Reviewing how we deal with concerns about doctors

A public consultation on changes to our sanctions guidance and on the role of apologies and warnings

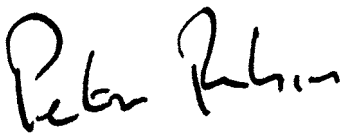
General Medical Council

Foreword

This consultation has been commissioned by the Council of the General Medical Council (GMC), which has overall responsibility for the sanctions guidance. His Honour David Pearl, Chair of the Medical Practitioners Tribunal Service (MPTS), chaired the sanctions guidance project board. Staff across the MPTS and the GMC have worked together to develop this consultation document.

After full consultation, a new version of the sanctions guidance will be agreed and published by the Council of the GMC.

The GMC's Registrar and other staff with delegated powers, the MPTS Chair, and fitness to practise panels, will use the new guidance to inform their decisions.



Sir Peter Rubin
Chair, General Medical Council

About this **consultation**

We are consulting on changes to what action we take when we believe a doctor may be putting the safety of patients, or public confidence in doctors, at risk.

This document sets out proposed updates to our sanctions guidance, which MPTS panels use to decide the outcome of cases at fitness to practise hearings. The guidance is also available to our other decision makers when deciding whether to refer a case to a hearing. The consultation also looks at the role of apologies and warnings in our processes, and changes to our guidance on suspension. The principles within this document will also help to inform our guidance for case examiners who make a decision on cases at the end of our initial investigation.

Any change to the range of sanctions available to panels or the circumstances in which we can issue warnings will require further public consultation to introduce legislative change. Later this year, we will also consult on separate explanatory guidance on candour.

Responses to this consultation will help us to understand the impact our proposals could have on groups who are protected under the *Equality Act ɛəəə*. Responses will also inform an equality analysis, which we'll publish before our Council decide whether to make changes to the guidance.

Changes to our sanctions guidance

Our proposed changes guide panels to:

- take appropriate action to protect the public interest without being influenced by the personal consequences for the doctor
- take action in all cases where a doctor's fitness to practise is impaired, unless there are exceptional circumstances which meet a specific definition
- take appropriate action to maintain public confidence in doctors even when a doctor has remediated
- consider more serious action where cases involve a failure to raise concerns, failure to work collaboratively, discrimination or abuse of professional position involving predatory behaviour
- consider the factors that may lead to more serious action where specific issues arise in a doctor's personal life which undermine confidence in doctors (eg criminal or civil proceedings)
- consider specific aggravating and mitigating factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs.

For more information about these changes, see pages 16–27.

The role of insight and apology

Our proposed changes include:

- considering whether panels should have the power to require a doctor to apologise
- clarifying the circumstances in which a doctor's failure to apologise may be considered evidence he or she lacks insight
- introducing more detailed guidance on other factors that may indicate a doctor has or lacks insight
- guiding panels to consider the stage of a doctor's UK medical career as a mitigating factor when making a decision (ie their experience or familiarity with what is expected)
- introducing verification checks for testimonials and new guidance on whether testimonials are relevant evidence of insight at a hearing
- making sure we routinely obtain a statement from a doctor's responsible officer or suitable person during our investigation for the panel to consider at a hearing.

For more information about these proposals, see pages 28–35.

Changes to our guidance on suspension

Our proposed changes are to give clearer guidance to panels on:

- deciding the length of suspension
- when suspension is appropriate for doctors where concerns are solely about their health
- how doctors can keep their clinical skills up-to-date during a suspension.

We are also seeking your views on the following question.

- Should a previous interim suspension order influence a panel's decision about whether or how long to suspend a doctor solely to uphold public confidence in doctors?

For more information about these changes, see pages 36–42.

Giving patients a voice

We are seeking your views on whether we should explore the benefits of meetings between doctors and patients where a doctor's actions have caused serious harm

For more information about this issue, see page 43.

Changes to our powers to give warnings

We are seeking your views on the following questions.

- Do you think warnings are an effective and proportionate means of dealing with low level concerns that involve a significant departure from *Good medical practice*?
- When do you think we should be able to give warnings?
- If we continue to give warnings, do you agree that any further concerns should lead to a more serious response?

For more information about these issues, see pages 44–49.

There are 24 questions in the consultation document. You do not have to answer all of the questions if you prefer to focus on specific issues.

How to take part

- Answer the questions online on our consultation website: **www.gmc-uk.org/isg_consultation.** Alternatively, you can answer the questions using the text boxes on pages 17–48 of this consultation document and either email your completed response to us at **ftpconsultation@gmc-uk.org** or post it to us at:

  Fitness to Practise Policy team
  General Medical Council
  350 Euston Road
  London NW1 3JN.

- Contact us using the details above if you would like us to send you a printed copy. Send your completed response to the address above.

This consultation runs from **22 August to 14 November 2014**.

Find out more

You can find further information about our fitness to practise processes on our website at **www.gmc-uk.org/concerns**.

What do we expect of doctors working in the UK?

We maintain a register of doctors who can work in the UK. These doctors must be familiar with and follow the standards set out in our guidance *Good medical practice* and in the explanatory guidance and statements that support it. Serious or persistent failure to follow this guidance will put a doctor's registration at risk.

Doctors must be competent, and keep their skills and knowledge up to date, to practise safely. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately including if they or a colleague fall ill and their performance or conduct suffers. They must also reflect on their practice, including any errors that affect patient safety and care, making use of the outcome of audits, patient and colleague feedback and lessons learnt through other patient safety and monitoring systems to improve the quality of care.

Updating the guidance in 2013

Following an extensive consultation, we published an updated edition of *Good medical practice* and supporting explanatory guidance in March 2013, which came into effect in April 2013.* This edition reflects what doctors and patients think are the important values and principles of good care.

What happens if a doctor fails to follow our guidance?

Failure to follow our guidance does not automatically mean we will take action. This is because the guidance sets out the principles of good practice, not thresholds at which we think a doctor is safe to work.

If we receive a complaint about a doctor, we use the guidance as a benchmark to assess whether a doctor's actions or decisions have fallen seriously or persistently below the standards we expect. But we also consider any mitigating or aggravating factors, the current risk that the doctor poses, and whether taking action is in the public interest – for example, to protect patients, maintain public confidence in doctors and to uphold proper standards of conduct and behaviour. To make sure we are consistent in our approach to dealing with concerns, including taking account of mitigating and aggravating factors, we have separate guidance to help the MPTS panels decide whether to take action.

The purpose of any action we take following a serious or persistent breach of our guidance is to protect the public by helping to make sure doctors on our register provide safe care and to uphold public confidence in doctors. It is not our role to punish or discipline doctors.

* You can read more about developing the updated guidance on our website at **www.gmc-uk.org/guidance/9879.asp**.

The relationship between *Good medical practice* and our fitness to practise process

01 DOCTORS' VIEWS

We speak to doctors at events and in focus groups, and we ask them to give their opinion on the draft guidance.

02 PUBLIC VIEWS

We speak to members of the public at events and in focus groups, and we ask them to give their opinion on the draft guidance.

03 SOCIETAL EXPECTATIONS

We gather opinions to understand what standards society as a whole expects of doctors.

04 POLITICAL CONTEXT

We gather information to understand how the political environment could affect expectations of doctors.

GOOD MEDICAL PRACTICE

Our guidance sets out the standards expected of doctors.

05 CASE LAW

When judges make decisions, they may have to make new interpretations of the law to tailor their decisions to the facts of individual cases. We take into account the principles that judges have followed in such cases involving doctors.

INDICATIVE SANCTIONS GUIDANCE

MPTS panels use this guidance to make a decision on a case.

