.

Comments from those who were not sure

One respondent who was unsure said the transcripts should be available on request and another said it may change the way the panel write their determinations in future, so they include more about the evidence heard.

Suggestions to refine proposal

BLM (a law firm) suggested two refinements. The first, a change to drafting so that the rule would read the MPTS/Registrar *shall* (as opposed to can) give a written record on request. The second, that the MPTS follow the coroner's practice of releasing digitally recorded discs of a hearing for a fee.

Impact on groups with protected characteristics

In addition to their comments above, the MPS highlighted the proposal may be unfair for an unrepresented doctor who may not appreciate the importance of a transcript to their review hearing.

Question 12 – We propose clarifying that the MPTS arranges recordings of panel hearings and the registrar arranges recordings of Investigation Committee hearings and that, on request, the MPTS or registrar (as the case may be) can provide a written record. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	76	87	15

No	4	5	2
Not Sure	6	7	1
Comment only	1	1	1
TOTAL	87	100	19

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	10	0	0	0	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	5	0	0	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	47	4	5	0	56
	Medical educator	2	0	0	0	2
	Member of the public	0	0	1	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents to the consultation, 87 answered this question. 76 (87%) of these strongly supported clarifying the arrangements for recording the proceedings of MPTS hearings and Investigation Committee hearings. 47 out of 56 doctors were in favour of the approach. The BMA, the MDDUS, the MDU, British Orthopaedic Association, Royal College of Physicians of Edinburgh, Scottish Medical and Scientific Advisory Committee and the Royal College of Physicians and Surgeons of Glasgow were also in favour of the proposal.

4 (5%) were opposed and 6 (7%) were unsure. One respondent did not say whether they were in support, opposed or unsure but made comments (recorded as comment only).

Comments in support of our proposal

The BMA supported this proposal, but noted the importance of assuring doctors and the public that the GMC has the technology available to support the process.

The Royal College of Physicians of Edinburgh were in favour of the proposal but highlighted the need for clear and detailed guidance on the circumstances a request for a written record would be granted or denied and, where denied, whether or not there would be an opportunity to appeal that decision.

The MDU requested assurance that parties would, on request, receive a written transcript and one respondent considered written records should be “made available free of charge”.

The Faculty of Public Health agreed that transcripts, available on request, would be helpful, particularly for those where English is not their first language. The faculty indicated this would be helpful in supporting parties to absorb the information and legal arguments put before the panel.

Comments opposed to our proposal

Two doctors opposed to this proposal indicated the need for an audio/visual recording to be made available to parties. One doctor stated that:

“the written word fails to capture the tone or strength of witnesses and advocate evidence or argument and is reliant on the good faith of the transcriber and his or her fidelity to the audio-recording”.

Question 13 – We propose clarifying the terminology we use, in particular what we mean by ‘witness’. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	72	85	11
No	7	8	6

Not Sure	4	5	1
Comment only	2	2	2
TOTAL	85	100	20

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	6	3	0	1	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	5	0	0	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	47	3	4	0	54
	Medical educator	2	0	0	0	2
	Member of the public	0	1	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents to the consultation, 85 answered this question. 72 (85%) of these supported the proposal to clarify the terminology we use. 7 (8%) of respondents opposed the proposal and 4 (5%) were not sure.

Two respondents did not say whether they were in support, opposed or unsure but made comments.

There was support from the BMA, MDU, Nursing and Midwifery Council, British Orthopaedic Association, Royal College of Physicians of Edinburgh, Royal College of Physicians of Edinburgh, the Scottish Medical and Scientific Advisory Committee and Royal College of Physicians and Surgeons of Glasgow.

The MDDUS opposed the proposal.

Comments in support of our proposal

The Royal College of Anaesthetists supported this proposal as they believed it would provide consistency with other “similar legal processes”. The Faculty of Public Health also welcomed the clarification.

One doctor who supported the proposal raised concern that greater weight was given to statements provided by the “investigation body (for example a hospital trust)” compared with those statements provided by witnesses.

Another doctor stated that witnesses should be appropriately qualified to ensure credibility although witnesses play a broader role in our proceedings beyond providing expert evidence.

The Royal College of Physicians, although supportive of the proposal, thought it would be helpful to have provided a clearer explanation of this proposal within the consultation document.

