General Medical Council

Agenda item:	**8**
Report title:	**Consultation on publication and disclosure policy – outcomes and recommendations**
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Considered by:	**Strategy and Policy Board**
Action:	**To consider**

Executive summary

From 1 July to 23 September 2015 we consulted on changes to our policy on what we publish and disclose about a doctor's fitness to practise. Our recommendations following the consultation are set out at Annex A and the report analysing the responses is at Annex B. This has been independently audited, and the conclusion of the auditors following their analysis is at Annex C.

Most of our proposals received majority support. However, the majority of respondents considered that the time limits we proposed were too long. We have therefore recommended some adjustments to our consultation proposals.

Recommendations

Council is asked to:

a Approve the consultation recommendations, at Annex A.

b Consider whether we should transfer historical data given the proposed changes in time limits.

Background to consultation

1 Between 1 July and 23 September 2015, we ran a consultation on changes to the information we publish and disclose about a doctor's fitness to practise. This was primarily driven by concern that, in a changing legal landscape, our policy of publishing fitness to practise information on a doctor's record indefinitely was disproportionate. We wanted to strike an appropriate balance between the transparency necessary to ensure public protection and maintain public confidence, and a proportionate response to matters that took place a long time ago, or where a doctor has given up their registration and is no longer seeking work as a doctor.

2 The consultation therefore proposed the introduction of time limits on the length of time that historical fitness to practise information will be published on a doctor's record. It also asked whether we should stop publication of fitness to practise information after a doctor dies; and sought views on whether we should disclose information to prospective employers outside of the time limits.

3 The consultation also asked for views on the following proposals, aimed at increasing transparency about fitness to practise decisions that have been taken:

- **a** Transferring historical data from 1994-2005 (which is not currently online) on to a doctor's online record, in line with any time limits agreed above.
- **b** Providing clearer information on a doctor's online record on the outcome of appeals of fitness to practise decisions.
- **c** Providing greater explanation of decisions where a doctor agrees undertakings without a hearing. Currently only the undertakings themselves are published.

Outcome of the consultation

4 We initially received 68 responses. These included seven bodies representing doctors but only one patient group – the Patient Liaison Group of the Royal College of Surgeons, although the Professional Standards Authority also responded. We contacted patient representative organisations to ask them to consider responding. AVMA then replied bringing the total to 69. Further approaches to patient groups resulted in a small number of further responses that made general points but did not address the questions in any detail - from the Board of Community Health Councils in Wales, Citizens Advice Scotland and Healthwatch. We don't know why, despite a direct approach, we had so few responses from patient groups. It is possible they do not have strong views on this or do not disagree with the proposals.

5 Our proposals on providing clearer information about appeal outcomes, and greater explanation of decisions to agree undertakings, received majority support. There was very strong support for our proposal to stop publication of fitness to practise information after a doctor's death. We recommend implementing these proposals.

6 While there was a positive response to the introduction of time limits, there was a majority view that the proposed limits, particularly for registered doctors, were too long. We recommend reducing the 20 year time limit proposed for all sanctions below erasure, to 15 years for suspensions of more than three months, and 10 years for conditions, undertakings, and suspensions of three months or less. We have considered if a further sanction should extend the original time limit but are content that, as our retention policy provides for this to enable us to maintain oversight of a doctor's fitness to practise history, and in view of the length of the publication time limits proposed, we do not consider that extending them in this way is necessary.

7 Opinion on whether or not we disclose fitness to practise information to prospective employers after time limits have expired was almost equally divided. On balance, we recommend that we do not. We consider a prospective employer to be a current employer once they have made a doctor an offer and that offer has been accepted and we will continue to disclose past sanctions indefinitely to current employers.

Proposals for the transfer of historical data

8 There was majority support for our proposal to transfer historical fitness to practise information from 1994-2005 to the online register. If time limits are introduced as recommended above, there would be a maximum of four years publication where the hearing concluded in 2005, reducing for each year before that, with information on sanctions imposed prior to 2001 not transferred at all. Only suspensions over three months and erasures would be published, as the time limit for lesser sanctions will expire this year. In the region of 25 doctors would have historical suspensions and 15 restored doctors would have historical erasures published.

9 At present there is an inconsistency between publication in relation to doctors with sanctions after 2005 and doctors before 2005 and this will remain for a small number of doctors for four years and for an even smaller number of erased and restored doctors indefinitely. However, in view of the small numbers we need to consider whether there is a public interest in publishing historical data particularly given the purpose of introducing time limits is to enable doctors to move on from actions a long time in the past that have not been repeated.

10 More detail about this is in Annex A paragraphs 29-35. We welcome Council's views.

Equality impact

11 Our impact assessment did not identify any disproportionate impact on people with protected characteristics* and nor did the majority of respondents to the consultation. However, issues were raised by some about the impact of publication on those with long term health conditions. We recommend that these should be considered as part of the review of our approach to doctors with health concerns.

* Except in so far as certain groups of people are overrepresented in our fitness to practise procedures overall, which is subject to ongoing data monitoring, research and analysis within the organisation.

General Medical Council

M8 – Consultation on publication and disclosure policy – outcomes and recommendations

M8 – Annex A

Recommendations following consultation on the publication and disclosure of information about a doctor's fitness to practise

Introduction

This annex sets out key points from the responses to the consultation together with our recommended way forward following analysis of those responses. Further information on the detail of the responses received can be found in the consultation outcomes report at Annex B. (Page references given are to the summary information, but detailed breakdowns of the responses are available in the Appendix to the report.) This report was independently audited, and the conclusion of the auditors following their analysis is at Annex C.

Introduction of time limits (Annex B: page 4)

1 There was a positive response to the introduction of time limits on publishing and disclosing fitness to practise information, but a majority view that the proposed limits, particularly for registered doctors, were too long. The British Medical Associate (BMA) and the three medical defence organisations (MDOs) which responded were among those expressing this view. The 20 year publication period for which any sanction below erasure would be published after revocation, if a doctor remained registered, caused the most concern. Strong arguments were also made for a staged approach to time limits according to the severity of the sanction.

2 We received limited response from patient representative groups, but of those responding, AVMA agreed with the level at which we had set time limits, but considered that different types of case merited different treatment. The Professional Standards Authority (PSA) also agreed with the proposed limits, but commented that they were set much higher than their own recommended minimums. In a 2010 publication, they recommended that erasure should be published for a minimum of five years, and that regulators should take a 'proportionate approach' to publishing lesser panel sanctions. Further approaches to patient groups resulted in a small number of further responses that made general points but did not address the questions in any detail.

3 The Board of Community Health Councils in Wales appreciated the argument for a level of proportionality. Their preference was for indefinite publication and they argued for publication for as long as the law allows, which we have considered to be in the region of 20 years. Citizens Advice Scotland did not address the proposals but made a general statement in support of transparency. Healthwatch England said they had no direct evidence on this topic from the public, and on time limits recognised the need for proportionality and suggested we consult with those affected by the incident in setting time limits in individual cases. They also suggested we provide notice before removing a sanction from the record to allow patients to come forward if they have concerns.

4 To reflect concerns about the length of time limits and the comments about distinguishing between different types of sanction, we recommend reducing the proposed time limits for registered doctors for sanctions below erasure from 20 years to 15 years for suspensions of more than three months; and to ten years for suspensions of three months or less[1] and for all conditions and undertakings. We recommend that all other time limits remain as in the consultation. The time limits would therefore be as follows:

Registered doctors

Sanction	Time limit
Doctor erased by FTP panel and subsequently restored to register	As long as the doctor is registered with the GMC plus five years if they leave
Doctor received a suspension of more than 3 months	15 years from the date the suspension expires
Doctor received a suspension of three months or less, or conditions or undertakings	Ten years from the date the sanction expires or is revoked
Doctor received a finding of impaired fitness to practise but no sanction[2]	Ten years from the date of the end of the fitness to practise hearing

Doctors not currently registered

Sanction	Time limit
Doctor was erased by FTP panel	Ten years from the date of erasure
Doctor received a sanction other than erasure, or a finding of impaired fitness to practise but no sanction.	Five years from the date the doctor left the register (subject to relevant 10 and 15 year maximum periods)

[1] Suspensions of three months or less are usually given by panels where the concern is at the lower end of severity but conditions are not workable or appropriate.

[2] This is an issue of more technical detail not specifically covered in the consultation, but this recommendation follows appropriately the principles of proportionality and transparency set out in the consultation.

5 Concerns were raised by several respondents about the fact that the proposals did not differentiate between restrictions imposed in health cases and those where there was misconduct. Reference was made to the impact of publication on a doctor's recovery and on their risk of suicide. Some respondents considered that publishing restrictions in health cases contravened the Equalities Act 2010.

6 Our publication policy is driven by the public interest in being transparent about a doctor's fitness to practise regardless of the reasons that may have affected it. We recommend that the issues raised by respondents to the consultation should be considered as part of the review of our approach to doctors with health concerns, on which Professor Appleby is advising.

Disclosure to prospective employers (Annex B: page 5)

7 Responses were split on the issue of whether we should continue to disclose fitness to practise information to prospective employers outside of time limits, although a small majority thought not (27 said no compared with 25 who said yes).

8 Concerns about disclosure focussed on the current relevance of the information; the impact on the doctor in terms of career, health and wellbeing; and whether it would infringe legislation e.g. data protection, human rights (and equalities in relation to health cases). Those in favour thought transparency was in the public interest, and that employers had a right to know to enable fully informed decisions.

9 There was support for a system that took into account the nature of the job and seriousness of the offence. The Information Commissioner's Office highlighted that a blanket approach of disclosing information might not be justified under data protection law, and thought we should develop a list of considerations to assist in making a decision with each request. However, introducing a system which considered the circumstances of each request for information, i.e. the nature of the job or the offence, would be very resource intensive, complicated for operational staff to carry out, and could lead to inconsistencies of treatment.

10 A key reason for introducing time limits is to allow for a time when a doctor can move on from past actions which have not been repeated. On balance, we recommend that we do not routinely disclose information to prospective employers outside of time limits as this is likely to have a disproportionate impact on their career prospects. This is consistent with our current approach to fitness to practise information which has been removed from the online register – e.g. warnings older than five years.

11 We will continue to disclose to current employers, which means that information can still be provided in post appointment checks. At this point, the doctor has got over the hurdle of selection and the employer can consider the information in the light of the overall suitability for the post; discuss with the doctor if any concerns; put in place any monitoring they think necessary; or withdraw the appointment if appropriate.

Publication and disclosure after a doctor has died (Annex B: page 6)

12 There was very strong support (90%) for our proposal to stop publication of fitness to practise information after a doctor's death. The PSA and the Patient Liaison Group of the Royal College of Surgeons disagreed, but AVMA agreed with the proposal providing information was still disclosed on request.

13 There was overall support for us continuing to disclose fitness to practise information about doctors who have died after we have removed it from publication, although several respondents considered this should only happen if the enquirer could demonstrate a legitimate interest in having that information. On reflection however, we consider this could be unduly burdensome for an enquirer and could prevent the public obtaining information in the public interest. Information about a doctor who has since died may still be relevant to an individual's decision to pursue a complaint or claim, as well as to judicial or public inquiries or investigations.

14 We recommend that we remove fitness to practise information from a doctor's public record after their death. However, we recommend that the same information as would have been published if the doctor had not died, should continue to be disclosed on request to general enquirers, within any time limits introduced.

15 Our proposal that the decision of a fitness to practise panel hearing should continue to appear on the MPTS' Recent decisions webpage for a fixed period, even if a doctor were to die shortly after a panel hearing, received majority support. The majority also agreed with our proposal that this period should be six months from the end of the hearing. However, taking into account the concerns of some respondents about removing this information from the public domain, we recommend extending this to one year, which is the usual length of time for which decisions remain on the MPTS webpage.

Publishing notes of appeal outcomes on a doctor's record (Annex B: page 8)

16 There was a high level of support for our proposals to provide greater clarity on appeal outcomes by placing a note on a doctor's online record for a period of 12 months to state, for example, whether an appeal was unsuccessful, successful, partially successful, or withdrawn. Support dropped a little for the proposal in relation to stating the outcome on a doctor's record of successful appeals and judicial reviews, but still remained at over 60%.

17 Those who agreed considered the proposals would bring greater transparency and would be in the public interest. Those who disagreed did so, either because they could not see what benefit the proposals would bring, or because of a potential negative impact on the doctor. In the case of successful appeals and judicial reviews, those who disagreed thought it inappropriate to continue to publish any information on the

doctor's record which showed there had been an FTP case, when the original decision had been overturned on appeal.

18 We consider that the proposals will bring greater transparency and clarity to enable the public to better understand the decisions that have been taken in a fitness to practise case. We recommend that we proceed with the proposals.

19 While we did not propose any changes to our approach to the publication of appeals of interim order decisions, we did invite comments on that approach, and propose that we would set it out for the first time in our publication and disclosure policy. 27 respondents provided comments on our approach of which only four were opposed. We recommend that we proceed with the approach as set out in the consultation paper, and include it in the content of our publication and disclosure policy.

Providing greater explanation of our decisions where a case concludes with a doctor agreeing undertakings without a fitness to practise panel hearing (Annex B: page 9)

20 The majority of respondents agreed with our proposal to publish, alongside the list of undertakings on a doctor's online record, a short summary of the concerns and the reasoning behind our decision to resolve the case consensually. Those in agreement included the PSA, AvMA, and the MDOs.

21 Reasons given by those who agreed included greater transparency and increased public understanding. Those who disagreed thought the proposal disproportionate; a breach of privacy; and were concerned it would discourage doctors from agreeing undertakings. The process of agreeing the summary was also a cause for concern for some respondents, including the BMA.

22 It is possible that some doctors may be deterred from agreeing undertakings as a result of the change. However, we believe it is very much in the public interest for our decisions to be as transparent as possible, so that the public can understand the action we have taken and why we consider it sufficient to address any concerns about a doctor. We therefore recommend that we proceed with this proposal. We will reflect on the comments made by respondents to the consultation as we consider how drafting of the summary will fit in to the current process of agreeing undertakings.

Equality issues (Annex B: page 10)

23 We asked respondents if they thought any of our proposals would affect people with protected characteristics covered by equality legislation. The majority of respondents (61%) did not think that they would.

24 Where respondents did raise issues, most related to doctors who had long term illnesses, or who may be classed as disabled under the Equalities Act. There was concern that publication of fitness to practise sanctions would have a detrimental

impact on the lives of doctors within this group, and that it was unfair that doctors who had received sanctions due to health conditions would be treated in the same way as doctors who had received sanctions due to malpractice or criminal activity. As set out at paragraph five above, we recommend that these issues should be considered as part of the review of our approach to doctors with health concerns, on which Professor Appleby is advising.

25 Concern was also raised that the proposed 20 year time limit for all sanctions might have a disproportionately detrimental impact on younger doctors, who would face publication for almost their entire career. These concerns will be mitigated by our proposals to shorten this 20 year limit, and to introduce two levels of time limit according to sanction.