THOUGHT PROCESS FOR PANELLISTS

- How **serious** is the allegation?
- Is there a need to **protect the public** from further harm?
- Has the doctor **undermined confidence** in the medical profession?
- What is a **proportionate** response?
- Is the doctor **suitable to work** as a doctor in future?
- Are there any **mitigating or aggravating factors** for the doctor's behaviour?
- Has the doctor shown **insight**?
- Has the doctor undertaken **remediation** steps?

06 LEGAL ADVICE

The panel can ask for advice from a legal assessor – an experienced barrister or solicitor who is appointed to advise the panel on points of law.

MPTS PANEL DECISION

07 INDEPENDENT JUDGEMENT

The MPTS panel hears the evidence. It then decides if the doctor's fitness to practise is impaired and what action, if any, is needed to protect the public and uphold confidence in the medical profession.

How do we deal with concerns about a doctor's fitness to practise?

If we receive a complaint about a doctor, we may need to investigate the concerns and take prompt action if we believe the doctor is putting the safety of patients, or public confidence in doctors, at risk. We can issue a warning, agree undertakings with the doctor that limit the type of work they can do or refer the case to an MPTS panel for a hearing. The MPTS was established in 2012 to separate our role in investigating concerns about doctors from the adjudication of cases, including holding hearings.

At a hearing, a fitness to practise panel will review the evidence to decide whether the doctor's fitness to practise is impaired. If it is, the panel will decide the appropriate action to take – it can take no action, agree undertakings with the doctor, impose conditions, or suspend or remove the doctor from the medical register. If appropriate, immediate action can also be taken to protect the public by imposing an interim order while we are investigating the concerns or the MPTS is holding the hearing.

If, following a hearing, a panel decides that a doctor's fitness to practise is not impaired, the panel decides whether to issue a warning or close the case with no action.

Possible actions to deal with concerns about a doctor

Warnings

What is a warning?
A warning tells a doctor and the wider medical profession that standards must be maintained and misconduct must not be repeated. It does not change a doctor's right to work in the UK.

When does this apply?
Warnings are issued to doctors at the end of an investigation or at a hearing if there is a significant departure from the principles set out in *Good medical practice* and supporting explanatory guidance, but their fitness to practise medicine in the future is not impaired.

Undertakings

What are undertakings?
Undertakings mean a doctor can continue to work in the UK, but only under certain restrictions – eg working under supervision.

When does this apply?
Undertakings may be agreed at the end of an investigation or at a hearing. Undertakings may be agreed when a doctor's fitness to practise medicine may be impaired, but the doctor can work safely if they are properly monitored and restricted.

Conditions

What are conditions?
Conditions are the same as undertakings except restrictions have been imposed on the doctor's registration without his or her agreement.

When does this apply?
Conditions are imposed by a panel at a hearing where a doctor's fitness to practise medicine is found to be impaired, but he or she can work safely if properly monitored and restricted.

Suspension

What is suspension?
Suspension is when a doctor is temporarily removed from the medical register and so cannot work as a doctor in the UK for a specified period of time. Doctors can be suspended for up to 12 months.

When does this apply?
Suspension is imposed by a panel at a hearing where a doctor's fitness to practise medicine is found to be impaired and restrictions are not sufficient to protect patients or maintain public confidence in doctors.

Removal from the medical register

What is removal?
A doctor's name is removed from the medical register and so they cannot work as a doctor in the UK. In such circumstances, there is no intention to restore the doctor's ability to practise medicine in the future.*

When does this apply?
This sanction is imposed by a panel at a hearing where a doctor's fitness to practise is found to be impaired and concerns are so serious they are considered to be incompatible with continued registration.

Interim orders

What is an interim order?
An interim order is a decision to immediately stop or restrict a doctor's right to practise on a temporary basis while we are investigating the concerns or the MPTS is holding the hearing.

When does this apply?
Interim orders are imposed by a panel at an interim orders hearing when concerns about a doctor's fitness to practise are so serious that it is in the public interest to intervene before the case ends. At this point, no facts have been proved.

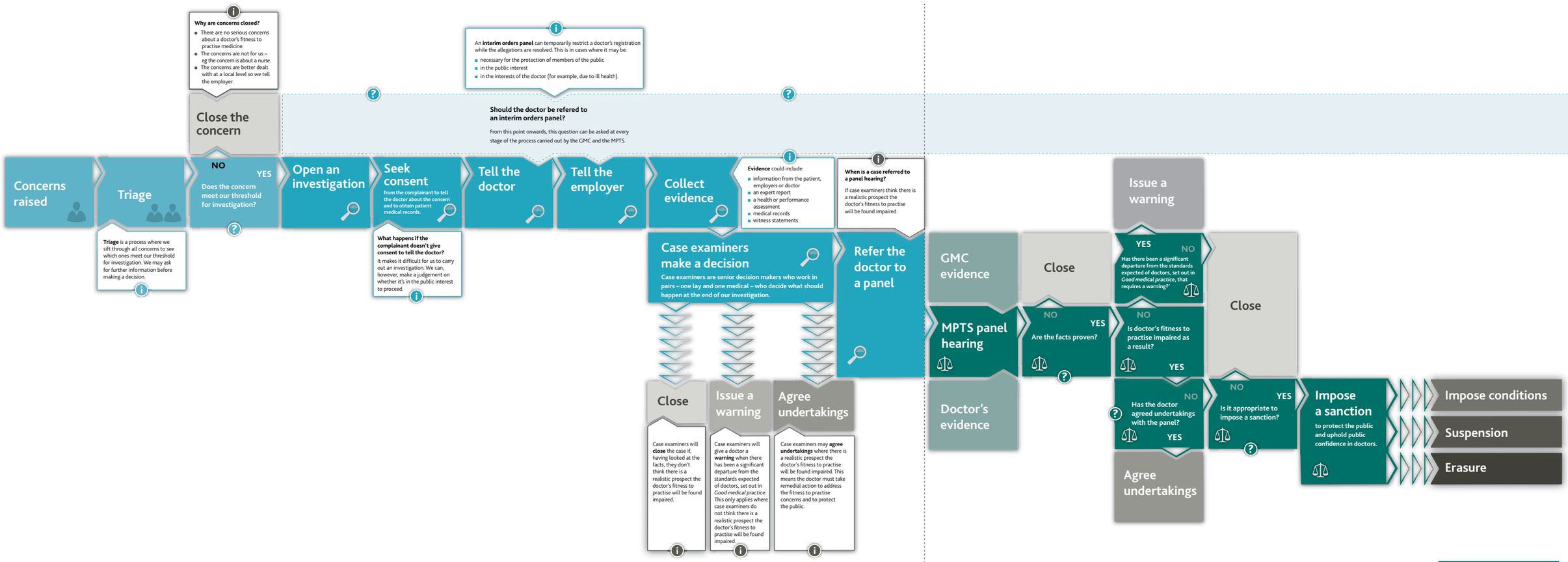
* Erased doctors may apply for restoration after five years. However, the onus is on the doctor to demonstrate they are fit to practise medicine again.

Our sanctions guidance

To make sure panel decisions are transparent, fair and consistent, we provide guidance to help panels decide what sanction is appropriate. This is called our *Indicative Sanctions Guidance for the Fitness to Practise Panel* and it is published on our website at **www.mpts-uk.org/sanctions_guidance**.

The sanctions guidance sets out the issues panels should take into account when making a decision, including whether a doctor's actions have fallen below the standards we expect, any mitigating or aggravating factors, the current risk that the doctor poses, and whether we need to take action in the public interest.

How we deal with concerns about a doctor's fitness to practise medicine



Fitness to practise

Section 1: Changes to our sanctions guidance

We propose a range of changes to our sanctions guidance to make sure it reflects society's values and expectations of doctors, which are set out in the updated edition of *Good medical practice* and supporting explanatory guidance, published in 2013. In particular, these changes will better guide panels on the types of concern where it may be appropriate to permanently remove a doctor's registration. There are nine questions in this section.

