

## Consultation Response

# GMC Sanctions Review



November 2014

## **MPS's response to the GMC's '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 Comments**

MPS welcomes the opportunity to comment on these changes to the indicative sanctions guidance. We are concerned that the proposals generally appear to dilute the discretion of Panels to use their experience and judgement on a case by case basis. Some of the proposals represent a creeping extension of the role and function of GMC into areas which are outside the GMC's self-stated purpose. They place further impositions on the personal and professional lives of doctors in a way that we believe unnecessary to provide effective oversight of the medical profession. The proposals are also supported by cases studies which are potentially misleading and could undermine the consultation process itself.

We outline our general concerns below and then provide specific answers to the questions in the consultation after that.

#### **Role of the GMC**

The GMC states that its role, and that of its sanctions, is to protect the public and to uphold public confidence in the professional but not to punish or discipline doctors. Some of the proposals would extend the GMC's actions beyond these purposes and create sanctions which are punitive. For example, the suggestion that a sanction could be part of 'sending a message to the medical profession that standards must be upheld' (question 16) is a disproportionate action from a healthcare regulatory body. There is no lack of understanding amongst healthcare professionals as to the importance of professional standards and such a sanction therefore becomes just a punishment. We think treating a single doctor more severely to produce a deterrent effect does not serve a useful regulatory function.

The GMC is also going beyond its remit by proposing that it could oblige doctors to apologise to patients. This neither serves to enhance patient safety nor necessarily confidence in the profession. A forced apology is usually easily discerned, would be of no meaning, benefit no one and undermine apologies given by doctors that are genuine.

## **Discretion of Panels**

The aim of the sanctions guidance is to 'promote consistency and transparency in decision-making' but it is not to 'be regarded as laying down a rigid tariff' (para. 9 of the current guidance). As a principle, Panels of the Medical Practitioners Tribunals Service should take all the evidence into account in their decision making, decide how much weight to give the various factors and make an appropriate decision based on their judgement and experience.

The proposed guidance generally appears to limit the discretion of Panels and attempts to direct Panels to reach certain decisions in certain types of case. This is inappropriate and will lead to decisions that are unfair and disproportionate. This is likely to lead to an increase in challenges to decisions. The guidance should seek only to set down general principles for the Panels which will then consider each case on its individual facts and merits.

## **Consultation questions and case studies**

The use of case studies in the consultation is poor. Those used often fail to illustrate the point the GMC is trying to make in relation to the proposals. Relevant details that would make the case useful are missing and there is no commentary on the case. The cases are also often misleading and use emotive scenarios which are unlikely to invite a considered answer.

Useful case studies would seek to establish the types of cases to which the proposals relate. They would include an explanation as to how the case could be analysed, what the key factors a Panel would already consider are and how the proposals may affect those considerations.

The discussion and consultation proposals also often fail to draw out issues that need to be considered. In particular question 13 is very poorly constructed and will lead to confused responses.

We are concerned that these issues will undermine the usefulness of the consultation and the validity of any conclusions based upon it.

# Questions

## Section 1: Changes to our sanctions guidance

### 1. Not being influenced by personal consequences of sanctions on doctors

No, we do not agree with this proposal. In the interest of fairness, Panels should consider the personal consequences on the doctor and weigh these alongside other considerations as they see appropriate in order to reach decisions proportionate to the case.

One of the key aims of the sanctions guidance is help ensure that Panels make judgements that are fair and consistent. In deciding what action it may be appropriate to take it would only be fair if a Panel was permitted to consider and weigh up all the factors of the specific case based on its experience and judgment. It would be within the Panel's discretion to determine how much weight to give each factor depending on the circumstances of the case. It would be unreasonable and unfair to give guidance to stop them taking this holistic approach.

The case study provided to illustrate this question is poor, overly simplistic and potentially misleading. The example involves a clear criminal act where no reasonable panel would be overly influenced by the doctor's personal circumstances. It therefore does not illustrate the point under consideration in a meaningful way and may lead the reader to agree the principle based on an extreme case. In reality there are a range of scenarios which Panels will have to consider. Fairness requires that the Panel is given full discretion to impose a sanction that is appropriate and proportionate to the specific circumstances of each case.