26 One respondent commented that the GMC would need to consider the impact of publication of any information which made reference to a doctor's sexual orientation as well as any mechanisms necessary to deal with cases where a doctor has undergone gender reassignment since the hearing. These are not issues that arise from the proposed changes, as currently, any public determinations are published indefinitely. It is worth emphasising however, that all determinations are carefully considered before publication and any confidential information is redacted.

27 One respondent was concerned about the potential unintended consequences of publication on people with long standing mental health problems who may be patients or relatives of doctors, although they did not specify their concerns. Again, this is not an issue that arises from the changes, as publication already takes place. In fact the changes will serve to mitigate any impact by providing an end point for publication of fitness to practise information.

28 Finally, one respondent had concerns that some groups may find certain complex proposals difficult to understand. We will take this into account when redrafting our publication and disclosure policy, and will review it for clarity and the use of plain English.

Transfer of historical data from 1995-2005 on to a doctor's online record (Annex B: page 7)

29 There was majority support of 59% for our proposal to transfer pre 2005 data, in the interests of transparency and equal treatment, although some of this support was qualified by the view that health cases should be treated differently, and that the transfer should depend on the severity of the offence.

30 30% of respondents disagreed, largely because of proportionality and the potential impact on doctors. The proposal was described as unfair retrospective punishment, which might have a severe impact on an individual doctor, but a negligible impact on patient safety.

31 The Information Commissioner's Office neither agreed nor disagreed, but commented that the GMC 'will have to be satisfied that this publication is necessary to fulfil its purpose and that it will not cause any unjustified adverse effects on the doctors in question'.

32 Any transfer would of course be affected by a decision to reduce the length of the time limits to 15 and 10 years. We do not hold sufficient information from before 2005 to allow us to run the time limits from the date of revocation of any sanction – rather they would need to be applied from the end date of the fitness to practise hearing. The transfer would not be completed until 2016, which would mean there would be four years of publication for any case where the hearing concluded in 2005, reducing for each year before that, with information on sanctions imposed prior to 2001 not transferred at all. The data transfer would apply only to suspensions of over three months, as the 10 year time limit for lesser sanctions will expire this year.

33 We would need to undertake a full review of data, and it would depend on the exact date on which the transfer happens, but we estimate that there would be in the region of 25 doctors where details of a historical suspension would be transferred on to their online record.

34 Where a doctor has been restored to the register following fitness to practise erasure, information would of course remain on their record for longer (the period for which they are registered, plus five years after they leave). Again, we would need to review the data at the time of transfer, but we estimate there are in the region of 15 to 20 doctors who have been restored to the register, where details of a historical erasure would be transferred on to their online record.

35 There is clearly a mandate from the consultation to carry out the data transfer. However, in the light of proposed changes to the time limits, there is a question about whether the benefit derived in terms of public protection from transferring data about historical sanctions for what will be a relatively short time period is sufficient to justify the impact on individual doctors.

M8 – Annex B

Consultation methodology, breakdown of responses and analysis

Introduction

From 1 July to 23 September 2015, we consulted on changes to the information we publish and disclose about a doctor's fitness to practise. The primary focus of the consultation was on the length of time for which we publish this information on our online register and disclose it to enquirers, but it also covered proposals on treatment of historical data; publication of appeals outcomes; and greater explanation of decisions to agree undertakings without a fitness to practise panel hearing.

This document sets out a summary of the responses to our consultation. It contains a broad overview; a detailed breakdown at Appendix A; and a list of organisations who responded at Appendix B.

Background

We are required by the Medical Act 1983 to publish, in such a manner as we see fit, a range of decisions by fitness to practise panels, interim orders panels, the Investigation Committee, and undertakings agreed with doctors. We have a discretionary power to withhold any information concerning the physical or mental health of a person which we consider to be confidential. We also have a discretionary power to publish or disclose any information about a doctor, to any enquirer, where we consider it to be in the public interest. We are subject to a range of legislative duties in relation to information governance including the Data Protection Act 1998, the Human Rights Act 1998, and the Freedom of Information Act 2000.

Our Publication and disclosure policy outlines our policy in relation to the routine publication and disclosure of fitness to practise information, including where a doctor has received a fitness to practise sanction on their registration (erasure, suspension, conditions or warning) or agreed undertakings in relation to that registration. Our consultation paper proposed some key changes to our publication and disclosure policy.

Our consultation

Our consultation covered six main areas:

Introduction of time limits

Currently, where a doctor receives a sanction on their registration or agrees undertakings, this information is published indefinitely on the doctor's record on our online register. This is the case even if the doctor subsequently dies. Our consultation proposed the introduction of time limits on the length of time for which fitness to practise information is published on the online register and disclosed to general enquirers. The proposed time limits vary according to whether the doctor remained registered or not. The consultation also sought views on whether we should disclose fitness to practise information to prospective employers (in addition to the disclosure we make to current employers) outside of any time limits; and on whether we should remove fitness to practise information from the online register after a doctor dies.

Transfer of historical data

Our online register was introduced in October 2005. Any sanctions in force at that date or imposed subsequently appear on the online register. However, any sanctions imposed before October 2005 which had expired by that date, do not – although this information is available by contacting the GMC directly. Our consultation proposed that information from before October 2005 should be transferred on to the online register, in line with any time limits introduced, in order to ensure that our fitness to practise information is as transparent and accessible as possible.

Publishing information about the outcomes of fitness to practise appeals

Fitness to practise panels hear evidence and decide whether a doctor's fitness to practise is impaired, and if so, whether a sanction should be imposed on his or her registration. Where a doctor appeals a panel's decision, and that appeal is dismissed or withdrawn, the original decision and any sanction are published on a doctor's record, but all mention of the appeal is removed. If an appeal is successful, the original decision and all mention of the appeal are removed from the doctor's record and from the recent decisions web page of the Medical Practitioners' Tribunal Service (MPTS). This can make it difficult to present a clear story to the public as to what has happened in the case, and why the final outcome is considered to be in the public interest.

In order to improve transparency and make sure that information about what has happened in a fitness to practise case is as clear and accessible as possible, our consultation proposed to include information on a doctor's online record, and in some cases on the web page of the MPTS, for a period of 12 months, stating the outcome of any appeal.

Clarifying our policy on publishing information about appeals of interim orders

An interim orders panel hearing considers whether a doctor's registration should be temporarily restricted while allegations about their practice or conduct are investigated. Our approach to publishing information about appeals of interim orders is not currently included in our publication and disclosure policy, but we propose going forward to include it. Our approach differs to that proposed for appeals of fitness to practise decisions because interim orders serve a different purpose. They aim to keep patients safe while we investigate concerns and are imposed before a panel finds whether the allegations against a doctor are proven. Our consultation did not propose changes in this area but set out our approach to publication and sought comments on it.

Providing greater explanation of our decisions where a case concludes with a doctor agreeing undertakings without a fitness to practise panel hearing

Fitness to practise cases can conclude with doctors voluntarily agreeing undertakings to restrict their practice without the need for a fitness to practise panel hearing. Currently all that appears on a doctor's online record in this situation is the list of undertakings. There is no explanation of the concerns the undertakings are intended to address or why they are considered to be a proportionate response. This differs from the approach taken where undertakings are agreed or conditions imposed following a fitness to practise hearing, and indeed from the approach taken where a warning is imposed. Our consultation proposed that we should include a short summary of the concerns and the reasons behind our decision with the list of undertakings on the doctor's record.

Equality

Our consultation also asked for views from respondents on whether any of our proposals would affect people with protected characteristics covered by equality legislation.

Our approach

We asked 19 questions about the proposed changes to our publication and disclosure policy. For 16 of those questions, respondents were asked whether they agreed or disagreed with each question, or were not sure. They were then asked to provide any additional comments. The remaining 3 questions asked for comments only.

The summary of findings section below highlights the key messages from the consultation for each of the six main areas covered by the consultation. Appendix A sets out the 19 questions we asked; the breakdown of responses; and a more detailed summary of the comments for each question.

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, which we uploaded to our e-consult website on receipt. We also published a Welsh language version of both the consultation document and response form.

Stakeholder events were held in London, Belfast and Cardiff, primarily to inform stakeholders of the content of the consultation and encourage responses. However, stakeholders did have the opportunity to discuss and express their view on some of the proposals, and where appropriate, these have been included in the summary of respondents' comments.

In analysing the responses to the consultation, we have undertaken a statistical breakdown of the answers to each question, and set out the percentage[1] of the total respondents to the question for each answer. These results can be found in the detailed breakdown of responses to each question in Appendix A. Not all respondents answered every question, so the total number of respondents for each question varies. Numbers are included where a respondent left an answer to the question blank but only if they provided a comment on that question. These are labelled 'comment only'. We have also set out a breakdown of the answers to each question according to the category of respondent.

Analysis of the comments made by respondents has been carried out by first theming the responses and, where possible, grouping those themes in the summary provided.

Breakdown of responses

We received a total of 69 responses to the consultation, 48 from individuals and 21 from organisations. The table below provides a breakdown of the categories of respondent.

		Total
Organisations	Body representing doctors	7
	Body representing patients or public	2
	Postgraduate medical institution	7
	Regulatory body	1
	Other	4
Individuals	Doctor	36
	Member of the public	4
	Other	8

[1] In general terms, we have rounded up percentages where .5 and above, and rounded down where .4 and below. However, there may be some slight variation to this in order to achieve 100% total.

Appendix B provides a list of the organisations who responded to our consultation (with their corresponding acronym where that is used in this summary).

Summary of findings

Introduction of time limits (questions 1 to 8)

Although the specific time limits proposed in our consultation did not meet with majority approval, it was apparent that the majority of respondents agreed with the move from indefinite publication and disclosure of fitness to practise information to the introduction of time limits. However, a few respondents argued for continued indefinite publication, or time limits longer than those we had proposed. This included one of the bodies representing patients, the Patient Liaison Group of the Royal College of Surgeons, who thought that information should be available to the public for as long as it is available to employers, in order to protect those using private medical services.

Just over a quarter of respondents, including the other two bodies representing patients' interests – AvMA and our regulator PSA – agreed with the levels at which we had set the time limits but the majority of respondents raised concerns that our proposed time limits were too long. This was a particular concern in relation to the proposed time limit of 20 years for registered doctors receiving a sanction less than erasure. The BMA and the three medical defence organisations who responded were among those who opposed the time limits on the grounds that they were too long.

Respondents disagreed with the time limits for a variety of reasons. Of those who thought they were too long, common themes were, that they:

- were unduly punitive given the adverse impact of publication on doctors, including on their ability to find work, on their health, and the potential for stigma and discrimination against them
- made no differentiation between different types of impairment – for example health or misconduct – or between different severity of sanction
- infringed a doctor's rights under the Data Protection Act 1998 and Human Rights legislation, and
- were disproportionate in relation to ensuring public protection, with some respondents unsure that publication provided this protection in any event.

Where respondents considered the time limits too short, reasons given included:

- the need to ensure public and patient safety, including for those using private medical services
- the maintenance of the profession's reputation, and
- the need to retain indefinite publication in certain situations, for example, where a doctor was on the sex offenders' register.

Where respondents supported the time limits proposed, this was largely because they considered the balance between transparency and proportionality was about right, although some also supported the idea of different time limits depending on the severity of offence or sanction. AvMA

agreed with the proposed time limits, but did think that the need for publication might vary according to the individual nature of the case.

Various alternative time limits were put forward, from ceasing publication as soon as a sanction is revoked, through a range of 3 years to 15 years for continuing publication after a sanction is revoked, to maintaining indefinite publication of all sanctions. There was no real consensus on the appropriate level of the time limits, but there was significant support, including from the BMA, the MDU and the MPS for a sliding scale of time limits according to the severity of the sanction. Undertakings, particularly those which are health related, were most frequently mentioned as meriting a lesser time limit for publication. Several respondents also raised more general concerns about health cases and misconduct cases being publicised in the same way.

Prospective employers

Regardless of how we ultimately take forward our proposals in relation to time limits, we propose to disclose fitness to practise information to a doctor's current employer on request after a time limit has expired. Our consultation asked for views on whether we should continue to disclose fitness to practise information to prospective employers outside of any time limits. Opinion was divided on this, with 42% of respondents saying no, including the MDU and two thirds of the doctors who responded; and 38% saying yes, including our regulator PSA and the other two bodies representing patients' interests. The MDDUS agreed with the provision for as long as doctors remain exempt from the provisions of the Rehabilitation of Offenders Act and are required to disclose spent convictions, but considered the matter should be revisited if this changed. The remaining respondents, including the BMA, were not sure, or did not provide a specific answer.

Reasons given for disagreeing with disclosure to prospective employers outside of the time limits included:

- the lack of current relevance of the information, particularly given the length of time limits proposed
- the disproportionate impact on doctors, in terms of career prospects, but also potentially on their health and well being
- concern that the proposal infringed a doctor's rights under the Data Protection Act 1998, Human Rights legislation and potentially the Equalities Act 2010, and was more stringent than provisions for the rehabilitation of offenders.

Those who agreed with the proposal did so for the following reasons:

- the importance of transparency to the public interest and to promote public safety
- the need for an employer to know in order to make fully informed decisions

Although they agreed that the information should be disclosed to prospective employers, the Patient Liaison Group of the Royal College of Surgeons thought that whatever was available to employers should also be available to the general public. They felt this was necessary to provide protection to those using private medical services direct from an individual. AvMA also thought there should be wider disclosure to other interested parties including patients and their representatives.

A number of respondents thought that requests for information from prospective employers should be determined on a case by case basis, depending on the seriousness of the original offence, the risk to the public, whether or not the doctor remained registered, and the nature of the job applied for. The ICO was not sure that a routine approach was appropriate, given that disclosure might be justifiable in some circumstances but not in others, and thought a list of considerations should be developed by which we could make a decision in each case.

Publication and disclosure after the death of a doctor

There was very strong support for our proposal to stop publication of fitness to practise information after a doctor dies, unless there is a public interest in continued publication. Support came from the BMA, medical defence organisations and other bodies representing doctors; from the majority of doctors and members of the public who responded; from AvMA; and from all postgraduate medical institutions, including four Royal Colleges. Respondents felt that there was no longer any risk to the public or any wider public interest once a doctor had died; and that there could be a negative impact on a doctor's family if we continued publication. Several respondents who agreed with the proposal, including AvMA, did emphasise the need to ensure that this information was available on request, as it might be relevant to ongoing inquiries, investigations or complaints, or indeed those that come to light some time later. The MDU however felt that such information should only be provided to those who could demonstrate a legitimate right to it. They and a law firm who responded questioned the need for a public interest exemption on publication.

Two respondents opposed the proposal – the PSA and the Patient Liaison Group of the Royal College of Surgeons, who both argued that there should be consistency in how all doctors were treated. The Patient Liaison Group saw this as necessary to ensure an easily accessible and understandable system. The PSA considered it important to keep the information in the public domain for reasons of public confidence, and in case of ongoing investigations of which the GMC was not aware.

