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Fitness to Practise
The General Medical Council (GMC)
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7 April 2011

Dear Ms Kilner

GMC Consultation: Reform of the Fitness to Practise procedures

I am grateful for the opportunity to respond to the GMC's consultation on the fitness to practise procedures. As Health Service Ombudsman for England I provide a service to the public by undertaking independent investigations into complaints of injustice or hardship resulting from maladministration or poor service by the National Health Service. The principles we have developed around good administration and complaint handling may be usefully applied in the context of this consultation.

We understand that the purpose of this reform is to develop a more proportionate way of protecting patients than the current approach of sending the majority of cases to a public hearing (and incurring the associated delays, costs and stress to both parties in doing so).

The paper sets out a number of proposals which seek to sharpen the focus on delivering value for money whilst at the same time ensuring doctors are fit to practise and public confidence is maintained. We would agree that where there is no significant dispute about the facts, there may be an appropriate alternative means of dealing with the matter other than referring it to a public hearing. We adopt a similar principle in our casework: in the appropriate circumstances, we find that an intervention other than a full investigation can deliver a more timely and cost effective means of resolving the issue satisfactorily.

The paper proposes that in all cases, once the nature of the allegations is established and the evidence assessed, discussions would take place with the practitioner to ensure first of all that all the relevant evidence has been



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taken into account and secondly, to explain the GMC's reasoning behind the likely sanction and to secure acceptance of that. Whilst we note the emphasis on the fact that this will **not** be a negotiation, it will be critical that the status of these discussions is fully understood by all concerned, including the wider public generally.

This leads directly into the implications of such a change in approach. There is clearly a significant risk that this could be seen as a secretive means of reaching 'a done deal' so it will be of paramount importance to ensure that the principles governing this change ensure transparency, fairness and consistency. There will need to be clarity about where this discussion stage 'fits' in terms of the fitness to practise procedures and a clear set of procedural rules which will apply. Furthermore, some forethought will be required as to how to minimise the risk of spending time and effort in trying to secure the appropriate outcome *without* the need for a public hearing, but ending up with a hearing even so.

Some of the risks and implications arising from this change in approach are discussed in the paper and, where relevant, we would comment as follows:

- *Facilitation of meetings*: this seems a sensible proposal, although it would be essential to clarify any ground rules which may apply: for example, whether this discussion is optional; whether, in view of the costs, facilitation will be reserved for particular cases/circumstances; whether there will be a record of the meeting (regardless of outcome) and if so, should that be an agreed - and public - record; and whether the doctor has the right to be represented.
- *Communicating the outcome to complainants*: we would agree that it is essential for complainants to be kept informed about the purpose of the meeting beforehand and of the subsequent outcome. We accept that the fitness to practise procedures are not aimed at resolving a complainant's concerns: nevertheless, as they are not present during these discussions, this could fuel suspicion about secret negotiations going on with little accountability for reaching a fair and consistent outcome. It will be important, therefore, to build in ways of reassuring complainants at the very least that their concerns - and the impact of these - have been fully understood in considering any proposed sanction.
- *Maintaining public confidence*: as outlined above, we agree that measures will need to be put in place to counter the perception that negotiated agreements are being reached behind closed doors. The proposal to publish details of the sanction, together with a description of the allegations and the evidence reviewed would, in our view, aid the transparency of the process. Similarly, implementing an independent audit of the decision-making in these cases (presumably also made public) will help to monitor consistency and fairness across the board.

- *Using the term ‘erased by mutual agreement’ rather than ‘voluntary erasure’*: this change is intended to signify that it is the GMC’s decision to remove the doctor’s registration and that this has been accepted. We think that ‘*by mutual agreement*’ still implies that agreement had to be reached and wondered whether the action might be more appropriately described by, for example, ‘the decision [to remove from the register] was accepted’.
- *Cases going to public hearings*: we agree that cases where the doctor does not accept the proposed sanction or where key evidence is disputed, will need to go to a hearing (although as previously mentioned, identifying this category as early as possible will avoid building in yet further delay in the process). We would also agree that even if a case can be resolved through initial discussion, this has to be balanced against the public interest test and there will be occasions where a public hearing is considered necessary even so. The profession needs to demonstrate its commitment to dealing robustly with cases of wider concern and disquiet in order to retain public confidence in the regulatory process.
- *Impact of criminal convictions*: the paper lists a number of serious criminal convictions which it regards as inherently incompatible with being a doctor and which would trigger a presumption of erasure (with the caveat of considering first any representations from the doctor involved). We would agree, although we were unsure of the rationale for including sexual assault but not violent non-sexual assault - and blackmail but not bribery and corruption, for example.
- *Refusal to cooperate*: similarly, the paper proposes automatic suspension from the register of any doctor who refuses to cooperate with the fitness to practise procedures (with the caveat of having to demonstrate that every attempt had been made to engage with that practitioner first). We would agree with this and would, in fact, like to see the GMC extend this principle to include any refusal to cooperate with the policy and/or practice of the NHS complaints system: if a doctor refuses to cooperate with an Ombudsman investigation (including a refusal to accept the Ombudsman’s findings or to comply with any recommendations), then in our view, this is equally unacceptable and should attract the same sanction. For the sake of clarity and transparency, we assume that this sanction will be made clear at the very start of the process.

I trust this is helpful. Do contact Sue Heaven on 0300-061-3964 (or by email to sue.heaven@ombudsman.org.uk) if we can offer any further assistance.

Yours sincerely

A handwritten signature in blue ink, appearing to be 'A.A.', written in a cursive style.

Ann Abraham
Parliamentary and Health Service Ombudsman