Not being influenced by personal consequences of sanctions on doctors

Sanctions can sometimes have an unintended punitive effect on doctors. For example, suspending a doctor to protect the public may reduce their earnings during that period or put them at risk of losing their job. But the panel's first duty must be to protect patients and maintain public confidence in doctors.

Case study: Dr Manchester lost his temper and physically assaulted a patient during a home visit. If the panel decides to remove his right to work as a doctor, he faces losing his job and being evicted from his home.

Proposed change: where action is necessary to protect patients and maintain confidence in doctors we propose to guide panels to consider taking the appropriate action without being influenced by the personal consequences for the doctor?

1 **Do you agree with this proposal?**

☐ Yes ☑ No

Do you have any comments?

While panels should be aware of their primary duty to protect patients and maintain confidence in the profession, they should nevertheless have the opportunity to consider the context as a whole and in the interests of fairness and proportionality doctors should still be able to tell panels about the likely impact of a sanction being imposed.

Taking action in all cases where a doctor's fitness to practise is impaired unless there are exceptional circumstances

Patients should be treated by doctors who are properly supervised, monitored and actively supported to address any deficiencies in their performance, health or conduct. We believe that, where a doctor's fitness to practise is impaired, we have a duty to consider appropriate steps to address this.

Doctors sometimes argue that, even where their fitness to practise has been found to be impaired, it is in the public interest to allow them to continue working without restriction, because they provide a particularly valuable service to the community. In order to make sure employers and healthcare commissioners can make arrangements for adequate patient care if a doctor's fitness to practise medicine is found impaired, they are given several months' notice of a hearing.

Where a doctor's fitness to practise is impaired, we propose to guide panels to take action unless there are exceptional circumstances.

Case study: Dr Cardiff was convicted of embezzling £100,000 from a charity he set up to raise money for sick children. He is now extremely ashamed and sorry. Because it is not unusual for doctors to express regret for their actions, this is not an exceptional circumstance, so the panel decides to impose a sanction.

Proposed changes: to guide panels to consider taking action where a doctor's fitness to practise medicine is found to be impaired unless there are exceptional circumstances.

To define exceptional circumstances as those that are unusual, special or uncommon. For example, it is not unusual for doctors to express regret for their actions, so this is not an exceptional circumstance.

2 **Do you agree with this proposal?**

☑ Yes ☐ No

Do you have any comments?

This is a reasonable proposal so long as the action is proportionate and appropriate to the circumstances.

Maintaining public confidence even when a doctor has remediated

In deciding whether a doctor's fitness to practise is impaired, panels focus on the care patients are likely to receive in the future and not on disciplining the doctor for past misconduct. Sometimes a doctor recognises their own failings and makes sure they do not pose a risk to future patients before we get involved. In these situations, we may not need to take any further action.

But a doctor's failings may be so serious or persistent that, even if they have fully remediated the concerns, the public may find it difficult to accept that no action is taken. In these cases, the doctor knew or should have known they were causing harm to patients and should be held accountable for that – as a result we believe panels should take action to maintain public confidence in doctors.

Case study: Dr Glasgow has been using outdated techniques to fix leg fractures for a number of years despite concerns raised by colleagues. This has caused poor recovery rates and high rates of post-operative infections. Several elderly patients have died as a result of infections contracted due to surgery. Many other patients needed further surgery to correct her errors. When questioned by senior hospital staff she blamed nursing staff. Since the GMC commenced investigating, the doctor has undergone retraining to resolve any issues with her performance.

Proposed change: to guide panels to consider taking action to maintain public confidence in doctors even when a doctor has remediated if the concerns are so serious or persistent that failure to take action would impact on public confidence in doctors.

3 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

Where cases are serious or persistent it is vital that public confidence is maintained.

Taking more serious action in specific cases

The current version of the sanctions guidance says it may be appropriate to remove a doctor from the medical register where their behaviour is fundamentally incompatible with being a doctor.* Following the update to *Good medical practice*, we propose to change our sanctions guidance to guide panels that they may wish to consider more serious outcomes where doctors have:

- failed to raise concerns where there is reason to believe a colleague's fitness to practise is impaired and may present a risk of harm to patients (*Good medical practice*, paragraph 25)
- failed to raise concerns where a patient is not receiving basic care to meet their needs (*Good medical practice*, paragraph 25)
- failed to work collaboratively with colleagues, respecting their skills and contributions, treat colleagues fairly and with respect, or be aware of how their behaviour may influence others within and outside the team (*Good medical practice*, paragraphs 35–37)
- used their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them (*Good medical practice*, paragraph 53)
- discriminated against patients or colleagues by allowing their personal views to affect their professional relationships or the treatment they provide or arrange (*Good medical practice*, paragraph 59)
- failed to ensure that a doctor's conduct justifies their patients' trust in them and the public's trust in the profession (*Good medical practice*, paragraph 65).

We have set out further detail about the proposed changes below.

Failure to raise concerns

The updated edition of *Good medical practice* introduced a new duty for doctors to take prompt action if they think that patient safety, dignity or comfort is or may be seriously compromised. Where a patient is not receiving basic care to meet their needs, doctors must immediately tell someone who is in a position to act straight away. This principle is key to maintaining a minimum acceptable standard of care for all patients.

All doctors also have a responsibility to promote and encourage a culture that allows all staff to raise concerns openly and safely. This includes responding appropriately to any risks to patients presented by inadequate premises, equipment, other resources, policies or systems. Where a doctor has concerns that a colleague may not be fit to practise and may be putting patients at risk they should seek advice and report the matter if appropriate.

* Such behaviour includes: a reckless disregard for the principles set out in *Good medical practice* or for patient safety; doing serious harm to others, either deliberately or through incompetence, particularly where there is a continuing risk to patients; abuse of position; violation of a patient's rights; exploiting vulnerable people; offences of a sexual nature or involving violence; dishonesty, particularly where persistent or covered up; putting your own interests before those of patients; and persistent lack of insight into seriousness of actions or consequences.

Doctors' duties to raise concerns are set out in *Good medical practice* (paragraphs 24–25) and in our explanatory guidance *Raising and acting on concerns about patient safety*. These duties apply to all doctors and not just those with specific management or leadership responsibilities.

Case study: Dr Belfast works at a mental health in-patient facility. Over a three month period he regularly notices patients lying in soiled sheets complaining they have not been given any water. He is concerned by the mistreatment of patients, but does not take any action either to address the immediate needs of those patients or to raise the issue with management or other staff.

Proposed change: to guide panels to consider more serious action where cases involve a failure to raise concerns and, in the most serious cases, to remove or suspend doctors from the medical register to maintain public confidence.

4 Do you agree with this proposal?

☐ Yes ☐ No

Do you have any comments?

Undecided. This would need to be context specific. For example, a very junior doctor may not have the confidence to challenge senior colleagues, there may not have been a whistle blowing policy, etc.

Panels would need to be provided with sufficient information that the doctor was the only person with an obligation. An unrepresented/absent doctor may find it difficult to get across the culture which prevented him/her from raising issues and it may be unfair for them to be held solely responsible.

Failure to work collaboratively with colleagues

Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in *Good medical practice* (paragraphs 35–37). Although many low level concerns about a doctor's working relationships with colleagues can be dealt with effectively through employers' local systems, we should deal with concerns that cannot be resolved locally or are particularly serious. The most serious concerns involve bullying, sexual harassment or physical violence towards colleagues. Cases where conduct issues affect working relationships and put patient safety at risk may also meet this threshold – for example, where deliberately obstructive or aggressive behaviour towards colleagues prevents a patient receiving emergency care.

Case study: Isaac is admitted to accident and emergency with acute severe asthma. The doctor in training responsible for his care does not feel sufficiently experienced to manage his condition and asks an on-call senior colleague, consultant Mr London, to examine him. Mr London is very rude and aggressive towards the doctor in training and refuses to see the patient despite repeated requests. As a result of the delay, the patient's health deteriorates and another consultant intervenes to make an immediate transfer to intensive care.