Our consultation proposed that we should still continue to publish fitness to practise information for a period of time after a panel hearing, if a doctor dies within that time, in order to ensure the transparency of our decisions and maintain public confidence. While the majority agreed, including the PSA, the BMA and the medical defence organisations, opinion was quite divided, with a quarter of all respondents disagreeing and nearly a fifth unsure. The reasons given by those in favour included the legal interest in publishing the outcome of a public hearing; the public interest in terms of transparency and any learning points arising from the case; and the importance for any ongoing investigations. Those who opposed the proposal raised concern about the impact on the doctor's family and stated that they could not see any ongoing risk. Some considered this issue should depend on the nature of the case, and any public interest issues arising.

With regard to the length of time that this information should be published after a hearing if a doctor subsequently dies, the majority of those responding to this question agreed with our proposal of six months. Support focussed on the fact that the time was proportionate and would give sufficient time for any legal points to be raised or legitimate interest explored, without prolonging distress to the doctor's family. Those opposed were concerned that six months was not long enough and that a year was more appropriate, or, in one case, that it was too long, and it should be three months. Others, including AvMA who were not sure about the proposal, thought that it should depend on the nature of the case. The other two bodies representing patients'

interests – the PSA and the Patient Liaison Group of the Royal College of Surgeons – were opposed because they did not agree with stopping publication when a doctor dies in any event.

Just over half of respondents agreed with our proposal to continue to disclose fitness to practise information to enquirers after the point at which we stop publication of the information. As previously indicated, the ability for such information to be available on request was a caveat for some respondents in their agreement to ceasing publication of the information. The PSA, AvMA, the MDDUS and five of the six postgraduate medical institutions who responded, supported our proposal. There was also general consensus on this at our stakeholder events, with some attendees indicating that they felt this was extremely important. However, opinion was split amongst doctors and members of the public, and the BMA and MDU disagreed. A common theme across respondents who commented on this proposal, whether they agreed, disagreed or were not sure, was that such information should be disclosed only to those who could demonstrate a legitimate interest, or where there was a clear public interest in doing so. Some considered this should be confined to formal or judicial investigative processes only.

Additional comments made in relation to the overall issue of whether information should be published after a doctor's death, included the need for a balance between public safeguarding and the family and relatives' rights to privacy; the importance of openness and transparency in ensuring public confidence; and concern about how the GMC interprets the public interest. The Information Commissioner's Office also highlighted the fact that, while other obligations such as the duty of confidence may still apply, the Data Protection Act 1998 only covers data about identifiable living individuals, so would not apply here.

Transfer of historical data (question 9)

While the majority of respondents (59%) agreed with our proposal to transfer historical fitness to practise data on to the online record from before 2005, which is when it came into existence, nearly one third disagreed. Those in favour included the PSA, AvMA, the MDDUS and the MPS. Members of the public were overall in favour of the proposed changes, while the views of doctors were split – approximately 50% either disagreed with, or were not sure about, the proposal. Concerns were also expressed by the BMA and the MDU. Overall, the Royal Colleges that responded to the consultation were in favour of the proposed changes, with the exception of the Royal College of Psychiatrists who raised a number of issues relating to the potential impact of the changes on affected doctors.

Where those who agreed with the proposal provided comments, the following were the most frequently mentioned:

- that it would be a fair approach, ensuring equal treatment between those who received a sanction before 2005, and those who received one after
- that it would improve levels of transparency and clarity, and therefore confidence in the register.

Those who disagreed raised concerns that:

- online publication of historical sanctions would be unfair given the time that had elapsed; the propensity for increased interest in the information pertaining to this particular group; and the potential impact on a doctor's employment and health prospects

- it would in general terms have a negative impact on the doctors concerned because of the increased accessibility, the invasion of their privacy, and the potential for the doctors to experience distress, stigma, shame and discrimination
- the proposal was not proportionate as the publication of the data would potentially have a serious impact on an individual doctor while the impact on patient safety was likely to be negligible.

In addition, the Information Commissioner's Office commented that, for publication to be fair, it needed to be in the reasonable expectation of doctors, with any previous assurances that data would not be published being relevant here.

We made clear in the consultation that any transfer of historical data would be in line with any time limits introduced under our earlier proposals. As with the responses to those proposals, some respondents expressed the view that the transfer of data should be dependent upon the reason that the sanction was imposed.

Publishing appeal outcomes (questions 10-16)

Our questions in this section set out proposals for changes to what we publish about an appeal or judicial review outcome in several different scenarios: unsuccessful; successful; partially successful; withdrawn; no appeal. The majority of respondents supported our proposals to improve the clarity of appeal outcomes, by including a note stating the outcome on a doctor's record for 12 months, with three quarters or more agreeing with the proposals for most scenarios (questions 10, 12, 13, 14 and 15). Those who agreed with the proposals across the board included AvMA, NHS Employers, the MDU and MDDUS, and the majority of doctors who responded to these questions. Respondents felt that the proposals would bring greater transparency and would be in the public interest, and some called for more information to be included, such as the basis for the appeal or reasons for an appeal being rejected. A belief that more information should be included than that proposed was also a reason why some respondents disagreed with the proposals. The information called for included: any criticism of the GMC or fitness to practise panel by the appeal court, and information on any dishonest or disreputable behaviour. The MDU highlighted that the GMC will in the future be able to appeal the decision of a fitness to practise panel decision and commented that the same principles must be applied to the publication of the outcome of those appeals (and those of the PSA) as are applied to the publication of the outcome of a doctor's appeal.

Some respondents, including the PSA, disagreed with the proposals where an appeal was unsuccessful or withdrawn, because they could not see any benefit to the public interest. One Royal College disagreed with the 12 month proposed time limit for including information about an unsuccessful appeal on a doctor's record because they considered the information formed part of the initial procedures and should be published for as long as the sanction.

The bodies representing doctors, while all agreeing with the proposals in the other scenarios, were divided in their opinion on the proposals where the appeal or judicial review was successful or partially successful. Those opposed – the BMA, the MPS and the Cambridgeshire Local Medical Committee – considered it inappropriate and unduly punitive to publish information on a doctor's record when an appeal had overturned the decision. Similar comments were made by other respondents who disagreed with these proposals, highlighting what they considered an unfair reputational risk to the doctor because of the potential for people to think 'no smoke without fire'.

In contrast, some respondents who agreed or were unsure about the proposal felt that it was fairer to the doctor to include a note on their record because it provided public exoneration. Other respondents supported the proposal in successful cases because they considered it to be in the public interest to provide a full history.

The BMA considered that a fairer approach to our proposal for successful appeals and judicial reviews would be to allow a doctor to decide whether a note about the outcome should be included on their record.

Publishing information about appeals of interim orders (question 17)

We did not propose any changes to our current approach to publishing information about appeals of interim orders, but we did invite comments on that approach, with a view to including it in our publication and disclosure policy for the first time. In total, 27 respondents provided comments. Of these, 17 responded positively to the GMC's approach, four expressed concerns, and six neither supported nor opposed the changes.

Several of those who responded positively to the approach commented on the increased transparency and clarity it would bring to include it in our publication and disclosure policy. This included NHS Employers who also considered it would help patients, the public and employers understand the purpose and role of interim orders in safeguarding the public. Others simply agreed that our approach seemed fair and appropriate.

Two of the respondents who expressed concern with our approach did so because they did not agree that information should be retained on a doctor's record in situations where the appeal court upheld the imposition of an interim order but decided it should no longer have effect. The other two respondents who expressed disagreement with the approach did so because they did not think that any information at all should be published about interim orders.

Other respondents who commented included the BMA and the ICO, who felt that the GMC should be clearer about the status of interim orders, and the difference between interim orders and fitness to practise decisions. AvMA supported the publication of information in relation to interim orders, but emphasised the importance of robust processes in order for decisions to be effective.

Providing greater explanation of our decisions where a case concludes with a doctor agreeing undertakings without a fitness to practise panel hearing (question 18)

The majority of respondents (64%) who answered this question agreed with our proposal to give greater explanation of the background and reasons for resolving cases consensually when we agree undertakings with a doctor. This included the majority of individual doctors who responded, the PSA, NHS Employers, AvMA, medical defence organisations and the Patient Liaison Group of the Royal College of Surgeons.

The main reason given for supporting the proposal was that it would increase transparency in relation to decisions to agree undertakings and help the public understand the reasons for disposing of a case in this way. A doctor also considered it would increase GMC accountability. Concern was expressed however about the form that the summary might take, and about the process by which it would be agreed. The BMA, who were unsure about the proposal, considered the doctor should be allowed to respond to any proposed summary, while the PSA stated that we should guard against

any bargaining in relation to summary content. AvMA also were concerned about the potential for plea bargaining, or the perception of it, and emphasised the vital importance of transparency in explaining consensual disposal decisions. Both AvMA and the PSA noted their lack of support for the extension of consensual disposal to more serious cases, but this is outside the scope of this particular consultation.

Respondents who disagreed with the proposal did so for a number of reasons, including that it was disproportionate; a breach of privacy; and that it would discourage doctors from agreeing undertakings to resolve the case consensually. One doctor, who was unsure, suggested that the information be published only where there was a patient safety risk; while BLM law firm thought that the summary should be provided to employers rather than published.

Several respondents, including both those who agreed with the proposal and those who did not, raised concerns about how health cases would be dealt with, with the Royal College of Psychiatrists for example, concerned that health problems would be identifiable from the summary. They further thought that there was no need for continued publication of undertakings in health cases after they had been revoked, where the doctor self-reported. One of the doctors who responded did not think there was a need for continued publication of information about undertakings in any case after they had been revoked.

Equality (question 19)

Consultees were asked whether they thought that any of our proposals would affect people with protected characteristics covered by equality legislation. The majority of respondents to this question said no (61%), with eleven respondents answering yes, and eight, not sure.

Where equality issues were identified, the majority of comments related to doctors who had long term illnesses, or who may be classed as disabled under the Equalities Act. A key concern expressed by respondents was that the publication and disclosure of fitness to practise sanctions would have a detrimental impact on the lives of doctors within this group. Several doctors and members of the public noted that doctors who receive sanctions may be subject to stigma, discrimination and shame. Amongst other respondents, the Royal College of Psychiatrists raised questions over the publication of information related to mental health conditions, arguing that the higher level of responsibility among doctors 'should not negate their human right to privacy if there is no risk to patients'.

Other equality issues raised in relation to doctors were: a potentially disproportionate impact on younger doctors arising from the proposed 20 year time limit for publication of some sanctions; the need for a mechanism to deal with issues arising from gender reassignment, where a doctor's gender was different at the time of the hearing; and the impact of any information published which made direct or indirect reference to a doctor's sexual orientation.

Some respondents raised concerns about the potential impacts of the proposals on people with protected characteristics other than doctors, including patients and relatives with mental health problems who may be affected by publication of information about a doctor. The Patient Liaison Group of the Royal College of Surgeons raised concerns that the complexity of some proposals, for example around appeal outcomes, might be difficult for some groups to understand.

APPENDIX A

Breakdown of responses and detailed summary of comments for each consultation question

Consultation – Changes to the information we publish and disclose about a doctor's fitness to practise

Introducing time limits

Question 1: Do you think the time limits proposed provide the right balance between being transparent and open in the public interest and being fair to individual doctors?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	20	29%	10
No	39	57%	36
Not sure	7	10%	6
Comment only	3	4%	3
TOTAL	**69**	**100%**	**55**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	3	3	0	1	7
	Body representing patients or public	1	1	0	0	2
	Postgraduate medical institution	3	1	3	0	7
	Regulatory body	1	0	0	0	1
	Other	2	1	0	1	4
Individuals	Doctor	7	27	2	0	36
	Member of the public	1	3	0	0	4
	Other	2	3	2	1	8

Introduction

Over half of respondents (57%) did not agree that our proposals on time limits provided the right balance between transparency and proportionality, compared with less than a third (29%) who did. Respondents' reasons for disagreeing varied, and included some who considered that sanctions should remain on the online register indefinitely. The majority who disagreed however, including the MDOs and the BMA, did so because they considered the proposed time limits were too long, particularly the 20 year limit for sanctions other than erasure. Three other bodies representing doctors; the Independent Federation of Doctors, the Medical Women's Federation and the Cambridgeshire Local Medical Committee, agreed our proposals struck the right balance. AvMA also agreed, but did raise concerns about a 'one size fits all' approach. The PSA agreed with the proposal whilst highlighting that the proposed time limits were well above their own recommended minimums.

Comments opposed to the proposal

Length of time limits

Of the 36 people who answered no to the proposal and provided comments, 30 said that they thought the time limits proposed were in some way too long. This figure includes those who thought the proposed limits too long overall; those who considered there should be greater variation according to severity of the concerns; and those who thought they were too long for specific types of sanction, eg undertakings. Twelve of these mentioned specifically the 20 year time limit proposed for publication of sanctions other than erasure where a doctor remains registered. One doctor described this as 'in effect most doctors' careers' and another as 'draconian'. The Royal College of Psychiatrists commented that 'a time limit of 20 years for a lesser sanction seems unduly punitive and not proportionate' and the MDU gave the example of 'a young doctor who committed an indiscretion, perhaps in part attributable to his or her youth and inexperience' as a situation where it would be disproportionate for such information to be public 20 years later. The impact of publication on the doctor in terms of their ability to find work, the knowledge that colleagues could view their history, and the potential to be discriminated against were raised by several respondents. These views were echoed by attendees at stakeholder events, one of whom commented that publication makes the most difference to doctors in finding work.

There were a range of views as to the time limits that should be introduced instead. Five respondents considered sanctions should be removed from publication as soon as they were revoked, although one of those thought erasure should be published for five years, and another that previous erasure should continue to be published following restoration. A further respondent thought that removal from publication of sanctions as soon as they are revoked was appropriate in health cases. Two respondents thought that three years was appropriate for all sanctions, particularly, in the view of one doctor, as the GMC works to the civil standard of proof. Five respondents advocated a five year time limit for all sanctions other than erasure; three respondents, including the MDDUS, called for ten years; and one, an NHS manager, for 15. One respondent considered that where a doctor who had previously been erased for fitness to practise reasons was restored to the register, the proposal to publish information indefinitely was inappropriate and should be changed to a limit of five to ten years.

Seven respondents who disagreed with this proposal thought that there should be a sliding scale of time limits depending on the sanction concerned, as did several attendees at the stakeholder events. This included the MDU, who highlighted that the Sanctions Guidance used by fitness to practise panels 'recognises the difference in severity between the three forms of sanction, and the need for consideration of the individual case'. They expressed concern that having the same time limits for publication of each sanction risked 'leading to the incorrect inference that the breaches are all of the same seriousness'. The BMA agreed, commenting that 'grouping within a single band a suspension which may have been on the cusp of erasure and a conditions order which may have been aimed at addressing a specific and readily correctable issue of a completely different order of severity may well lead to unfairness in practice if publication of either matter is likely to have a significant stigmatising impact on the practitioner's professional reputation and employment prospects'. Lack of distinction between the severity of concerns was generally the reason given for support of a

sliding scale of time limits, with suspension being seen as meriting a longer time limit than conditions or undertakings. Some of those calling for a sliding scale highlighted their belief that undertakings and/or health cases should be treated differently, and this was echoed in the comments of several other respondents. These issues are addressed in a separate section below.

