Nursing & Midwifery Council

GMC consultation: Reviewing how we deal with concerns about doctors

1 The GMC consultation can be found here – below are the answers that the NMC gave in response to the survey questions.

Section one: Changes to sanctions guidance

Question 1 (The influence of personal consequences on sanctions)

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.

Do you agree with this proposal? We agree in part

2 We agree with the general principle that panels should take appropriate action on a healthcare professional's registration without being unduly influenced by the personal consequences for that individual. However, we consider that instructing panels to take no account of the impact on a registrant's personal circumstances would be a step too far and vulnerable to legal challenge on the grounds that it was not a proportionate approach.

Question 2 (Taking action in all cases where a doctor's fitness to practise is impaired)

Proposed change: 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.

Do you agree with this proposal? We agree in part

3 We consider there will be very few occasions where it would be appropriate for a panel to take no action following a finding of impairment. Furthermore, even if exceptional circumstances were present, we still do not think that it would be ever be acceptable for no further action to be taken in situations where the healthcare professional is considered to pose an ongoing risk to the public. Bearing this in mind, if such guidance were to be introduced, it would be very useful to see specific examples of circumstances that could properly be considered exceptional.

Question 3 (Maintaining public confidence even when a doctor has remediated)

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.

Do you agree with this proposal? We agree

4 We agree with this proposal and consider that it would accurately reflect the existing case law on this issue, especially the point covered at paragraph 74 of *CHRE v Grant [2011] EWHC 927.*

Question 4 (Taking more serious action in specific cases)

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.

Do you agree with this proposal? We agree

5 We consider that a healthcare professional's failure to raise concerns can amount to an aggravating factor and that it will sometimes be appropriate to remove or suspend in such cases.

Question 5 (Failure to work collaboratively with colleagues)

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.

Do you agree with this proposal? We agree

6 We agree with the general principle behind this proposal, although we would suggest that cases involving sexual harassment, violence and / or patient safety issues will normally go well beyond a mere failure to work collaboratively and indicate serious fitness to practise issues.

Question 6 (Abuse of professional position)

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.

Do you agree with this proposal? We agree

7 We are of the view that given that there is an inherent power imbalance within the doctor/patient relationship, panels considering cases where a doctor has abused their professional position and pursued a patient in a predatory manner should be encouraged to consider the full range of available sanctions. We would stop short of suggesting that there should be a presumption of removal in such cases as we recognise that each case is necessarily fact-sensitive.

Question 7 (Discrimination against patients, colleagues and other people)

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.

Do you agree with this proposal? We agree

8 We consider that discrimination can amount to an aggravating factor and that it will sometimes be appropriate to remove or suspend in such cases. We are of the view that the level of harm suffered by the subject of the discrimination and the damage to the reputation of the profession are important factors in such cases.

Question 8 (Doctors' lives outside medicine)

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**
- **misuse of alcohol or drugs leading to a criminal conviction or caution**
- **unfair discrimination related to characteristics protected by law**
- **any other behaviour that may undermine public confidence in doctors including issues resulting in criminal or civil proceedings**

(list is not exhaustive)

Do you agree with this proposal? We agree

9 We agree that panels should take into account the factors listed (above) when deciding on the most appropriate sanction. We consider that public confidence could be undermined if such behaviour did not result in panels taking some form of action against a doctor.

Question 9 (Drug and alcohol misuse linked to misconduct or criminal offences)

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:

- **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.**

Do you agree with this proposal? We agree in part

10 We agree that the factors listed above should lead panels to take serious action on a healthcare professional's registration, but consider that the key issue is the potential risk of patient harm and a healthcare professional's ability to perform their duties safely and effectively. Panels should also be guided to consider other factors such as the type, nature and frequency of the drug or alcohol misuse and the potential impact on public confidence and the reputation of the profession.

Section two: The role of apology and insight

Question 10 (The role of apology in fitness to practise procedures)

Do you think panels should require a doctor to apologise where patients have been harmed? We do not agree

11 We recognise the importance of apologies from doctors and other healthcare professionals being given at the time when things go wrong in a clinical setting. However, we do not think that imposing a formal requirement for apologies within the context of the fitness to practise process is the right way of dealing with this. We consider that such a step could actually have the potential to undermine confidence in the substance of any apology offered.