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

No, we do not agree with this proposal. Action should only be taken when it is required to protect the public or public confidence in the profession. There should not be a presumption that a Panel will take action. They should be free to consider the risk of the failure being repeated or any other mitigating factors.

Should this proposal be taken forward, there should be no further definition for 'exceptional circumstances.' A professional Panel will understand what is meant by "exceptional". Any attempt to refine or re-define this would result in additional confusion and potential litigation to determine what these new definitions mean in the context of a given case. The current guidance states that cases in which exceptional circumstances may exist are likely to be "very rare" and we think this offers sufficient guidance.

Again the case study used is poor and potentially misleading. It involves a clear criminal offence, uses the emotive example of sick children and therefore leads the reader to agree with the proposition. In reality there are a variety of situations of a different nature and seriousness that Panel will consider.

### **3. Maintaining public confidence even when a doctor has remediated**

No, we do not agree with this proposal. There will be a few serious cases in which it would be appropriate to take action to maintain public confidence in the profession even when a doctor has remediated. However, these cases should be rare and there should be exceptional circumstances involved otherwise applying sanctions in this way would only be serving a punitive function.

Panels ought to be entrusted to consider the circumstances of the case, and exercise their own judgment to determine the extent to which the matters complained of are capable of being remediated and the extent to which they have been remediated.

The case study provided is unhelpful in illuminating the circumstances in which sanctions may be appropriate despite remediation. In the example, it is unclear that the use of the 'outdated' technique would not be supported by a responsible body of the doctor's peers. It would be unreasonable for a doctor to be punished for using a treatment supported by a responsible body of his peers.

Furthermore, a Panel cannot be sure the infection was contracted as a result of the specific surgery carried out rather than the simple fact they had undergone surgery. This case study reinforces the importance of allowing Panels to consider and weigh up all the factors of the case using their judgement and experience.

### **4. Taking more serious action in specific cases**

No, we do not agree with this proposal. The consultation does not explain why a failure to raise a concern should be treated more seriously by a Panel and this proposal would lower the threshold for applying serious sanctions in certain circumstances, both of which are inappropriate.

It is appropriate that suspension or removal from the register is a possible sanction in some cases and a Panel would have the discretion to apply these for particularly serious cases. However, a Panel should do so only upon a proper consideration of all the facts of the case. To direct Panels to extend serious sanctions across all these circumstances could be disproportionate. The Panel ought to be entrusted to assess the gravity of the individual matters found proved without being directed to reach a specific decisions in certain types of case.

GMC guidance should take into account the realities of practice and recognise the challenges doctors face. Doctors already have major challenges with unrealistic workloads, huge educational requirements, and pressures on their private lives. In the vast majority of cases doctors are working

hard in the interests of their patients and will raise concerns despite serious conflicting pressures. It would be unreasonable for a doctor's well intentioned actions in raising concerns to be criticised in retrospect or to attract serious sanctions when they behaved in a way they thought appropriate at the time.

Increasing the likelihood of serious sanctions, where concerns were not raised as they might have been in an ideal situation, will not help the overall objective of improving an open learning and reporting culture. Issues of raising concerns are complex and often a real challenge for doctors is the fear of recrimination. Greater use of serious sanctions will add to this sense of fear and help encourage a bureaucratic, top-down, compliance-driven, blame culture and will undermine a culture of transparency and learning.

### **5. Failure to work collaboratively with colleagues**

No, we do not agree with this proposal. There is no need to change the guidance. A Panel can already impose serious sanctions where bullying, sexual harassment or violence or risk to patient safety is involved, and can continue to do so. However, there is no justification for extending more serious sanctions to all issues where there is a 'failure to work collaboratively.' Such issues that do not include bullying, sexual harassment or violence or risk to patient safety are likely to be more effectively resolved through employer's mechanisms. Better education, training, and leadership would address issues of collaborative working more effectively than sanctions from the GMC.

Again the case study used is poor and misleading. The issue with Mr London's performance is that he refused to see a patient which potentially led to harm to a patient rather than a straightforward failing to work collaboratively. The case study fails to provide a useful scenario in which a failure to work collaboratively that did not involve bullying, sexual harassment or violence or risk to patient safety should face serious sanction.