Three of the respondents who did not answer yes or no to this question also commented that they thought there should be a sliding scale of time limits. In the view of an individual medical educator and also the MPS, the severity of the case should be taken into account. The MPS also made a distinction between a junior doctor subject to a short period of undertakings or conditions for a relatively minor matter and a more senior doctor subject to prolonged conditions for something more serious, and considered GMC policy on time limits should recognise this distinction. One Royal College commented that their lay members thought the 20 year time limit proposed was too long for sanctions other than erasure and that the time limits proposed for non-registered doctors, that is ten years for erasure and five for other sanctions, should apply to all. Their clinical members thought that it would be fairer to have a sliding scale because 'misconduct leading to suspension is much more serious than that leading to conditions or undertakings, and this should be reflected in the time that the sanctions are published'.

Three respondents who answered 'no' to this question were concerned that the proposals were more stringent than the Rehabilitation of Offenders Act 1974, and considered that the time limits should be more in line with the time limits for spent convictions. Health Education England, who was not sure about the proposal, also raised concerns in this regard, asking what the 20 year time limit was benchmarked against, given that prison sentences of up to four years are spent after eleven. This view was also expressed at the stakeholder events. The Information Commissioner's Office, who did not answer yes or no to the question, also considered that parallels could be drawn with the disclosure of criminal convictions. (In this regard, it is worth highlighting that registered medical practitioners are exempt from the basic disclosure provisions of the Rehabilitation of Offenders Act, and are expected to declare criminal convictions, spent or otherwise, except in very exceptional circumstances.)

One member of the public disagreed with the proposed time limits because they believed that sanctions against a non-registered doctor should be visible for life. Another respondent, a doctor, thought that the time limits for non-registered doctors should be increased to 20 and ten years (rather than the proposed ten years for erasure and five years for lesser sanctions) in order to increase patient safety if a doctor is practising abroad. One doctor answered 'no' to the question because he considered the time limits proposed should be 'baseline measures, not absolute' and there should provision for maintaining publication if there is 'continued relevance in the interests of public and patient safety'.

Two respondents who did not answer yes or no to the question made comments relevant here. One doctor thought that the information should remain permanently with 'the very important caveat that this occurs with much increased attention to getting the nature of the sanction correct and agreed by all parties before anything is published'. Health Education England, while questioning the proportionality and rationale of the proposed 20 year time limit, did comment that there might be some cases where indefinite publication might be appropriate, for example where people were on the national sex offenders' register. Attendees at the stakeholder events made similar comments,

suggesting that certain issues, for example sexual misconduct, should remain indefinitely, but clinical mistakes should be time limited.

Some doctors attending the stakeholder events thought that indefinite publication should remain, partly because it helped maintain the reputation of doctors, and partly to save the costs of implementing changes. Although not related to the specific length of the time limits, another attendee highlighted that the GMC is an organisation whose role is to protect patients, not doctors, and wondered whether the proposal to move away from indefinite publication was in line with the organisation's values.

Treatment of health issues and undertakings

Nine respondents raised concerns about the time limits specifically in relation to how health issues and/or undertakings were treated. One member of the public stated 'it is unfair to treat sick doctors in the same punitive manner as doctors who have broken the law or committed other forms of misconduct.' Three other respondents, two doctors and an individual solicitor, echoed the view that health and misconduct cases should be treated differently. The same member of the public also commented that 'publishing historical information risks causing prejudice, stigma and discrimination. It is acknowledged that stigma can have an adverse impact on the health and performance of professionals in recovery from mental illness.' These views were also expressed by several other respondents, with one doctor, who had previously had conditions for health reasons highlighting a difficult experience. He described how a friend of his had contacted him to ask why he had conditions, having seen it on the GMC website. In highlighting the impact on doctors of publication of fitness to practise sanctions, two doctors raised concern about the high risk of suicide among doctors with mental health problems, and those facing GMC investigation.

One individual respondent considered that publication of fitness to practise information where a doctor was impaired on the grounds of health breached the Equalities Act 2010 and the Human Rights Act 1998. They commented that publication 'can cause discrimination and result in doctors, with physical and/or mental impairments, being denied employment opportunities, arising from prejudice within the health service'.

Public interest/confidence

One individual doctor questioned the argument expressed in the consultation that publication increased public confidence in the profession, commenting that 'if it is felt that the publication of undertakings is in the public interest then the GMC should spell out exactly what public interest is being served'. The doctor believed that, if undertakings are revoked, they should immediately be removed from the public domain. This view was also expressed by an individual solicitor who commented 'there is no rational connection between the ongoing publication of historic undertakings in such cases and the Council's statutory purpose of protecting patient safety'. He highlighted that revocation of undertakings 'reflects a positive determination that the practitioner's fitness to practise is not impaired' which in health cases 'includes a consideration of the risk of relapse'. One individual doctor, who called for much shorter time limits, asked what the benefit to the public was of publication if the doctor has been continuing to practise without problems. They considered that this may in fact 'reduce the credibility of the doctor to the patient and have a negative impact on the therapeutic relationship'.

An attendee at the stakeholder events also questioned whether publication actually protected the public, commenting that there were other local governance measures that did this.

Compliance with information legislation

Two of the respondents who answered 'no' to this question raised concerns that the proposal infringed an individual's rights under the Data Protection Act 1998 and under human rights legislation. One, a solicitor, considered that transparency about the GMC's actions could be achieved by the publication of aggregated statistical data rather than 'impinging on a registrant's Article 8 and DPA rights'. Another individual respondent considered the publication of sanctions that are no longer current breached the principles of the Data Protection Act and Human Rights Act, in terms of relevance and the impact on a doctor's privacy.

Concerns raised by some respondents about the Rehabilitation of Offenders' Act 1974 are reflected in the section on the length of time limits above.

Other comments

The Patient Liaison Group of the Royal College of Surgeons disagreed with the proposal because they considered there should be a consistent approach to both the public and to employers (to whom sanctions are disclosed indefinitely) 'in the interests of patient safety and protecting the public'. They commented that 'those using private medical services direct from an individual should have the same level of protection and information as those who use doctors employed by another'.

One doctor commented that any cases where the GMC was at fault should also be recorded, although it was not wholly clear what was meant by this.

One member of the public thought that publication in relation to non-registered doctors should depend on the reason for removal, and that former doctors should apply to have their details removed each time they changed jobs in order to ensure past conduct is not relevant to any new employment.

An attendee at the stakeholder events asked whether we had carried out any assessment of the likelihood of a doctor reoffending after receiving an initial sanction, and the time in between a first and second offence, in determining the length of the proposed time limits.

Comments in support of the proposal

Of the ten respondents who answered yes and provided comments on the proposal, five of them simply expressed general agreement that the balance between transparency and proportionality seemed about right.

Two respondents answered yes, but also made alternative suggestions – one doctor supporting a sliding scale of 5 to 20 years depending 'on the seriousness of the infraction and the considered risk to patient safety'; whilst the Royal College of Radiologists suggested that for all groups, the sanction should continue to be published while the doctor remained registered with the GMC, with a further publication of 10 years if they left the register.

NHS Employers considered that where doctors remained registered, the proposed time limits were suitable to act as a deterrent to poor practice. Where a doctor was no longer registered, they

pointed to a difference between erasure due to capability and erasure due to conduct, and commented that while the need for publication may decline over time, 'there may still be occasions where that information should be made available to anyone with reasonable grounds'.

AvMA supported the proposal, but thought that the need for publication might vary according to the individual case, commenting that 'there are some cases that may warrant appearing on the public register for an even longer period and others where one might feel sympathetic to the view that the nature and circumstances of the original breach of GMP is such that there is very little risk if any of a repetition or a continuing risk to patient safety'. They expressed concern about transparency of decision making and public confidence in the context of a proposed shift towards greater use of consensual disposal to resolve fitness to practise cases.

The PSA emphasised the need for information to continue to be disclosed to employers after the time limits expire and stated its assumption that the GMC would continue to keep its own records about sanctions indefinitely, which is indeed the case.

Comments from those who neither agreed nor disagreed

The Information Commissioner's Office stated that they welcomed the move from indefinite publication to the introduction of time limits, as they considered the current blanket approach was problematic from a data protection perspective. They did not express a view on the time limits proposed, commenting that it was for the GMC as data controller to assess this balance in line with data protection principles. They highlighted that it would be important to ensure the approach is 'a justifiable and proportionate one which balances the GMC's functions in protecting the public with the effect publication and disclosure has on individual doctors'. They suggested completion of a privacy impact assessment may assist.

The Royal College of Physicians of Edinburgh was concerned that there may be some instances where publication periods were shorter in erasure cases than for those cases involving lesser sanctions. They considered this to be illogical.

Some attendees at the stakeholder events, while not specifically agreeing or disagreeing with the time limits, considered that more could be done by the GMC to explain what the information we publish means – for example, making it clear that there are no longer current concerns if a sanction has moved to a doctor's history page on their record.

Alternative approaches suggested

Alternative approaches from respondents focussed either on alternative timescales, or the introduction of sliding scales according to the severity of either sanction or offence. These have been reflected in the text above.

Introducing time limits

Question 2: Do you consider that, if time limits are introduced, we should routinely disclose information about sanctions to prospective employers once the time limit has expired?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	25	38%	15
No	27	42%	16
Not sure	9	14%	8
Comment only	4	6%	4
TOTAL	**65**	**100%**	**43**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	3	1	2	1	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	2	3	1	1	7
	Regulatory body	1	0	0	0	1
	Other	1	1	1	1	4
Individuals	Doctor	10	19	4	0	33
	Member of the public	3	1	0	0	4
	Other	3	2	1	1	7

Introduction

Opinion was divided on whether prospective employers should receive information about sanctions outside of any time limits introduced, with 42% of respondents disagreeing and 38% in agreement. Nine respondents were not sure. One of the four respondents who commented without answering specifically yes, no or not sure, was clearly in favour of information being disclosed to prospective employers outside of the time limits. There was no consensus amongst bodies representing doctors, with three, including the MDDUS answering yes, two, including the BMA not sure, and one, the MDU opposed. The postgraduate medical institutions were also divided on the issue. Almost twice as many doctors who responded disagreed with disclosure than agreed with it. Both of the bodies representing patients or the public were in favour of disclosure to prospective employers, as were the PSA and three of the four members of the public who responded.

Comments opposed to the proposal

Relevance

Three respondents – two postgraduate institutions and a doctor – did not consider it necessary to disclose to prospective employers given the length of the proposed time limits, and another respondent, BLM law firm, commented that 'if the time limits are sufficient to protect patients and maintain public confidence, we cannot see why this enhanced disclosure should be necessary'.

Similar issues in relation to the current relevance of the information were raised by two other respondents, The Royal College of Psychiatrists and the MDU, with the latter commenting that if the prospective employer 'considered that doctor suitably qualified, trained and experienced for the post, it should be of no additional benefit to that employer to find out, additionally, that the prospective employee had been subject to conditions that had expired 20 years ago'. One doctor thought that a prospective employer should only receive this information if they could demonstrate how it was relevant to the particular job. The Royal College of Psychiatrists similarly felt that the onus should be on the enquirer, for example police or medical director, to approach the GMC and explain why they needed the information. Two doctors who commented on this proposal thought that disclosure should depend on whether there had been serious harm to a patient or were serious issues of fitness to practise, with one commenting that revoked undertakings did not justify continued disclosure. BLM law firm stated that, where an employer had concerns, disclosure 'should only be in exceptional circumstances, subject to the doctor's consent'.

Impact on doctors

Several respondents raised the impact on doctors as a concern. Mostly, this focussed on a doctor's future work prospects which could be affected by disclosure of fitness to practise information even if it was historical. This point was illustrated by a comment from a solicitor – 'The fact that stale sanctions continue to be disclosed is likely to create the impression in the mind of the prospective employer that the statutory regulator continues to attach real weight to the historic matters as pointing to a current and relevant risk'. However, one member of the public also raised concern about the potential impact on a doctor's rehabilitation and/or on health if disclosure was made so long after the event; and a doctor highlighted the risk of suicide among those doctors referred to the regulator.

Compliance with information legislation

Two individual respondents thought that the proposal to disclose to prospective employers outside of the time limits breached the Data Protection Act, Human Rights legislation, and potentially the Equalities Act if the sanction had been imposed because of a health issue. Two others were concerned that the proposals were more stringent than the requirements for disclosing criminal convictions under the Rehabilitation of Offenders Act.

Comments in support of the proposal

General agreement

Seven of those who answered yes and commented on the proposals, expressed general agreement with the proposal, commenting for example that 'it is important to be transparent to employers' and that 'it is in the best interest of all concerned, employer and patient'. One doctor felt that, as a patient, he would want this disclosure. The PSA commented that they felt strongly that the GMC should continue to disclose this information to prospective employers, as well as to current ones and overseas regulators. (There are no plans to change the current situation of indefinite disclosure with regard to the latter two categories.)

Transparency

Two respondents highlighted why they considered it important that disclosure was made to prospective employers, with CAIPE commenting that it would enable them to make 'fully informed decisions' and one individual doctor highlighting that it was the employer's reputation and responsibility that was at stake.

Public safety

Two doctors specifically raised issues of public safety. One considered disclosure to prospective employers necessary to ensure this; while the other expressed agreement with disclosure providing 'there is a test of its being in the interests of patient and public safety'.

Consistency

Both bodies representing patients and the public who provided comments against this proposal agreed but thought that the disclosure of information should be extended more widely. The Patient Liaison Group of the Royal College of Surgeons thought that 'the same information that is disclosed to employers should be made available to the general public'; while AvMA commented that 'this information should be disclosed to other interested parties including patients and their representatives'.

Other comments

The MDDUS expressed agreement with the proposal while medical professionals are exempt from provisions relating to spent convictions under the Rehabilitation of Offenders Act, but considered it should be revisited if that were to change. The Royal College of Physicians of Edinburgh thought that it would be less burdensome administratively for the GMC and for employers if there was a routine method of disclosure rather than it being on request.

Comments from those who neither agreed nor disagreed

Several of the comments made by those who agreed or disagreed were echoed by those who were not sure. One doctor was concerned about the impact on a doctor's employability, and the lay members of one Royal College agreed that disclosure could be detrimental to a doctor's career. Their clinical members thought however that prospective employers should be made aware of past sanctions; and NHS Employers thought this might be appropriate to enable a fully formed decision on making an appointment.

