

Response to GMC consultation on consensual disposal

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1) We believe the agreement of undertakings with a doctor in cases involving poor performance, where retraining and rehabilitation is likely to be effective, is more proportionate than referring them to a Fitness to Practise panel. Do you agree?

We agree that where undertakings that protect the public while permitting the doctor to re-train or be rehabilitated can be agreed and are subsequently adhered to, this is likely to be a more effective and proportionate outcome than referring the matter to a Fitness to Practise panel in circumstances where the likely outcome of such a referral would be the imposition of similar undertakings or conditions.

2) Do you think the extension of our use of consensual disposal in cases where a doctor's clinical treatment falls below the expected standard will impact disproportionately on any particular groups?

It does not seem likely that this will impact disproportionately on any particular ethnic or minority group. It does however appear possible that any doctors who are not legally represented at an early stage of the investigation process may not fully appreciate the significance of agreeing to undertakings and might at a later date seek to challenge the basis on which the undertakings were agreed; or alternatively may not appreciate the advantages to all parties in agreeing undertakings at an early stage.

3) We believe that undertakings, particularly involving requirements relating to remediation or retraining, are likely to be more effective in performance than misconduct cases. Do you agree?

We agree that misconduct cases are less likely to involve circumstances where remediation or retraining is likely to be beneficial (save perhaps for cases where the issues arose out of poor communication skills, which may be capable of remediation) and that therefore undertakings relating to remediation or retraining are more likely to be an appropriate outcome in performance cases than in conduct cases.

Such undertakings are however unlikely to be effective where the performance issue that requires remediation/retraining has become entrenched over a number of years, and/or where previous attempts at remediation or retraining have failed. We assume that the criteria used by the GMC to identify performance cases that are suitable for disposal by use of undertakings would lead to the exclusion of cases where such factors arise.

4) What are your views on the advantages and disadvantages of an emphasis on retraining and rehabilitation when dealing with poor performance in doctors?

Logically it appears likely that doctors may be more willing to report issues relating to colleagues if the likely outcome in individual cases is focused on remediation or retraining, rather than on sanctions that might be perceived as punishment. If that proves to be the case, then emphasising retraining and rehabilitation will have contributed to ensuring public protection, as ultimately a larger number of concerns will be reported to the regulator.

However, that would be insufficient justification for emphasising remediation and rehabilitation if outcomes that are focused on remediation/rehabilitation did not also ensure public protection in individual cases, e.g. if undertakings to retrain were frequently breached by doctors. It is important that there is no confusion on the part of patients and the public (as well as the profession) about the regulator's primary role, which is to ensure public protection - otherwise this could damage public confidence in the regulator, and in self-regulation of the medical profession.

5) We believe that undertakings published on the GMC register and which remain on a doctor's entry on the List of Registered Medical Practitioner's for life are effective in sending a clear message to doctors about acceptable standards and behaviour

We agree that the publication of such undertakings for life will clearly act as a significant deterrent to any individual doctor who has agreed to provide such an undertaking. Whether or not the publication of undertakings will deter other doctors from conduct that might lead to their fitness to practise being called into question is likely to depend on the extent to which they are aware of the frequency of the provision of undertakings, and the circumstances in which other doctors have provided such undertakings.

For example, if it is the case that the GMC publicise in their printed publications examples of cases that have led to the provision of undertakings, or that such examples are used as part of medical training, then it appears likely that there may be a real deterrent effect on doctors generally. If however doctors are generally unaware of the types of cases that might lead to the provision of undertakings, any deterrent effect may be significantly less effective.

6) We believe that there is a category of doctors whose shortcomings are so profound that removal from the register is the only appropriate action. Do you have any comment to make on this approach?

We agree with this approach. Cases that have been appealed to the High Court support the proposition that there are some instances in which erasure from the regulator's register is the only appropriate outcome, in order to ensure either public protection, maintenance of appropriate professional standards and/or public confidence in the medical profession.

