Protecting children and young people: the responsibilities of all doctors

Factsheet: paediatricians and our fitness to practise procedures
This factsheet has been produced as part of work conducted by the GMC’s Working Group on Child Protection.
Introduction

The Working Group on Child Protection was set up in July 2010 to identify issues within current guidance available for doctors who work in a variety of roles and circumstances to protect children at risk of abuse or neglect and to prepare new guidance to help doctors understand the standards of professional conduct and performance expected by the GMC in this area of work.

The concern that led to the establishment of the Child Protection Working Group was that doctors may be deterred from specialising in paediatric work because they believe that doctors doing child protection work, and in particular paediatricians, are significantly more likely than other specialties to be referred to the GMC.

Child protection work is different in nature to other work. A doctor treating a child usually works in partnership with the child’s parents. In child protection work the parents’ relationship with the doctor may become compromised and be perceived as one of conflict rather than support.

The Working Group received presentations about the GMC’s fitness to practise procedures and discussed the involvement of paediatricians within those procedures. As a result of those discussions, the Group identified a clear need for information about the fitness to practise procedures and the profile of paediatricians within them to be more widely available. This factsheet is designed to provide that information.

Our current fitness to practise procedures

Our role is to protect, promote and maintain the health and safety of the public. The GMC is required by law (the Medical Act 1983) to investigate any allegations that a doctor’s fitness to practise might be impaired. A doctor may only be found impaired as a result of one of the following factors:

a. a determination by another body
b. a conviction or caution
c. misconduct
d. adverse physical or mental health
e. deficient professional performance.

Concerns about a doctor usually come to our attention as a result of a complaint by an individual or a referral by a body or organisation such as a doctor’s employer or the police. In 2010, we received 7,153 complaints.

Initial assessment

All the complaints or queries that we receive are considered by a senior member of staff who has three options available: to close the case, to refer the case to the doctor’s employer (known as Stream 2 cases) or to begin an investigation (known as Stream 1 cases). Over the last five years, an average, 40% of all complaints received are closed at initial assessment, approximately 30% are referred to the doctor’s employer and the remaining 30% are investigated.

Cases are closed at the initial assessment stage if the matters raised, even if proven, would not raise a concern about a doctor’s fitness to practise and would, therefore, not require any action to be taken. Cases are referred to a doctor’s employer if the matters raised, in and of themselves, would not require any action to be taken but might do so if they formed part of a wider pattern of behaviour. The GMC asks the employer if they have any further information about the matters raised or any other cause for concern. Unless the employer raises further matters at this stage, the case is closed.

The investigation stage

We conduct an investigation where the concerns, if proven, would raise concerns about a doctor’s fitness to practise and would require action to be taken to protect patients. Evidence is gathered which may include reports from a doctor’s employer, an independent assessment of the doctor’s health or clinical performance, an expert opinion and witness statements.
We aim to complete 90% of investigations within six months and we currently meet that target in 88% of cases. An average investigation involves the following activities.

a. We obtain the complainant’s consent to share the content of their complaint with the doctor. We allow two weeks for this activity.

b. Once consent is obtained, we disclose the complaint to the doctor and ask them to comment if they wish to and to give us details of all relevant employers. At this stage we collect a range of information which will help to establish whether there is a fitness to practise concern and this takes on average about 16 weeks.

c. Before we make a decision about what should happen next, we share all the information we have collected with the doctor and the doctor is invited to respond. This whole process takes about five weeks.

An investigation may take longer than six months if we are waiting for information. This typically happens where the outcome of a criminal investigation is awaited before we can proceed with our own investigation or where court documents (for example copies of evidence given in family proceedings) are required. There can be long delays in obtaining copies of court documents.

Once we have sufficient evidence, two case examiners (one of whom is medically qualified) consider the case and apply the ‘Realistic Prospect Test’. This test allows them to decide whether, if established, the facts would demonstrate that the doctor’s fitness to practise is impaired to a degree justifying action on registration, i.e., their right to practise medicine in the UK. If not, the case examiners may decide to close the case with no action, issue advice to the doctor or issue a warning.

If, however, the case examiners consider that the ‘Realistic Prospect Test’ is met, they may, in certain cases, invite the doctor to agree undertakings whereby the doctor agrees to limit their practice in some way to protect patients. This may include having additional supervision, attending remedial training or not treating certain kinds of patients.

We will only agree undertakings with doctors in certain circumstances and case examiners have comprehensive guidance on when to pursue this option. Finally, if the case examiners consider that appropriate safeguards cannot be put in place through undertakings, or if the doctor will not agree to appropriate safeguards, they will refer the case for a public hearing.