An individual medical educator considered disclosure would no longer be significant after 20 years of the information being in the public domain. Other respondents thought that disclosure should depend on the circumstances of the case, both in terms of the seriousness of the original offence and the particular nature of the job applied for. The Cambridgeshire Local Medical Committee commented for example: 'If the doctor is still registered, then the Committee agrees that the information should still be disclosed to prospective employers. If the doctor is no longer registered, then consideration should be given to the nature of the proposed employment and the relevance the sanction could have to it'. The MPS considered that there was 'a real risk of prejudice against an individual doctor for no good reason, unless the process of disclosing information about sanctions to prospective employers is subject to a test of proportionality'. The BMA considered that disclosure

should be made only where it is necessary to protect public safety, which they did not consider would be the case in relation to all requests.

One individual respondent considered that the GMC should be much more careful about disclosing information in complex cases involving a doctor's mental health.

Alternative approaches suggested

The ICO was uncertain that the proposal for the routine disclosure of information to prospective employers was the right approach, as they considered that disclosure may be justifiable in some circumstances but not in others. They thought it might be preferable for the GMC 'to set out a number of considerations to take into account in the event that a request for disclosure is made after the publication time limit has expired, to assist in making a decision'.

The MDU thought that the GMC should inform its approach in this area by interrogating its data to establish what kind of predictor a sanction provides in terms of the likelihood of a further breach; and whether there is any variation according to the severity of the offence or any other factors.

Introducing time limits

Question 3: Do you have other comments on the issues discussed in the above section?
[ie on time limit proposals – general]

Number of respondents who provided further comments: **25**

Summary of comments

Many of the comments made here reiterated themes raised under the previous two questions. They can be broken down as follows:

Impact on doctors

Seven respondents raised concerns about the impact of publication on doctors, including five doctors, two of whom highlighted their own personal experience. One considered it unfair that undertakings for health reasons, which she had adhered to, would remain in the public domain for 20 years. Another, also with health undertakings, commented that she never looked at the information online because it was so upsetting. She contrasted bankruptcy status and credit ratings, which can both change, with the GMC keeping 'information about me in aspic, for all the public to see'. Another doctor thought that disclosure after a sanction had been revoked 'smacks of retribution and punishment and not of encouraging learning'.

Relevance

Four respondents emphasised their view that it was inappropriate to publish fitness to practise information that was no longer relevant. In the words of one doctor, 'If you have determined that they are fit to practise unsupervised, then that should be it'. Another of these respondents was concerned that the GMC's approach would not comply with best practice in data protection because, in their view, irrelevant information would continue to be published. A law firm considered that 'the proposals are weighted towards publishing as much information as possible' and 'a better balance needs to be found between transparency and the publication of irrelevant material'.

Fairness

One doctor commented on the need to ensure fair decisions were taken, in terms of a proper assessment of the evidence, before any disclosure of sanctions was made. Another doctor expressed concern about whether the GMC was the appropriate arbiters of what was in the public interest, commenting that 'The GMC needs to be more accountable to doctors and able to justify their decisions'. A member of the public considered it unfair to publish information about undertakings, whether health or practice related, where there had been no fitness to practise panel hearing, because the decision was based on the subjective opinion of a case examiner with no opportunity for cross examination by a doctor's legal representative.

Transparency and public protection

One individual respondent emphasised the importance of transparency regarding fitness to practise sanctions, while the Royal College of Physicians of Edinburgh commented that it was unclear why, if the GMC was committed to transparency, 'information should be available to employers for longer than to other enquirers'. One member of the public felt that data protection and human rights legislation should not be used to 'cover up matters where patient care is involved'.

Severity of sanction

AvMA commented that 'there are some cases that may warrant appearing on the public register for an even longer period and others where one might feel sympathetic to the view that the nature and circumstances of the original breach of GMP is such that there is very little risk if any of a repetition or a continuing risk to patient safety'. The Royal College of Psychiatrists also supported a sliding scale of time limits according to the severity of sanction and degree of remediation.

Other comments

The ICO emphasised the importance of clearly setting out any changes to the publication and disclosure policy to doctors 'to ensure that they are aware how their personal data will be processed and made available in the event of sanctions being applied to them'. The Cambridgeshire Local Medical Committee emphasised the importance of distinguishing between employers and general enquirers, with no disclosure to general enquirers outside of the time limits. Another thought there was only significance to disclosing to employers outside of the time limit if that limit was less than 20 years. One doctor asked what safeguards would be brought in to ensure that once the time limit was over, the data would actually be 'forgotten'; and another commented that at least the right to be forgotten was there, even if it was too late. Another doctor did not think that the time limits as they stood did anything to change the current situation, but felt like 'paying lip service as fair to doctors'.

Introducing time limits

Question 4: Do you agree with the proposal to stop publication of fitness to practise information after a doctor has died, unless there is a public interest in continued publication?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	57	90	19
No	2	3	2
Not sure	3	5	3
Comment only	1	2	1
TOTAL	**63**	**100**	**25**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	6	0	1	0	7
	Body representing patients or public	1	1	0	0	2
	Postgraduate medical institution	6	0	0	0	6
	Regulatory body	0	1	0	0	1
	Other	3	0	0	1	4
Individuals	Doctor	31	1	0	0	32
	Member of the public	3	0	1	0	4
	Other	7	0	0	0	7

Introduction

There was strong support for ceasing publication of fitness to practise information after a doctor has died, unless there is a public interest in continued publication. 90% of respondents agreed with the proposals and 3% disagreed. All postgraduate medical institutions, including four royal colleges, who responded to the consultation supported this proposal, along with AvMA, the BMA, MPS, and MDDUS.

The MDU said they were not sure, because, while they agreed with the proposal to cease publication, they questioned what situations would give rise to there being a public interest need to continue publication.

31 of the 32 doctors who responded to this proposal were in favour, along with three out of four members of the public and a number of attendees at our stakeholder events.

The PSA did not agree with this proposal based on concerns around consistency and public interest, views shared by the Patient Liaison group of the Royal College Surgeons.

Comments in support of the proposal

Risk to patients or the wider public interest

Three doctors who provided comments in support of this proposal indicated that they felt it was unnecessary to continue publication as there would no longer be any risk to the wider public interest. This opinion was echoed by a member of the public.

Information on request
Although supportive of this proposal, AvMA, the Royal College of Physicians, NHS Employers, and two members of the public highlighted the importance of providing information on request. NHS Employers stated that: '…there will be some cases where there is a legitimate reason for enquiring about previous fitness to practice history (for example in the case of complaints, claims, inquiries etc which arise sometime after the event)…patients and the public should be made aware of their ability to obtain this information should a legitimate need arise.'

An attendee at our stakeholder events commented that this is particularly important where there are ongoing criminal investigations.

Public interest exception
BLM law firm supported our proposal to cease publication of fitness to practise information after a doctor has died, but argued that it would be '…a rare case where there would be a public interest in continued publication' and therefore the public interest exception should be removed.

The MDU supported this view, and commented that information should '…only be provided on application to a person or organisation that can demonstrate a legitimate right to have the information.'

This view was also supported by a doctor, who further argued that public confidence would actually decrease without robust justification for continued publication.

Fairness to doctors' families
One individual, who identified themselves as the relative of a doctor who had passed away, said that this change was necessary to allow relatives to grieve.

Length of interim publication
The Royal College of Radiologists supported this proposal and suggested that publication should continue for a year after the doctor's death.

Comments opposed to the proposal

Two respondents opposed this proposal.

The Patient Liaison Group of the Royal College of Surgeons argued that, in order to allow for an 'easily accessible and easily understandable' system, a consistent approach should be taken across all doctors' records, whatever has happened subsequently. Furthermore, they stated that continued publication was necessary as a deterrent to those on the register.

The PSA felt it wasn't clear 'why the timeframes for the publication of deceased doctor's fitness to practise history differ from those for doctors who are still alive.' They argued that there are important reasons for continued publication, even where the information could be disclosed on request, for example ongoing investigations or inquiries the GMC may not be aware of. They stated that it is important the information is kept in the public domain so that '…the functions of maintaining public confidence in the profession and upholding professional standards can be fulfilled.'

Comments from those who neither agreed nor disagreed

One doctor, who neither agreed nor disagreed with this proposal, thought that the proposal would not make much difference to doctors or their families, but commented on the need to deal with investigations based on the severity of the problem, and to support doctors to practise safely where 'minor mistakes' have happened.

One member of the public suggested that the only reason for continued publication would be to assist with any historical cases that should be reinvestigated.

As already indicated, the MDU could not see any reason why publication would ever be in the public interest. They considered information should only be provided to those who can demonstrate a legitimate interest.

Introducing time limits

Question 5: Do you agree that we should continue to publish the outcome of a public fitness to practise hearing for a period of time after the end of the hearing, even if a doctor subsequently dies?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	33	52	13
No	17	27	11
Not sure	11	18	8
Comment only	2	3	2
TOTAL	**63**	**100**	**34**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	7	0	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	3	1	2	1	7
	Regulatory body	1	0	0	0	1
	Other	3	0	1	0	4
Individuals	Doctor	13	12	7	0	32
	Member of the public	2	1	1	0	4
	Other	2	3	1	0	6

Introduction

Of the 63 responses received to our written questionnaire, 52% supported the continued publication of the outcome of a fitness to practise hearing for period of time after the end of the hearing, even if a doctor subsequently dies. 27% opposed the proposal.

The PSA, AvMA, BMA, MDU, MPS and MDDUS all agreed with the proposal, although some made comments on how they felt we should approach this. Opinion was divided amongst the postgraduate medical institutions, with two in favour, two unsure and two opposed. There was also no consensus amongst doctors who responded to this proposal, with 13 in favour, 12 opposed, and 7 unsure. Members of the public who responded to this proposal also held split views.

Comments in support of the proposal

Length of publication
The PSA broadly agreed with this proposal, but felt that six months wouldn't be sufficient to fulfil the functions of maintaining public confidence in the profession and upholding professional standards. The Royal College of Radiologists appeared to support this view, suggesting that publication for a year after a doctor's death would be appropriate.

The MDU supported the proposal, but on the assumption that the agreed publication period would begin when the hearing concluded, rather than on the date the doctor died.

An attendee at our stakeholder events suggested that the publication period should follow the time limits agreed for living doctors.

Public interest
BLM law firm stated that there would be a legal interest in publishing the outcome of a public hearing. One member of the public who provided comments under this proposal highlighted the importance this information would hold if there were any other ongoing investigations. AvMA agreed with the proposal on the basis that information would still be available on request after it had been removed from publication, commenting that 'there will be a number of cases where this information will be relevant to current cases, for example, where harm caused by that individual has only just come to light or is subject to a current inquiry process'.

One employer organisation which supported this proposal stated that 'although the individual doctor has died there might still be a public interest in publishing the outcome to demonstrate transparency or to support learning and service improvement.'

One royal college stated that there needs to be an explanation about why '…the public fitness to [practise] hearing continues after the death of some doctors.' This appears to be based on a misunderstanding of our processes – if we had concerns about a doctor and they subsequently died, we wouldn't continue to hold a hearing.

Although they supported this proposal, the Patient Liaison Group of the Royal College of Surgeons felt that the outcome of a fitness to practise hearing should only be removed when a doctor's name was removed from the register.

Comments opposed to the proposal

Fairness for doctors and their families
One royal college raised concern about the impact of this proposal on the doctor's family. A doctor appeared to share this concern. Another doctor thought it was unfair on the doctor to publish findings of hearings at all.

One respondent commented that hearings were blunt instruments which might not properly identify issues relating to the mental health of the doctor under investigation.

Ongoing risk/nature of the case

Two respondents who were opposed to this proposal (one doctor and one member of the public) highlighted that there would no longer be any risk posed.

Two doctors who opposed this proposal indicated that they felt it depended on the nature of the case. One stated that they could understand this approach where other doctors (presumably with linked cases) were still alive. The other stated that the proposal would be fair where the case wasn't health related, but that it would be disproportionate and unfair on the doctor's family if the case had a health element.

Another doctor opposed to this proposal argued that it should only be the case if it was 'clearly in the public interest, and it should be the exception rather than the rule.'

Comments from those who neither agreed nor disagreed

Fairness/ongoing risk
One doctor questioned why it was necessary to keep this information in the public domain when there was no ongoing public interest. This view was shared by Health Education England, who stated

that: ‘Patients and other people with a specific interest can be informed directly about the outcome of the Fitness to practise hearing and, if the hearing is public, then the media will know the outcome at the time’.

They were concerned about the impact keeping information in the public domain would have on the doctor’s family. This view was shared by two doctors, one of whom commented that there could be a note on LRMP to state the doctor was deceased, but that information would be available on request.

One member of the public suggested that the only reason for continued publication would be to assist with any historical cases that should be reinvestigated.

One doctor felt no difference would be made if information was retained in the public domain following the death of a doctor. Another considered that information should only continue to be published if a sanction had been applied.

Introducing time limits

Question 6: If you have answered yes to question 5, do you agree that six months from the end of the hearing is an appropriate length of time?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	26	67	6
No	5	13	5
Not sure	6	13	6
Comment only	2	7	2
TOTAL	**39**	**100**	**19**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	7	0	0	0	7
	Body representing patients or public	0	1	1	0	2
	Postgraduate medical institution	3	1	2	0	6
	Regulatory body	0	1	0	0	1
	Other	2	0	1	1	4
Individuals	Doctor	12	1	1	0	14
	Member of the public	0	1	1	0	2
	Other	2	0	0	1	3

Introduction

The majority (67%) of respondents to the written questionnaire were in favour of a six month publication period from the end of the hearing, while 13% disagreed.

Those in agreement included the BMA, MDU, MPS, MDDUS and one royal college. 12 of the 14 doctors who responded to this proposal were also in favour of the six month publication period proposed. Only two members of the public responded to this proposal, with one disagreeing and one not sure.

The PSA disagreed with the proposal because they felt it was inappropriate to stop publication of fitness to practise information after a doctor has died. The Royal College of Radiologists also disagreed with the proposal as they felt 12 months would be a more appropriate publication period. AvMA were not sure as they thought the appropriate length should depend on the nature of the case and type of sanction imposed.

Comments in support of the proposal

BLM law firm stated that a six month publication period 'would provide sufficient time for any legal points to be raised where necessary'. This view was supported by a royal college who felt that a six month publication period would be 'more than enough'.

The MDU supported the proposal as it considered a six month publication period 'would give any person or body with a legitimate interest in that information sufficient opportunity to gain access to it.' Furthermore, that it would protect against any 'prolonged distress to a grieving family'.

Comments opposed to the proposal

Three respondents who were opposed to this proposal, including the Royal College of Radiologists, a doctor and a member of the public, suggested that a publication period of one year would be more appropriate.

The Patient Liaison Group of the Royal College of Surgeons argued that the information should be published as long as the doctor's name remained on the register.

Comments from those who neither agreed nor disagreed

There were mixed views expressed by those who neither agreed nor disagreed with the proposal of a six month publication period after the hearing. One member of the public wasn't sure whether or not this was long enough, whilst a doctor suggested three months was more appropriate. AvMA thought it should depend on the nature of the case and that there may be legitimate reasons for publishing the information for a longer period. NHS Employers agreed with the proposal, on the condition that this would be reviewed in cases where there was a public interest to publish for longer.

