To consider

Revalidation arrangements for doctors involved in our fitness to practise processes

Issue

1. We have powers to postpone some or all revalidation activity in relation to a doctor involved in our fitness to practise processes. We are revising our guidance for decision makers to clarify when we might exercise these powers. Before we finalise this, there are two outstanding issues on which we seek the Board’s advice.

Recommendations

2. The Strategy and Policy Board is asked to:

   a. Agree that we should not postpone a revalidation decision for doctors subject to a stream one investigation or open fitness to practise enquiry that has not been disclosed (for example because of an ongoing police investigation).

   b. Agree that we can revalidate doctors who are subject to conditions or have agreed to comply with undertakings as long as the Responsible Officer or Suitable Person confirms that the doctor continues to comply with those conditions or undertakings and there are no further concerns about their practice.
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3 The **GMC (Licence to Practise and Revalidation) Regulations 2012** (‘the regulations’) set out our powers in relation to revalidation. They allow us to postpone the revalidation process when a doctor is in a fitness to practise process.

4 We are updating our guidance for decision makers on when such a decision should be made. There remain two particular issues on which we would like to seek the Board’s advice before a new version of the guidance is finalised.

Doctors with an open and undisclosed enquiry or stream one investigation

5 In some instances we are unable to disclose that there is an open enquiry or stream one investigation to the doctor and, where relevant, their employer/Responsible Officer. This is generally where there is an ongoing police investigation and the police have asked us not to disclose, or we are waiting for further information from the police. This is likely to be a rare occurrence as only a very small proportion of enquiries and stream one investigations are not disclosed and the timing of the police investigation would have to coincide with the doctor’s five yearly revalidation date. Additionally it would have to be a case where there is no risk to patients sufficient to warrant referring the doctor to an interim orders panel, as in these cases it would be necessary for us to make disclosure in order to permit our application for an interim order to be considered. Of this small pool of cases where we cannot disclose, most are at the enquiry stage, as we are waiting until we have sufficient information from the police to promote the case to a stream one investigation.

6 However, should these circumstances arise, the use of our powers to postpone revalidation carries a risk of inadvertent disclosure of, and therefore prejudice to, the police investigation. This is because we are required to provide doctors with reasons when we make a decision to postpone taking action on their revalidation. The alternative to postponing revalidation is revalidating a doctor. This presents a risk for us because we are affirming that the doctor is fit to practise in the full knowledge that there may be a potential question of impairment if the police investigation subsequently leads to a prosecution and conviction.

7 On balance, we consider that we would need to revalidate the doctor where we have received a positive recommendation but are unable to disclose the fact of a fitness to practise process, for example, when we know that there is an ongoing police investigation. We suggest this approach on the basis that the number of occasions where an undisclosed fitness to practise issue coincides in time with the receipt of a recommendation from a Responsible Officer is likely to be extremely rare. Also there
are likely to be sound and justifiable reasons for withholding the fact that there is a fitness to practise issue – for example the risk of prejudicing a criminal investigation. We would welcome the Board’s view on this approach.

**Doctors subject to conditions or undertakings**

8 Currently where a doctor is subject to conditions or has agreed to comply with undertakings we continue to receive recommendations (and annual submissions for doctors who do not have a connection) and revalidate doctors where they have met our requirements. This has been our policy since the launch of revalidation in December 2012, and this approach has not caused any problems to date. Recently we have been considering whether doctors without a connection who are subject to conditions or undertakings should be required to sit the revalidation assessment. These considerations led us to reflect again on the risks within our existing approach.

9 The main risk of making revalidation decisions about doctors who are subject to conditions or undertakings is the potential for us to be seen as making inconsistent decisions within our different processes. Section 29A of the Medical Act defines revalidation as an ‘evaluation of a medical practitioner’s fitness to practise’ so in revalidating a doctor we are confirming that we have evaluated the doctor’s fitness to practise and found them fit to practise. However, doctors with conditions have been found impaired to a degree justifying imposing restrictions on their registration.

10 While doctors with undertakings have had no formal finding of impairment, we will have determined that there was a realistic prospect of their fitness to practise being found to be impaired; case examiners can only recommend undertakings where “it appears” that the practitioner’s fitness to practise is impaired. In both cases it could be seen as inconsistent to declare these doctors fit to practise, whilst continuing to consider them impaired through maintaining restrictions on their registration.