Comments opposed to our proposal

A number of respondents raised concern that a doctor's role in proceedings is wider than that of a witness. The MDDUS stated that the role of a witness of fact or expert “is to assist the panel on matters within their knowledge of expertise. A party has rights and protections at law which require different definition.” Similarly, BLM argued that Rule 34(11) relates to a witness of fact, not the doctor, and stated that the definition of a witness needed “further refinement”. RadcliffesLeBrasseur agreed with this and argued that the distinction should be reflected in the Rules.

One doctor stated that this was not analogous to criminal proceedings and was therefore inappropriate. It is worth noting that MPTS hearings are civil proceedings.

Comments from those who were unsure

One doctor requested further clarification on the meaning of ‘legal representative’.

Suggestions to refine proposal

One respondent suggested that doctors should be required to take an oath when they provide evidence to the panel, in the same way as a witness would.

Impact on groups with protected characteristics

One respondent commented on the impact this proposal might have on unrepresented doctors some of whom may be from groups with protected characteristics.

Question 14 – We propose allowing case managers and Investigation Committee members to adjourn hearings that are part heard when either party requests this. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	67	80	12
No	8	9	7
Not sure	8	9	3
Comment only	3	3	3
TOTAL	86	101	25

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	7	1	1	1	10
	Government department	0	0	0	1	1
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	5	0	0	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	2	0	0	1	3

	Other	2	0	0	0	2
Individuals	Doctor	41	6	7	0	54
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	0	1	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents to the consultation, 86 answered this question. 67 (80%) agreed with allowing case manager and Investigation Committee members to adjourn hearings that are part heard when either party requests this. 41 out of 76 doctors were in favour of the approach. The Nursing and Midwifery Council, the MDU, the British Orthopaedic Association, the Royal College of Physicians of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and the Law Society of Scotland were in favour.

8 (9%) opposed the proposal including the BMA and 8 (9%) were unsure. Three respondents, including the Chief Nursing Officer's Directorate of the Scottish Government, did not say whether they were in support, opposed or unsure but made comments.

Comments in support of the proposal

Three respondents said this proposal was practical and would contribute to streamlining our process.

Six respondents (three in favour, two against and one who was unsure) said care would need to be taken to avoid unnecessary delay as a result of adjournments. Those opposed said delays were detrimental to the doctor and would also have an impact on experts attending the hearing who had requested leave from work. One respondent noted that the long adjudication process could remove a good doctor from clinical practice resulting in the need for re-training.

Comments opposed to the proposal

Eight respondents (five opposed and two in favour) thought the adjournment should only be allowed where both parties agree. The BMA gave specific suggestions set out below and were concerned that the doctor should not lose their right to make oral representations on adjournment to the panel. Two respondents (one who was unsure) from this group of eight suggested that where the parties did not agree the panel should decide.

One respondent (who was unsure) said there should be good evidence for the need for an adjournment. Two respondents said the panel should decide instead of the case manager.

Comment only responses

The Chief Nursing Officer's Directorate commented that there was no process to deal with the situation where one party agrees with the adjournment and the other party doesn't.

Suggested refinements

The BMA suggested that adjournments should be allowed where: both parties agree, and where they do, provide an alternative date; and where parties agree to the case manager making a decision on adjournment in writing.

Question 15 – We propose that, to protect the public, when the panel has adjourned a review hearing before it has made a finding of impairment, a panel should be allowed to extend a sanction until the panel can reconvene to consider impairment. Do you agree?

Responses:

Option	Response number	Percentage	Number of comments
Yes	58	67	13
No	15	17	9
Not Sure	13	15	8
Comment only	1	1	1
TOTAL	87	100	31

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	7	3	0	0	10
	Government department	0	0	0	1	1
	Independent healthcare provider	1	0	0	0	1

	Postgraduate medical institution	3	0	2	0	5
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	3	0	0	0	3
	Other	2	0	0	0	2
Individuals	Doctor	33	12	10	0	55
	Medical educator	1	0	1	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 responses to the consultation, 87 responded to this question. 58 (67%) supported a panel extending sanctions in the event that a review hearing is adjourned before it has made findings of impairment. Various organisations were in favour including the MDDUS, the MDU, the PSA and the Royal College of Physicians and Surgeons of Glasgow.

15 (17%) of respondents opposed the proposal including the BMA, MPS and Faculty of Pain Medicine of the Royal College of Anaesthetists. 13 (15%) were unsure. The Chief Nursing Officer's Directorate of the Scottish Government did not say whether they supported, opposed or were unsure about the proposal but made a comment.