The Royal College of Physicians of Edinburgh were unsure why there should be a different approach for doctors who had died, compared with those still alive. Whilst another royal college indicated that their members suggested a period of between 6 and 12 months, depending on the complexity and gravity of the case.

The Information Commissioner's Office highlighted that: 'As the definition of personal data in the DPA covers only data about identifiable living individuals, the DPA would not apply to the publication of information about an individual doctor after their death. Other obligations such as any duty of confidence may, however, still apply.'

Introducing time limits

Question 7: Do you agree that, where a doctor has died, we should continue to disclose fitness to practise information to enquirers after the point at which we stop publication of the information (subject to our overall publication time limits) to enable us to deal transparently with queries where there is a public interest?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	32	52	8
No	17	28	9
Not sure	9	15	3
Comment only	3	5	3
TOTAL	**61**	**100**	**23**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	2	3	1	1	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	5	1	0	0	6
	Regulatory body	1	0	0	0	1
	Other	2	1	0	1	4
Individuals	Doctor	16	9	6	0	31
	Member of the public	2	1	1	0	4
	Other	2	2	1	1	6

Introduction

52% of respondents agreed that we should continue to disclose fitness to practise information to enquirers after the point at which we stop publication of the information, while 28% did not. The PSA, AvMA, MDDUS and five of the six postgraduate medical institutions who responded, supported our proposal. There was also general consensus on this at our stakeholder events, with some attendees indicating that they felt this was extremely important. However, opinion was split amongst doctors and members of the public.

The BMA and MDU disagreed with the proposal on the basis that it would only be necessary or proportionate where there was a legitimate request, for use as part of a public inquiry.

Comments in support of the proposal

Certain circumstances

One royal college which supported this proposal, highlighted the importance of ensuring that disclosures are only made to interested parties, whilst a doctor commented that disclosure should only be made where a doctor has been found impaired.

NHS Employers indicated that there are 'some cases where there is a legitimate reason for enquiring about previous fitness to practise history (for example in the case of complaints, claims, inquiries, etc which arise sometime after the event).' They also commented on the need to highlight to

patients and the public that this information is available – a view shared by the Patient Liaison Group of the Royal College of Surgeons.

One member of the public requested that this information is not withheld to protect the interests of the GMC or doctors – this appears to be based on a misunderstanding of the proposal.

Comments opposed to the proposal

Exceptional circumstances

The MDU opposed this proposal and argued that 'FTP history should only be made available where a person or body can demonstrate a legitimate reason for having access to that information'. This opinion was echoed by the BMA who stated that 'the proposal should be refined to provide for a narrower and more specific set of circumstances in which disclosure should take place after the suggested six months period has elapsed.' The BMA suggested that it might be appropriate in cases where there was a public inquiry or other formal investigative or judicial process, but that disclosure to general enquirers was not appropriate.

The view that information should only be disclosed in exceptional circumstances was shared by an individual doctor and a royal college.

Public interest

One doctor stated that the information should only be disclosed after the publication period if it was clearly in the public interest to do so, whilst BLM law firm indicated that they didn't feel there would be any public interest reasons for doing so.

Fairness

One member of the public who opposed this proposal raised concerns about the rights of a doctor to have 'dignity and privacy after they have died'.

Comments from those who neither agreed nor disagreed

Public interest

Cambridgeshire Local Medical Committee neither agreed nor disagreed with this proposal. They asked for more information about what situations the GMC considered might engage the public interest in this regard.

The MPS stated that the information should only be disclosed where there was a 'genuine public interest' and suggested that this could be 'limited to [inquiries] fulfilling a statutory function, such as the coroner or a court order.' One doctor shared this view and stated that the only justification for disclosure after the publication period would be where 'information is directly related to the coroner's inquiry'.

Introducing time limits

Question 8: Do you have other comments on the issues discussed in the above section?
[ie on time limit proposals – doctors who have died]

Number of respondents who provided further comments: Nine

Introduction

Nine respondents provided further comments in relation to proposals four to eight; five doctors, one academic clinical researcher, one member of the public, the Information Commissioner's Office and a royal college.

Summary of comments

There were a range of comments made in relation to this question. One academic clinical researcher highlighted the importance of openness and transparency in ensuring public confidence. This was echoed by comments made by a member of the public.

The Information Commissioner's Office indicated that: 'the DPA covers only data about identifiable living individuals, [so] the DPA would not apply to the publication of information about an individual after their death. Other obligations such as any duty of confidence may, however, still apply.'

There were a number of suggestions related to the approach in these cases. One doctor suggested that a panel should decide whether there was a public interest in disclosure of fitness to practise information following the death of a doctor. Another doctor submitted that disclosure should be limited to official requests, for example by the coroner. One doctor stated that it depended upon the gravity of the concerns.

Another doctor who provided comments against this question raised a concern about the test of public interest, whilst a royal college highlighted the need to balance public safeguarding with the family and relatives' rights to privacy. This view was echoed by a doctor who stated that there 'is a fine balance' between continuing publication and disclosure of information about a doctor following their death, and the need to be transparent.

Transfer of historical data

Question 9: Do you agree that, in the interests of transparency, we should transfer information on to the medical register about sanctions imposed on a doctor's registration between 1994 and 2005, where that doctor is currently registered?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	36	59%	10
No	18	30%	15
Not sure	5	8%	3
Comment only	2	3%	2
TOTAL	**61**	**100%**	**30**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	4	3	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	6	1	0	0	7
	Regulatory body	1	0	0	0	1
	Other	2	1	0	1	4
Individuals	Doctor	15	10	5	0	30
	Member of the public	3	1	0	0	4
	Other	3	2	0	1	6

Introduction

The majority of respondents (59%) agreed that, in the interests of transparency, we should transfer information onto the medical register about sanctions imposed on a doctor's registration between 1994 and 2005. 30% disagreed with the proposal.

Respondents in agreement included the PSA, AvMA, the MDDUS and the MPS. Members of the public were overall in favour of the proposed changes, while the views of doctors were split; approximately 50% either disagreed with, or were not sure about, the GMC's proposal. Concerns were also expressed by the BMA and the MDU. Overall, the royal colleges that responded to the consultation were in favour of the proposed changes, with the exception of the Royal College of Psychiatrists who raised a number of issues relating to the potential impact of the changes on affected doctors.

Comments in support of the proposal

Consistency

Five respondents, including a doctor, an employer's organisation, a patient body, and a royal college noted that the GMC's proposal to transfer information onto the online medical register about sanctions imposed on a doctor's registration between 1994 and 2005 would ensure equal treatment

among all doctors and make the system fairer. As one doctor noted, 'If there is any publication at all, it should apply to everyone'. This statement was echoed by NHS Employers who stated that the proposal would ensure consistency in terms of the way that all currently registered doctors are treated. However, as noted in the next section, the BMA cautioned that the GMC's proposals would continue to be inequitable, unless data relating to historical sanctions received by all doctors, including those imposed prior to 1994, was also made available online.

Transparency and clarity

Three respondents who agreed with the proposal commented specifically on the issue of transparency, including one employer's organisation, one regulatory body, and one postgraduate medical institution. The Royal College of Physicians, for example, noted that the measures were 'sensible and should increase confidence in the transparency of the Register'. This was supported by CAIPE, who commented that 'good inter-professional practice is based on honest and transparent information'. The PSA also supported the publication of decisions in order to uphold public confidence in the medical profession and help maintain standards, but did caution that this information may need to be anonymised after a certain period of time in the interests of fairness.

Other respondents stated that the proposals would also help to improve levels of clarity among those unfamiliar with the way the system currently works. The Patients Liaison Group of the Royal College of Surgeons noted, for example, that, 'we think it is vital that this happens as currently the situation is confusing to members of the public'.

Comments opposed to the proposal

Fairness

Eleven respondents felt that the online publication of historical sanctions would be unfair. This included five doctors, the BMA, MDU, one royal college, a law firm and a solicitor, and one member of the public.

Several respondents felt that it would not be fair to publish historical sanctions data online given the amount of time that had elapsed since the sanctions were imposed. An individual doctor described the publication of this information as a 'retrospective punishment', especially if the doctor was no longer practising. Other respondents, including the MDU, felt that that the proposals would be also unfair to doctors that were still working, as there would be increased interest in, and accessibility of, sanctions data relating to a particular group. The MDU noted, for example, that the publication of historical sanctions data was likely to unfairly expose a group of doctors to increased scrutiny from the media and other organisations or individuals who 'may not have the best interests of the medical profession or patient interests at their core'. The Royal College of Psychiatrists also pointed out that the increased accessibility of historical sanctions data may also impact on the employment prospects and health of doctors affected by the GMC's proposed changes.

A number of respondents also felt that the proposed measures to transfer all historical sanctions data from 1994 unfairly impacted doctors who had received a sanction due to ill health. The Royal College of Psychiatrists, for example, highlighted the long-lasting impact that a sanction may have, and stated that they do not believe 'there is a good reason to disclose that a doctor's fitness to practise, has, in the past, been impaired by virtue of a mental health condition when they have complied with treatment and had insight'. This was echoed by several doctors, as well as other

individuals, including a member of the public, who stated that 'publishing information about sick doctors is unfair, causing shame, stigma and discrimination'. Several other respondents also suggested that there should be a level of discretion in terms of the publication of historical data. One individual suggested, for example, that there should be a distinction made between those who had received sanctions for ill health and those who had received sanctions for professional misconduct or criminal activity, as treating both groups in the same way was unfair.

Finally, the BMA also felt that the proposed transfer of information would be unfair. However, the BMA raised this point from a slightly different perspective from the other respondents. While they agreed that publishing data from 1994 onwards would expose a particular group to a 'heightened level of visibility', they felt that the answer would not be to prevent the transfer of information, but to extend it so that it also included information about sanctions that were imposed prior to 1994. The BMA stated that unless all doctors were treated the same way, the process would be unfair and inequitable.

Proportionality

The issue of proportionality was also raised by six respondents, including two bodies representing doctors, one doctor, and one royal college. While acknowledging the GMC's role in patient protection, several respondents called for the GMC to ensure that this was balanced to ensure fairness towards doctors. The MDU stated that, in their opinion, the GMC was already able to ensure transparency through its current disclosure mechanisms, where information about a doctor's sanctions is made available on request, and noted that the online publication of this data could have a significant impact on a particular group of doctors. They called for the GMC to take this into account and stated that 'while the GMC's duty is to protect patients and not the medical profession, there does need to be an appropriate balancing of interests'.

The Royal College of Psychiatrists echoed these concerns and questioned the relevance of publishing details about long-expired sanctions, particularly in cases where the doctor has had no further fitness to practise issues. They noted that while the publication of this data would potentially have a serious impact on an individual doctor, the impact on patient safety was likely to be negligible given the amount of time passed since the expiration date of the sanction. Finally, the Information Commissioner's Office, while adopting a neutral stance to the GMC's proposals, did caution that the GMC 'will have to be satisfied that this publication is necessary to fulfil its purpose and that it will not cause any unjustified adverse effects on the doctors in question. This will involve an assessment of the benefit of doing this in terms of the GMC's role in protecting the public and ensuring that publication is a proportionate action to take in order to fulfil that role'.

Impact on doctors

Ten respondents felt that the GMC's proposals would have a negative impact on affected doctors. This included four doctors, two bodies representing doctors, one royal college, one solicitor, and two individuals. An independent public body also raised concerns over the GMC's proposals.

Several respondents, including five doctors and two bodies representing doctors, felt that placing historical sanctions data in an easily accessible online format would have a negative impact on doctors. The MDU, for example, stated that, 'this information is already available to anyone who

requests it, but transferring the information to the online register will automatically make it far more accessible and we are concerned about the adverse impact this will have on some doctors', noting that sanctions data would become easily available to groups that might not have doctors or patients best interests at heart.

Other respondents, including doctors and members of the public echoed these concerns, stating that making historical data available in an online domain may result in affected doctors experiencing distress, stigma, shame and discrimination. The Royal College of Psychiatrists, for example, highlighted the impact of the publication of this data on doctors, particularly those with mental health conditions, stating that 'it is punishment enough to have to come under the GMC process without having to live with the shame and distress inevitably associated with the publication of undertakings and other processes on the register and on the GMC and Medical Practitioners Tribunal Service (MPTS) websites'. They also highlight the issue of cyber-bullying. They, and other respondents, also noted the impact of sanctions on a doctor's career, and raised questions over whether the online publication of historical sanctions data might further impact a doctor's future employment opportunities.

The focus of several responses was on the impact of the GMC's proposed changes on those with long term health conditions, including mental and physical illnesses classified as disabilities under the Equality Act 2010. This issue is discussed further in the response to question 19, which specifically considers the impact of the GMC's proposals on doctors, patients and the public with protected characteristics. However, to briefly summarise the issues in response to this question, seven respondents raised issues relating to doctors who had received sanctions as the result of being unwell. This included three doctors, one member of the public, two other individuals, and one royal college. In particular, concerns were raised that doctors who had received sanctions due to health issues were treated in the same way as those who had carried out professional misconduct and may suffer discrimination and impacts on their health and career as a result of disclosure of prior sanctions.

Four respondents also raised questions relating to the impact of the proposed changes on a doctor's privacy, and questioned whether the measures would be seen as fair under the Data Protection Act. The Information Commissioner's Office, for example, stated that, '… the provision of fair processing information is a requirement of the DPA. It will be vital for the GMC to consider what the doctors in question have already been told about how information about their sanctions will be made available. If publication is to be fair it will have to be within the reasonable expectations of doctors, so any previous assurances that the data would not be published, for example, will be relevant here. The doctors in question should be informed of any change in policy, and made aware of how this will change how their personal data is processed. As the data is historic, accuracy of the data should also be considered. If the GMC is to make this information available online it is important that it is checked for accuracy, as the publication of inaccurate data could cause damage and distress to the individuals involved.'

Comments from those who neither agreed nor disagreed

Discretion

Although 59% of respondents supported the GMC's proposals, there was some disagreement over the circumstances in which historical sanctions data should be published. The Royal College of

Radiologists, for example, stated that they were in agreement with the proposal as long it reflected the new time limits on data retention proposed by the GMC (see question 1 of this consultation), which is indeed the intention. Two doctors stated that they supported the proposals where the sanctions are still place, or where the doctor is still practising. Another individual doctor agreed with the proposal but commented that information about interim orders should not be included 'where the subsequent fitness to practice hearing has not resulted in erasure/suspension or conditions'. This is in fact current position in relation to publication of interim orders, and there is no proposal to change that.

Other respondents felt that the addition of historical sanctions data should be dependent on the reason the sanctions were imposed. Several respondents, mainly doctors and other individuals, felt, for example, that it was important to distinguish sanctions that resulted from criminal, sexual or violent behaviour, from those that related to minor offences and, in particular, ill health.