Proposed change: to guide panels they may consider more serious action where cases involve a failure to work collaboratively including bullying, sexual harassment or violence or risk to patient safety.

5 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

Failure to work collaboratively can encompass a broad range of failings and may be one-off events or prolonged patterns of behaviour. Any sanction would need to be proportionate to the circumstances, taking into account risk to patient and colleague safety, whether that is another health care professional or a trainee.

Abuse of professional position

Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in *Good medical practice* (paragraph 53) and in our explanatory guidance *Maintaining a professional boundary between you and your patient* and *Ending your professional relationship with a patient*.

Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.* If a patient pursues a sexual or improper emotional relationship with their doctor, the doctor should treat them politely and considerately and try to re-establish a professional boundary. Doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them.

Personal relationships with former patients may also be inappropriate depending on the nature of the previous professional relationship, the length of time since it ended, the vulnerability of the patient and whether the doctor is caring for other members of the family.

Doctors are expected to be responsible and ensure their relationships with patients are contained within professional boundaries. Where a patient is vulnerable, there is an even greater onus on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of their illness, disability or frailty, or because of their current circumstances (such as bereavement or redundancy). Patients younger than 18 years should be considered vulnerable. If a doctor engages in an emotional or sexual relationship with a patient who is vulnerable, the risk to patient safety and public confidence in doctors is particularly significant.

A doctor engaging in predatory behaviour, motivated by the desire to establish an emotional or sexual relationship with a patient, may not constitute a criminal offence, but it does indicate a significant risk to patient safety and may significantly undermine public confidence in doctors. For example, where a doctor makes inappropriate use of a social networking site or uses personal contact details from medical records to approach a patient outside their doctor-patient relationship.

In cases where concerns do not constitute a criminal offence, it can be difficult for panels to be certain about the seriousness of concerns and to navigate the complex range of factors to decide on an appropriate action. For example, a doctor may argue that a sexual or emotional relationship with a patient was consensual in nature, or instigated by the patient. The sanctions guidance already provides guidance that panels may consider removing doctors from the medical register who have abused their professional position, but we want to provide greater clarification of the cases in which removing a doctor from the register would be an appropriate response. We also propose to update the section in the sanctions guidance relating to sexual misconduct in line with this approach.

* A definition of 'someone close to them' is provided in our explanatory guidance on maintaining a professional relationship between you and your patient, (paragraph 6), available at **www.gmc-uk.org/guidance/ethical_guidance/21170.asp**.

Case study: Following the death of her husband, Emma is referred by her GP for treatment from a consultant psychiatrist, Mr Edinburgh. After a few sessions of therapy, he invites her to a romantic dinner. She later finds out that he previously tried to establish a sexual relationship with three other recently bereaved patients.

Proposed changes: to guide panels to consider removing doctors from the medical register when abuse of their professional position involves predatory behaviour towards a patient, particularly where the patient is vulnerable.

6 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

In cases where there is clearly predatory behaviour this would be appropriate.

Discrimination against patients, colleagues and other people

Doctors must not discriminate against patients or colleagues by allowing their personal views to affect their professional relationships or the treatment they provide or arrange. This includes personal views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by law: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy and maternity, religion or belief, and sex and sexual orientation.

Doctors may choose to opt out of providing a particular procedure because of their personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients. Doctors must not express their personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.

Discrimination is unacceptable in a modern society, undermines public confidence in doctors and is a serious risk to patient safety. This is consistent with our expectation that doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession. Doctors' duties are set out in *Good medical practice* about discrimination (paragraphs 54–59) and justifying patients' trust (paragraph 65).

The sanctions guidance already advises panels to consider removing a doctor from the medical register if they violate a patient's rights or exploit vulnerable people. We propose also to advise panels to consider removing a doctor from the medical register if they have discriminated against others.

Case study: A same-sex couple ask their doctor about fertility treatment on the recommendation of gay friends who successfully conceived via IVF at a local NHS clinic. Dr Wrexham makes offensive homophobic remarks.

Proposed change: to guide panels they may consider more serious action where cases involve discrimination against patients, colleagues or other people who share protected characteristics* in any circumstance, either within or outside their professional life.

7 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

It is illegal to discriminate against people with protected characteristics and this should be acknowledged in the sanctions guidance.

* It is unlawful to discriminate against someone based on any 'protected characteristic' set out under the *Equality Act 2010*.

Doctors' lives outside medicine

The updated edition of *Good medical practice* includes that doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (paragraph 65). If a doctor's behaviour in their personal life undermines public trust in doctors, we may need to take action.

Case study: Dr Birmingham had been going through a difficult divorce for many months. After one session in court, he forced his way into his wife's home, causing severe bruising to her wrists. During the confrontation he also hit his seven-year-old son, fracturing his skull.

Proposed change: to guide panels to consider the factors which may lead to more serious action where the following issues arise in a doctor's personal life:

- misconduct involving violence or offences of a sexual nature
- concerns about their behaviour towards children or vulnerable adults
- concerns about probity (being honest and trustworthy and acting with integrity)
- misuse of alcohol or drugs leading to a criminal conviction or caution
- unfair discrimination related to characteristics protected by law: age, disability, gender reassignment, race, marriage, civil partnership, pregnancy and maternity, religion or belief, and sex or sexual orientation
- any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings

The list is not exhaustive – if there are other specific issues that you think we should consider, please include them in the comment box below. We discuss aggravating and mitigating factors related to alcohol and drug misuse in the next question.

8 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

It may be appropriate to take action when a doctor's behaviour in their personal life would mean public confidence in the medical profession is questioned. Action should take into account health status and engagement in any appropriate treatment programmes.

Drug and alcohol misuse linked to misconduct or criminal offences

Misuse of alcohol and drugs in a doctor's personal life is one of the issues we suggest may undermine public confidence in doctors. When a doctor is unwell, including because of drug or alcohol addiction, they must take appropriate steps to make sure this does not affect patient safety. We may need to take action where a doctor's health has compromised patient safety and/or led to involvement in criminal activity. If we receive information that a doctor has been charged with, or received a conviction or caution, for a crime related to alcohol or drug misuse, we usually refer them for a health assessment to see if they have an addiction that may pose a serious risk to patients.

We propose to add specific advice to the sanctions guidance to help panels assess the seriousness of concerns about a doctor's misuse of alcohol or drugs, inside or outside the workplace.

Case study: Dr Durham went to a nightclub with Dr Oxford, and they both took illegal drugs. The next day, Dr Oxford was off sick from work, but Dr Durham went to work while he was still under the influence of illegal drugs. Dr Durham stole morphine intended for a patient, which he self-administered in the staffroom before going into theatre.

Proposed change: to guide panels that they may consider specific factors when deciding on the action to take in cases involving addiction or misuse of alcohol or drugs.

We take all issues relating to drug or alcohol misuse seriously. Some are more serious and have aggravating features and therefore would attract more serious outcomes. We believe panels should consider more serious action in cases involving the following factors:

- intoxication in the workplace or while on duty
- misuse of alcohol or drugs that has impacted on the doctor's clinical performance and caused serious harm to patients or put public safety at serious risk
- misuse of alcohol or drugs that has resulted in violence, bullying or misconduct of a sexual nature
- misuse of alcohol or drugs that led to a criminal conviction particularly where a custodial sentence was imposed.

This approach is consistent with our guidance on assessing the risk posed by doctors with health issues.*

9 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

As stated above, this approach would be consistent with GMC guidance on assessing the risks posed by doctors with health issues. Action should take into account health status and engagement in treatment, particularly for alcohol and substance misuse. The sanction should protect the public during the period of risk.

* **www.gmc-uk.org/Guidance_for_decision_makers_on_assessing_risk_in_health_cases.pdf_48690195.pdf**.