In 2010, case examiners closed 497 cases, gave advice in 458 cases, issued a warning in 183 cases, agreed undertakings in 102 cases and referred the case for a hearing in 314 cases.

At any time, a case may be referred to an interim orders panel. The remit of an interim orders panel is to place restrictions on a doctor’s practice, if necessary, on an interim basis to protect patients while an investigation is being carried out or a case is being prepared for a hearing. Interim orders panels do not make findings of fact. They assess the available evidence and make a judgement about whether the doctor may pose a serious risk to patients if allowed to continue in unfettered practice while we investigate or prepare a case for a hearing.

Where the concerns about a doctor raise clinical issues, an expert will usually be involved in making an assessment of whether their fitness to practise is impaired. In a case involving a single clinical incident, we usually instruct an expert in the relevant specialty to provide advice on whether and to what extent the doctor’s actions fell below the standard expected. If the doctor is a paediatrician, for example, then we would instruct a paediatric expert to provide advice.

If there is a pattern of poor performance, the doctor will usually be asked to undertake a performance assessment and the performance assessment panel will include a doctor from the relevant specialty. If the case progresses to a hearing, the expert would usually give evidence on our behalf. A doctor may also instruct their own expert to give evidence at the hearing. We maintain a list of experts which is regularly updated.
One of the key factors in reducing stress for doctors involved in the fitness to practise process is concluding matters as quickly as possible. In many cases, an investigation can be expedited and there may be no need for any further action once inquiries have been made. However, in any case which involves court proceedings, an application may need to be made to the relevant court to obtain the necessary documentation to support an informed decision. There are significant delays in getting information from courts and these delays create considerable additional stress for paediatricians or any other doctors involved in a fitness to practise case.

The hearing stage

Once a case has been referred for consideration by a fitness to practise panel, the case is prepared for a hearing. A fitness to practise panel is usually made up of a chair and two members, at least one of whom must be medical and one of whom must be non-medical. A legal assessor, who must be a solicitor or barrister of at least ten years standing, will also be present to advise the panel on points of law. The doctor may be represented either by a solicitor or counsel, a representative from a professional organisation or, at the discretion of the panel, a member of their family or other person. We will be represented by a solicitor or counsel.

Hearings have three stages: the fact finding stage, the finding of impairment stage and the sanction stage. If the panel find a doctor’s fitness to practise is not impaired they may close the case or issue a warning. If the panel finds a doctor’s fitness to practise is impaired they may agree undertakings, impose conditions, suspend the doctor or erase the doctor from the register. Panels cannot erase a doctor from the register where adverse physical or mental health is the cause of their fitness to practise being impaired.

Our guidance on when it is appropriate to issue a warning or agree undertakings at the hearing stage is the same as for the case examiners at the end of the investigation stage. The chart below shows the outcomes of fitness to practise hearings for 2010 for all doctors.
Analysis of paediatricians involved in the GMC’s fitness to practise procedures

The data we collect about fitness to practise cases, and the way we store it, are dictated by our role in dealing with complaints and referrals about doctors’ fitness to practise.

In 2006, we introduced an electronic case management system. This is not a general database designed to provide data for research or other interests and there are limits therefore on the data that can be provided about child protection matters. For example, when a complaint is received, an initial assessment is carried out to determine whether the case should be investigated. If the case is closed at the initial assessment stage, there may be limitations to the information available.

If a case is taken forward at the initial assessment stage, we contact the doctor to gather a range of information. The information collected at this point includes the doctor’s specialty (for example, GP, surgeon, anaesthetist, paediatrician) and the nature of the allegations (for example, poor record keeping, criminal conviction, inappropriate sexual conduct). We do not record whether or not a doctor was dealing with a particular type of issue such as child protection. This means our fitness to practise data can be interrogated and analysed about paediatricians but not about doctors undertaking child protection work.

In analysing the data contained in this factsheet, it is also important to note that the data we hold identifies doctors on the GP or specialist registers but not if a doctor is in a training or a non-training post. Gathering data about a wider group of doctors would involve getting consent and be time consuming and expensive. Given the significant demands on resources in gathering information that is required in order to support our core function of managing fitness to practise cases effectively, we do not plan at this time to collect additional data.

As mentioned above, the concern that led to the establishment of the Child Protection Working Group was that doctors may be deterred from specialising in paediatric work because they believe that doctors doing child protection work, and in particular paediatricians, are significantly more likely than other specialties to be referred to the GMC.

