

PHSO Consultation on the use of clinical advice

Q1. What are your impressions and views on the clinical assessment of complaints, particularly whether they seem generally comprehensive, well-founded, and authoritative? Examples from complainants or from organisations that PHSO investigates of their experience of clinically-based reports or communications would be particularly valuable?

As the GMC is not a complainant or an organisation that the PHSO investigates, we are unable to comment on the content of clinical assessments from the perspective of an interested party. However we have provided some general comments on the clinical assessment of complaints which we hope are helpful.

We generally agree with the approach of undertaking a clinical assessment of complaints where it is considered necessary to assist decision makers during or following an investigation, and we often obtain clinical advice during our fitness to practise processes.

Clinical advice can be requested at the triage, investigation and/or hearing stages of a fitness to practise case. Some of the GMC's employed decision makers ('case examiners') are medically qualified and may be asked to provide general advice on issues raised within their area of speciality. They can also assist in determining when and what type of independent expert opinion is required. Usually at the investigation and hearing stages a written report is obtained but in some instances, such as when conducting a provisional enquiry, we may hold a documented discussion with an expert. We note from the background documentation provided that the PHSO is also flexible in its approach and obtains clinical advice through documented discussions and written reports.

Q2. How should clinical advice received by PHSO be balanced with other evidence received from complainants and from the organisations that PHSO investigates? In the reports that you have read do you feel that the assessment of, or judgements on, complaints adequately and fairly balance clinical and non-clinical factors?

As we aren't able to comment specifically on how the PHSO balances clinical and non-clinical factors in their reports we have provided some general information about our approach which the PHSO may wish to consider.

We produce guidance to support decision makers at all stages of the fitness to practise process. A key principle that underpins our approach is that the issue of weight to be attached to a piece of evidence is a matter for the individual decision maker, taking into account the wider circumstances of the case. Decision makers are encouraged to balance the information available to them. This applies to both clinical factors and non-clinical factors, such as witness evidence or information relating to the environment within which the alleged incident occurred. When balancing the evidence, decision makers at the GMC/MPTS will also refer to the regulatory rules and case law to provide help on what is relevant, what needs to be considered and the weight to be given to the different pieces of evidence.

Our key decision making guidance is available on the GMC and MPTS websites.

Q3. Based on your experience, in what other ways could the way clinical content that underlies the Ombudsman’s decision-making be improved? Why do you think this is necessary?

We acknowledge the PHSO has identified a link between improving clinical content and greater transparency of its decision-making processes. We have considered the related proposals which appear comprehensive.

We believe the intended move towards greater involvement of clinical advisers to ensure their advice has been recorded clearly and accurately following a documented discussion will have a positive impact on decision making. The GMC also recognises the importance of the expert having an opportunity to quality assure the record of their advice and we have a process in place where the expert is sent the notes of a documented discussion to review before being asked to sign a final agreed version for use in the ongoing case.

We note there is a further proposal to request feedback from all parties of a PHSO enquiry on the management of the request for clinical advice, the opinion itself and how the evidence is communicated. We recognise that this is intended to support the principle of transparency in the PHSO’s processes and to uphold the new approach of ensuring standards of clinical content are maintained. The GMC has quality assurance processes to help monitor the quality of the expert clinical advice we receive. Quality assurance is a necessary part of ensuring that the advice relied upon by decision makers is fit for purpose.

Q4. What are your views on the issues outlined in the section on transparency, in particular about how the new final investigation reports can support better understanding about how and why clinical advice is used; and whether clinician’s names should be routinely published? Do you have any evidence or examples you can share with the Review to inform your view?

We agree that transparency is an important regulatory objective. As public bodies we are accountable to the public for our actions and need to maintain the public’s trust in our

ability to discharge our statutory functions. The GMC is also committed to transparency as detailed in our corporate strategy 2018-2020 (available [here](#)).

1) New final investigation reports

We agree that it is important for all parties of an investigation to understand how and why clinical advice is used. Whilst the PHSO intends to provide relevant information in the body of the new final investigation reports themselves, there may be other opportunities to communicate this information, such as through information leaflets or letters. The GMC is able to discuss questions that Trusts have on our use of expert advice through the Employer Liaison Service and complainants have access to the Patient Liaison Service through which we try to support their understanding of our fitness to practise processes, including on how decisions are reached.