Comments in support of the proposal

Five respondents said this change would protect the public. One thought it was a logical step and another pointed to the fact it happens already in some circumstances.

One noted that this should only be used where the doctor presented a risk and another that the sanction imposed should be proportionate to the risk.

One doctor said this should only be used where both parties consented.

One respondent said that this should only be used in exceptional circumstances.

Comments opposed to the proposal

Ten respondents, including four who were unsure and the Chief Nursing Officer's Directorate, said this change would be detrimental to the doctor. The Chief Nursing Officer's Directorate also questioned whether the change was compliant with the Human Rights Act. One doctor referred to guidelines that prevent an employing Trust from excluding a doctor for more than 3 months without board level involvement on the basis that those absent from clinical practice for more than 3 months find it more difficult to return to work.

Seven respondents, including three respondents in favour and one who was unsure, said a time limit on the extended sanction was necessary to prevent the case continuing for months.

Two respondents suggested that review hearings be listed before the end of the review period to allow for another hearing if necessary before the sanction expired. Similarly, one respondent in favour, commented that the adjourned review hearing should be expedited to reduce the stress on the doctor.

Comments from those who were unsure

One respondent commented that the use of the power would depend on the charge and the reasons for delay. Another said the proposal was unfair as in most cases the GMC caused delay.

One respondent also suggested that both parties should be able to make submissions about any order made.

Suggestions to refine proposal

To avoid the necessity of extending sanctions before a finding of impairment is made, the BMA made the following suggestions:

- adequate case management for IOP review hearings
- listing of hearings appropriate to their complexity
- holding the review hearing in good time to allow for a further hearing if necessary.

Impact on groups with protected characteristics

Three doctors highlighted that this proposal could have a disproportionate impact on a doctor's health, with one noting this would be the case, in particular where there were concerns about self harm or suicide.

Question 16 – Do you agree with the circumstances we have set out in the draft rules for when case management decisions will not be treated as binding?

Responses:

Option	Response number	Percentage	Number of comments

Yes	54	64	6
No	9	11	5
Not Sure	20	24	6
Comment only	1	1	1
TOTAL	84	100	18

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	6	4	0	0	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	3	0	2	0	5
	NHS/HSC organisation	1	0	1	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	33	4	16	0	53
	Medical educator	2	0	0	0	2
	Member of the public	0	1	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	0	0	1	0	1

Introduction

Out of the 109 respondents to the consultation, 84 answered this question. 54 (64%) agreed with the circumstances we have set out in the draft rules for when case management decisions will not be treated as binding.

9 (11%) respondents opposed the proposal, including the MDDUS, the MDU and the BMA. 20 (24%) were unsure.

One respondent did not answer yes, no or not sure but did make a comment.

General comments

This question asked for a response relating to the criteria to be applied in determining if a direction should be considered as binding and in particular the two suggested exceptions to the rule that a direction should be considered not binding.

No respondent had concerns in principle about case manager's directions being binding and nor did any respondent suggest that either of the proposed exceptions were inappropriate. One respondent (who opposed) noted:

'Care must be taken that the case management regime does not become unduly burdensome'.

Comments in support of our proposal

One doctor said "Case management decisions must be binding, with a cost sanction, if they are to be obeyed, and the current prevarication and delay avoided".

Comments opposed to the proposal

The BMA did not agree with our proposals although they recognised that there is presently an issue that parties criticise one another for failing to adhere to case management directions. They felt that the proposed rules would not go far enough in holding the GMC to account and that:

"it would be appropriate to provide that the MPT has the power to strike out the case, or specific charges, where a doctor's ability fairly to respond to the charges has been undermined in consequence of the GMC's non-compliance".

Noting that a party can request a further case review to be held, the BMA suggested that the rules should explicitly state whether a case manager is bound by earlier case management decisions. They suggested that there should be a clear mechanism to review case managers' directions, and that at present there is no procedure set out as to how to challenge an unfavourable direction. The concern about how to challenge a case management decision was shared by another respondent (who was not sure about the proposal).

Comments from those who were not sure

A number of respondents dealt with the question of how the proposal might impact upon the efficiency of the hearing process. One respondent commented that at present case management hearings do not achieve the objective of ensuring that a case proceeds efficiently. Another stated that it was essential that case management decisions could not be circumvented. Another commented that it was important to prioritise the correct outcome over speed.