Other comments

The Information Commissioner noted that the GMC would need to ensure that their procedures are fair, and compliant with the Data Protection Act. The GMC also needs to ensure the accuracy of any historic data.

Alternative approaches suggested

As noted above, several respondents made suggestions relating to alternative approaches. The majority of these focused on the implementation of a more discretionary system. One doctor suggested making it clear which sanctions related to criminal proceedings and which were related to civil proceedings, while another suggested that less severe cases should be removed from the register.

Fitness to practise appeal outcomes

Question 10: Do you agree with the proposal in relation to appeals that are unsuccessful in scenario A?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	44	75%	11
No	10	17%	8
Not sure	4	7%	1
Comment only	1	1%	1
TOTAL	**59**	**100%**	**21**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	7	0	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	5	1	1	0	7
	Regulatory body	0	1	0	0	1
	Other	3	0	0	1	4
Individuals	Doctor	20	6	3	0	29
	Medical student	0	0	0	0	0
	Other healthcare professional	0	0	0	0	0
	Member of the public	3	1	0	0	4
	Other	4	1	0	0	5

Introduction

75% of respondents to this question agreed with the proposal in relation to unsuccessful appeals, while 17% disagreed. Those in agreement included 20 doctors, 3 Royal Colleges, and all of the bodies representing doctors, as well as three out of four members of the public, AvMA and the Patient Liaison Group of the Royal College of Surgeons. The PSA and one other royal college were among those who did not agree however.

Comments in support of the proposal

There were eleven comments from the respondents who answered yes to this proposal. Six just reflected general agreement with the proposal, although one said this was dependent on the overall approach being consistent with his view on time limits generally, which was that a sanction should cease to be published once spent.

NHS Employers supported the proposal on the basis of public interest, commenting 'it is in the public interest that the full fitness to practice history is available, including where this has been subject to appeal. This allows patients, the public and employers to follow the whole progress of the case and have the best information available to them in order to meet their respective needs'.

Three individual respondents called for more information to be recorded, including the basis for the appeal and the reasons for it being rejected. The MDU highlighted that the GMC will in the future be able to appeal the decision of a fitness to practise panel decision and commented that the same principles must be applied to the publication of the outcome of these appeals (and those of the PSA) as are applied to the publication of the outcome of a doctor's appeal.

Comments opposed to the proposal

Eight of the respondents who said no to this proposal provided comments.

The PSA disagreed with the proposal because they could see no benefit to the public interest in publishing the record of an unsuccessful appeal. One individual doctor also thought there was little benefit to the proposal but added that she felt it penalised the doctor for taking up their option to appeal. Another doctor commented that the doctor concerned had the right to be asked about whether the appeal outcome, and legal reasons for it, should be included on his or her record.

One doctor who disagreed did so because she considered the GMC was one sided in what it published and that if anything was to be published, it should include all details of an appeal, including any criticism of the GMC. One member of the public also called for more information, saying that any dishonesty or disreputable behaviour should also be recorded. The Royal College of Psychiatrists considered the appeal outcome should be published for as long as the sanction because they saw an unsuccessful appeal as forming part of the initial hearing or procedures.

Two individuals, a doctor and an NHS manager, considered that the same information recorded on the online register should also be included on the MPTS web page.

Comments from those who neither agreed nor disagreed

Health Education England answered 'not sure' to this question because they did not consider the benefits to public and employers were clear. The Information Commissioner's Office considered that the proposals on publication of appeal outcomes appeared likely to result in increased accuracy of the information published. They considered that a privacy impact assessment in this area would be helpful however.

Fitness to practise appeal outcomes

Question 11: Do you agree with the proposal in relation to appeals that are successful in scenario B?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	36	62%	6
No	14	24%	14
Not sure	6	10%	2
Comment only	2	4%	2
TOTAL	**58**	**100%**	**24**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	4	2	0	1	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	6	1	0	0	7
	Regulatory body	1	0	0	0	1
	Other	2	1	0	1	4
Individuals	Doctor	16	7	6	0	29
	Member of the public	2	2	0	0	4
	Other	3	1	0	0	4

Introduction

62% of those who answered this question agreed with the proposal in relation to successful appeals. This included the PSA, AvMA, the MDU and the MDDUS. 24% disagreed with it however, including the BMA and the MPS. Twice as many doctors agreed with the proposal as disagreed, and members of the public were split in their views.

Comments in support of the proposal

There were only six comments from those who agreed with the proposal. These included comments that it was in the public interest to provide a full history; and that it was fair to the doctor to provide such information when a doctor is exonerated. One doctor considered that a formal apology to the doctor should also be published in the event of a successful appeal, and another that any criticism of the GMC should be published.

The PSA agreed with the proposal, but queried what the GMC's approach would be if they were asked for disclosure of the original decision after it had been removed from the record.

One Royal College, while agreeing with the proposal, commented that some of its members had argued that 'if a doctor is found innocent, then there should be no mention at all of the hearing and appeal processes'.

Comments opposed to the proposal

Of those who said no to this proposal, 14 provided comments. Over half of these disagreed because they thought it was inappropriate to publish any information on a doctor's record if an appeal had found him or her to be unimpaired. The Cambridgeshire Local Medical Committee described the proposal as unnecessarily punitive and thought that the current system of removing all information was far more appropriate. A member of the public agreed, commenting that 'many interested parties may conclude 'no smoke without fire' quite unfairly'; and another individual respondent thought that the proposal breached data protection principles. Although not answering yes or no to the question, the MPS' comments made it clear that they disagreed for similar reasons, considering the proposal prejudicial to a doctor who has been found unimpaired. The BMA made similar points, and suggested that it would be appropriate instead to let the doctor decide whether such a note should be added to their record.

Of the other comments made, three simply said that there was no need to change the current system and one highlighted the negative reputational impact on a doctor of any publication of fitness to practise information. However, one member of the public disagreed with the proposal because she thought that the original concerns should continue to be published even following an unsuccessful appeal, as the public need to know about them.

Comments from those who neither agreed nor disagreed

One doctor answering 'not sure' also raised the question of whether there was any reason to keep information on record for 12 months if a doctor had been cleared. Another doctor was not sure because, while agreeing with that argument on the one hand, she thought that there was also an argument that it was important to publish there had been a successful appeal, given that the original decision and sanctions would have been on the register and visible previously.

Alternative approaches suggested

As indicated above, the BMA suggested that the doctor should be able to decide whether a note about a successful appeal should be added to his record.

Fitness to practise appeal outcomes

Question 12: Do you agree with the proposal in relation to appeals that are partly successful and sent back to the GMC for a new hearing in scenario C?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	47	81%	8
No	2	3%	2
Not sure	8	14%	2
Comment only	1	2%	1
TOTAL	**58**	**100%**	**13**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	7	0	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	7	0	0	0	7
	Regulatory body	1	0	0	0	1
	Other	3	0	0	1	4
Individuals	Doctor	20	2	6	0	28
	Member of the public	2	0	2	0	4
	Other	5	0	0	0	5

Introduction

81% of respondents to this question agreed with the proposal in relation to partially successful appeals sent back to the GMC for rehearing. This included 20 out of 28 doctors, all of the bodies representing doctors and the Royal Colleges, AvMA and the PSA. Two members of the public agreed and two were not sure. Only two respondents (3%) said no to the proposal, both doctors.

Questions 12 to 16 of the consultation were very similar in nature to questions 10 and 11, with all of them setting out proposals for recording appeal or judicial review outcomes in different scenarios. Many respondents, rather than commenting individually on each proposal, did not comment at all on the later proposals or referred back to their answers to questions 10 and 11. We have therefore just reported here any additional comments made under this question.

Comments in support of the proposal not already reflected in questions 10/11

One Royal College, while agreeing with the proposal, commented that the situation could be confusing to a lay person.

Comments opposed to the proposal not already reflected in questions 10/11

One doctor considered that a partially successful appeal should lead to all details being removed from a doctor's record.

Fitness to practise appeal outcomes

Question 13: Do you agree with the proposal in relation to appeals that are part successful and the original outcome is changed by the appeal court in scenario D?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	46	78%	4
No	6	10%	5
Not sure	6	10%	3
Comment only	1	2%	1
TOTAL	**59**	**100%**	**13**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	6	1	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	6	0	1	0	7
	Regulatory body	1	0	0	0	1
	Other	3	0	0	1	4
Individuals	Doctor	21	3	5	0	29
	Member of the public	3	1	0	0	4
	Other	4	1	0	0	5

Introduction

78% of respondents to this question agreed with the proposal where appeals are partially successful and the original outcome is changed by the appeal court. This included the MDOs and the BMA, and 21 out of 29 of the doctors who responded. The Medical Women's Foundation and the Independent Federation of Doctors also agreed as did AvMA, and three of the four members of the public. 10% of respondents disagreed including the Cambridgeshire Local Medical Committee.

Questions 12 to 16 of the consultation were very similar in nature to questions 10 and 11, with all of them setting out proposals for recording appeal or judicial review outcomes in different scenarios. Many respondents, rather than commenting individually on each proposal, did not comment at all on the later proposals or referred back to their answers to questions 10 and 11. We have therefore just reported here any additional comments made under this question.

Comments in support of the proposal not already reflected in questions 10/11

None not already reflected

Comments opposed to the proposal not already reflected in questions 10/11

The Cambridgeshire Local Medical Committee commented that information should be removed where the appeal results in the doctor being found unimpaired, in line with their views on question 11 regarding successful appeals. They considered that the current system of dealing with cases on a

case by case basis is more sensible. An individual doctor also commented that these situations should be dealt with on a case by case basis.

Another individual respondent disagreed because he thought there should be disclosure of even more information than that proposed where a fitness to practise panel had been found to be wanting by an appeal court.

Comments from those who neither agreed nor disagreed not already reflected in questions 10/11

One doctor questioned why the information should be retained for twelve months and not for six months.

Fitness to practise appeal outcomes

Question 14: Do you agree with the proposal in relation to appeals that are withdrawn in scenario E?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	44	77%	4
No	4	7%	3
Not sure	8	14%	4
Comment only	1	2%	1
TOTAL	**57**	**100%**	**12**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	7	0	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	6	0	1	0	7
	Regulatory body	0	1	0	0	1
	Other	3	0	0	1	4
Individuals	Doctor	18	3	6	0	27
	Member of the public	4	0	0	0	4
	Other	4	0	1	0	5

Introduction

Over three quarters of respondents to this question agreed with the proposal in relation to appeals that are withdrawn, including all bodies representing doctors, all but one of the royal colleges, all members of the public, AvMA and the Patient Liaison Group of the Royal College of Surgeons. The PSA and three doctors disagreed with the proposal.

Questions 12 to 16 of the consultation were very similar in nature to questions 10 and 11, with all of them setting out proposals for recording appeal or judicial review outcomes in different scenarios. Many respondents, rather than commenting individually on each proposal, did not comment at all on the later proposals or referred back to their answers to questions 10 and 11. We have therefore just reported here any additional comments made under this question.

Comments in support of the proposal not already reflected in questions 10/11

None not already reflected

Comments opposed to the proposal not already reflected in questions 10/11

None not already reflected

Comments from those who neither agreed nor disagreed not already reflected in questions 10/11

One respondent who answered not sure questioned the time limit of 12 months, asking why not six. Another commented that it depended on why the appeal was withdrawn, but did not elaborate on this.

Fitness to practise appeal outcomes

Question 15: Do you agree with the proposal in relation to cases where no appeal is made in scenario F?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	50	85%	5
No	3	5%	1
Not sure	5	8%	1
Comment only	1	2%	1
TOTAL	**59**	**100%**	**8**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	7	0	0	0	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	6	0	1	0	7
	Regulatory body	1	0	0	0	1
	Other	3	0	0	1	4
Individuals	Doctor	23	3	3	0	29
	Member of the public	3	0	1	0	4
	Other	5	0	0	0	5

Introduction

50 out of the 59 respondents (85%) who answered this question agreed with the proposal relating to where no appeal is made. This included all bodies representing doctors, 23 out of 29 doctors, AvMA and the PSA. Only three respondents (5%) said no, all of whom were doctors.

Questions 12 to 16 of the consultation were very similar in nature to questions 10 and 11, with all of them setting out proposals for recording appeal or judicial review outcomes in different scenarios. Many respondents, rather than commenting individually on each proposal, did not comment at all on the later proposals or referred back to their answers to questions 10 and 11. We have therefore just reported here any additional comments made under this question.

Comments in support of the proposal not already reflected in questions 10/11

One doctor who agreed with the proposal did add that she was not sure why the additional comment was needed.

Comments opposed to the proposal not already reflected in questions 10/11

The only comment made by a respondent who said no was not directly relevant to the question, but rather focussed on the fact that he considered the 28 day time limit for appeal was not enough given the GMC's record of bringing cases to a hearing.

Comments from those who neither agreed nor disagreed not already reflected in questions 10/11

None not already reflected

Fitness to practise appeal outcomes

Question 16: Do you agree with our proposed general approach to situations where a fitness to practise panel's finding of impairment with no sanction, or a decision to give a warning, is overturned on judicial review?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	42	71%	6
No	12	20%	10
Not sure	3	5%	1
Comment only	2	4%	2
TOTAL	**59**	**100%**	**19**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	4	2	0	1	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	6	1	0	0	7
	Regulatory body	1	0	0	0	1
	Other	2	1	0	1	4
Individuals	Doctor	20	7	2	0	29
	Member of the public	3	1	0	0	4
	Other	4	0	1	0	5

Introduction

71% of respondents to this question agreed with the proposal in relation to a successful judicial review. 20% disagreed however. The opinion of bodies representing doctors was split on this question with the MDU, MDDUS, Medical Women's Federation and Independent Doctors Federation in support, and the MPS, the BMA and the Cambridgeshire Local Medical Committee opposed. 20 out of 29 doctors and three out of four members of the public agreed with the proposal, as did the PSA, the Patient Liaison Group of the Royal College of Surgeons and AvMA.

Questions 12 to 16 of the consultation were very similar in nature to questions 10 and 11, with all of them setting out proposals for recording appeal or judicial review outcomes in different scenarios. Many respondents, rather than commenting individually on each proposal, did not comment at all on the later proposals or referred back to their answers to questions 10 and 11. We have therefore just reported here any additional comments made under this question.

Comments in support of the proposal not already reflected in questions 10/11

One royal college commented that it was appropriate to treat successful judicial reviews in the same way as successful appeals (as discussed at question 11). One doctor thought that, where the decision of a fitness to practise panel had been overturned, the judicial review decision and the reasons

behind it should be made public 'in the interests of fairness and transparency'. Another doctor also thought there should be a summary of the case on the record, with the GMC publicly accepting responsibility and making an apology. This should be published for as long as it is proposed to publish information about a doctor who loses a case.

Comments opposed to the proposal not already reflected in questions 10/11

The majority of comments from those who said 'no' reiterated concerns about whether it was appropriate to include any information about fitness to practise on the register after, in the words of one doctor 'what is in effect a 'not guilty' verdict'. One doctor said no however because she was apprehensive of judicial review if a panel has made a decision based on its expertise and the evidence presented.

