

Changes to our Rules consultation - Recommendations

Section 1: Formally separating our investigation and adjudication functions

Establishing the MPTS as a statutory committee

- 1 The majority of respondents agreed with our proposal though a small number of respondents raised concerns about membership, preferring that there be a registrant majority, and the proposed criteria for disqualification of a member.
- 2 Changes to *the Medical Act 1983* (publicly consulted on in 2014 by the Department of Health and included in a Section 60 Order approved by Parliament) prohibit a registrant majority on the MPTS Committee and the Rules must reflect this.
- 3 A small number of respondents disagreed with some of the criteria for disqualification of a MPTS Committee member, including an ongoing FTP investigation where appointment will undermine public confidence in the profession. We drafted the criteria to be consistent with similar provisions for the General Council. We believe that the General Council should disqualify a Committee member if it believes that such an appointment will undermine public confidence in the profession. This will ensure a proportionate response.
- 4 Other issues included:
 - a A suggestion by one respondent that the MPTS be responsible for appointing the Chair and Deputy Chair. As a statutory committee of the GMC we consider that the role of appointing the committee chair and deputy chair should fall to Council and most respondents agreed with this. As the Chair and Deputy Chair are two of the five members of the MPTS Committee, this proposal would involve the MPTS committee appointing itself and consequently we do not propose to take that forward.
 - b Provision for a casting vote where a meeting has four members and opinion is evenly split.

Recommendation: We propose to explore amending the draft Rules so they are consistent with the approach taken to casting votes in meetings of the General

Council (as set out in the Medical Act 1983 as amended, where the Chair has a casting vote).

- c One respondent commented that the changes will not address concerns about whether decision-making by MPTS panels can be influenced by unconscious bias. There are a number of safeguards in place to address this including independent quality assurance and audits. The MPTS also conducts annual refresher training for all panel members to ensure that procedures are fair and this includes equality and diversity and managing unconscious bias. The MPTS will continue to emphasise the importance of this training.

Criteria for appointing panellists and legally qualified chairs

- 5 The PSA raised a concern that current and former employees of the GMC are not excluded from being appointed as members of the MPTS Committee.

Recommendation: The draft Rules allow the General Council to set and publish the criteria for MPTS Committee members and we will consider the points raised by PSA when developing these criteria.

- 6 The majority of respondents agreed that the MPTS be responsible for setting and publishing the criteria for appointing panellists and chairs, though a minority asked how this would be done and whether the criteria would be made public.

Recommendation: Panel members and chairs are appointed against a set of competence based criteria. We will make sure the criteria are made public.

- 7 A large majority of respondents (79%) agreed that where legally qualified chairs advise the panel in camera (not in the presence of the parties) they should include their advice in the written decision. Two respondents thought legally qualified chairs should not give advice at all. In relation to advice given in private, three thought no advice should be given, one that the decision should include the reasons for the advice and four that there should be an opportunity to challenge the advice.

Recommendation: We will consider amending the Rules to include, where advice is given after a panel has begun to deliberate, a discretion for the panel to return to open session where the legally qualified chair can give advice in the presence of the parties and invite submissions from them.

- 8 One respondent was concerned that legally qualified chairs may be more pointed in the way they express themselves and two thought an overly legal process might be detrimental to a doctor's health.

Recommendation: We will continue to provide training for our panellists that will include emphasising the importance of the Chair take into account all points expressed by his or her colleagues and equality and diversity.

Separating out the notice of allegation from the notice of hearing

- 9 85% of respondents who answered the question agreed that the MPTS send the notice of hearing and the GMC send the notice of allegation, though four said that the resulting duplication would cause stress for the doctor and in particular, those who may be at risk of suicide.

Recommendation: Following a review of suicides among doctors while involved in our fitness to practise procedures we are currently reviewing the way we investigate and hear cases involving vulnerable doctors and will consider, as part of this work, how best to correspond with them to minimise stress.