2) Publishing clinicians' names

(i) Process when the case does not go to a hearing

The GMC is committed to complying with our legal obligations under data protection law and taking a proportionate approach to the disclosure of personal information. During a fitness to practise case we will disclose the expert's name to the doctor under investigation so that they can consider whether there is a conflict of interest. However, we don't routinely publish a clinician's name or provide this information to the complainant or any third parties. We consider that details such as the expert's specialism and the assurance that there is no conflict of interest are the most relevant information to share. Case examiner decisions only refer to the expert's specialism and contain quotes from the report where necessary.

It is open for a party to formally request the identity of an individual involved in providing clinical advice on their complaint under the relevant legal framework. If the expert or clinical adviser does not agree to their identity being disclosed, we will conduct a balancing exercise to decide if disclosure is appropriate.

(ii) Process when an investigation goes to an MPTS hearing

MPTS hearings may be heard publicly or in private depending on the nature of the allegations and the information to be discussed. The information that is made publicly available in the written Record of Determination and in the hearing transcript, including the name of any experts whose evidence has been relied upon, will vary accordingly. Where a case is heard fully in public, the expert's name will usually be a matter of public record.

Q5. Do you agree that the new clinical standard is clear?

We consider there are a number of aspects of the PHSO's new clinical standard which are clear. For example, the standard is well structured and each paragraph flows logically to

the next. We believe this may be particularly helpful for service users to fully understand the steps followed by the PHSO when considering complaints relating to clinical care and treatment.

The tone and language used also reads as clear and accessible. As a result, members of the public with little or no specialist medical knowledge should find it easy to understand.

Lastly, we note that the PHSO has set out examples of potentially relevant standards or guidance at paragraph three. Although we have made some suggestions about how this paragraph could be expanded in our response to question six, we support the idea of setting out examples of relevant materials to ensure that service users understand the reference documents the PHSO may consider during an investigation.

Q6. Do you have any views on how either the standard itself, or the contextual information preceding it, could be improved to increase this clarity?

The clinical standard

We understand that the PHSO's standard of what constitutes 'good clinical care and treatment', including what resources and materials will be relevant, will vary depending on the circumstances of the case. The PHSO may wish to consider whether there is an opportunity, perhaps in the body of the investigation report, to provide additional information to make it clear in each individual case how the PHSO has decided on the relevant standard. The PHSO might also be able to publish supplementary guidelines which set out the standards and guidance that will be broadly relevant in different types of cases. These types of additional measures may support the PHSO's aims for increased transparency.

We note at paragraph six of the standard the PHSO makes reference to the 'Principles of Good Administration' (the 'Principles'). The current reference is brief and users may find it helpful if the standard explained what the Principles are, why they are relevant and where full details can be found.

The Ombudsman's contextual information

Contextual information can usefully set the scene as to why the new clinical standard has been developed. We recognise that these passages are intended to set out the Ombudsman's reasons for reviewing the standard. Although helpful, the PHSO may wish to consider reducing the level of detail as this may have the benefit of encouraging readers to focus on the standard.

The PHSO may also wish to review the language used to ensure it is appropriate and accessible for a range of audiences. For example, members of the public may find it difficult to understand what is meant by phrases such as 'inquisitorial processes', 'the adversarial approach taken by the court', and references to the

legal standard used in clinical negligence cases. The PHSO may be able to simplify or explain these concepts further to ensure that they are understood.

Q7. Do you have any comments or views you wish to feed in on the recommendations and proposals in the Background Paper, summarised in Appendix 2?

In the background paper the PHSO has emphasised the importance of improving its quality assurance processes. We support the idea of enhanced and robust quality assurance processes and believe quality assurance is important for all regulators to ensure that standards are being upheld, including in respect of the quality and use of clinical advice.

We note that the PHSO has also made recommendations to introduce enhanced training and accreditation for caseworkers. Given the crucial role played by PHSO caseworkers in the process of obtaining, recording and conveying clinical advice, we think this is a good way of ensuring that high standards are maintained.

Finally, we note that the background paper references transparency but not fairness – other than a reference in Appendix 1 to say that “the system used is consistent with the new organisational values of independence, fairness, excellence and transparency”. If fairness is a new key organisational value, we would suggest that the PHSO includes it very visibly alongside transparency with a narrative of what fairness means in the context of this guidance.