11 We justify our current approach, as we also say that a revalidation decision is based on the doctor’s current scope of practice and so does not include any areas of practice they are restricted from carrying out (as doctors are required to practise within their area of competence). In addition a case examiner or panel has determined the doctor to be fit to practise as long as they comply with their conditions or undertakings. The doctor’s continuing compliance with the restrictions on their registration is checked as a part of the revalidation process. For example, where a doctor has a Responsible Officer or Suitable Person, they must confirm that the doctor continues to practise in accordance with these restrictions.

12 Where a doctor does not have a Responsible Officer or Suitable Person, our decision to revalidate would rely on declarations of fitness to practise from the doctor and any employer(s) and on the Case Review Team’s oversight of the doctor’s continuing compliance with their conditions or undertakings (and in some cases by the doctor
taking the revalidation assessment of their fitness to practise). It is also worth noting that release from restrictions currently requires the approval of a case examiner or panel, and in future may include the doctor undertaking an assessment.

13 There is a risk that where a doctor meets the required standard in the revalidation assessment they may wish to interpret this as evidence that they should be released from the restrictions on their practice. We will wish to be clear that meeting the required standard in the revalidation assessment does not automatically remove any restrictions placed on a registrant by a fitness to practise panel or imposed by agreement. It could be argued though that the assessment result could legitimately form part of the evidence that a case examiner or panel might consider when determining whether the restrictions need to be varied or continued. This might particularly be the case where it is issues of clinical competence, rather than health, which have led to restrictions being imposed.

14 Case examiners’ and panels’ use of the revalidation assessment as part of the evidence when considering whether to continue or vary restrictions, would be on the basis of an understanding of the context of this assessment. The revalidation assessment is likely to involve just a knowledge test, at least initially, and is just one part of the evidence used to make revalidation decisions about doctors without a prescribed connection. All of the evidence used to make a revalidation decision could be made available to the case examiner or panel should they wish to consider it. Also, revalidation would only provide evidence of the doctor’s current scope of practice, and therefore would not include evidence about a doctor’s fitness to practise in any areas from which they are currently restricted.

15 There are also risks to changing our approach. It may result in some doctors going more than five years without revalidating, as doctors can be subject to conditions or undertakings for a long time. This risk is mitigated to some degree, as these doctors would still be required to engage with the processes underpinning revalidation (such as annual appraisal), and to continue to meet the requirements of Good medical practice, which include keeping professional skills and knowledge up to date.

16 It may also result in a perception that doctors who pose a greater risk are being exempted from the requirements of revalidation and are under less scrutiny. However, doctors subject to conditions or undertakings are subject to regular and robust monitoring (e.g. by the Case Review Team, and often by an educational or clinical supervisor). We could therefore mitigate this risk by providing clear information on our expectations of these doctors and of the controls we have in place.

17 We would be grateful for the Board’s view on this issue, and in particular whether the Board is content for us to continue to revalidate doctors who are subject to conditions or undertakings. Whichever policy we follow, doctors will still be required to continue to engage with revalidation.

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Supporting information

How this issue relates to the corporate strategy and business plan

18 Strategic aim five: to work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions. This work ensures that we are working across teams within the GMC to make the best use of all available knowledge and deliver effective regulation.

How the issues support the principles of better regulation

19 The publication of guidance for decision makers increases the transparency of our decision making process. Specifying the factors that should inform the decisions we make within this guidance, also helps to ensure that we make consistent and proportionate decisions.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

20 We have engaged with colleagues in the Fitness to Practise Directorate to determine the appropriate approach, and have sought advice from our in-house legal team on our interpretation and use of the powers in the regulations. We will publish the guidance on our website.

What equality and diversity considerations relate to this issue

21 The trigger for putting revalidation on hold will come from existing fitness to practise processes. As we are aware that some groups of doctors are disproportionately represented within our fitness to practise processes, the same profile of doctors are consequentially more likely to have their revalidation put on hold for this reason. The process of putting revalidation on hold due to involvement in fitness to practise processes will not in itself cause a disproportionate impact on doctors from different groups. We will work with colleagues in the Fitness to Practise Directorate to monitor these cases.

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