One respondent commented that directions were not always realistic in terms of timing.

The Royal College of Surgeons of Edinburgh noted:

'The circumstances are defined as "material change in circumstances" or "not in the interests of justice" – however they are not expanded on and it is not clear who would make a judgment about this".

Suggestions to refine proposal

BLM, who agreed with the proposals suggested that in order to save the panel time, decisions pursuant to 16(7)A could be made by a case manager in advance of the hearing, or agreed by the parties.

Another body representing doctors, who disagreed, also suggested that there should be an exception where the parties agree a variation of a direction.

One respondent who disagreed suggested the addition of a third category of case where a direction issued by a case manager would not be binding, namely if the Tribunal considered that it would assist them to classify the direction as non-binding.

Impact on groups with protected characteristics

In addition to comments set out above, the BMA also said the binding nature of the directions should be made plain to unrepresented doctors.

Question 17 – Do you agree with our proposals for awarding and assessing costs, as outlined in the draft rules?

Responses:

Option	Response number	Percentage	Number of comments
Yes	38	46	10
No	25	30	16
Not Sure	16	19	8
Comment only	4	5	4

TOTAL	83	100	38
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Response by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	2	6	1	1	10
	Government department	0	0	0	1	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	2	0	2	0	4
	NHS/HSC organisation	2	0	0	0	2
	Regulatory body	0	1	0	2	3
	Other	2	0	0	0	2
Individuals	Doctor	24	12	16	0	52
	Medical educator	2	0	0	0	2
	Member of the public	0	0	1	0	1
	Responsible Officer	0	1	0	0	1
	Other	2	0	1	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents to the consultation, 83 responded to this question. 38 (46%) of respondents agreed with our proposals for awarding and assessing costs as outlined in the draft rules, including bodies representing doctors and a post graduate medical institution.

25 (30%) of respondents opposed our proposals, including the BMA, the MDDUS, the MDU, other bodies representing doctors and the Law Society of Scotland.

16 (19%) respondents were not sure. Four respondents, including the Chief Nursing Officer's Directorate of the Scottish Government, did not answer yes, no or not sure but made comments.

Comments in support of our proposal

Three respondents commented that they welcomed this measure, on the basis that it would increase efficiency and reduce delays. Another respondent who agreed felt that financial sanctions may be needed in order to ensure that case management decisions are enforced, and commented

'These sanctions must be effective at preventing delays as they will otherwise be useless'.

One respondent who agreed suggested that there should be a fixed tariff of contributions to costs, rather than an order made for actual costs incurred. A respondent who was not sure stated "the scale of costs should be very clear", and not punitive.

One doctor who agreed warned that care must be taken to ensure that it does not become the case that a disproportionate amount of time is spent on arguing about/appealing costs (these concerns were also voiced by a respondent who disagreed, who gave the example of the civil courts where "parties become misdirected into procedural detail")

One respondent who agreed said that costs needed to take into account the cost of paying GP witnesses a reasonable amount towards locum cover.

Two respondents queried how costs would be enforced.

One doctor suggested that an order for costs should also be made when charges against a doctor are found proved.

Comments opposed to our proposal

Three respondents (including the Chief Nursing Officer's Directorate) sought clarification as to the meaning of the term "unreasonable". One respondent who disagreed felt that "unreasonable" was very wide. Another who disagreed stated "the proposed rule changes are unclear as to precisely the circumstances in which the power to make a costs order would be triggered" and a second noted a "wider scope to order costs set out in the draft rule than in the consultation paper". A party who was not sure commented that the draft rules are unclear "as they appear to suggest that costs could be awarded in cases where there has either been a failure to comply with a direction or there has been unreasonable behaviour". The Chief Nursing Officer's Directorate also asked who would make the decision about unreasonable behaviour and whether this could be challenged (including in Scottish courts).

Seven respondents (including two who agreed and two who were not sure) raised the question of ability to pay, particularly where a doctor has been unable to earn whilst under investigation. One suggested that the costs to be paid should be proportionate to a doctor's wages, rather than to a lawyer's.

Four respondents (one who agreed and two who disagreed) raised the question of whether such decisions would be appealable. Three who disagreed queried whether it was right for the case manager to have these powers. One respondent who disagreed was concerned about “lay individuals” making decisions on costs. A respondent who was not sure felt that tribunals would need clear guidance and training.

One respondent took the view that the proposed changes would penalise doctors without the support of a defence organisation and four stated that the costs would simply be passed on to other registrants.