- 10 We also proposed amending the Rules to reflect the current practice of giving a doctor at least 28 days' notice of all matters relating to a hearing. 83% of respondents who answered agreed, though three suggested that 28 days should be a minimum and three that the notice period should be brought in line with the six week notice period required for doctors to request leave.

Recommendation: We will consider developing guidance to make it clear that where possible doctors should be given six weeks' notice to coincide with notice periods required by employers.

- 11 One law firm suggested we retain the current provision at Rule 15(1) that the notice of allegation is served as soon as reasonably practicable after referral. The proposed Rule as drafted states the Registrar or the MPTS (as appropriate depending on which is responsible for the particular notice) gives *at least* 28 days' notice. We consider this allows earlier notice to be given where possible.
- 12 The MDU made suggestions to allow for the MPTS only to decide on a shorter notice period where it is in the public interest *and* the exceptional circumstances of the case to do so. The proposed Rule 15(2) allows for the Registrar or MPTS to give a shorter notice period where it is in the public interest to do so. We consider this is an appropriate threshold for giving a shorter notice period.

Removing the need for the MPTS to refer cases to the GMC where an interim order is set to expire

- 13 69% of the respondents who answered this question agreed with the proposal, with the proviso suggested by a small number that a robust system for identifying an order about to lapse be put in place.

Recommendation: We have reviewed our arrangements to ensure robust systems are in place and will continue to bear this in mind when implementing this change.

Section 2: Streamlining and modernising our hearing process

Clarifying our use of undertakings

- 14** 81% of the respondents who answered question 7 supported our proposal to refer to a review hearing a case involving a doctor with undertakings where the doctor does not agree to changes to the undertakings. The PSA and one other respondent noted that the criteria for a referral were not included in the Rules. One respondent suggested referrals should be made where there is a change in circumstances or new evidence.
- 15** 81% of respondents who answered question 8 supported clarifying our Rules so that doctors with undertakings whose language skills deteriorate or otherwise give rise to concern can be referred to a panel. The BMA and a small number of respondents commented that there should be clear referral criteria including how deterioration would be evidenced. The BMA also highlighted a risk of discrimination on the basis of race and disability in making these referrals.

Recommendation: In relation to both questions, we will review our guidance and develop relevant criteria for referrals where necessary, making sure that all equality and diversity considerations are taken into account.

Streamlining our hearing process

- 16** We made a number of proposals to streamline our hearings (questions 9 – 13) which a majority (question 11) or large majority of respondents supported.
- 17** Question 9 proposed identifying the doctor before hearing legal argument. Three respondents suggested that, if a stay of proceedings was successful, the current position allowed doctors to say they have not appeared before their regulator.
- Recommendation:** We will review the proposal and consider whether the doctor will be disadvantaged in the way suggested.
- 18** 63% of those who answered question 11 supported removing the need to refer to transcripts of previous hearings in review or restoration hearings unless necessary. A small number of respondents commented that transcripts of previous hearings are important in understanding the nuance of evidence heard and may impact on the review or restoration hearing. Panels will be able to request a transcript if they consider this necessary to support their decision making.
- 19** The MPS also highlighted that our proposal may be unfair to unrepresented doctors (some of whom will be from groups with protected characteristics) who may not appreciate the importance of a transcript to their review hearing.

Recommendation: We will review and update MPTS factsheets for unrepresented doctors to reflect this point.

20 Given the strength of support, we will progress proposals:

- in question 10 to make clear in Rules that parties can make submissions on the facts (92% in favour).
- In question 12 to clarify responsibility for recording hearings (87%), subject to one respondent's suggestion that we develop criteria for requesting a written record.
- In question 13 to clarify the terminology we use (85%), subject to comments in relation to the definition of witness needing further clarification.

Recommendation: We will consider whether we need criteria for requesting written records.

Recommendation: We will further consider the definition of witness and refine the drafting of Rules if necessary, and make sure any change is clearly communicated in materials for unrepresented doctors.