In analysing the involvement of paediatricians within our fitness to practise procedures, two questions might usefully be asked:

a. Are paediatricians overrepresented in the GMC’s fitness to practise procedures? and

b. What happens to them once they are in the GMC’s fitness to practise procedures?
The graph below shows the proportion of complaints received by the GMC about doctors in different specialties compared to the number of doctors on the register in that specialty in 2010. Where a case is closed at initial assessment, we may not know the doctor’s specialty which explains the ‘not known’ category in the graph below. The number of complaints received about paediatricians is proportionate to the number of paediatricians on the register and paediatricians receive proportionately less complaints than general practice, psychiatry and surgery.
However there has been a rise in the number of complaints against paediatricians (63 in 2008, 77 in 2009, 121 in 2010) although this may simply reflect the general rise in the number of complaints received across the board (5195 in 2008, 5773 in 2009 and 7153 in 2010).

The outcome of the initial assessment for cases involving paediatricians does vary significantly from year to year. One trend that can be identified year-on-year, and is apparent in the graph below, is that proportionately more cases about paediatricians are referred for an investigation compared to the average across all complaints in each year. At the initial assessment, the decision to close a case, refer it to the doctor’s employer (Stream 2) or investigate (Stream 1) is made on the face of the allegation. This decision may be made on incomplete information and, in the case of paediatrics and a number of other high risk specialties, the nature of the work that the doctor is engaged in may be more likely than other work to give rise to allegations that, on the face of it, appear serious. We cannot ignore an issue if it potentially engages our fitness to practise procedures and we are required by law to investigate. Nevertheless, on further investigation, in some cases, the matters may prove not to be as serious as they initially appeared, leading to the closure of the case at the end of the investigation stage.
The graph below shows the breakdown of outcomes at the end of an investigation comparing the proportion of decisions about paediatricians in each outcome category to the average across all specialties. There is a wide variation each year and caution should be exercised in drawing conclusions from this data. The sample size is small, as shown by the numbers in brackets along the horizontal axis (2006, (16), 2007 (23), 2008 (15), 2009 (26), 2010 (42)). Nevertheless, proportionately more cases involving paediatricians seem to be concluded or concluded with advice at the end of an investigation and since 2007 only a very small proportion of cases have been referred to a hearing (2006 (1), 2007 (7), 2008 (4), 2009 (1), 2010 (3)). This demonstrates that, although the allegations present as serious on the face of it, in a number of cases the seriousness of the allegations were not borne out on investigation.
The involvement of paediatricians at the impairment stage (the second stage of the hearing procedure) can also be examined and the table below compares the impairment decision for paediatricians compared to the average across all hearings. However given the extremely small numbers of hearings involving paediatricians each year, as shown in brackets along the horizontal axis (2006 (1), 2007 (7), 2008 (4), 2009 (1), 2010 (3)), it is difficult to draw any conclusions from this data.
Conclusion

The fitness to practise information we hold allows us to analyse trends about paediatricians in our fitness to practise procedures and not about a wider group of doctors who may be involved in child protection matters.

In any given year, there is a variation in the numbers of complaints we receive about doctors in different specialties and some specialties are over-represented in our procedures while others are under-represented. The GMC’s fitness to practise data broadly shows that paediatricians are consistently:

a. either slightly underrepresented or proportionately represented in terms of complaints received since 2006

b. slightly overrepresented in terms of what percentage of incoming complaints are subject to a full investigation.

c. underrepresented in terms of what percentage of investigated cases are referred for a hearing with the majority resulting in no further action at the intermediate decision stage.

d. underrepresented in terms of more serious outcomes at the hearings stage.

This suggests that although we do not receive a disproportionate number of complaints about paediatricians, the presenting allegations are, on the face of it, sufficiently serious to require further investigation slightly more often than is the case for many other specialties (possibly because of the nature of the work). Nonetheless, in a significant proportion of these, the allegations fail to meet our evidential test at the end of the investigation stage and the case is subsequently closed.

In real terms, we have received nearly 27,000 complaints about doctors of all specialties since April 2006. Of these, nearly 15,000 resulted in some form of investigation and 210 (1%) of these related to paediatricians. During the same period, fitness to practise panels have considered just over 1,200 cases and 17 (1%) of those related to paediatricians. In depth analysis of the 17 cases shows that only two could reasonably be said to have been about paediatricians involved in child protection.

Nonetheless, the experience of going through a GMC investigation, even for a doctor whose case is subsequently closed at the end of that investigation, is stressful and can take some time, particularly if transcripts from court proceedings need to be obtained.
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