Section 2: **The role of apology and insight**

This section looks at the role of apology and insight in our processes. We are reviewing this because doctors have a duty (*Good medical practice*, paragraph 55) to offer an apology when a patient is harmed or suffers distress as a result of a doctor's actions.

The Francis report recommended that introducing a professional duty of candour for health and social care professionals would encourage a culture of openness and honesty to be the norm.*

* The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* available at **www.midstaffspublicinquiry.com/report**.

In this section, we propose ways to strengthen our guidance for panels on apology and insight when dealing with concerns about doctors at MPTS hearings. We would also update our other guidance for decision makers to reflect these principles. There are six questions in this section.

The role of apology in our fitness to practise procedures

Good medical practice says doctors 'must be open and honest with patients when things go wrong and offer an apology when a patient under their care suffers harm or distress'.* However, we do not currently have a sanction that can require a doctor to apologise. If a patient wants an apology, we advise them to first contact the place where they received care; they can also use other routes, such as local mediation processes or civil proceedings. However, information that a doctor has apologised may be considered evidence of insight as part of our process for monitoring a doctor's progress with remediation.

We are considering whether panels should be able to require doctors to apologise where patients have been harmed. This would help us to hold doctors to account for their actions, for example where a serious clinical error has adversely affected a patient's life expectancy or quality of life.

If there is support for this in principle, we will do further work to develop proposals for how this might work in practice. Any proposals to change the range of sanctions available to panels will require further consultation prior to legislative change.

Issue to consider: should panels be able to require doctors to apologise where patients have been harmed.

10 Do you think panels should require a doctor to apologise where patients have been harmed?

☐ Yes ☑ No

Do you have any comments?

To be genuine, apologies should be a genuine expression rather than something that is imposed by a panel or other external party. By the time a doctor appears at a FTP hearing there is likely to have been a long time gap between the incident(s) and hearing. If a doctor has not already apologised it is perhaps less likely to be a genuine apology.

The College would appreciate clarification on who would decide whether the apology is genuine, and what would happen if the apology was not deemed genuine?

There may be some difficulty for doctors from different cultures to provide an apology - how would this be dealt with and is there a danger that some doctors would be disadvantaged?

* General Medical Council (2013) *Good medical practice* (paragraph 55) available at **www.gmc-uk.org/gmp**.

Deciding whether a doctor has insight

In our current sanctions guidance, we define insight as where a doctor is able with hindsight to stand back and accept that they should have behaved differently, and take steps to address their failings. We believe panels should remove doctors from the medical register if they have a persistent lack of insight into the seriousness of their actions or the consequences. An apology may be evidence of insight, but a range of factors can influence whether, or how, a doctor apologises – such as fear of legal action and personal circumstances (eg ill health).

We propose to strengthen our guidance for panels on how to assess whether a doctor has insight, and the extent to which an apology is evidence of insight. In principle, we believe that where a patient has been harmed as a result of a doctor's actions or omissions, a doctor's failure to apologise is evidence that they lack insight.

This change would allow panels to hold doctors to account where they fail to apologise for harm caused to a patient, and increase consistency in our decision making when considering the role of insight.

11 Do you agree with this proposal?

☐ Yes ☐ No

Do you have any comments?

Undecided. In a case such as the one described it would be relatively easy to identify a lack of insight. However, there are many cases which are less clear cut and the reasons for not making an apology can be complex. Failure to tell the truth in the hearing may be easier for panels to treat as showing a lack of insight.

Doctors who are represented are more likely to get better advice about taking remedial steps to demonstrate that to panels that they have insight - care would need to be taken not to treat unrepresented doctors more harshly because they have not had the benefit of such advice.

Case study: Dr Swansea failed to assess or examine vulnerable residents in a care home where he was responsible for providing GP services. Dr Swansea's sloppy attitude to performing clinical examinations caused the avoidable death of five elderly patients. For the following 12 months, he failed to be open and honest with bereaved relatives about what happened and refused to apologise. On the day before the hearing is due to start, Dr Swansea apologises for his actions but fails to tell the truth when giving evidence.

Proposed change: to introduce more detailed guidance on the factors that indicate a doctor has or lacks insight.

- A doctor is likely to have genuine insight if they: accept they should have behaved differently, consistently express insight,* take steps to remediate and apologise at an early stage before the hearing.
- A doctor is likely to lack insight if they: refuse to apologise or accept their mistakes, do not consistently express insight, or fail to tell the truth during the hearing.
- A doctor may also lack insight if they promise to remediate, but fail to take appropriate steps or only do so when prompted or immediately before or during the hearing.

* Expressing insight involves a demonstration of genuine reflection and remediation.

Stage of a doctor's UK medical career can affect insight

When a newly qualified graduate is first accepted onto the UK medical register and begins working as a doctor in the UK, they may well experience a steep learning curve as they take on new responsibilities. As a doctor's medical career progresses, we expect their understanding of the social and cultural context of their work, and appropriate standards, to improve.

Many doctors joining the medical register have previously worked, lived or were educated overseas, where different professional standards and social, ethnic or cultural norms may apply. In 2013, 37% of doctors on our medical register had gained their primary medical qualification outside the UK.* We expect these doctors to familiarise themselves with social and cultural norms where they work, although we recognise that experience of working as a doctor in the UK also plays a key role.

Case study: Dr Lisburn started surgical training in trauma and orthopaedics six weeks ago. He is very enthusiastic about his new role and uploads several radiographs of patients' fractures onto his Facebook page.

Proposed change: to guide panels they may consider the stage of a doctor's UK medical career as a mitigating factor, and whether they have gained insight once they have had an opportunity to reflect on how they might have done things differently, with the benefit of experience. However, in cases involving serious concerns about a doctor's performance or conduct (eg predatory behaviour to establish a relationship with a patient, or serious dishonesty), the stage of a doctor's medical career should not influence a panel's decision on what action to take.

12 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

If doctors are to have a good understanding of what is expected of them, in order for them not to behave inappropriately, this proposal will be more workable if there is a coordinated approach to communicating expectations and if all doctors are given appropriate induction.

Locum agencies, Deaneries and Colleges may have to provide additional support, information and guidance, particularly to doctors who have not been trained in the UK.

* 37% (94,952) doctors on the medical register at 31 December 2013 gained their medical qualification outside the UK.

Assessing the value of testimonials

Sometimes doctors whose fitness to practise medicine has been found impaired submit testimonials from patients, colleagues and other people who know them. This may help panels to take a wider view of the extent to which doctors have reflected on and remediated the concerns, and what action if any is required. For example, a person who has recently supervised a doctor may be able to provide a useful perspective on the extent to which they have reflected on and remediated concerns in a clinical environment.

The testimonials are not always directly relevant to the concerns raised and there may be limited information about the context in which they were obtained. It is sometimes not clear whether the person providing the testimonial knew that the doctor intended to submit it as evidence in a hearing. Some doctors may also find it easier than others to seek testimonials depending on the length of their career and their access to social networks.

We are considering ways to improve how information from patients, colleagues and other people is used to inform decisions as to what action to take. In the short term, as part of this consultation, we are looking at the approach to assessing the value of testimonials by verifying their authenticity and making sure they are relevant. This reflects best practice in other tribunals.

Case study: Dr Reading persistently sexually harassed three female colleagues over a 12-month period. Each of the women rejected Dr Reading's advances, but this did not alter his behaviour. One female doctor was so intimidated that she was signed off work for three months due to stress. Dr Reading has provided around 30 testimonials from his neighbours detailing youth projects he has set up in the community. He has not provided any testimonials from colleagues or patients.

Verification checks on testimonials

Proposed change: to introduce a robust verification process to check the authenticity of testimonials before they are accepted as evidence in a hearing. This would involve checking the identity of anyone who has a written a testimonial to eliminate the possibility of fraud or misrepresentation. We also propose to check that those who write testimonials are aware of the concerns about the doctor, what their testimonials will be used for, and that they are willing to come to the hearing to answer any questions if a panel asks them to do so. To allow sufficient time for checks to take place, doctors will have to submit their testimonials before the hearing starts.