7) Our objective in seeking to extend our use of consensual disposal is to encourage a more mature responsible approach in doctors to recognise their failings and take appropriate action. Do you think this is the right approach?

We agree that doctors should be encouraged to prioritise public protection, and to report concerns about colleagues and to demonstrate insight into their own failings (where appropriate) and take remedial action as soon as possible. It is however not clear why the GMC considers that extending the use of undertakings will encourage doctors to recognise their own failings unless the GMC believes that doctors will view an outcome of agreed undertakings as part of some sort of plea-bargaining exercise whereby the individual doctor ends up with a less serious outcome in recognition of an early acknowledgement of their guilt.

It is of course the case that a complainant or the public generally might equally consider that the doctor has ended up with a less serious outcome as a result of an early plea and might consider that to be inappropriate. The GMC will only be able to assess the success of extending its use of undertakings once it has data indicating levels of compliance/non-compliance with undertakings. If doctors frequently do not comply with undertakings that have been provided, or seek to challenge the basis on which the undertakings were agreed at a later date, the GMC may wish to review the circumstances in which undertakings can be agreed.

If on the other hand the long-term data demonstrates that undertakings are routinely complied with, the GMC will be able to show that extending their use has enabled it to target its resources effectively, reserving the lengthy and expensive Fitness to Practise Committee hearings process for those most serious cases, where erasure is the likely outcome.

8) Do you agree we should extend our use of consensual disposal as described in the consultation paper? Do you have any other comment to make on this proposal?

We suggest that the GMC puts in place systems to allow it to monitor the types of cases where consensual disposal is used, and the nature of the undertakings agreed, so that meaningful comparisons can be made between cases which are disposed of at the investigation stage by means of undertakings and cases which proceed to Fitness to Practise hearings. This will enable the GMC to ensure consistency of treatment across the caseload, and avoid a situation where cases being closed with undertakings at the investigation stage are divergent either from each other, or from cases that proceed to a Fitness to Practise hearing. It will also provide information for dissemination to the profession, in order to assist in the objective of encouraging doctors to admit their failings at an early stage.

9) Revised guidance on undertakings is attached to this consultation. Do you agree with the approach taken in the guidance? How could it be improved? Do you have any other suggestions to make regarding the guidance?

We would suggest that the guidance should incorporate reference to the agreements to be signed by doctors admitting the facts alleged and the resulting impairment of their fitness to practise, and what actions the decision makers should take in the event that the doctor is not willing to sign such an agreement. We also suggest that the guidance should make clear the extent to which the complainant is consulted prior to undertakings being agreed with the doctor and the extent to which the complainant's views as to the suitability of the case for disposal by undertakings is taken into account by the decision-makers.

While the GMC is not a complaints-handling body, nevertheless maintenance of public confidence in its regulation of doctors is important, and might be damaged if complainants consider that the GMC is agreeing to informal disposal of cases behind the complainant's back. This could be seen as the GMC closing ranks with the profession. We consider that paragraph 14(c) should include specific reference to a scenario where after undertakings have been agreed, the GMC receives information that indicates either that the facts alleged against the doctor are more serious than previously thought, or that there are additional factual circumstances of a similar nature which were previously unknown (this presumably is currently covered within the term ...or otherwise casting a fresh light on the case, but we consider it could usefully be made more specific).

Our view in relation to paragraph 27 is that if the matter is so serious that effectively suspending the doctor from all medical practice is the only appropriate outcome, it would be more appropriate for the case to be dealt with by the Fitness to Practise Committee and if appropriate, a suspension imposed, rather than the agreement of an undertaking that effectively achieves the same end but without there being a hearing where the relevant evidence can be tested. We consider that this applies equally to health as well as non-health cases. We consider that unrepresented registrants who are suffering from ill-health may be more vulnerable than other registrants, and therefore more willing to agree to an undertaking of this type in circumstances where, if the matter were considered by the Fitness to Practise Committee, the outcome might be different.