Comments from those who neither agreed nor disagreed not already reflected in questions 10/11

None not already reflected

Interim orders appeal outcomes

Question 17: Do you have any comments on our proposed approach to publishing information about appeals in interim orders cases, as set out in the section above?

Number of respondents who provided comments: 27

In total, 27 respondents provided comments. Of these, 17 responded positively to the GMC's approach, four expressed concerns, and six neither supported nor opposed the approach. The majority of doctors agreed with the approach, as did all of the postgraduate medical institutions that responded to this question. Bodies representing doctors were divided. The BMA expressed neither support nor opposition, although the Cambridgeshire Local Medical Committee commented favourably on the approach. Members of the public and other organisations were divided on the issue; approximately half of the respondents in these groups supported the approach, while the other half either opposed the approach or neither supported nor opposed it.

Comments in support of our approach

In total, 17 respondents expressed their agreement with the GMC's proposed approach to publishing information about appeals in interim orders cases. Ten respondents stated that they agreed with the proposals, without leaving further comments. Seven respondents gave more detailed responses.

Fairness

Two doctors noted that the GMC's proposed approach seemed fair, while one royal college and another postgraduate medical institution each stated the proposals appeared 'appropriate' and 'sensible'.

Transparency and clarity

Five respondents, including one doctor, one employer's organisation, one body representing patients, one postgraduate medical institution, and one member of the public commented that the proposals would increase transparency and clarity. In particular, respondents noted that inclusion of information on our approach within the publication and disclosure policy would be beneficial to both the public and the public interest. NHS Employers, for example, stated that although there is no change to the approach to publishing interim orders, setting out the publication and disclosure policy should help patients, the public and employers understand their purpose and the role that they have in safeguarding the public'. The Patients Group of the Royal College of Surgeons, also welcomed the proposal, commenting, 'we agree that there should be clear information for the public on the approach that is taken, why and what this means in terms of a doctor's practice'.

Comments opposed to our approach

In total, four respondents, including three doctors and a law firm, expressed concerns over the GMC's proposed approach. The law firm and one doctor did not agree with the proposed approach in situations where the original decision to impose interim orders is upheld but the court decides it should no longer have effect. They thought all information about the original order should be

removed from a doctor's record as there was no longer a risk to the public. The other two respondents did not think that any information should be published about interim orders.

Comments from those who neither agreed nor disagreed with our approach

Six respondents expressed neither agreement nor disagreement with the proposals, including the BMA, the Information Commissioner's Officer, AvMA, one doctor, and two other individual respondents. The BMA commented that while it was 'no doubt desirable for the GMC's approach to publication to be made clear', it would also be important for the GMC to point out that interim orders don't reflect in any particular way on a doctor as the panel has not carried out a full enquiry on a doctor, and the sanction is therefore 'provisional in character'. The Information Commissioner's Office raised a similar point, stating that, 'it would be helpful to set out why this approach is different from the publication of fitness to practise appeals'. AvMA supported the publication of information in relation to interim orders, but emphasised that the effectiveness of any decisions were reliant on 'the robustness of the investigative and adjudication processes and of their implementation in practice'.

Alternative approaches suggested

None of the respondents suggested an entirely new approach, but, as noted above, the BMA and the Information Commissioner's Office suggested that the GMC provide further information on the nature of interim orders and the differences between the publication of fitness to practise appeals and interim orders appeals.

Explanatory background for undertakings

Question 18: Do you agree that we should give greater explanation of the background and reasons for resolving the case consensually when we agree undertakings with a doctor and conclude the case without a fitness to practise panel hearing?

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	37	64%	14
No	12	21%	8
Not sure	6	10%	6
Comment only	3	5%	3
TOTAL	**58**	**100%**	**31**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	4	0	2	1	7
	Body representing patients or public	2	0	0	0	2
	Postgraduate medical institution	5	0	1	1	7
	Regulatory body	1	0	0	0	1
	Other	2	0	1	1	4
Individuals	Doctor	17	9	2	0	28
	Member of the public	3	1	0	0	4
	Other	3	2	0	0	5

Introduction

64% of respondents who answered this question agreed that we should give greater explanation of the background and reasons for resolving cases consensually when we agree undertakings with a doctor. This included the majority of individual doctors who responded, the PSA, NHS Employers, AvMA, medical defence organisations and the Patient Liaison Group of the Royal College of Surgeons. 21% of respondents opposed the proposal including nine doctors and a member of the public. The BMA, BLM (a law firm representing doctors), a royal college and the Cambridgeshire Local Medical Committee were unsure about the proposal. The Information Commissioner's Office, the Medical Protection Society (MPS) and the Royal College of Psychiatrists did not say whether they supported or opposed the proposal but made a comment.

Comments in support of the proposal

Transparency

Five respondents in favour, including the PSA, NHS employers and the Patient Liaison Group of the Royal College of Surgeons, and the Information Commissioner's Officer (who neither agreed nor disagreed) said that the proposal would increase transparency in relation to decisions to agree undertakings and help the public understand the reasons for disposing of a case in this way. A doctor

added that this would also increase GMC accountability and another said it would be useful to all parties.

Process

The MDU and the MDDUS (both in favour) and the Information Commissioner's Officer and the MPS (which both made comments only), noted that there would need to be a process for agreeing the wording of the summary published as a link to the medical register, with one doctor noting that this would have to involve the doctor and their representative. The BMA, who were unsure about the proposal, raised similar concerns saying the doctor should be allowed to respond to any proposed summary. The PSA were disappointed that the consultation did not set out details in relation to agreeing the summary and said this should guard against any bargaining in relation to summary content.

Other comments

The PSA and one member of the public said where a health related undertaking was agreed, this should be a matter of public record. AvMA agreed with the proposal, but expressed their concern about the process of consensual disposal itself and any plans to extend that process to more serious cases. They emphasised that any such process must operate 'on the basis of maximum transparency and avoiding any suggestion of compromise through negotiation that might result in a lesser sanction than would be anticipated following a full investigation and determination by a FTP panel'. With regard to publication, they argued that, in any situation where the GMC's initial decision changes as the result of a final meeting with a doctor, then 'the GMC's original findings and sanction should be published together with a full explanation of why the GMC changed its original decision'.

Comments opposed to the proposal

Proportionality

Three respondents disagreed with the proposal on the basis that it was disproportionate. One doctor suggested that a letter to the complainant explaining the circumstances would be sufficient. Another thought that all information should be removed when undertakings were revoked.

Health cases

Four respondents, including one who agreed with the proposal and the Royal College of Psychiatrists (who made a comment only) said no information should be published in relation to impairment on the grounds of health with one suggesting that this would be a breach of the doctor's human rights. The Royal College of Psychiatrists raised concerns that any health problem would be identifiable from the summary of concerns published.

Other comments

Two respondents thought this proposal would backfire with doctors less likely to agree to consensual disposal as a result. And, two doctors who responded said this amounted to a breach of the doctor's right to privacy.

Comments from those who neither agreed nor disagreed

In addition to concerns raised by others, ie the proposal potentially being a barrier to consensual disposal and the need for a process to agree the summary, one doctor said the length of disclosure (20 years) was disproportionate particularly where there was remediation. One royal college also noted that a detailed explanation of what happened may not always be helpful.

BLM said there was the possibility of satellite litigation around the wording of the summary.

Alternative approaches suggested

BLM suggested that, as an alternative, the summary be provided to employers and the proposal be revised to differentiate between health and non-health cases (in line with some of the other respondents).

One doctor, who was unsure, suggested that the information be published only where there was a patient safety risk.

The MPS and the Royal College of Psychiatrists both suggested that the summary should make clear that the concerns were not proven.

The Royal College of Psychiatrists also said: 'as the net is widened to agree voluntary undertakings for more serious cases, it is important that doctors at the milder end of the spectrum are not disadvantaged (or tarnished) by a 'one size fits all' decision to publish a 'short summary of concerns'. They suggested the GMC 'make a clear distinction between sanctions and undertakings made because of health problems where there has been no complaint or fault, such as self-reporting'. In relation to these cases, 'there is no need for any publication after the undertakings have been lifted'.

The PSA noted their lack of support for the extension of consensual disposal to cases where suspension or erasure are the likely outcome. They said that, should the GMC go ahead with this, they would 'expect these consensual outcomes to be published and disclosed in the same way as those imposed by a panel'.

Equality

Question 19: Do you think that any of our proposals will affect people with protected characteristics that are covered by equality legislation? This could include doctors, patients and members of the public.

Numerical analysis of consultation responses

Option	Response number	Percentage	Number of comments
Yes	11	20%	9
No	34	61%	2
Not sure	8	14%	1
Comment only	3	5%	3
TOTAL	**56**	**100%**	**15**

Analysis of responses by category of respondent

		Yes	No	Not sure	Comment only	Total
Organisations	Body representing doctors	1	5	0	1	7
	Body representing patients or public	1	0	1	0	2
	Postgraduate medical institution	0	5	0	1	6
	Regulatory body	0	1	0	0	1
	Other	0	2	0	0	2
Individuals	Doctor	6	18	4	0	28
	Member of the public	1	1	2	0	4
	Other	2	2	1	1	6

Introduction

The majority of respondents (61%) did not think that any of the GMC's proposals would affect people with protected characteristics covered by equality legislation, but 20% thought that there would be some impact.

Respondents who did not think the proposals would affect people with protected characteristics included most doctors, postgraduate medical institutions, the PSA, and the majority of bodies responsible for representing doctors that responded to the consultation. Individual respondents and members of the public were divided on the issue, with around half of each of these groups answering yes, and the other half answering no or stating that they were unsure. AvMA was not sure, and the Patient Liaison Group of the Royal College of Surgeons stated that they felt that the proposals would affect people with protected characteristics covered by the equality legislation. Three respondents, including the MPS, the Royal College of Psychiatrists and one individual did not answer either yes or no to the question posed, but all raised concerns about how doctors and other groups may be affected by the GMC's proposals.

Equality issues raised

Respondents raised a number of equality issues, the majority of which related to doctors who had long term illnesses, or who may be classed as disabled under the Equalities Act. Although not all respondents raised the issue of mental health, this was also a common topic of discussion within the responses. Equality issues relating to age and gender reassignment and sexual orientation were also raised.

Impact on doctors with health conditions - disability

Two doctors, four individuals, and one royal college raised issues relating to the impact of the GMC's proposals on doctors that have (or have had) long term health conditions. Several respondents highlighted the fact that doctors who are unwell (whether mentally, physically, or both) for a long period are likely to be classed as disabled under the Equality Act 2010, and raised concerns over how the GMC's proposals will affect people within this group. A key concern expressed by respondents was that the publication and disclosure of fitness to practise sanctions would have a detrimental impact on the lives of doctors within this group. Several doctors and members of the public noted that doctors who receive sanctions may be subject to stigma, discrimination and shame. This was echoed by the Royal College of Psychiatrists in their answer to question 9, where they noted that sanctions may impact on a doctor's career and health. Overall, respondents reported that it was unfair that doctors who had received sanctions due to health conditions could potentially be impacted in the same way as doctors who had received sanctions due to malpractice or criminal activity. As one doctor noted, 'those who are genuinely unwell are being tarred with the same brush as those who have been negligent'.

Although most respondents discussed health issues in general terms, several respondents specifically referred to the effect that the GMC's proposals would have on doctors with mental health issues. The Royal College of Psychiatrists, for example, referred to both the stress of involvement in fitness to practise processes on a doctor's mental health, and the longer term impact of sanctions on a doctor with a mental health condition. They also raised questions over the publication of information related to mental health conditions, arguing that the higher level of responsibility among doctors 'should not negate their human right to privacy if there is no risk to patients'.

Other equality issues

Other respondents raised a number of different points relating to the impact of the GMC's proposals on people with affected characteristics. The BMA, for example, noted that the GMC's 'blanket imposition of a 20 year time limit for sanctions short of erasure may have a disproportionate detrimental impact on grounds of age'. The MPS touched on the issue of doctors who had undergone a gender reassignment while under the GMC's fitness to practise procedures and stated that the GMC 'should consider what mechanisms would be needed within the system to deal with issues pertaining to gender reassignment, i.e. the gender of the doctor was different at the time of the hearing'. They also stated that the GMC would need to consider 'the effect these proposals could have if any published information makes direct reference, or implied reference, to the doctors' sexual orientation'. Finally, NHS Employers did not raise any equality issues relating to one particular group but did note that 'the more difficult question is that some groups of doctors with protected

characteristics may be subject to GMC investigation and action more than others', although they went on to note that 'these proposals will not affect that issue'.

Wider impact

Finally, several respondents commented that the GMC's proposals may have an impact on other groups in society with protected characteristics. The Royal College of Psychiatrists, for example, noted that disclosure 'may have unintended consequences for individuals other than doctors' and that the proposals 'could potentially have an adverse effect on individuals with long-standing mental health problems who are covered by this legislation and who are patients/relatives of doctors about whom information is published on the medical register, on the GMC website and on the MPTS website'. The Patient Liaison Group of the Royal College of Surgeons also noted that they had concerns 'where the GMC's proposals were complex' as different groups may find these difficult to understand, and urged us to take as simple and straightforward an approach as possible to the publication of outcomes. They also pointed out that the GMC's 'use of white text on a blue background is not a helpful form of publication for those with some sight difficulties'.

APPENDIX B

List of organisations who responded to the consultation

Action against Medical Accidents (AvMA)
BLM Solicitors
British Medical Association (BMA)
Cambridgeshire Local Medical Committee
Centre for the Advancement of Interprofessional Education (CAIPE)
Faculty of Intensive Care Medicine (FICM)
Health Education England
Independent Doctors Federation
Information Commissioner's Office (ICO)
Medical and Dental Defence Union of Scotland (MDDUS)
Medical Defence Union (MDU)
Medical Protection Society (MPS)
Medical Women's Association
NHS Employers
Patient Liaison Group of the Royal College of Surgeons
Professional Standards Authority (PSA)
Professional Support Unit HENWEL
Royal College of Anaesthetists
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists

General Medical Council

M8 – Consultation on publication and disclosure policy – outcomes and recommendations

M8 – Annex C

Independent Quality Assurance Report carried out by Frontline Management Consultants

Conclusion

Overall our analysis has identified that the key findings on the consultation are in correlation with the analysis produced by the GMC.

Where minor differences exist these are a result of the individual approaches applied to the theme analysis and groupings. These differences were minimal and are discussed within the narrative of each section.

For some questions, where there was a larger volume and better quality of responses, it was possible to provide a deeper level of analysis and review of GMC findings (e.g. Proposal 1). At the other end of the scale, for some questions where there were fewer responses, this was reflected in the GMC findings, and it was subsequently, difficult to provide detailed analysis (e.g. Proposal 4 and 5).

Based on our analysis we believe that the GMC analysis of the consultation data on the publication and disclosure policy is an accurate reflection of the responses received.

Frontline

January 2016