To consider

Review of advice at the end of fitness to practise investigations

Issue

1 A review of our approach to issuing advice following a successful legal challenge and issues raised in response to our consultation on the Indicative Sanctions Guidance.

Recommendations

2 The Strategy and Policy Board is asked to agree that:

a Fitness to practise Case Examiners and/or the Investigation Committee should only issue specific advice in cases where the concerns relate to low level breaches of Good medical practice and the underlying facts are admitted, or are beyond dispute and/or there is a likelihood of repetition.

b The publication and disclosure of such advice should be considered as part of work to respond to the Indicative Sanctions Guidance consultation together with proposals for the publication and disclosure of warnings.

c All fitness to practise closure letters should include a reminder to the doctor that they should reflect on the complaint in question along with any others as part of their annual appraisal.
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3 Issuing advice by direction of the Case Examiners at the end of a Stream 1 investigation has become commonplace. In fact it has no specific statutory basis as a fitness to practise outcome; but it has the appearance of a sanction, including by virtue of its status as a designated outcome on Siebel. We have also routinely reported it as an outcome in fitness to practise statistics alongside formal sanctions.

4 Advice is often phrased in admonitory terms, giving an impression of a sanction that sits just below a Warning. Even the terminology of ‘issuing’ advice carries a judgemental tone. When issuing advice, usual practice is to notify the employer and the complainant if any of this outcome.

5 As our approach to advice has evolved, we have issued advice in some cases – and told third parties we had done so - where we had not given the doctor an opportunity to comment. In two cases, where we closed such cases with advice, this led the doctor to commence Judicial Review proceedings. In these cases, we have conceded that it was inappropriate to have issued advice without following the proper procedure.

Should we issue advice at all?

6 We publish guidance to the profession on the standards to be expected of registered doctors. Our assessment of fitness to practise is in relation to current and future practice and to the protection of patients. It is therefore entirely reasonable and in keeping with our aims and values that we should be able to give doctors tailored guidance as to how to uphold the standards we expect of them in their future practice. With the introduction of revalidation from 2012, and the requirement on all licensed doctors to reflect on their practice and participate in appraisal, the regulatory context has changed. In addition, as we have previously reported in the State of medical education and practice Report, a lower level complaint places a doctor at heightened risk of a more serious complaint later on.

7 However, there is a distinction between providing guidance as to future practice, and issuing an admonition in relation to past actions. In the way advice is currently delivered and referenced, there is considerable scope for this distinction to be blurred. Admonitory advice can be helpful in marking conduct that has been found to involve a breach of our guidance but is insufficiently serious to warrant a warning; but it is this indication of censure to third parties without following a representation process that appears to have drawn the most robust objection from doctors and their representatives.
Therefore, while communicating advice remains a helpful and useful function for the regulator at the end of investigations, we need greater clarity about the context in which it is provided, particularly in the fitness to practise framework.

**Purpose of advice**

There can be some attraction to identifying in decision outcomes behaviour which has fallen short of our published standards and issuing advice. Given our protective rather than punitive role, it follows that the primary purpose of advice is to try to mitigate the risk of future breaches of our guidance where there have been breaches in the past. In this way, advice should look forward not back, and so be consistent with the purpose of our fitness to practise procedures generally. Doctors must, of course, discuss complaints made about them, and how they have responded, within their appraisal. This is whether or not they accept that a complaint was valid ([http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp)).

**Types of advice**

Advice where the underlying facts are admitted, or are beyond dispute

Where the underlying facts are admitted, or are beyond dispute, it is reasonable to advise the doctor in terms that are specific to the issues of the case. This is a fitness to practise function.

In response to our consultation on the Indicative Sanctions Guidance (ISG), a number of respondents supported a greater range of tools in fitness to practise to deal with lower level concerns (tools that would not have a disproportionate impact on doctors).

In discussion with key interest groups during the ISG consultation process, a possible model emerged of three levels of warnings (although not necessarily to be called that) to include a first informal warning to respond to low level concerns, a second warning ‘on the record’ to respond to issues just below the threshold for impairment, (this is the current warning) and thirdly a formal warning to respond to issues just above the threshold for impairment where conditions or undertakings are not considered appropriate and suspension would be disproportionate.

The notion of a first informal warning is similar in concept to one of the ways we currently use advice to deliver admonition to doctors for low level concerns in order to discourage repetition.

Legislative change would be required to include this concept within our warnings framework but given that we currently operate this model by issuing advice, we could in the short term continue to do this as part of our fitness to practise framework.
the longer term we could consider legislative change to provide a bespoke power to issue this type of admonition.

15 It goes without saying that this would only be appropriate where due process had been followed, the doctor had been provided with an opportunity to comment and we have concluded that there had been a lower level breach of Good medical practice.

16 It will be important that this tool does not have a disproportionate impact on doctors so careful consideration will need to be given to our approach to publication and disclosure. We recommend this is picked up as part of the work to respond to the ISG consultation.

Advice where the underlying facts are in dispute or where there is little likelihood of the concerns being repeated

17 Where the concerns relate to lower level concerns and the underlying facts are in dispute or are such that repetition is unlikely, it is not appropriate for the fitness to practise process to do anything other than close the case with no further action.

18 However, as part of revalidation, doctors have an obligation to reflect on complaints. With that in mind, fitness to practise closure letters will all include a reminder that the doctor should reflect on this complaint along with any others as part their annual appraisal.
Supporting information

How this issue relates to the corporate strategy and business plan

19 This issue relates to Strategic Aim 3: To improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety.

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

20 Once the approach is agreed we will update our guidance for case examiners, train the case examiners and publish the amended guidance on our website.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director of Policy, Business Transformation and Safeguarding, ARowland@gmc-uk.org, 020 7189 5077.