Two doctors who disagreed felt that in some cases the doctor should be entitled to costs and compensation.

Two respondents stated that there was no evidence of any need for costs sanctions, one suggesting that other avenues for improving efficiency should be explored before the costs regime is imposed.

A respondent who was not sure, and two bodies representing doctors who disagreed, raised a concern about a dispute as to whether costs should be paid by a doctor or by his representatives, and issues of legal professional privilege. One suggested that the test for whether a legal representative should have to pay costs should be the same as that applied in other jurisdictions.

One respondent who disagreed, felt that the proposed changes were unfair, first because “there seems to be no liability on the MPTS to pay costs where it is the cause of delays” and secondly that “ability to pay is more likely to be a factor when assessing the cost liability of a complainant, as opposed to a doctor who holds indemnity cover”. This respondent had related concerns about indemnity cover becoming unaffordable.

One respondent who did not agree noted that there was no legal aid available to doctors, that the regime would lead to “inequality of arms”, and that a human rights issue arose under Article 6 of the European Convention of Human Rights (ie the right to a fair trial).

A respondent who disagreed queried whether non-payment of costs would itself be regarded as a regulatory matter.

Comments from those who were unsure

A body representing doctors felt that the power could be appropriate, in some circumstances, but that they had “wide-ranging concerns”. They invited the GMC to launch a separate consultation on costs, to deal with a number of “foreseeable practical implications”, noting that the suggested 28 day period for disclosure of a schedule of costs and a written response to it with evidence of means, would place extra pressure on a doctor who may be considering and preparing an appeal, making arrangements for patient care following sanction, and/or meeting the cost of his defence (if he was privately represented before a panel).

A body representing doctors noted that in some circumstances there can be practical difficulties in abiding by directions.

One respondent who was not sure felt that it was not possible to give a substantive response before the GMC guidelines were published, but queried whether there would be set fees, what evidence would be needed and whether the panel could raise the issue of costs of their own volition.

Suggestions to refine proposal

A respondent who was not sure suggested that parties should be required to give a notice of an intention to seek an order for costs.

Impact on groups with protected characteristics

One respondent noted the suicide rate amongst doctors facing proceedings at the GMC in the context of additional pressure a doctor would face in relation to a costs order.

Five respondents thought special care would be needed in the case of an unrepresented doctor, one of whom felt that it was essential that unrepresented doctors be given lots of information and suggested that a dedicated website be set up to give impartial advice.

Question 18 – When we make provisional enquiries to decide if we need to carry out an investigation, we propose removing the need to tell a doctor's employer. Do you agree?

General analysis table:

Option	Response number	Percentage%	Number of comments
Yes	71	84	21
No	11	13	8
Not Sure	3	4	1
Comment only	0	0	0
TOTAL	85	101	30

Category analysis table:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	9	1	0	0	10

	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	2	2	1	0	5
	NHS/HSC organisation	1	1	0	0	2
	Regulatory body	3	0	0	0	3
	Other	1	1	0	0	2
Individuals	Doctor	48	5	1	0	54
	Medical educator	1	0	1	0	2
	Member of the public	0	1	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3
Unknown	Blank	1	0	0	0	1

Introduction

Out of the 109 respondents, 85 answered this question. 71 (84%) agreed with the proposal to remove the requirement to disclose preliminary enquiries to a doctor's employer, including 48 out of 54 doctors and seven bodies representing doctors.

11(13%) respondents opposed the proposal, including five doctors, and 3 (4%) were unsure.

Comments in support of the proposal

Six respondents said this was fair for doctors, including the MDU and the NMC. Eight respondents (including one who opposed the proposal) including the Royal College of Surgeons, Edinburgh, felt this would protect doctors from reputational damage, particularly where a complaint was vexatious, and so save them distress. One doctor commented that "mud sticks" and any hint of a fitness to practise issue can adversely affect the employer-employee relationship.

Four respondents, including the PSA, said there was risk to patient safety in not telling the employer, the preliminary enquiry process should be time-limited and there should be

clear guidance for GMC staff about when it would be necessary for public protection to alert an employer at this stage.

One doctor commented on the process for sending letters of good standing that is outside the scope of this consultation but we will reflect on the comment as part of our ongoing review of our processes and procedures.

The Medical Protection Society asked whether this proposal would also apply to the Secretary of State and associated offices (to whom the GMC has a duty to disclose an investigation under section 35B(1) of the *Medical Act 1983*).