### **6. Abuse of professional position**

Yes, we agree with this proposal but with some reservations. We think it important that Panels always consider the facts of the case and acknowledge that it is sometimes possible for relationships based on genuine love and affection to arise between a doctor and patient. It would be unreasonable and unfair to both doctor and patient to suggest that there was a complete ban on such relationships in all circumstances.

### **7. Discrimination against patients, colleagues and other people**

No, we do not agree with this proposal. We entirely agree with the principle that a doctor must not discriminate against patients and colleagues but it is not clear why an extension to the use of serious

sanctions is needed. It is not clear that doing so would have any particular effect or deter discriminatory behaviour. Panels should consider any case on its facts and weigh up the seriousness of the doctors behaviour in determining the appropriate sanction.

The choice of case study here is again unhelpful in explaining why sanctions should be extended.

### **8. Doctors' lives outside medicine**

No, we do not agree with this proposal. We accept that some of the behaviours listed should lead a Panel to consider more serious sanctions but think that a Panel should have the discretion to consider each case based on its own facts and a consideration of the seriousness of the behaviour.

The inclusion of 'any other behaviour that may undermine public confidence in doctors' is vague, offers no practical guidance at all and should not be included.

### **9. Drug and alcohol misuse linked to misconduct or criminal offences**

No, we do not agree with this proposal. The proposed change would confuse two separate grounds of impairment; health and misconduct. As these are two separate heads of impairment, it is appropriate for the Panel to consider which of the matters alleged amount to allegations of misconduct and which amount to an allegation of impairment on the grounds of adverse health. In doing so, the Panel will, as it currently does, be able to determine the level of any appropriate sanction.

In addition, 'misuse of alcohol or drugs that led to a criminal conviction particularly where a custodial sentence was imposed' could have predated working with patients or have no impact upon patient safety. This is not necessarily a factor indicating a need for greater sanctions and should not be included.

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

### **10. Do you think Panels should require a doctor to apologise where patients have been harmed?**

No. We strongly disagree that a Panel should be able to require a doctor to apologise. Forced apologies are meaningless and this is a very unhelpful proposal. The fact that a doctor does or does not choose to apologise can be considered with all the other factors in the case in making a decision. However, a forced apology has no meaning and would benefit no one, least of all the patient who would likely feel cheated of the opportunity for a genuine apology.

Almost all doctors will be happy to apologise where they feel they have made an error which has, or may have, harmed a patient. Forcing doctors to apologise is unhelpful and will only undermine apologies given by doctors which are genuinely intended.

Such a sanction would not enhance patient safety or confidence in the professional. Its effect could be interpreted as only punitive and therefore beyond the scope of appropriate sanctions available the GMC.

### **11. Deciding whether a doctor has insight**

No, we do not agree with this proposal. It is not clear why any change is necessary. Whether a doctor has gained insight is a necessarily subjective matter and Panels should be given the widest discretion to determine this on a case by case basis. A checklist of what does and does not amount to insight is simplistic and could result in unfairness.

There are many factors, including cultural factors, which could influence whether and in what manner a doctor expresses empathy or regret over his/her actions. The extent to which a doctor has insight is a matter which is appropriately left to the judgment and experience of the Panel, who will have had the benefit of hearing all of the evidence and importantly the manner in which it is given.

It would be unreasonable for a doctor, who may lack genuine insight but has nevertheless 'ticked all of the boxes', to be judged to have insight on that basis. Equally, it is unreasonable for an inference to be drawn that a doctor who has not ticked these boxes is likely to lack insight. Furthermore, it would be unjust for an inference to be drawn in these circumstances from a doctor who, in exercising his right to a fair trial, has not admitted allegations which are subsequently proved on the balance of probabilities.

The case study for this proposal is particularly unhelpful as it includes the doctor lying to a Panel. This is not a matter of insight at all but a much more serious issue of probity.

### **12. Stage of a doctor's UK medical career can affect insight**

No, we do not agree with this proposal. It is not clear why any change is necessary. Panels should consider all the facts of each case and give appropriate weight to issues. Any distinction between 'serious concerns' and others types of concern is not helpful. Cases will fall on a wide spectrum of severity and a cut-off point between the two would be arbitrary.

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

No. This question is very poorly worded and will lead to some confused responses to the consultation. The yes/no responses of respondents to the consultation must not be relied upon to indicate support or otherwise for this proposal.