Adjourning hearings

21 80% of those who answered question 14 agreed that case managers and IC members should be able to adjourn hearings that are part heard removing the need for a panel hearing to consider a request for an adjournment. Respondents thought this would save time though some felt it should only happen where both parties agree. The case manager or IC member would only be able to adjourn after both parties had had a reasonable opportunity to give their view and agree on a new date.

22 The BMA made specific suggestions in relation to the powers of case managers to agree adjournments and the doctor losing their entitlement under current Rules to make representations to a panel where they disagree with an adjournment.

Recommendation: We will consider reserving a discretion to the case manager to allow a panel to consider an adjournment application and providing for the circumstances in which this may be appropriate.

23 67% of respondents who answered question 15 proposing a power to extend a sanction to protect the public during an adjournment, agreed that a sanction be extended if a review hearing is adjourned before a finding of impairment is made, though ten respondents who opposed felt this would be detrimental for the doctor, seven that the sanction be time-limited, and three that a review hearing be listed so that adjournments could be accommodated within the sanction period or that the adjourned hearing be expedited. We recognise there may be circumstances in which

this would disadvantage the doctor concerned and this situation would only arise where the extension of the sanction was necessary to protect patients or uphold confidence in doctors, ensuring that the approach is proportionate and justifiable.

Section 3: Making case management more effective

Making case management decisions binding

- 24** 64% of those who answered question 16 agreed with the proposed circumstances in which a case management decisions will not be binding, though some felt the Rules were unclear.
- 25** We consider Rule 16 (7A) clearly sets out the position – ie that case management decisions will be binding except in certain circumstances and that it is the panel that will decide whether the decision is binding or not.
- 26** The BMA called for a power for the GMC to strike out a case or charges if a doctor's ability to respond was compromised by non-compliance. The powers for panels to refuse to admit evidence or draw adverse inference provide mechanisms for responding to non-compliance that has serious consequences.
- 27** The BMA also noted that the binding nature of case management decisions should be clearly spelt out to doctors who are not represented before a panel.

Recommendation: We will ensure our communications are clear regarding the binding nature of case management decisions and update guides for unrepresented doctors to reflect this change.

Awarding costs

- 28** 46% of respondents who answered question 17 agreed with our proposal for awarding and assessing costs. 30% of respondents opposed this and 19% were unsure.
- 29** Those opposed to the proposal raised a number of concerns.
 - a** There is no evidence that costs will be effective and, as doctors have no access to legal aid, there will be an inequality of arms. The power to award costs was introduced through the Section 60 Order following a consultation by the Department of Health and therefore the principle of costs is out of scope of this consultation. The proposals in this consultation relate to the way the proposal will be implemented. Costs awards will be in relation to wasted costs only and the amounts involved should not deter doctors from defending themselves at our hearings.

- b** There should be clarity around the amount of costs that can be claimed which include reasonable amounts for the costs of witnesses.
- c** Costs may take up a disproportionate amount of time and the Rules lack clarity about who and at what stage decisions will be made. Our proposal for the panel to make the award of costs and for there to be a separate case manager-led assessment process will minimise the time necessary at a hearing to consider costs.
- d** A lack of clarity about when costs may be awarded and the need for guidance.
- e** Consideration should be given to a party's ability to pay. The proposed Rules allow for this at Rule 16A(6).
- f** Unrepresented doctors will be penalised.
- g** A doctor will be put under pressure to submit evidence in relation to costs assessments at the same time as considering an appeal.
- h** How the costs award can be challenged.
- i** Legal representatives may have difficulty defending a costs award due to client confidentiality.

The power to award costs was included in the Section 60 Order (which was previously subject to consultation by the Department of Health last summer) and aims to disincentivise unreasonable conduct for which at present there are few consequences. Compliance with a basic set of pre hearing directions (for example notifying the MPTS in advance how many witnesses will be called) is critical to running an effective hearing and avoiding delays and adjournments. However, to ensure the power is proportionate it has been drafted so that costs will be awarded in narrow circumstances. The panel will apply a two stage test when awarding costs ie where a party does not comply with a case management decision and their conduct is unreasonable in the conduct of the proceedings, for example introducing witnesses at short notice without good reason.