Deciding whether testimonials are relevant

Proposed change: to introduce guidance for panels on the factors they may consider when deciding whether testimonials are relevant to their decision:

- whether the testimonial is relevant to the specific concerns about the doctor
- the extent to which the views expressed in the testimonial are supported by other available evidence
- how long the author has known the doctor
- how recently the author has had experience of the doctor's behaviour or work
- the relationship between the author and the doctor (eg a senior colleague)
- whether there is any evidence that the author has a conflict of interest in providing the testimonial (eg personal friendship).

13 **If we introduce verification checks on testimonials, do you agree that we should continue to accept them as evidence?**

☐ Yes ☑ No

Do you have any comments?

Testimonials may be better regarded as being relevant information rather than "evidence".

For doctors who are not represented, especially those who are not of UK origin, and without the benefit of advice, it might be less likely that they would be able to obtain testimonials which can be verified. Care would be needed to ensure that they were not disadvantaged and panels may need some discretion for them to consider unverified testimonials even if they might give them less weight.

14 **Do you agree that we should use the factors above to decide whether testimonials are relevant to the panel's decision?**

☑ Yes ☐ No

Do you have any comments?

Feedback from responsible officers

In 2010, we introduced revalidation, which is a system of regular checks on every doctor practising in the UK to make sure they are competent and have kept their skills and knowledge up to date. Most doctors now have a responsible officer – a senior doctor who makes sure they are meeting our standards and monitors any fitness to practise concerns. In many cases, the doctor's responsible officer is likely to be the medical director at their main workplace. We believe the doctor's responsible officer should be more involved in the process for assessing the extent to which a doctor has reflected on and remediated the concerns at a hearing.

Case study: During our investigation, Dr Birmingham's responsible officer is asked to provide a statement on the extent to which Dr Birmingham has shown insight and remediation in the workplace. The responsible officer confirms Dr Birmingham is complying with interim conditions on his registration and there have been no further complaints about his behaviour.

He also comments that Dr Birmingham has volunteered with the employee assistance programme at the hospital which supports staff who are struggling to cope at work.

Proposed change: to make sure we routinely request a statement from a doctor's responsible officer* during our investigation for the panel to consider at a hearing. The statement should set out the extent to which the doctor has reflected on the matter before the panel, the extent to which they have shown insight and how far any issues about their performance or behaviour have been addressed. The panel may wish to consider the extent to which any evidence of insight in testimonials provided on the doctor's behalf is supported by other available evidence, including the responsible officer's statement.

We would also introduce guidance for panels to make sure doctors who do not have a responsible officer because they have given up their licence, or who are using alternative routes for revalidation, are not treated unfavourably.

15 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

Care might also need to be given in circumstances where there is a conflict between the responsible officer and the doctor facing allegations.

* Some doctors without a responsible officer may have a suitable person as set out in *The Medical Profession (Responsible officer) Regulations 2010*. In those cases, we will obtain a statement from the suitable person.

Section 3: Changes to our guidance on suspension

We propose several changes to our guidance to help panels make consistent decisions about suspending doctors. There are four questions in this section.

Deciding the length of suspension

Panels can suspend doctors for up to 12 months. We propose to strengthen our guidance to make sure that the seriousness of the concerns is the primary factor when panels decide length of suspension. The box on page 38 sets out the aggravating factors that indicate the seriousness of concerns for different types of cases.

For example, where concerns are about a doctor's knowledge, skills and performance, the seriousness may be indicated by the extent of any significant departure from our expectations of doctors and the extent to which the behaviour was reckless. Whereas, in cases about a doctor's probity (being honest and trustworthy and acting with integrity), key factors may be the extent of any significant and/or sustained acts of dishonesty or misconduct and risk to patient safety and public confidence.

We believe panels' decisions should not be influenced by the personal consequences for the doctor (see question 1) or by the potential disruption to the health service. Where a panel has determined that the concerns about a doctor require that doctor be removed from practice, employers and healthcare commissioners should try to make arrangements to ensure adequate patient care is maintained.

The aggravating factors a panel considers when deciding the length of a doctor's suspension from the medical register

When panels set the length of a doctor's suspension from the medical register, they consider any aggravating factors which may indicate the seriousness of the concerns. The table below sets out examples of these under broad categories, depending on the nature of the case.

Knowledge, skills and performance

- The extent of the doctor's reckless behaviour.
- The extent to which the doctor departed from the principles of good medical practice.

Probity

- The extent of the doctor's significant or sustained acts of dishonesty or misconduct.
- The extent to which the doctor's actions risked patient safety or public confidence in doctors.

Compliance with GMC investigation

- Whether the doctor is reluctant to take remedial action and/or apologise.
- Whether the doctor fails to be open and honest with GMC and local investigations.

Relationships with patients

- The extent of the doctor's predatory behaviour.
- The impact that the doctor's actions had on vulnerable people and risk of harm

Working with colleagues

- Whether the doctor has shown a lack of responsibility toward clinical duties and patient care.
- The seriousness of a doctor's inappropriate behaviour

Teaching and supervision

- The extent to which the doctor failed to comply with requirements.
- Whether the doctors has shown a deliberate disregard for requirements.

Safety and quality

- The extent to which the doctor failed to address serious concerns over a period of time.

Case study: Sarah took her 18-month-old son to her GP surgery with bruising to his arms and back. She told Dr Hull that her son had fallen down the stairs and she just wanted him checked over. Although she noticed unusual bruising, not consistent with the explanation of the injuries, and a change in the child's behaviour, Dr Hull failed to refer the child for an urgent paediatric assessment or to notify other professionals involved in his care. Three months later the child was admitted to accident and emergency with a severe brain injury later found to be caused by being shaken aggressively by his father. The child died several days later in hospital. Dr Hull has expressed remorse for failing to consider the possibility of child abuse. She recognises the seriousness of her actions and has undertaken several courses to help her spot signs of child cruelty in the future.

Proposed change: to guide panels they may consider five key factors when deciding the length of suspension:

- the risk to patient safety
- the impact on public confidence in doctors
- the seriousness of the concerns, and any mitigating or aggravating factors (as set out on the opposite page)
- sending a message to the medical profession that standards must be upheld
- ensuring the doctor has adequate time to remediate.

Panels may also wish to consider the time all parties may need to prepare for a review hearing if one is needed.

16 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

The case study presents a particularly serious scenario for consideration, and in these particular circumstances the doctor's actions have shown unacceptable standards which would require serious sanctions. In more general terms the five key factors described above are sensible.

Suspending doctors with health issues

If a doctor has a serious health condition which could affect patient safety they must seek medical advice and take appropriate steps to protect the public as set out in *Good medical practice* (paragraph 28). Where a doctor fails to do this and their fitness to practise is impaired solely on the basis of health, GMC decisions makers or panels will usually agree undertakings or impose conditions to protect patients. But, where this will not offer the level of public protection required, it may be necessary to suspend a doctor. We propose to clarify our guidance to panels on the factors to consider in these circumstances.

Proposed change: where concerns are solely about a doctor's health, to guide panels to consider suspending the doctor if this is required to protect patients or if the doctor fails to comply with any restrictions on their registration.

17 Do you agree with this proposal?

☑ Yes ☐ No

Do you have any comments?

Patient safety is paramount and in rare cases where a doctor with a serious health condition does not take appropriate steps to protect the public, then sanctions must provide the level of public protection required.

How can doctors keep their clinical skills up to date while they are suspended?