Comments opposed to the proposal

Seven respondents said that the GMC must tell the employer or RO. Respondents identified a number of reasons why this was important including: allowing the employer to make an informed decision about how they respond to the complaint locally; so they can support the doctor; and they can give the GMC any relevant information.

The Royal College of Physicians and Surgeons of Glasgow said it was not clear why informing the employer could not happen in parallel with an investigation and the circumstances in which the GMC would disclose preliminary enquiries to a doctor.

Suggestions to refine proposal

Two of the respondents in favour of the proposals pointed out this proposal conflicts with Trust policies that require a doctor to inform their employers of any investigative action. The BMA recommended that doctors be explicitly advised that there is no regulatory requirement for them to inform their employers of fitness to practise issues and Good Medical Practice be amended accordingly.

Another doctor suggested employers are not told about investigations that result in no further action being taken.

One respondent pointed out that public health doctors may need to be treated differently as their employer is not their designated body. They fear that only informing an employer 'could put PHEs RO in a difficult position'.

Impact on groups with protected characteristics

One doctor said referrals for health problems should be deferred or rejected where a doctor is receiving treatment.

Question 19 – We propose introducing a process for a new type of non-compliance hearing to deal with substantive non-compliance with assessments or requests for information required in order to enable us to investigate concerns. Do you agree with that process?

Responses:

Option	Response number	Percentage%	Number of comments
Yes	63	75	11
No	9	11	7
Not Sure	11	13	5
Comment only	1	1	1
TOTAL	84	100	24

Responses by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	5	4	1	0	10
	Government department	0	0	0	0	0
	Independent healthcare provider	1	0	0	0	1
	Postgraduate medical institution	4	0	1	0	5
	NHS/HSC organisation	1	1	0	0	2
	Regulatory body	2	0	0	1	3
	Other	2	0	0	0	2
Individuals	Doctor	40	4	9	0	53
	Medical educator	2	0	0	0	2
	Member of the public	1	0	0	0	1
	Responsible Officer	1	0	0	0	1
	Other	3	0	0	0	3

Unknown	Blank	1	0	0	0	1
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Introduction

Out of the 109 respondents to the consultation, 84 answered this question. 63 (75%) were in favour of introducing a new type of non-compliance hearing, including the PSA, the NMC, the MDU, the Faculty of Public Health, the Royal College of Anaesthetists, and the Law Society of Scotland.

9 (11%) were opposed, including the MDDUS, the MPS, Radcliffes Le Brasseur and 11 (13%) were unsure, including the BMA and the Royal College of Radiologists.

One respondent did not answer yes, no or not sure but made a comment.

Comments in support of our proposal

Three respondents, including the Faculty of Public Health, said that doctors have a duty to comply with their regulator in order to protect patient safety. The Royal College of Anaesthetists also approved of the proposal on the grounds that it would avoid time-wasting. One respondent suggested these powers already exist.

One doctor noted that employers may need to be advised that the doctor required time off work in order to comply.

The MDU response was favourable but made comments about the clarity of the eventual internal guidance on non-compliance referrals.

The PSA agreed, assuming that the reason for the change was to avoid convening an interim orders panel hearing for non-compliance. They noted that:

- non-compliance in itself may be serious enough to constitute misconduct
- there was no explanation of how concerns arising out of non-compliance, separate to those giving rise to the original assessment or investigation would be dealt with
- it was likely that non-compliance with an assessment over a long period would constitute impairment and warrant striking off
- repeated non-compliance should result in a referral to a fitness to practise panel
- it was unclear whether the panel could order a review
- it was unclear what the purpose would be of a referral to the PSA under section 29 as this only applied to fitness to practise hearings.

Comments for those who were unsure

One doctor questioned the propriety of forcing a doctor to comply, arguing that a doctor may already be sure of a negative outcome (potentially erasure) and may have chosen not to comply to save some additional stress.

Comments opposed to our proposal

Four doctors and the MDDUS made comments against the proposal. They expressed the concern that the changes were 'draconian' and failed to allow for actions of doctor's under the stress of an investigation. In particular, the MDDUS thought the proposal was not specific enough, highlighting that many different circumstances could apply to a request for information.

The Royal College for Anaesthetists expressed concern that the new power would give the GMC 'quasi-legal- powers that are 'incongruent with usual legal processes'.