All parties to proceedings will be subject to costs (the GMC may be ordered to pay the doctor's costs and vice versa). There are a number of safeguards proposed to ensure the operation of the costs regime is fair and proportionate and also that it is simple to administer and does not become onerous to operate. The amount a party will pay will:

- a** reflect only the additional costs incurred by the receiving party as a direct result of time they have wasted
- b** will be based on guideline amounts set at a reasonable and proportionate level

- c will take account of a party's ability to pay
- d and an overall cap will be applied.

Challenge will be by way of judicial review in the appropriate jurisdiction.

Recommendation: We will ensure the Rules are clear about the circumstances in which costs may be awarded and develop appropriate guidance to reflect these circumstances. We will update guides for unrepresented doctors to reflect the process for awarding costs. We will look at how other tribunals that have powers to award wasted costs against legal representatives deal with the issue of client confidentiality.

Section 5: Making our investigation processes simpler and more effective

Removing the need to tell employers about allegations against doctors in some circumstances

- 30 84% of respondents who answered question 18 agreed, though seven respondents felt it was important that the GMC tell ROs about complaints so they could support a doctor and take any action necessary. We are removing the *requirement* to inform a doctor's employer of a provisional enquiry. We will still inform employers and/or ROs where appropriate to do so.
- 31 Two respondents highlighted that this proposal contradicted Trust policies that required doctors to inform their employer if a complaint is made against them however we propose that we would continue to notify doctors about provisional enquiries which would enable them to comply with Trust policies. Another said public health doctors may need to be treated differently as their employer is not their designated body. This is true of many doctors and this would not affect how this proposal applies. One doctor said those cases involving health where a doctor is receiving treatment should be deferred. Following the report of suicides among doctors while in our fitness to practise procedures, we are reviewing our approach to cases involving health.

Section 6: Improving compliance and making assessments more effective

Failure to comply with investigations and health, performance and language assessments

- 32 75% of those who answered question 19 agreed with our proposal for a new type of non-compliance hearing on the basis that doctors have a duty to comply with their regulator to protect patients. A small number of respondents felt that this measure was draconian and potentially a human rights law breach. The MDU were concerned that the power be exercised reasonably and the BMA suggested that a referral be cancelled where the doctor complies. The powers are contained in the S60 which was consulted on by DH and the legality was considered as part of that process.

Recommendation: We will develop guidance setting out the factors to consider when making a referral for a non-compliance hearing to ensure that we achieve an appropriate balance between the need to protect the public where a doctor fails to co-operate and the doctor's rights. The guidance will include arrangements for cancelling a non-compliance hearing and seeking a review hearing where a doctor subsequently complies.

33 The PSA raised a number of queries about how the power would work in practice.

Recommendation: In response to concerns raised by the PSA, we will ensure the Rules and guidance are clear about how the provisions will work, taking into account their comments.

Equality

34 We asked respondents whether they thought our proposals would adversely impact on people from groups with protected characteristics. The majority (57%) said there would be no adverse impact, with those who thought there would (15%) commenting generally on the overrepresentation of BME, IMG and older male doctors in our processes. Comments were also made in relation to the impact of English language proposals on those BME doctors with English as a second language. One respondent thought there would also be an impact on doctors with health problems and female doctors who were pregnant and may go into labour. In relation to the latter, we currently have powers to adjourn hearings which the panel could exercise if a doctor was unable to attend a hearing. In relation to English language proposals we will only take action where we identify a risk to the public or confidence in doctors.

Recommendation: In addition to the recommendations we have made in relation to specific proposals (including those about doctors with undertakings related to English language and health cases), we will continue to monitor the impact on people who share protected characteristics throughout the development and implementation of our proposals.