We expect suspended doctors to keep their clinical skills up to date to avoid any deterioration of their fitness to practise. If the original matter related to clinical concerns, they are also required to bring those skills up to a level where they will be allowed to practise again. The sanctions guidance says suspended doctors may do similar work to that of a final year medical student, provided they are supervised by a fully registered doctor. In such cases, they must explain to patients that they are suspended and the events that led up to it, and seek the patients' consent.

However, as the panel has decided that it is not appropriate for the doctor to work under restrictions, it may be that members of the public would expect that a suspended doctor should not have any direct contact with patients (eg, by treating patients under supervision) and that contact with patients should be confined to observation roles.

Case study: Dr Aberdeen was suspended from the medical register for six months after she repeatedly provided false information about her attendance on continuing professional development courses. Her specialist area of practice is general practice. To keep her clinical skills up to date during this period, she found a placement shadowing colleagues so that she could observe them conducting patient consultations.

Proposed change: to provide guidance that suspended doctors should keep their clinical skills up to date by working in ways that do not allow them to be able to play any part in interactions with patients. This would still enable them to observe and later reflect on clinical care such as observing clinics related to their area of practice and of course by engaging in continuing professional development.

18 Do you agree with this proposal?

☐ Yes ☐ No

Do you have any comments?

Undecided. Care would need to be given to ensuring that there isn't too much burden put on Deaneries, Trusts etc.

While it would be reasonable to ensure that doctors do not lose skills while suspended, some consideration might need to be given to the fact that, while suspended, the doctor may not have the financial resources to participate in some courses or take time off any other work they might be doing, and that some courses are not available to doctors who are suspended.

Consideration should also be given to the fact that colleagues may not wish to be shadowed by a suspended doctor and patients may not want to be observed in a consultation by a suspended doctor.

The influence of previous interim orders

Where there are very serious allegations against a doctor, a panel may decide to impose an interim order. This immediately stops or restricts a doctor's right to practise while we are investigating the concerns or the MPTS is holding a hearing in order to avoid unnecessary risk to patients or public confidence in doctors.

Interim orders are given on the basis of untested evidence as it emerges during our investigation or the hearing – ie before the facts are proved. By contrast, sanctions are given at the end of a hearing, once all the evidence has been heard and the facts found proved. Currently, panels do not usually consider the impact of previous interim orders when they are deciding on the sanction.

However, when it has been established that the doctor is no longer a risk to patients and the panel is considering suspension solely to uphold public confidence in doctors, it could be argued that panels should be able to take into account the time a doctor has been suspended under previous interim orders when they are deciding on the sanction. This is because the interim order itself may have helped to maintain public confidence in doctors. The impact on the suspended doctor is the same whether it has been imposed as an interim order or following a full panel hearing. However, where a doctor remains a risk to patients and suspension is needed for patient safety, any previous interim orders should not influence the panel's decision.

There are arguments against changing the current approach. Different legal tests apply to interim orders and fitness to practise sanctions – the former deals with an assessment of risk to patients based on unproven allegations, while the latter deals with an assessment of risk based on facts. It may also be seen as unfair to treat suspension differently to conditions.

Case study: During a locum placement, Dr Newport was verbally aggressive to a number of patients and physically assaulted a colleague. He has been subject to an interim order of suspension for 18 months, and a fitness to practise panel has now found him impaired because he continues to present a risk to the public.

Issue to consider: whether panels should take account of previous interim suspension orders in a panel's sanction decision on suspension where action is solely to uphold public confidence in doctors.

19 **Where a panel suspends a doctor solely to uphold public confidence in doctors, should any previous interim order influence the panel's decision?**

☑ Yes ☐ No

Do you have any comments?

This would need to be very context specific. However, if criminal law is allowed to take periods of remand into consideration, then should it not follow that panels recognise time spent under suspension pending an investigation?

Section 4: Giving patients a voice

We are exploring ways to enhance the role of patients in our fitness to practise procedures. We are already undertaking a pilot to involve patients and relatives who have complained about a doctor – this consists of a meeting with a member of GMC staff at the start and end of our processes. The aim is to ensure we fully understand the patient's concerns, to explain our role and procedures and to explain the outcome of the case following a decision.

In addition to this, we are considering the benefits of meetings between doctors and patients where a patient has been harmed as a result of a doctor's actions or omissions to enable them to tell the doctor how they feel about what happened and ask the doctor any questions. This would only apply where a meeting had not already taken place as part of a local process and where the patient wishes to meet with the doctor.

If there is support for this in principle, we will do further work to develop how this could work in practice.

Case study: Tom's leg had to be amputated when a wound became infected due to Dr Colchester's failure to comply with basic hygiene guidelines. He meets with Dr Colchester to explain how this has affected him and to ask questions to help him understand what went wrong.

Issue to consider: the benefits of meetings between doctors and patients where a doctor's actions have seriously harmed a patient.

20 **Do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed?**

☐ Yes ☐ No

Do you have any comments?

Undecided. In theory mediation may be helpful, but in the situation described this is likely to have occurred in a hospital setting; would it not be better for any meeting to have occurred at Trust level rather than being organised by the regulator?

The HCPC are currently trialling this and it might be worth waiting for the outcome of their pilot.

Section 5: Changes to our powers to give warnings

This section looks at when we give warnings to doctors to make sure we identify and address gaps in our ability to take action and take a proportionate approach. There are four questions at the end of this section.

The role of warnings

We give warnings to doctors who have made a significant departure from the principles set out in *Good medical practice* and supporting explanatory guidance, but the concerns are not so serious that their fitness to practise medicine in the future is impaired. A warning sends a message to the doctor and the wider medical profession that standards must be maintained and misconduct must not be repeated. It does not affect a doctor's right to work in the UK.

We introduced warnings when we reformed our fitness to practise processes in 2004. They replaced reprimands for doctors' past failings because the new approach recognised the principle that fitness to practise relates to a doctor's current ability to practise medicine safely. The original intention was that warnings would help to escalate repeat low level concerns that involve a significant departure from our guidance, but there is currently no formal mechanism for this.

Warnings can be given at two stages of the fitness to practise process.

- The end of an investigation: two senior GMC staff (called case examiners) can give a warning if the concerns are significant, but not sufficiently serious to call the doctor's fitness to practise into question.
- The end of a hearing: a panel can give a warning if it finds some or all of the allegations proved, but decides this does not amount to impairment.

Case study: Dr Bristol received a conviction for driving while under the influence of alcohol on her way home from the pub. A health assessment confirms that she does not have any issues with addiction. A case examiner decides this does not meet the threshold for impaired fitness to practise and issues a warning.

Why should we change the current model?

Warnings allow us to respond to concerns that involve a significant breach of our standards which do not meet the threshold for impairment. But we are aware of several concerns about them.

Proportionality

One of the key principles of good regulation is proportionality.* Doctors and their representatives have raised concerns that employers do not always treat information about a warning proportionately as the least serious of our actions. We publish warnings on the online medical register and disclose to all enquirers for five years. In addition, we disclose warnings to employers indefinitely. Sanctions in more serious cases where the doctor's fitness to practise is impaired (suspension, conditions and undertakings) are published and disclosed to all enquirers indefinitely.† We are aware that the reaction of employers and insurers to warnings can have serious consequences for the affected doctors. In view of this, it may be worth considering whether warnings in their current form are a proportionate action for dealing with less serious concerns that involve a significant departure from *Good medical practice*.

* The Better Regulation Executive has identified five principles of good regulation: proportionate, consistent, targeted, transparent and accountable.

† For more information see our publication and disclosure policy for fitness to practise information at: **www.gmc-uk.org/DC4380_Publication_and_disclosure_policy_36609763.pdf**.

If we decide to retain warnings as a mechanism for dealing with significant departures from our guidance that do not amount to impairment, it may be useful to review our approach to the publication and disclosure of warnings. There have been some concerns about the length of time for which we currently publish and disclose warnings. We are interested in your views about how long we should publish and disclose warnings in the future.