The MPS disagreed on the grounds that the process would place the burden of proof on to the practitioner, a reversal of the current system, and suggested that this may be inconsistent with Article 6 of the European Convention of Human Rights (ie the right to a fair trial).

One respondent said it would be very difficult for a panel to make a decision about the reasonableness of a request without examining the merits of the underlying allegation.

Suggestions to refine proposal

The BMA suggested Rule 28 should explicitly state that complying with a GMC request for information or assessment would be a reason to cancel a hearing. They say this would be in line with our stated commitment to make it 'clear in our rules that a referral made to the MPTS in relation to a non-compliance hearing could be cancelled if the doctor subsequently complied'.

The MDU suggested that the power to refer a doctor for a non-compliance hearing where the GMC has asked for factual information be exercised 'reasonably so that the failure would have to be serious enough to justify the doctor being brought before a tribunal'.

Impact on groups with protected characteristics

The Royal College of Anaesthetists suggested that the GMC make every effort to find out if there were legitimate reasons for non-compliance, such as illness (mental or physical).

Some respondents commented that sick doctors may be adversely affected by the non-compliance process.

Question 20 – Do you think that any of our proposals will adversely affect people from groups with protected characteristics? This could include doctors, patients and members of the public.

Responses:

Option	Response number	Percentage	Number of comments
Yes	13	15	9
No	48	57	4

Not Sure	21	25	7
Comment only	2	2	2
TOTAL	84	99	22

Response by category of respondent:

		Yes	No	Not Sure	Blank	TOTAL
Organisations	Body representing doctors	1	4	2	1	9
	Government department	0	0	1	0	1
	Independent healthcare provider	0	1	0	0	1
	Postgraduate medical institution	0	3	2	0	5
	NHS/HSC organisation	0	2	0	0	2
	Regulatory body	0	2	0	1	3
	Other	0	1	1	0	2
Individuals	Doctor	12	27	14	0	61
	Medical educator	0	2	0	0	2
	Member of the public	0	1	0	0	1
	Responsible Officer	0	1	0	0	1
	Other	0	3	0	0	3
Unknown	Blank	0	1	0	0	1

Introduction

Out of 109 respondents to the consultation, 84 answered this question. 48 (57%) thought the proposals would *not* adversely affect people from groups with protected characteristics.

13 (15%) respondents, , thought the proposals would adversely affect those with protected characteristics. There was a notable concern amongst this group about the overrepresentation of BME doctors in GMC fitness to practise processes. 21 (25%) were unsure as to whether there would be adverse effects.

Comments that proposals would have no adverse effects

The Law Society of Scotland noted the proposals would apply to everyone.

One panellist questioned how the new processes will take account of criminal offences that are different in Scotland and England, giving two examples of drink driving and motoring offences.

Comments that proposals would have adverse impact

Five respondents commented that BME and International Medical Graduate (IMG) doctors are over-represented in the fitness to practise process, with a sense that sufficient action is not being taken to redress this balance. One of these respondents also noted that older males were also over-represented in the process.

The BMA expressed concerns that changes in respect of language assessments were likely to adversely affect BME doctors who do not speak English as a first language and the Royal College of Radiologists who were unsure of the impact were also concerned about language assessments.

One doctor expressed concern about the potential for adverse effects on those with a chronic health problem that meets the definition of disabled and pregnant women (who, for instance, could not attend a hearing when in labour).

One doctor said doctors needed to be treated as equal to the public and one doctor suggested the GMC should be sanctioned for its transgressions more harshly than doctors due to the disproportionate resources at their disposal.

Comments from those who were unsure

The Royal College of Physicians of Edinburgh has suggested that the process is fairly legalistic and may disadvantage doctors with health concerns or unrepresented doctors.

Suggestions to refine proposal

Two respondents said that Equality and Diversity training for GMC staff was key.

Two respondents said the consultation should have included an equality impact assessment.

Appendix B

Comments outside the scope of this consultation

General comments

- 1 MENCAP responded to the consultation making a number of general comments about our processes, particularly in relation to a lack of understanding of the needs of patients with learning disabilities and delay.

Changes in terminology

- 2 In response to question 1, two respondents raised concerns about the change in terminology from panels to tribunals. One thought the change was not sufficient to support operational separation and the MPTS would always be seen as part of the GMC. The other thought the use of the word 'tribunal' would cause confusion with the Tribunal Service. The change in terminology was introduced in the Section 60 Order and was not part of this consultation.