There are two distinct questions as part of this proposal: whether or not it is appropriate for Panels to continue to accept testimonial witnesses as evidence; and, whether or not it is appropriate for the GMC to introduce verification checks in relation to those testimonials.

In relation to the first question, we think the Panels should continue to accept testimonial witnesses as evidence.

In relation to the second question, we do not think verification checks on testimonials are appropriate.

We do not think there should be a presumption by the GMC that testimonials provided by the defence might be dishonest or irrelevant to the factors in question. Where the GMC has reason to suspect that a testimonial has been obtained or relied upon dishonestly, then it could investigate this as a separate matter relating to the fitness to practise of the doctor concerned. Equally, Panels can consider the evidence presented and come to a reasoned decision about how much weight, if any, to give to that evidence. If there are doubts about the authenticity of testimonial evidence, or it is not directly relevant to the case, then Panels can attach less weight to it, or even disregard it altogether.

There will also be practical difficulties if doctors have to provide the GMC with testimonials before the hearing so that the GMC has sufficient time in which to carry out the verification checks. This will be especially difficult for Interim Orders Panels where there can be very little time to prepare for a hearing but there will still be problems for Fitness to Practice hearings. Testimonials for Fitness to Practice hearings are usually requested once the full extent of the GMC case is known i.e. after the notice of hearing has been served. It is not clear what would happen if the GMC is not been able to complete its verification checks. It would be unreasonable if doctors were not then able to rely on the testimonial or for its authenticity to be doubted because of this process.

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

No. The factors which have been set out are matters which are already considered by Panels when assessing the weight, if any, to attach to testimonials which have been provided by a doctor. We disagree with the suggestion under the new proposal that the mere fact that a potential witness has a personal friendship with the doctor would mean that he or she has a conflict of interest in providing the testimonial. The content of evidence should be considered and the Panel allowed to use its judgement to weigh this up alongside consideration of who provided it.

### **15. Feedback from responsible officers**

No, we do not agree with this proposal. We think it is reasonable to request a statement from a doctor's responsible officer but we think that in many cases it will be of limited value and in some cases will be unfair. Therefore, we think the proposal to routinely request such statements is unhelpful.

Many responsible officers will not have the relevant information to provide a useful statement and many will not know or have met every doctor they oversee. For example, the responsible officer for a GP who has had a complaint about manner and attitude may be based some distance away as part of the Local Area Team. It would be difficult for them to make a useful contribution. If the responsible officer has information of use or relevance, their evidence should be presented to a Panel but routinely requesting statements is unlikely to offer helpful information over and above that obtained during the GMC's investigation in most cases and will inevitably cause further delays.

There is also the possibility of bias where both doctor and responsible officer work in the same hospital trust. It is possible that the Responsible Officer is the individual who has referred a concern to the GMC and has had previous disagreements with the Registrant. It would be difficult to mitigate against this possibility on a routine basis.

## **Section 3: Changes to our guidance on suspension**

### **16. Deciding the length of suspension**

No, we do not agree with this proposal. Panels should consider each case on its facts and weigh the various issues involved including consideration of the seriousness of the doctor's behaviours. Some of this guidance adds nothing to the existing guidance for Panels. Some of it clearly goes beyond the appropriate scope of sanctions as defined by the GMC itself.

The GMC states its sanctions are to protect the public and to uphold public confidence in doctors but not punish or discipline doctors. The proposal that Panels should consider 'sending a message to the medical profession that standards must be upheld' does not fit with this stated purpose. It is unreasonable that a single doctor be treated more severely just to send a message to the profession.

The proposal that Panels may 'consider the time all parties may need to prepare for a review hearing if one is needed' is unreasonable. The time it takes to prepare for a hearing should have no bearing on the length of time a suspension is imposed for. This would be wholly unfair and disproportionate given the consequences of a suspension on a doctor's ability to earn a living and future career. This would result in suspension length being determined by a factor that has nothing to do with protecting the public or confidence in the profession and could result in longer suspensions for doctors because of administrative failings on behalf of the GMC. This is unacceptable.

### **17. Suspending doctors with health issues**

Yes, we agree with this proposal. However, we think that this adds nothing to the existing guidance (paras. 72 and 73). Also this guidance must not prevent Panels from listening and obtaining proper specialist medical advice.