It may also be useful to consider whether warnings could be used to escalate repeated departures from *Good medical practice*. This would enable faster, targeted action to protect patients where a pattern of low level concerns raises more serious issues. It would also help us to communicate that doctors must make sure they do not repeat behaviour that led to a warning.

Case study: In 2012, Dr Exeter examined a patient who had been diagnosed with an irregular heartbeat and had spent six days in an overseas hospital after she collapsed on holiday. Dr Exeter failed to refer the patient to a specialist on her return to the UK, and instead booked her for a blood test the following week. Before the patient was able to have the blood test, she collapsed at home and needed urgent treatment.

There was no evidence of a pattern of concerns and Dr Exeter exhibited insight into his failings in relation to that patient. The GMC decision makers decided that this was a significant departure from our guidance that did not amount to impairment and gave Dr Exeter a warning, which said that he should take greater care in assessing the risks associated with certain conditions and make sure he followed local referral procedures. His medical director has since referred Dr Exeter to the GMC again for failing to refer three patients to specialists in accordance with local referral procedures in the last three months.

Action to deal with misconduct

Warnings can only be issued in response to concerns that do not call into question the doctor's fitness to practise. However MPTS panels have suggested that that it would be useful for them to be able to respond to misconduct where they decide the doctor's fitness to practise is impaired but more serious action seems disproportionate. In such cases, the lack of an appropriate alternative means the case can end with a finding of impairment but no action. Panels have suggested that a warning or a similar response would be useful to indicate unacceptable behaviour.

If we make this change, one option would be to stop giving warnings in cases where there is no finding of impairment. However this would mean that low level concerns that involve a significant departure from *Good medical practice* would result in no action and that could have an impact on the confidence of patients and reputation of the profession.

Another option would be to retain warnings to deal with unacceptable behaviour in cases with no impairment, while introducing new powers to give warnings in cases with impairment. It would be necessary to review the terms used to describe these two types of warnings to make sure they were seen to be different. This would have the advantage of providing a more precise system to separate behaviour above and below the threshold of impaired fitness to practise.

Any change to the threshold for issuing warnings will require legislative change supported by public consultation.

Case study: Dr Derby is convicted of causing death by careless driving. Her driving licence is suspended for 18 months and she is given a community order. This is an isolated incident and she has demonstrated significant insight through her voluntary work with a local road safety charity. Following legislative change, a panel would have the option to find the doctor's fitness to practise impaired and issue a warning.

Issue to consider: how effective and proportionate is our current warnings system, when should we be able to issue warnings, and should more serious action be taken where there are repeat low level concerns that involve a serious departure from *Good medical practice*?

21 Do you think warnings are an effective and proportionate means of dealing with low level concerns which involve a significant departure from *Good medical practice*?

☑ Yes ☐ No

Do you have any comments?

However, warnings currently appear to be imposed for a range of issues and are the same length irrespective of the circumstances. It may be worthwhile examining if different gradients of warnings would be appropriate.

22 When do you think we should be able to give warnings?

- ☐ **a** Not in any circumstances.
- ☑ **b** Only to deal with low level concerns that involve a significant departure from *Good medical practice* where a doctor's fitness to practise is not impaired.
- ☐ **c** Only to deal with misconduct where a doctor's fitness to practise has been found impaired.
- ☐ **d** To deal with low level concerns and misconduct (see b and c) if different terms are used to describe them.

Do you have any comments?

23 **If we continue to give warnings, do you agree that more serious action should be taken where there are repeat low level concerns that involve a significant departure from *Good medical practice*?**

☑ Yes ☐ No

Do you have any comments?

This would be a proportionate response to repeat concerns.

24 **How long do you think we should publish and disclose warnings issued in cases where the doctor's fitness to practise is not impaired?**

☐ **a** Publish warnings for **five years** and disclose to employers and responsible officers indefinitely.

☐ **b** Publish warnings for **one year** and disclose to employers and responsible officers for five years.

☑ **c** Issue guidance to case examiners and MPTS panels on determining length of publication on a case by case basis up to a maximum of five years. Indefinite disclosure to employers and responsible officers.

Do you have any comments?

Warnings currently appear to be imposed for a range of issues and are the same length irrespective of the circumstances. A more flexible system which enables panels to impose warnings of different lengths could be helpful.

Next steps

We will publish a report on the outcome of this consultation next year. The findings will be used to inform a new version of the indicative sanctions guidance and the future role of apologies and warnings in our procedures. We will also update our guidance for decision makers in line with these principles. Changes to legislation may be required to take some proposals forward.

About you

Finally, we'd appreciate it if you could give some information about yourself to help us analyse the consultation responses.

Your details

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Would you like to be contacted about our future consultations?

- [x] Yes
- [ ] No

If you would like to know about upcoming GMC consultations, please let us know which of the areas of the GMC's work interest you:

- [x] Education
- [x] Standards and ethics
- [x] Fitness to practise
- [x] Registration
- [x] Licensing and revalidation

Data protection

The information you supply will be stored and processed by the GMC in accordance with the *Data Protection Act 1998* and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

Responding as an individual

Are you are responding as an individual?

☐ Yes ☑ No

If yes, please complete the following questions. **If not, please complete the 'responding as an organisation' section on page 55.**

Which of the following categories best describes you?

☐ Doctor
☐ Medical educator (teaching, delivering or administering)
☐ Medical student
☐ Member of the public
☐ Other healthcare professional
☐ Other (please give details) _____

Doctors

For the purposes of analysis, it would be helpful for us to know a bit more about the doctors who respond to the consultation. If you are responding as an individual doctor, could you please tick the box below which most closely reflects your role?

☐ General practitioner
☐ Consultant
☐ Other hospital doctor
☐ Trainee doctor
☐ Medical director
☐ Other medical manager
☐ Staff and associate grade (SAS) doctor
☐ Sessional or locum doctor
☐ Medical student
☐ Other (please give details)_____

If you are a doctor, do you work ☐ Full-time ☐ Part-time

What is your country of residence?

☐ England ☐ Northern Ireland ☐ Scotland ☐ Wales

☐ Other – European Economic Area

☐ Other – rest of the world (please say where) _____

To help ensure that our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

What is your age?

☐ Under 25 ☐ 25–34 ☐ 35–44 ☐ 45–54 ☐ 55–64 ☐ 65 or over

Are you:

☐ Female ☐ Male

Would you describe yourself as having a disability?

☐ Yes ☐ No ☐ Prefer not to say

The *Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

What is your ethnic group? (Please tick one)

White

☐ English, Welsh, Scottish, Northern Irish or British

☐ Irish ☐ Gypsy or Irish traveller

☐ Any other white background, please specify _____

Mixed or multiple ethnic groups

☐ White and black Caribbean ☐ White and black African ☐ White and Asian

☐ Any other mixed or multiple ethnic background, please specify _____

Asian or Asian British

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Any other Asian background, please specify _____

Black, African, Caribbean or black British

☐ Caribbean ☐ African

☐ Any other black, African or Caribbean background, please specify_____

Other ethnic group

☐ Arab

☐ Any other ethnic group, please specify _____

Responding as an organisation

Are you responding on behalf of an organisation?

- [x] Yes
- [ ] No

If yes, please complete the following questions. **If not, please complete the 'responding as an individual' section on page 52.**

Which of the following categories best describes your organisation?

- [x] Body representing doctors
- [ ] Body representing patients or public
- [ ] Government department
- [ ] Independent healthcare provider
- [ ] Medical school (undergraduate)
- [ ] Postgraduate medical institution
- [ ] NHS/HSC organisation
- [ ] Regulatory body
- [ ] Other (please give details) _____

In which country is your organisation based?

- [x] UK wide
- [ ] England
- [ ] Scotland
- [ ] Northern Ireland
- [ ] Wales
- [ ] Other (European Economic Area)
- [ ] Other (rest of the world)

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