Legally qualified chairs

- 3 A number of respondents opposed the introduction of legally qualified chairs in their responses to both questions 2 and 3. Among them, the BMA said that the power dynamic of the panel would be skewed in favour of the legally qualified chair with the other two panel members unable to challenge the chair's legal advice and the lack of a legal assessor would lead to delay. Another respondent cautioned against the MPTS becoming a quasi-judicial body with decisions being made by single chairs. We asked about the introduction of legally qualified chairs in our consultation *Reform of the fitness to practise procedures at the GMC* in 2011 and consider these comments outside the scope of the current consultation.

28 days' notice period of hearing

- 4 In response to question 5, two respondents comments on notice periods for Interim Orders hearings, not included in this consultation, one commenting that this change should also apply to IOP hearings as the short notice period for these hearings was unfair for doctors, whilst the other said interim order panels should be excluded from the change as, on occasion, they have to be held on no notice.
- 5 Two respondents commented on changes to the Medical Act allowing for service of notices of hearings and allegation by email to the effect that a read receipt will not be sufficient as proof of service. This change was consulted on by the Department of Health and introduced in the Section 60 Order. We have not included these comments in our analysis.

Removing the need for the MPTS to tell the GMC when an interim order is due to expire.

- 6 One respondent commented on the impact on BME doctors of lengthy investigations and recent cases in which judges have criticised the GMC for delay.

Section 2: Consensual disposal

- 7 The PSA made a number of comments about consensual disposal that were outside the scope of the consultation. They disagreed with allowing case examiner undertakings to be available when there is a realistic prospect of a panel imposing a suspension and that undertakings are available at a hearing.
- 8 The PSA noted that there were no rules to implement the power for the GMC to agree undertakings with a doctor after a case has been referred to a hearing. The introduction on this power has already been the subject of the public consultation by the Department of Health (England). Given this, we drafted rules 17(2)(n), 17(3), (4) and (5) to implement this power and did not ask a question about the changes.
- 9 Specifically, the PSA questioned who has the authority to agree undertakings, at what stage and through what process. We consider this remark referred to the General Council agreeing undertakings post-impairment. These provisions were included in the Section 60 Order and were not a subject of this consultation.

Clarifying that the GMC is responsible for recording Investigation Committee hearings

- 10 In response to question 12, RadcliffesLeBrasseur questioned why the Investigation Committee sits within the remit of the GMC and has not transferred to the MPTS. This would require changes to our primary legislation and as such, is outside the scope of this consultation.

Case management

- 11 A number of comments made by respondents in response to question 16 did not address the question but commented on issues which would arise from a party failing to comply with a direction ie drawing adverse inferences and excluding evidence. These powers exist in our current rules and are outside the scope of this consultation.
- 12 A body representing doctors raised a concern about the deletion of Rule 16(5) – requiring case managers to act independently of the parties stating “This is an important requirement to avoid both bias and the perception of bias”. This comment did not directly relate to the question asked and we have not included it in our analysis.

Section 5: the five year rule

- 13 The PSA and MPS both commented on changes to the five year rule. This change was the subject of the public consultation by the Department of Health (England) dealing with changes to our primary legislation. Given this, we have not included these comments in our analysis.

Equality and Diversity

- 14 The Chief Nursing Officer’s Directorate referred to changes made to our rules to reflect amendments to the Medical Act allowing the Registrar to direct a performance

assessment where it is proportionate to do so. They asked how proportionate will be defined and highlighted the importance of this being understood by all sides.

Appendix C

List of Organisations (*those who were happy to disclose their participation):

BLM

British Medical Association

British Orthopaedic Association

Chief Nursing Officer's Directorate, Scottish Government

Faculty of Pain Medicine of the Royal College of Anaesthetists

Faculty of Public Health

General Healthcare Group (BMI Healthcare)

Independent Doctors Federation

Medical Defence Union

Medical Protection Society

National Clinical Assessment Service

Nursing and Midwifery Council

Professional Standards Authority for Health and Social Care

RadcliffesLeBrasseur

Royal College of Anaesthetists

Royal College of Ophthalmologists

Royal College of Physicians and Surgeons of Glasgow

Royal College of Physicians of Edinburgh

Royal College of Psychiatrists

Royal College of Radiologists

Royal College of Surgeons of Edinburgh

Scottish Medical and Scientific Advisory Committee

The Law Society of Scotland