We suggest that it might assist the decision makers and aid in transparency generally if the criteria for agreeing undertakings were aligned with/differentiated from the factors that are taken into account by the Fitness to Practise Committee in imposing either undertakings or conditions at a hearing.

10) We are proposing to retain the rule that provides that decision makers at the investigation stage shall not invite the doctor to agree undertakings, when there is a realistic prospect that the doctor would be erased, if the allegations were referred

We do agree with that approach. If the allegations are so serious that erasure is a realistic prospect, it is in the public interest for the matter to be dealt with in a public hearing where the evidence can be appropriately tested.

11) Do you agree that we should extend our use of Voluntary Erasure as described in the consultation paper? If not please explain why.

The paper highlights the risks of permitting voluntary erasure, the most serious of which is ensuring that should the doctor at some future date seek restoration, the fitness to practise matters that were outstanding at the date of their voluntary erasure are appropriately taken into account. We agree that where doctors sign formal agreements making admissions as to the facts and the resulting impairment of their fitness to practise, that should provide sufficient assurance that the matters can be appropriately taken into account at a later date on any application for restoration.

We presume that the GMC is satisfied that its system for flagging individual doctors' records is sufficiently robust to guarantee that such a former registrant would not be restored without proper account being taken of the fitness to practise matters that were under investigation as at the date of their voluntary erasure. The paper does not explain the nature of the guidelines that the GMC proposes to introduce in relation to cases in which the doctor is not prepared to sign an agreement containing admissions as to the facts and impairment of their fitness to practise, prior to voluntary erasure. We assume that these guidelines will be to the effect that doctors would only be permitted to voluntarily retire from the register without having signed such an agreement in less serious cases where the outcome is unlikely to be erasure from the register/suspension/the imposition of conditions.

We consider that in circumstances where such agreements are not entered into by the doctor prior to voluntary erasure, there may be significant difficulties should the doctor at a later date seek restoration to the register. Unless the investigation into the allegations is completed at the time, it is likely that it will be far more difficult to complete the investigation at a later date, should the doctor apply for restoration to the register. Witnesses' memories of the events will be much less reliable at some later date (or indeed the witnesses may be untraceable); equally, relevant documents may have been destroyed in the interim. Even if the investigation is completed at the time of the voluntary erasure, should there need to be a formal hearing in the future when the doctor applies for restoration to the register there may still be difficulties, as the former registrant or any witnesses may struggle to recall the facts several years after the relevant events occurred.

We do however appreciate that, realistically, should a doctor voluntarily remove themselves from the register, in future the requirements they will need to meet in order to demonstrate that they are eligible for a license to practise will effectively mean that applications for restoration to the register would have to be made within a relatively short time frame after their erasure. While we appreciate the advantages of permitting voluntary erasure from both the regulator's and the registrant's perspective, it is less clear that the immediacy of the outcome presents a real benefit in terms of public protection "presumably any case in which erasure from the register was the likely outcome would not be one in which voluntary erasure would be permitted, unless the

doctor signed a formal agreement making appropriate admissions as to the facts and impairment of fitness to practise.

It is therefore not the case that voluntary erasure would effectively be removing a doctor who presented a risk to the public more quickly than would otherwise be the case (indeed the GMC would undoubtedly impose an interim order on such a doctor, removing them from practice immediately). We are unable to comment on whether it would be appropriate for the GMC to permit voluntary erasure in circumstances where the doctor concerned has not signed formal agreements admitting the relevant facts and allegations, without understanding the types of cases that the GMC considers might be appropriate for voluntary erasure in these circumstances, and the factors that the GMC intends to incorporate into the guidelines to be produced.

12) Do you have any other comments to make on this proposal?

None

13) Do you think extending our use of Voluntary Erasure as described in this consultation paper will impact disproportionately on any particular groups?

We have not identified any groups that we think will be disproportionately impacted by the proposal.