### **18. How can doctors keep their clinical skills up to date while they are suspended?**

No, we do not agree with this proposal. We agree that a suspended doctor should not be allowed to treat patients even with supervision. However, we are concerned at the way the proposal is framed. The phrase: 'to play any part in interactions with patients,' needs clarification. If this means the doctor may only observe but not speak or touch the patient then this will have a chilling effect on some forms of remediation, such as communication skills, history taking, examination technique.

The opportunities for remediation for a suspended doctor are already limited by virtue of the fact that he or she is unable to perform any role that would require registration with the GMC. It cannot be in the public interest to further deprive a doctor who has the potential to remediate the opportunity to do so.

### **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. In the interest of fairness and proportionality interim order suspension should be taken into account when applying sanctions.

The GMC's guidance for Interim Order Panels and Fitness to Practise Panels on imposing interim orders requires Panels to consider the effect it may have on public confidence in the medical profession were a doctor be permitted to continue to hold unrestricted registration until his case has been heard by a Fitness to Practise Panel. It follows that regard to an interim order ought to be had in cases where a substantive order of suspension is being considered solely to uphold public confidence in doctors, as the doctor has already served a period of suspension for the same reasons.

## **Section 4: Giving patients a voice**

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

No, we do not agree the GMC should facilitate meetings between doctors and patients. We do think that such meetings can be useful in resolving issues or benefit the doctor or patient. However, by the time an issue reaches the GMC this sort of meeting would be unhelpful. In our experience, by the time an issue reaches the GMC positions are already entrenched and such meetings would be highly charged, potentially hostile and unlikely to be beneficial.

For such a meeting to achieve the purpose envisaged by the GMC, there would need to be the freedom for both patient and doctor to express themselves without fear of their words being used at a hearing before a FTP Panel. As both parties will be witnesses in any forthcoming hearing there is a real risk of evidence becoming contaminated, and prejudice creeping into the process. We would also be concerned that adverse inferences could be drawn from a doctor declining to participate.

This proposal also appears to be beyond the scope of the GMC's current statutory objectives. It would be more appropriate for these kinds of meetings to be facilitated by other organisations.

## **Section 5: Changes to our powers to give warnings**

### **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?**

Our experience here is mixed, and whether warnings are an effective and proportionate mechanism varies from case to case. This demonstrates that their effect is not consistent and that there is a problem with their overall use.

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

D - To deal with low level concerns and misconduct (see b and c) if different terms are used to describe them.

We think that it is useful to have two distinct types of action available to the GMC to replace the existing system of warnings:

- One type of warning for circumstances in which a doctor's fitness to practise is found impaired but where the current options of either more serious sanctions or no action are not appropriate. This would form a new sanction available to panels and they should be able to determine for how long such a warning is published and disclosed to employers. A maximum of five years should be set for publishing such warnings.
- A second type of warning should be for low level concerns that involve a significant departure from Good Medical Practice but where a doctor's fitness to practise is not impaired. It needs to

be recognised that any formal response from the GMC concerning behaviour will be viewed seriously by employers and the public and will in effect be considered a sanction. Therefore, in order to maintain the position that these types of warning are not sanctions they should be kept confidential between the GMC, the doctor and the doctors' responsible officer.

There would need to be different terms to refer to the different types of warning in order to clearly mark their different functions. Misconduct warnings could be referred to as 'warnings' whilst low level concern warnings could be referred to as 'advice'.

**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?**

No. We think that, in general, unless the concerns are related this should not lead to further action and each concern should be considered on its own merits. If the doctor has disregarded the terms of a previous warning in his subsequent conduct then it would be appropriate to consider more serious action than would otherwise have been the case.

Mechanisms at employer level would also be more appropriate to deal with these circumstances.

**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?**

We do not think any of the options is appropriate. As we discussed in the response to question 22, we think that a new type of warning needs to be created for cases where the doctor's fitness to practise is not impaired. This would not be a sanction and in recognition that any formal action by the GMC may be considered a sanction they should be kept confidential between GMC, the doctor and the doctors' responsible officer.

## About MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 290,000 members around the world. Our benefits include access to indemnity, expert advice and peace of mind. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association.

## CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

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