Question 11 (Deciding whether a doctor has insight)

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.**

Do you agree with this proposal? We agree

12 We agree with the above principles. Where a doctor takes steps to remediate and makes an early apology, panels should consider whether the doctor's subsequent actions are consistent with that apology. We have recently published guidance on insight, remediation and risk of reoccurrence.

Question 12 (Stage of doctor's UK medical career can affect insight)

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.

Do you agree with this proposal? We agree

13 We agree that in most cases a healthcare professional's experience and insight are relevant factors when panels are considering what action to take. We also agree that there will be occasions whereby the concerns are so serious that these factors will have less relevance. See our response to question 3.

Question 13 (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 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 a 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.

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

14 We agree that robust verification checks of testimonials are important. However, we recognise that there will be certain occasions whereby such checks are not feasible due to reasons of practicality. We consider that, ultimately, the question of

whether it has been possible to verify a testimonial is primarily linked to the amount of weight that a panel can attach to it and not to the general issue of admissibility.

Question 14 (Deciding whether testimonials are relevant)

Proposed change: to introduce guidance for panels of 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 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).**

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

15 In addition to the factors outlined above, we consider that testimonials from a responsible officer or other supervisor are likely to carry more weight than those from friends or colleagues. We consider that it should be clear that the author is aware of the full details of the allegations against the doctor, and of the doctor's acceptance of the charges. This is also covered in our guidance on remediation.

Question 15 (Feedback from responsible officers)

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.

Do you agree with this proposal? No comment

16 We have no comment to make on this proposal.

Section three: Changes to guidance on suspension

Question 16 (Deciding the length of suspension)

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**
- **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.

Do you agree with this proposal? We agree in part

17 We agree with the above principles. We have no further comment to make on this proposal other than to note that our current legislation requires us to conduct a review of every case where a suspension order is imposed.

Question 17 (Suspending doctors with health issues)

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.

Do you agree with this proposal? We agree

18 We agree with this proposal.

Question 18 (Doctors maintaining clinical skills while suspended)

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.

Do you agree with this proposal? No comment

19 We have no comment to make on this proposal at this stage. We think this proposal needs further consideration and development to ensure that patient safety and public confidence are maintained as even simply observing might not be appropriate in some instances.

Question 19 (The influence of previous interim orders)

Where a panel suspends a doctor solely to uphold public confidence in doctors, should any previous interim orders influence the panel's decision? We agree in part

20 We agree that previous interim orders may be relevant when deciding which sanction to impose, but this will depend on the nature of the case. We do consider that panels should be discouraged from giving disproportionate weight to the mere existence of a previous interim order, bearing in mind that the panel considering the interim order made no findings of fact and applied a different legal test.

Section four: Giving patients a voice

Question 20 (Meetings between doctors and patients)

Do you think there are benefits to doctors and patients meeting where a patient has been seriously harmed? We agree in part

21 We consider that there may well be benefits to meetings between patients and doctors being arranged at a local level in situations where the patient has been

seriously harmed by the actions of a doctor. However, we do not understand how such meetings would fit into the fitness to practise model.

Section five: Changes to our powers to give warnings

Question 21 (The role of warnings)

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?* Further information required

22 We can see the benefits of a system whereby a healthcare regulator is able to conclude a fitness to practise case at an early stage by issuing a notice to a registrant that they have significantly departed from the standards applicable to their profession, provided that there is no current impairment and no ongoing risk or any other need for regulatory involvement. We consider that there is a need for clear criteria in this area.

Question 22 (The role of warnings)

When to 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 **Answer d.** We consider that warnings could be appropriate to deal with both low level concerns where there is no current impairment and misconduct cases where no restriction on practice is required for public protection, provided different terms are used to describe them. We consider that this would provide sufficient flexibility

to ensure that all decision-makers are able to adequately address fitness to practise issues at all stages of the process in a proportionate manner.

Question 23 (The role of warnings)

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?*

Do you have any comments? We agree

24 We agree with this proposal.

Question 24 (Publishing and disclosing warnings)

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?

25 The imposition of a warning suggests a low level concern with no ongoing fitness to practise risk. We consider that to publish this decision for a year and make it available to prospective employers and ROs for five years would fit in with the GMC's revalidation cycle and would be proportionate.

26 If "warnings" are to be used in different situation, after a finding of misconduct or impairment, then different timescales may be appropriate. It may also be necessary for the finding of misconduct/impairment to be published.

27 We also consider that the regulator should always be able to take a previous warning into account in considering a later allegation.